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Looking to the Future

Charting our Direction

In this Issue:

CSPE Canadian Society of Physician Executives
SCMG Société canadienne des médecins gestionnaires

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Opinion:

The condition of the Canadian health care system does not have to be discouraging

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Abstract

Society is reaching a turning point, where current mindsets and approaches no longer meet the challenges. The same can be said for our Canadian health care system. The older models of systems thinking and change no longer work in an overconnected world where systems become increasingly integrated with other systems.

Despite decades of investment to transform our health care system by policy reform, recent research[1,2] indicates that, "Without some sort of insurmountable disruptive force, either a major shift in medical science or technology, or a catastrophic economic or political crisis, fundamental health policy reform in Canada is unlikely."[2]

Since the 17th century, when health care started in Quebec, until today in the many health regions across Canada, we have focused mainly on hospital care and physician services. Despite Saskatchewan's introduction of medicare in 1962, the *Canada Health Act* becoming law in 1984, and the federal and provincial governments signing an agreement on the future of health care in 2004, all we have done is tinker with existing concepts without fundamentally changing the system. The largest obstructions are embedded in our political system at large and in the opposing interests of various stakeholders: physicians, nurses, unions, hospitals, and consumers alike.[1,2] As a result, we prefer the status quo over the uncertainty of any change, even if the outcome may be better.

No business can transform without knowing what its goals or objectives are, and only after defining the *what*, can it determine the *how*. Because we have not been able to define what it is we want from our health care system in the last four or five decades, it is no surprise that we do not know how to deliver it. If we have no clear goals and defined outcomes, then how can we expect policy reform leading to transformation?

Have we been limited in our approach to health care transformation by applying outdated mental models of change and systems thinking? What if we think about systems using an advanced change model, a model that is more appropriate for the times? What would that mean to you and me, as physicians, as consumers, or as patients? As members of the Canadian Society of Physician Executives (CSPE)? Some of these questions are addressed here, some are intended to invite a collaborative dialogue and a solution.

When Saskatchewan introduced medicare, the framework that worked best was the **technical** change model. This type of framework is used when the problem is relatively clearly defined, the solutions are well known, the needed skill set can be learned, and the goal is to fix the problem so as to maintain the system

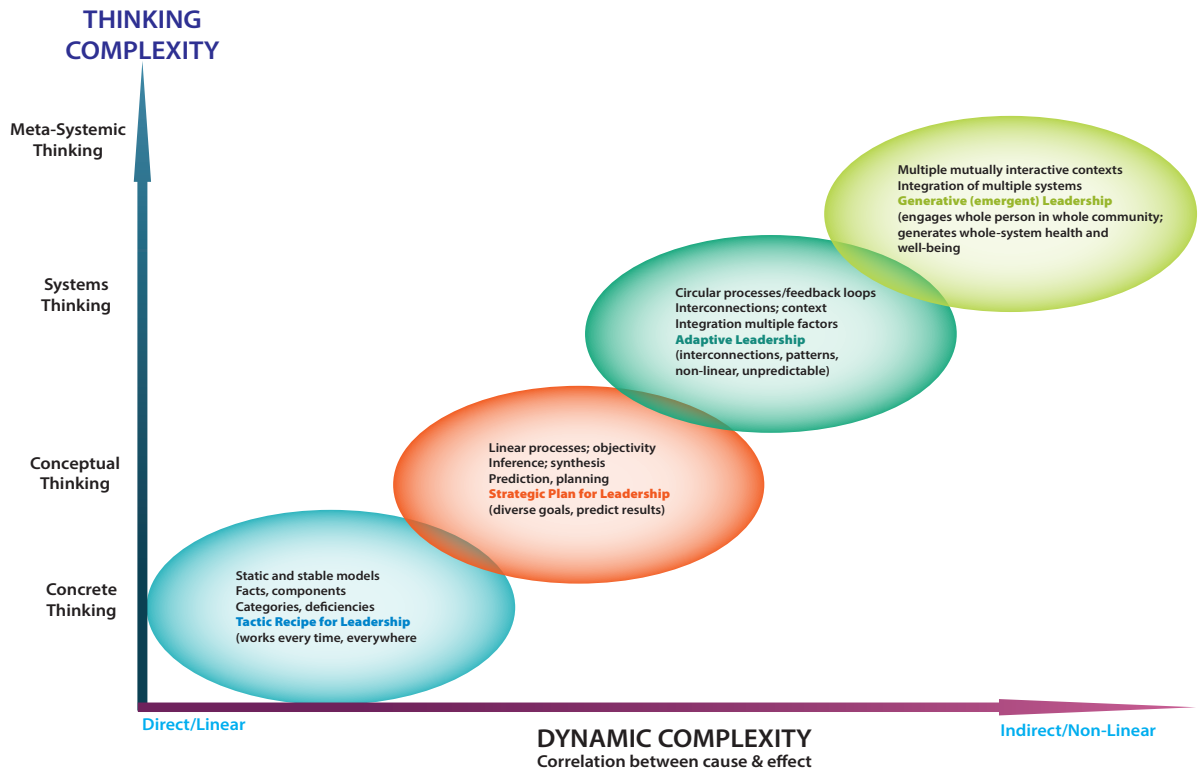
in its current state. Both tactical and strategic thinking fit into this technical change model (Figure 1). In those days, the Canadian health care system was simple enough to do well under the technical model of systems thinking. The mental model of health and disease that goes with this technical framework is that of treating or curing disease (Figure 2). As physicians, we are familiar with this type of change model because we were trained as problem-solvers, and we use the model daily in our medical practice.

Although we continued to use the technical model, the complexity and the context of the health care system around us changed in the late 1980s and early 90s. At that time, the **adaptive** model would have been more appropriate to change the health care system. That model is used when the challenge is complex, there is little agreement on the problem or on the solution, innovation is required because the old ways no longer work, and the goal is to foster resilience and equilibrium in the system by adapting to changing conditions (Figure 1). The mental model in adaptive systems thinking is that of health promotion by preventing disease and a health care system functioning independent of other systems outside health care (Figure 2).

The time has come for shifting to a **generative** model of systems thinking, a (w)holistic meta-systemic approach. The verb "generate" means "to bring into existence, to be the cause of." Generative change is a particular way of focusing attention on change challenges by creating possibilities of further change ensuing through time as a result of the initial change. This promotes sustainable thriving. For example, giving people one fish a day only deals with the immediate problem of hunger, but focusing on a preferred future includes teaching them how to fish, which would enable them to provide their own food, earn their living, and teach others. Similarly, generative change empowers us to become architects of a preferred future for health.

Paying attention to problems and possibilities at the same time would foster health, well-being, and healthy development now and for future generations. Whereas technical and adaptive change thinking will keep us in the world of disease treatment and disease prevention, generative thinking

Figure 1: Thinking complexity, characteristics, and leadership style for increasingly complex systems.



will empower us to become architects of health promotion for individuals, for communities, for the environment, and for the world. To nudge our health system toward a preferred future, we need to learn and practice intentional generativity and meta-systemic thinking as a society.

What then is that preferred future for our health system? It is one of salutogenesis, the process by which health is created. Thirty-five years ago, Antonovsky[3] coined this term, describing the relation between health, stress, and coping, and he focused on factors supporting health and well-being rather than disease. He explained the "health-ease versus dis-ease continuum," the health-ease component of which is generated by salutogenesis. Once we understand the factors that generate health, we can create more of it.

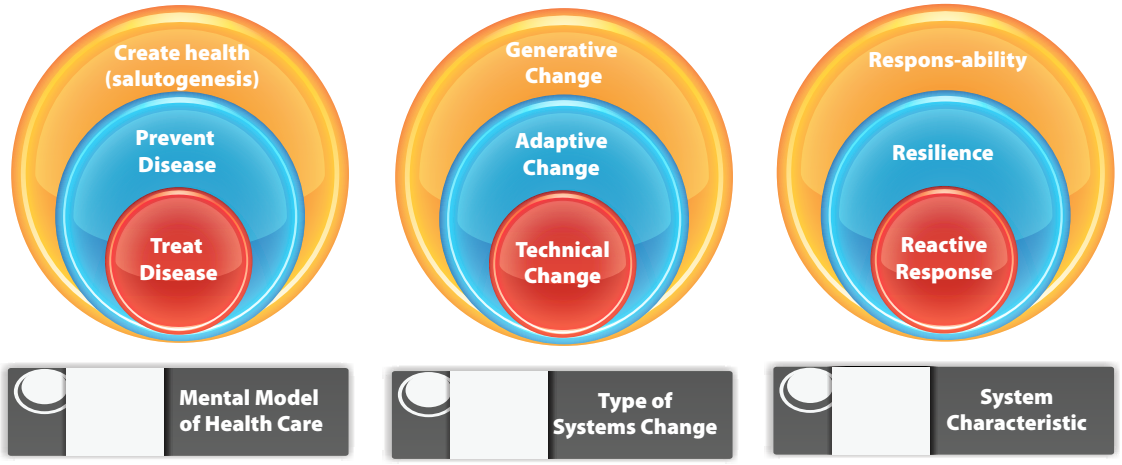
The use of the word salutogenesis helps us reframe our thinking about health by shifting our focus from disease and health care to health creation and sustainability, not only for individuals, but also for communities, organizations, and the world.[4] Despite the World Health Organization's guiding principle "health for all," adopted 30 years ago, the gap between the world in which we would like to live and the world we create through our actions continues to grow.

The new commitment for the 21st century has to be "health for all, health by all." By adding these three simple words, our global commitment to "health for all" is activated by our local commitment to "health by all." We should generate health through our daily actions and behaviours, through our relationships with others, through our local systems and services that shape our shared lives: economy, education, justice, social services, governance, transportation, production, and availability of food, water, and waste management, and the health care system.[4]

Health, then, is the concern of everybody, not just the health professionals. Because there is no single sector that can address the challenges and the opportunities facing us, everybody can and has an obligation to contribute. So far, such true collaboration has not happened in the Canadian health care system and certainly not for Canada's health.

Considering that the overall health of a population is not determined by acute care and public health services, why have the socioeconomic determinants of health never been included in the dialogue, using the lens of generative change? Although the Canadian Medical Association's town hall document, *Health Care in Canada: What Makes Us Sick?*[5] clearly identified socioeconomic factors as fundamental to our health, one year later no visible action has been taken to

Figure 2: Mental models of health and characteristics of evolving models of change and systems thinking.



implement its 12 recommendations because the CMA could not find a government partner. Yet, another technical advisory committee on health care innovation was formed recently, despite Lazar's[2] and Picard's1 findings that most health care reports by advisory committees have been ignored and have rarely been a trigger for policy change without the political will to do so.

In today's world, we need a diverse set of leadership capabilities depending on what systems model we are working in. What are some of the skills and tools we need for salutogenesis in a generative model of systems thinking? Whereas tactic and strategic leadership skills serve the technical model and adaptive leadership skills are appropriate for the more unpredictable adaptive change model, they limit us in dealing with generative thinking. To be successful in the five factors and their integrated combinations at the heart of generative change,[6] we need emergent, generative leadership skills to apply meta-analytical generative systems thinking (Figure 1).[4] The five factors for generative change toward salutogenesis are simplified in the next five paragraphs.

Shift mental models to create space for new potential and possibilities to emerge. So far, we have viewed health as the opposite of disease; as a result, the disease pole of the health continuum has captured most of our attention.[7] But by letting go of the expert stance and being willing to access our ignorance, we create an environment that supports ongoing learning and a willingness to question and explore new perspectives that allow us to apply the new knowledge continuously.[8] The old mental models of treating and preventing disease have to be supplemented with or replaced by health creation, by salutogenesis.

Add a heart-centred, appreciative mindset to the traditional head-centred, deficit-based mindset that tends to focus on overcoming limitations and fixing problems. Developing an appreciative mindset is not about looking at the world from a Pollyanna perspective; it is about being intentional about shifting the paradigm from problem-solving to focus on potential and possibility.[6] Roy et al[9] suggested positive analysis and positive deviance, in the context of emergent strategy and experimentation, as generative strategies in network systems.

Develop a shared vision

Picard[1] repeatedly asserts that a vision with specific goals and outcomes was and remains missing from the Canadian health care system. Roy et al[9] identify a clear vision of the desired outcome as one of the factors to handle increasingly complex systems. A shared vision is an idea for the future that inspires people to work together, cooperatively and collaboratively. For example, when Walmart developed the vision of a zero-waste business using 100% renewable energy and offered customers more environmentally preferable products, the company ended up creating its sustainability program through collaboration with the David Suzuki Foundation.[6] When have we ever seen the food industry sit down with health professionals, scientists, shareholders, governments, and consumers in a collaborative fashion to develop a shared vision of salutogenesis?

Engage in narrative, active listening, and dialogue

The art of dialogue and active listening is interwoven throughout the generative change model, to develop vision, deal with today's problems, and create potential for the future. It means suspending preconceived mental models and being curious and open to possibilities. Narrative is the framework through which we comprehend life[10] and it helps us understand others and ourselves by creating a collective framework. This would encourage participation, which matters because contribution in itself generates higher levels of health. Len Duhl, a cofounder of the International Healthy Cities Foundation wrote about health causality, "We have learned that active participation, in itself, leads to health."[11] In other words, contribution creates ownership, and it is salutogenic because it generates higher levels of health. How does each Canadian participate in generating health for him- or herself, for the community and for the environment we live in?

Develop a systems perspective, a conceptual framework for understanding complex patterns and interrelations that exist among individuals, organizations, and across sectors. Such a viewpoint

helps us understand that everyone shares responsibility for what is happening within a given system, rather than responsibility or blame falling on one individual or agency.[12] It can take the form of "the kind of relationships, social experiences, social environment and patterns of interaction known to both promote health and over which a community has considerable control."[13] By reconnecting the seemingly separate parts into a more inclusive and integrative whole, our change efforts will generate more resilience (the ability of an individual or system to cope and adapt in the face of adversity) and more response-ability (the intentionally creative capacity to respond positively and proactively to present problems and future potential).[4] "Integration might be the principle underlying health at all levels of our experience, from the microcosm of our inner world to our interpersonal relationships and life in our communities."[14]

The meta-system approach to interconnected systems moves us closer to the goal of healthy people, healthy communities, and a healthy world where we pay as much attention to generating health as we do to socioeconomics, public health, and preventing or curing disease. The evidence is growing,[1,2,5] the proof is staring us in the face. A successful health system cannot care for disease sustainably without being connected with and integrated into the food system, the environment, the economy, and the education system.

As a Canadian society, we have claimed that health care is part of our identity. We are about to give that identity away by focusing solely on acute care and disease, while ignoring the health of the community, its members, and the environment within which these communities evolve. As members of our great Canadian community, each and every one of us has to claim back ownership of our health. We have a choice: either we stay in the present condition, which makes the Canadian health care system look discouraging, or we truly transform ourselves into a society that embraces salutogenesis.

What would that mean for you and me, as physician, as patient, as a consumer of either health care services or of unhealthy and addictive foods, as a voter, as a leader? What role can the CSPE and each of its members play in salutogenesis?

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This article has been reviewed by a panel of physician leaders.

Opinion

Challenges and opportunities to ensure effective physician leadership in Canada

Dennis Kendel, MD

Several thousand Canadian physicians serve in formal leadership roles. Medical leadership positions may be full or part time. They may be based in health authorities, hospitals, medical schools, medical regulatory and advocacy organizations, cancer agencies, health ministries, or community-based health service programs. The titles attached to these positions may be CEO, chief of staff, senior medical officer, VP medicine, medical or academic department head, dean, college registrar, public health officer, or medical director.

Although highly structured medical residency programs prepare physicians for their clinical careers, no standardized educational pathways exist to guide one into medical leadership roles. Some physicians complete master's of business administration programs, some take PMI courses, and others access a growing array of generic leadership skill development programs. Regrettably, some physicians take on leadership with no explicit educational preparation.

Some leadership positions are filled through rigorous recruitment and selection processes. Others are filled through reluctant volunteerism or peer coercion.

Some leadership positions are filled through rigorous recruitment and selection processes. Others are filled through reluctant volunteerism or peer coercion. Once in these leadership roles, some physicians are offered or arrange for ongoing support and learning through mentorship and coaching. Some simply "fly by the seat of their pants."

Recently, I was asked to offer an opinion about how effectively most physicians are serving in this diverse array of medical leadership roles in Canada. I had to confess that my opinion could be based on little more than anecdotal awareness of some fantastic physician leaders and some who have failed miserably. I am not aware of any mechanism in Canada to measure objectively our profession's collective performance in formal leadership roles.

However, I am aware of evidence that there may be considerable room for improvement in some facets of medical leadership and leadership development in Canada. That evidence has come through dialogue with physician colleagues at the Canadian Medical Protective Association (CMPA), an organization that I very much respect.

The CMPA provides peer guidance and support as well as legal support to physicians who face civil litigation related to their practice as well as investigation or discipline by colleges of physicians and surgeons, health authorities, hospitals, and governmental paying agencies. One might expect that the CMPA would be pleased any time it is able to prevent a physician member from being subjected to any penalty or sanction by any of these agencies. Such a perception would be short-sighted.

We need to remember that the CMPA is a medical organization with over 40 physicians on staff and governed by an elected physician council. These physicians are subject to the same CMA Code of Ethics that pertains to all of us. They are no less committed to safe, high-quality patient care than are their clinical colleagues.

Colleagues at the CMPA have shared with me concern about the frequency with which interventions by health authorities and hospitals in response to perceived physician misconduct or incompetence are thwarted or overturned on appeal because of failure to follow procedures set out in health authority or hospital bylaws. Most medical staff bylaws include provisions to ensure procedural fairness and due process in dealing with alleged physician misconduct or incompetence. Physicians in formal leadership roles in health authorities and hospitals seem to overlook or disregard these provisions with troubling frequency.

...misconduct or incompetence are thwarted or overturned on appeal because of failure to follow procedures set out in health authority or hospital bylaws.

Although this situation enables the CMPA to easily declare "victory" for the implicated physician, it may be a pyrrhic victory. If the physician's performance or conduct is, indeed, putting patients at risk of harm, the CMPA will find itself engaged in subsequent proceedings, and patients may indeed suffer preventable harm in the interim. The CMPA's organizational values make it sensitive to preventable patient harm. It is as committed to prevention of patient harm as the Canadian Patient Safety Institute.

My CMPA colleagues note that, with rare exceptions, interventions undertaken by the colleges of physicians and surgeons are not so fraught with failure to adhere to principles of procedural fairness. I am prompted, therefore, to consider what differences in physician leadership at the colleges versus the health authorities and hospitals may account for this variance. Could it be because physician leaders at the colleges serve in full-time positions and deal with such issues daily, whereas physician leaders at health authorities and hospitals are part time and may deal with such cases infrequently? Could it be because physician leaders at the colleges are appointed through competitive and well-structured selection processes, whereas many health authority and hospital leaders are volunteers who may have been reluctant to accept the role, but were pressured to do so because it was "their turn"? Could the variance be attributable to differences in education preparation for the leadership roles and ongoing mentoring/support once in the roles?

I believe this issue calls out for some reflection and action by our profession. We may be placing patients at protracted risk of preventable harm if we ignore it. We may also be compromising our profession's collective leadership reputation.

I expect the CMPA would be very pleased to partner with a number of other medical organizations to study this issue and identify strategies for improvement. This might be an opportunity for the Canadian Society of Physician Executives (CSPE) to step forward to offer to work with the CMPA in addressing this challenge.

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This article has been reviewed by a panel of physician leaders.

Closing the gap: a Canadian health leadership action plan

Kelly Grimes, MHSc and
Gillian Kernaghan, MD

Abstract

Strong leadership, including high-quality physician leadership, is a critical factor in the performance and success of our health care system. The time has come for a collective approach to increasing Canada's leadership capacity and capabilities, one that is linked to policy imperatives, such as "Triple AIM" (better care, better health, and better costs) and patient experiences and outcomes. Such an approach requires a national health leadership action plan that can form a foundation for an evidence-informed conversation among Canada's health care leaders.

CHLNet as a value network

In 2013, the Canadian Health Leadership Network (CHLNet), a purpose-built coalition of 40 organizations (called network partners of which the CSPE is one) initiated a consultative process to develop a Canadian health leadership strategy. Created in 2009, this value network is founded on the belief that it can achieve something collectively that leaders cannot do on their own. Its members believe that new and more innovative ways of working together to cultivate leadership capacity are required and that no one organization can own leadership in health. Over the last year, an ad hoc expert working group made up of network partners has guided efforts to draft a working paper and action plan on this topic.

What the research says

Most major policy reports[1–3] identify strong leadership as a critical factor in improving performance and quality in our health care system. Yet a leadership gap exists across Canada. The recently released Canadian Health Leadership Benchmarking Survey Report[4] shows that 84% of health care leaders are concerned about the overall leadership gap, with 42% of Canadian academic health sciences centres reporting that they do not have the leadership they need to meet the challenges of the future.

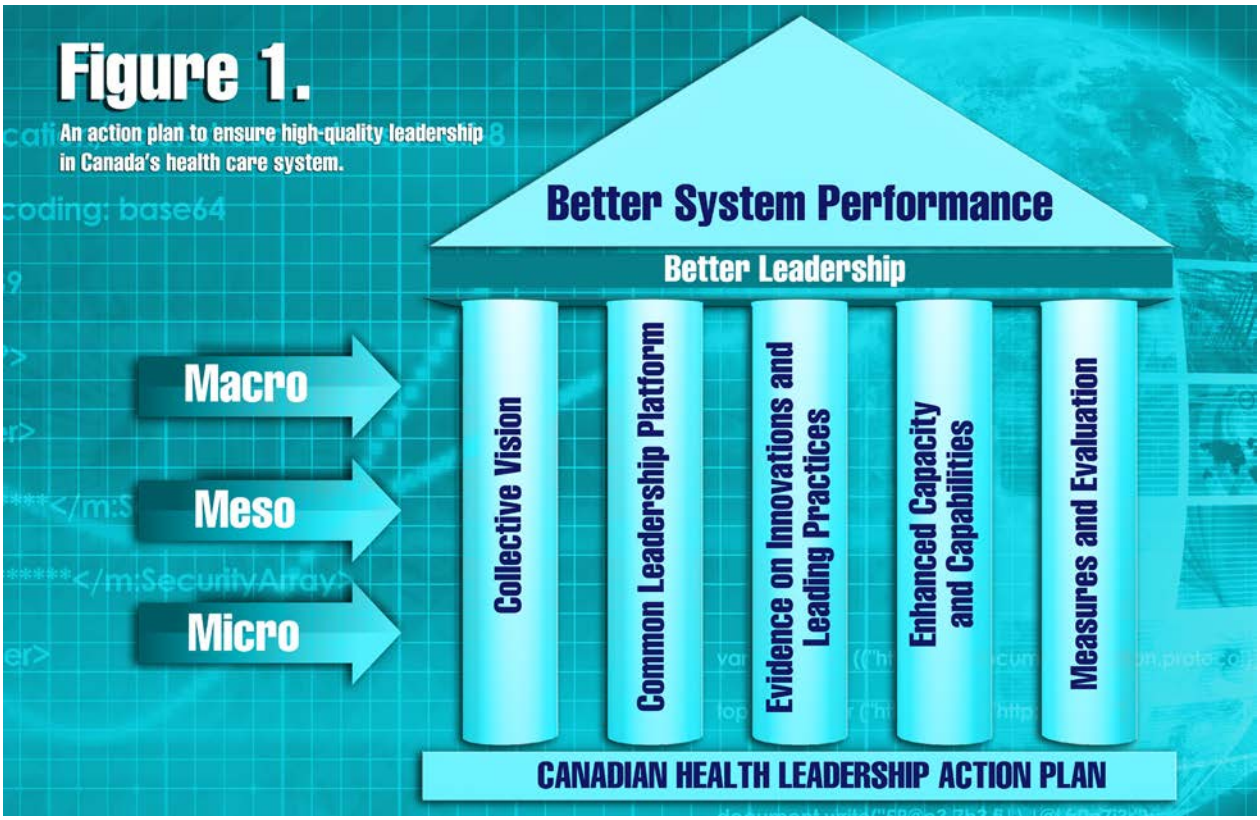
In the wake of the 2008 recession, Canada is also still feeling the results of one of the deepest and most long-lasting economic downturns in its history. Health system performance continues to decline when compared internationally. Recent research shows that leadership, especially quality physician leadership, is a key enabler of health system performance and health reform and that new leadership skills are needed for formal and informal leaders.[2,5] Aging of our current leaders, increased scrutiny of their work, and the requirement for greater public accountability are making it difficult to attract and retain talent.

A health leadership action plan

The time has come for a collective approach that cuts across jurisdictions and health disciplines over the life cycle of leadership, from emerging health leaders to senior executives. Concrete actions are required. Key elements have been outlined below after consultations with CHLNet's network partners; a Healthcare Leadership Forum cosponsored by the Canadian Association for Health Services and Policy Research, the Canadian Foundation for Healthcare Improvement, and CHLNet (Montréal, 14 Feb. 2014); a deliberative dialogue session hosted by McMaster University (4 Mar. 2014); and a presentation to the Federal/Provincial/Territorial Committee on Health Workforce, which comprises assistant deputy ministers. The intention is to bring a proposal to the Conference of Deputy Ministers of Health in fall 2014.

Recent research and expert opinion[6,7] show that growing quality leadership requires a multi-pronged and collaborative strategy to achieve large-scale, transformational change. Based on the evidence gathered to

date, a five pillar action plan is proposed (Figure 1) with each pillar representing the elements that would be applied at macro, meso and micro levels of the health system, with the overall objective of improving health system performance. Only a macro level approach is discussed here.



Confirm a collective vision:

A common vision with clear and compelling shared goals with measurable outputs and outcomes is essential as a reference point for a collective approach to building the distributed leadership capacity needed to realize Canada's leadership potential. Countries such as the United Kingdom[8] and Australia[9] have created national strategies linked to their national health reform agendas.

Endorse a common leadership platform:

Although many options exist, LEADS in a Caring Environment (LEADS)[10] has become the preferred health leadership learning platform and provides a common language and focus. Created in 2006, the LEADS framework is a useful basic building block for leadership in a complex adaptive system with distributed leadership at its core.

British Columbia's deputy minister at the time provided the initial $3 million earmarked for a "proof of concept" provincial leadership talent development strategy over three years. Adoption of the resulting framework was accelerated by pioneering organizations, such as CHLNet, the Canadian College of Health Leaders, Accreditation Canada, the Canadian Medical Association, provincial governments (BC Health Leadership Development Collaborative, Alberta, Saskatchewan, Manitoba, Yukon, Nova Scotia, and Prince Edward Island) and numerous health regions (Alberta Health Services, Eastern Health and others) across Canada. Even Australia has adapted it for its own context, with many other countries expressing interest.

Gather more evidence on innovation and leading practices:

Evidence and leading practices must continue to be gathered from a variety of sources and this information used to influence action in a purposeful way, even though significant research has been

undertaken on health leadership in the last decade.[3,11] We need to fund and coordinate research and knowledge-mobilization efforts and sustain a Canadian health leadership research network (or clearinghouse) as an ongoing collaboration of researchers, service providers, and decision-makers.

Enhance capacity and capabilities:

Large-scale change requires new or enhanced capabilities for our formal leaders around systems thinking, strategic thinking, relationship development, and self-leadership.[2] It seems that leadership development programs are not letting us get to where we need to be and are often the first items to be decreased in the face of budget constraints.[12] Planning and coordination of health leadership is required as part of broader health human resources or talent management strategies, so that health leaders are seen as a collective and succession planning as a top priority.

Health care organizations must help build capacity, but governments must encourage and promote capacity and the new capabilities required through funding and other incentives. New programs to support future leaders that are action research oriented and occur in situ (at the local level) are shown to be needed. Such programs would not replace other leadership offerings, but instead could be built on existing leadership programs.

Measure and evaluate success:

A clear and compelling vision must be supported by key measures of success. What are the expected results or desired outcomes and how will the system know when these have been reached? If results are not met and evidence shows a need to change, how will corrective action be taken? Targets and benchmarks must be defined through national dialogue to monitor pan-Canadian health leadership and its effect on health system performance on an ongoing basis.

Conclusion

A decade ago, leadership was not on the policy landscape. Leadership was assumed, but evidence shows that better, stronger, more supportive health leadership, especially for physician leaders, is required to put Canada back among the best performing health systems in the world. It will take collective action that cuts across jurisdictions and disciplines. We believe such action should be focused on our future leaders and be built with an evidence-based approach, tailored to each jurisdiction but tied together nationally.

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This article has been reviewed by a panel of physician leaders.

Career transition: planning for your third act

Chris Carruthers, MD and Mamta Gautam, MD, MBA, FRCPC, CCPE, CPDC

Abstract

Although physicians have always worked longer in their careers than other professionals, the increase in longevity means even they must plan for retirement. In this article, we explore the challenges for physicians who seek a career transition in the later years of their medical careers and discuss the timing of this as well as how to replace work with other meaningful activities and maintain social connections. We also offer tips for successful retirement, including the need to plan ahead, prepare financially, and explore hobbies and activities in advance.

The retirement age for physicians has increased over the last few years. Physicians have always worked later in their careers compared with other workers,[1] as many enjoy the meaning their work brings to their lives as well as the interactions with patients. However, as physicians age, their competency can decrease and affect their ability to practise safely. Some may lose their enthusiasm or passion for medicine.

The challenge we are facing is the increase in longevity and how to best plan for these extra years. We are living 10–15 years longer today, compared with life expectancy in the 1970s.[2] Planning for these years, our "third act,"[3] is the key to living a happy and meaningful life. These years will not be what is considered traditional retirement, but busy and active, often including what we call an encore career.

In 2013, over 41% of Canadian physicians were 55 years of age or older.[4] These physicians will need to plan their life for the next 25 years. Evidence points to few of us planning appropriately, with the risk of unfortunate consequences.

Some physicians and their spouses look forward to a life of leisure. Playing golf, traveling, and more time spent with grandchildren can be satisfying during this part of life. However, we know couples of which one would love to travel, yet the other has no interest in that; thus, they do not travel, and one of them is very disappointed. After retiring from a fulfilling career and spending five years playing golf and skiing, a close colleague commented, "Is this all there is now to life?" A retired friend, not a physician, spends a good deal of time negotiating a better cell phone plan, but this would likely not satisfy most physicians as a meaningful, passionate retirement activity.

Challenges of transition

The challenges physicians face when they leave practice are several. The first is in knowing when to stop. Some can successfully reduce their practice, working on a part-time basis until they finally quit. Others whose practice may be hospital-based, e.g., surgeons, often cannot gradually decrease their practice and often leave abruptly. Some are asked to leave sooner than they wish to make room for a younger physician with newer skills. Some find the necessary burden of being on call to maintain their access to hospital resources just too difficult. Still others recognize a serious deterioration in their skills.

To live a rewarding third act of life, physicians need to replace their practice with other meaningful activities about which they can be passionate.

To live a rewarding third act of life, physicians need to replace their practice with other meaningful activities about which they can be passionate. Their personal value has been tied to their role as doctors, providing care to patients. But when they leave practice, this will be lost: they are no longer physicians. Some articles suggest this is the time to prepare to be a "nobody."[5]

Physicians' social networks often revolve around their medical careers. When they leave medicine, this network can be lost. Maintaining a strong social network is the key to happiness.

Staying healthy through physical activity is important. During their careers, many physicians are too busy to be involved in regular exercise; they should consider making time to do this in retirement. Risk of dementia is a real concern; many physicians have seen the consequences and the burden of this disease. Carol Dufouil, a scientist at France's Institut National de la Santé et de la Recherche Médicale, and colleagues showed that the risk of dementia is reduced by 3.2% for each additional year one works beyond 60.[6] Thus, a working 65 year old has a 15% less chance of suffering from dementia than someone who stopped working at age 60. This is evidence supporting the expression "use it or lose it." Retirement, it has been reported, can also increase the probability of suffering from depression by up to 40%.[7] Physical activity can decrease this risk.

Staying healthy through physical activity is important. During their careers, many physicians are too busy to be involved in regular exercise; they should consider making time to do this in retirement.

For couples, adjusting to these times can be difficult. Unfortunately, the divorce rate for older couples ("grey divorce" or "silver separation") is increasing. Divorce at this age can be the ultimate wealth destroyer.

Spouses may not have the same idea of what to do during this act of their career. In July 2014, the Royal Bank of Canada published a report containing some interesting, but disturbing, facts.[8] The vast majority of couples do not discuss these three key questions:

- How will either manage if the other encounters health issues?
- How will either manage if the other passes away prematurely?
- What activities will they do in retirement?

Only 36% of couples discussed how they will finance their retirement and where they will live once retired. Other observations from this study included the fact that men expect to spend more time with their spouse or partner, but fewer women expressed the same sentiment. Women are more interested in spending time with other family members and friends. Couples can often have a difference of opinion over when one should retire, particularly when both are working. One article suggested that professional women have the most difficulty transitioning to retirement.[9]

Toward a successful retirement

The most important step toward enjoying these years is planning.

Planning — together with one's spouse — should start 5–10 years ahead of time. It may well include taking a mini-sabbatical of at least 3 months to explore activities and opportunities to enjoy as a couple or separately in an encore career.

Understanding one's financial situation and doing some financial planning are crucial. One advantage of part-time work or activities is the potential for some additional income to supplement savings. This can make a significant difference in terms of the activities, e.g., travel, that one can fund in retirement.

Many physicians looking to pursue a hobby or volunteer work may wait until they leave medicine before becoming involved. This is not the best approach. We advise physicians to take up these activities gradually while they are still working. Thus, when they stop medicine, they are able to ramp up their participation easily, knowing this is something they will enjoy.

There are champions of the "never retire lifestyle," who claim that staying in the workforce doing meaningful and satisfying work keeps one engaged, intellectually stimulated, and healthy. They would agree that the best retirement, perhaps, is no retirement. It is said, "He who retires least, retires best."

Final messages

- Physicians have to plan ahead for a rewarding retirement and an encore career.
- Activities in this phase still need to be meaningful ones about which you are passionate.
- Most physicians will likely work part time once they retire, because they want to.[10]

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This article has been reviewed by a panel of physician leaders.

Canadian National Study of Interprofessional Relationships between Physicians and Hospital Administrators

Part 1: The importance of physician–hospital relations in the Canadian health care system*

by Atefeh Samadi-niya, MD, DHA(PhD), CCRP

*Part 2: A summary of CANSIRPH will be published in a subsequent issue of the CJPL.

Abstract

Studies have shown that physician–hospital relations are among the most important concerns of hospital leaders and paying attention to this issue is urgent if health care decision-makers plan to improve the quality of patient care and reduce health care costs. Industrialized countries have been focusing on improving the quality of relations between medicine and management, but in Canada no national detailed study has addressed such interprofessional relations. Physician–hospital relations have a tremendous effect on quality of patient care, and good hospital relations are crucial to the professional lives of physicians. This article explores the role of physician–hospital relations and the need for Canadian data in this area. In a subsequent article, I summarize the Canadian National Study of Interprofessional Relationships between Physicians and Hospital Administrators, a quantitative multivariable correlational study designed to understand how physician leaders and non-physician leaders perceive the relations between medical staff and hospital management across Canadian hospitals.

Introduction and background

The results of a survey by the American College of Healthcare Executives showed that physician–hospital relations are among the most important concerns of hospital leaders and have remained so for many years.[1,2] A survey by the American Hospital Association's Society for Healthcare Strategy and Market Development and Mitretek Health Care showed similar results.[3,4] Members of the American College of Physician Executives reported that lack of trust is one of the main issues affecting the development of collaborative physician–hospital relations.[5] However, such relations are an important aspect of health care systems in industrialized countries, and paying attention to this issue is urgent if health care decision-makers plan to improve the quality of patient care and reduce health care costs.[6] According to Weiner et al [7] road blocks to physician involvement are the most important barriers to improvements in quality of health and patient care.

Physician–hospital relations in OECD countries

In industrialized countries, differences in the viewpoints of physicians and hospital executives tend to occur in most hospitals.[2,4,8–12] The situation is similar in Australia, Sweden, the United States, Canada, Denmark, the Netherlands, the United Kingdom, and other countries.[13] In fact, in comparing the quality of the health care systems of its members, the Organisation for Economic Co-operation and Development (OECD) found that any simple change in one system eventually disseminates to other member countries.[14,15]

Physician–hospital relations have been a topic of research in the United States, the United Kingdom, Norway, Germany, and Australia.[9,10,16–19] Neogy and Kirkpatrick[18] compared physician–hospital relations in European countries, where reforms in health care began during the 1980s, with France holding back until recently. Denmark is most advanced in terms

of involving doctors in managerial roles. France and the United Kingdom are less advanced than Denmark and Germany in this respect, while, in the Netherlands and Italy, some hospitals have medical personnel involved in management and some do not.

Physician–hospital relations in Canada

In Canada, the use of effective clinical leadership varies among provinces and among hospitals in each province. One might argue that Canada has a national health care system and does not have any issues with physician–hospital relations. Nevertheless, the results of the National Physician Survey showed that Canadian physicians have also been dissatisfied with their relations with hospital or health care administrators: about 20% are dissatisfied and about 30% indicated borderline satisfaction (neither satisfied nor dissatisfied).[20]

Good physician–hospital relations are crucial to the professional lives of physicians and their overall level of satisfaction with other aspects of their lives.[21] Physicians who are satisfied with their hospitals are twice as content as other physicians.[22]

In contrast to the large number of research studies in other OECD countries, a review of the literature through to 2010 showed only a few studies focusing on physician–hospital relations in Canada.[23–25] To address this gap, the Canadian National Study of Interprofessional Relationships between Physicians and Hospital Administrators (CANSIRPH) was undertaken in 2011–2012 to examine such relations in all provinces and territories. In CANSIRPH, the term "interprofessional relationships" referred to physician–hospital relations, physician–hospital relationships, and doctor–manager relationships.[26,27] The focus on the term interprofessional was intended to emphasize relations between physicians and hospital administrators as intertwined rather than interdisciplinary and separate.[28–30]

In contrast to the large number of research studies in other OECD countries, a review of the literature through to 2010 showed only a few studies focusing on physician–hospital relations in Canada.

Physician–hospital relations and quality of patient care

Lack of collaboration with physicians is one of the most important challenges that hospital administrators face.[1] In contrast, patient satisfaction is at the bottom of the list of hospital CEOs' concerns, although paying attention to "customer" needs improves performance and, consequently, the financial status of hospitals.[31] Patients and physicians are among the most important customers of hospitals.[25] Patients want choice, ease, and access to physicians' services; administrators should be asking about the needs of patients and physicians instead of thinking on their behalf.[32]

Noncollaborative interprofessional relations between physicians and

hospital administrators adversely affect the quality of patient care, patients' satisfaction, and the number of adverse events at the hospital.[23,25,33–36] Currently, the quality of interprofessional relations between physicians and hospital administrators in Canada and the factors that affect these relations are unclear.[23,25,33,36,37] However, improving such relations would be useful in improving the quality of patient care.[7,25,33,38–40]

Regardless of financial issues, the core values of physicians and hospital administrators are very similar, and both groups have common ground for successful interprofessional collaboration.[11] Physicians are not regular employees, even if they are employed by the hospitals. Rather they collaborate with hospital administrators, but only if the voices of physician leaders are as strong as those of hospital administrators.[41] Participating in decision-making meetings when hospital administrators make the final decision does not constitute having an equal voice. Physicians should be equally involved in advocating as well as finalizing any strategic decisions that affect patient care in hospitals.[41] Shared control is an important factor in successful physician–hospital relations.[42]

Paying careful attention to the intertwined needs of physicians and hospital administrators has a positive effect on the quality of patient care as well as on the financial outcomes of hospitals.[37,38] According to Gosfield and Reinertsen,[43] establishing common grounds to improve the quality of patient care will resolve most challenges that exist in physician–hospital relations.

Patient care in a hospital is only as strong as the interprofessional relations between physicians and hospital administrators.[25,33,44] Porter and Teisberg[45] asserted that if physicians lead the value process in health care, hospital administrators, board members, patients, and other health care professionals will benefit, because physicians allocate the use of resources in health care systems.[46,47] Physicians have also emphasized that hospital administrators should listen to their ideas and include their viewpoints in hospital decision-making processes.[48]

Regardless of financial issues, the core values of physicians and hospital administrators are very similar, and both groups have common ground for successful interprofessional collaboration

Canada's health care system values interprofessional and interdisciplinary relations among health care professionals because of their importance in patient care and patient satisfaction.[30] Among the most important such relations is that between physicians and hospital administrators, who share common values and have extremely important roles in clinical and administrative aspects of health care management.[11] Successful interprofessional relations benefit the quality of care, decrease the number of adverse events, reduce health care costs associated with inadequate interdisciplinary decision-making, and, eventually, increase patients' satisfaction.[25,49–53] The business of hospital administrators and physicians is health care and patient care,[54] thus, improving relations between these professionals means improving patient care and health care.[38,40] As Weiner et al [7] emphasized, anything that negatively affects physician collaboration with hospital administrator results in worsening the quality of patient care.

Physician–hospital relations and physician leadership

A UK national survey showed that open communication and clinical leadership help align priorities and shared decision-making among hospitals and physicians.[17] Hospital strategies that not only focus on economic incentives, but also on including physicians in decision-making processes as part of the management team can benefit both hospitals and physicians.[55–57] Walker et al[58] recognized that managers and hospital administrators have specific talents that complement those of physicians, thus strengthening the partnership between medicine and management.

Hospital administrators consider physicians to be a main pillar of the health care system, and strengthening their relations with physicians creates a strong and error-free system.[25,33,59] Physicians should remember the role health care leaders play in dealing with many stakeholders to provide the

facility and environment for the patient care; without administrators, quality patient care is not possible.[1,33] Governing boards should emphasize the inclusion of both physicians and administrators in the hospital decision-making process to create balance in satisfying both internal and external stakeholders by providing quality patient care.[33,37,60]

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Facilitation skills for physician leaders — an emerging necessity in a complex health system

Mary Yates MEd and
Monica Olsen MHRD

Abstract

Facilitative leaders ask questions, collaborate, share, consult, and focus on the process of decision-making. This style is replacing the earlier directive or autocratic approach, and physician leaders are eager to acquire the skills needed to be a facilitative leader. In this first of a series of articles, we describe the facilitative approach and how it relates to quality improvement, leads to healthy dialogue, and transforms the culture of organizations.

Why facilitation and why now?

More than ever before, physicians (and other health care professionals) are yearning for transparent and meaningful engagement with their work that genuinely and safely explores their knowledge, opinions, feelings, and talents. Recently, we were contracted by a group of hospital physicians who are in the midst of transforming their mortality and morbidity rounds into a model that is consistent with quality improvement assumptions and practices. Specifically, the role of "meeting facilitator" has been created for this reconstituted quality improvement exercise, and the physicians were looking for support to help them

- lead the transition from a culture that focuses on errors, fear, and blame to one of learning
- create a safe, productive, and comfortable "learning space"
- be empathic and approachable, less directive and less authoritarian
- foster team problem-solving and decision-making

We piloted a 1-day facilitation skills program with this physician group, and participant feedback strongly demonstrated the value of this kind of development, at both a fundamental and advanced level. Further design work is underway to help meet these emerging needs.

In addition, we are both certified trainers in Crucial Conversations® and we provide a 2-day program on how to master high-stakes interactions for a provincial medical association. Over the last two years, physician participants at these workshops have emphasized the pervasive lack of healthy dialogue in their organizations and have exhibited a strong desire to change their culture to solve problems and achieve innovative solutions. It has been encouraging to see the majority of participants committed to implementing a new approach to facilitating healthier conversations. In another variation of this same program, which was run as a four-part series, many physicians were able to apply their learning immediately between sessions and reported on significant positive shifts in relationships as well as outcomes.

Given the widespread adoption of LEADS in a Caring Environment, a framework of leadership capabilities, across Canada, it seems reasonable that facilitation skills would greatly strengthen the type of leadership that Dickson and Tholl[1] define as "the capacity of an individual or group to influence people to work together to achieve a constructive purpose." The significance of "distributed leadership" or "shared leadership" is also increasingly noted in the literature.

Facilitative leadership is replacing top-down, directive, or autocratic styles. Zimmerman et al[2] also noted how important front-line ownership is in fostering resilient safety cultures in health care. This requires a departure from the traditional health care culture where leaders attempt to get buy in from front-line workers and, ultimately, may only succeed in obtaining short-term compliance.

"Facilitation is a way of providing

leadership without taking the reins." Ingrid Bens[3]

Making it easy

A facilitator is an objective, neutral third party who can guide team members in sharing information, solving problems, and making decisions. Facilitation comes from the word "facile" which is French for easy. The role of the facilitator is to help make information-sharing, problem-solving, and decision-making processes easy or at least easier than if the facilitator is not present.

The facilitator has little or no investment in the outcome of the meeting; rather his or her focus is on helping the team members clarify the meeting's outcome and then help them manage processes so that they can achieve this agreed upon outcome. The facilitative style of leadership is to ask questions rather than provide answers. Because the facilitator is not there to provide subject matter expertise, the focus is on helping team members contribute to the dialogue in a meaningful and authentic way.

Beliefs that underlie the practice of facilitation

The practice of facilitation is grounded in the belief that the members of the problem-solving team are capable of solving problems that affect their work. The role of the facilitator is to help the team members access this expertise. The practice of facilitation is also predicated on the belief that when team members feel respected and safe (to share what is important to them), the team is more likely to achieve its outcome.

Table 1. Differences between a traditional and a facilitative leader

Traditional leader	Facilitative leader
subject-matter expert	problem-solving expert
provides answers	asks questions
focuses solely on results, the "task"	focuses on results and group process
authoritarian, a "parent"	collaborative, a "partner"
believes the "correct" answer lies within the leader	believes the "correct" answer lies within the individual or team
commands	consults and achieves consensus
tells	asks
owns leadership	shares leadership
makes decisions	collects information
solves problems and makes decisions	helps individuals and teams solve problems and make decisions
triggers discussion	invites dialogue

Traditional versus facilitative leadership

The traditional leadership style is characterized by providing answers; in contrast, the facilitative leader asks questions. The traditional leader believes the correct answer lies within the person with the most subject matter expertise; the facilitative leader believes the correct answer lies in the collective intelligence of the team members. The traditional leader uses his or her expertise to inform the group's problem-solving and decision-making and will often focus on convincing team members that he or she is right; the facilitative leader has acquired expertise in helping groups share information, solve problems, and make decisions (Table 1).

It is important to note that a facilitative style of leadership it not always preferred. In the event of a crisis, for instance, a traditional style of leadership may be more appropriate.

Content and process

All human interaction consists of two components: content and process. Content refers to the "what": the tasks that need to be accomplished and what is being said. Content is typically reflected in the agenda and includes the meeting goal, the topic that will be

discussed, the problem that must be solved, and the decisions that have to be made. Process refers to "how" the task gets completed and includes a focus on how things are being said and on the relations among team members as they go about solving problems and making decisions.

Process includes how constructive relations among team members are built and maintained, including unspoken beliefs, acknowledging group norms, creating meeting guidelines, and the psychological climate of the team meeting. Although these dynamics are rarely referred to in agendas, they have an enormous impact on the way the team does its work and achieves its goals. When people come together to solve problems, facilitators need to pay attention to both of these aspects of human interaction.

Because problem-solving and decision-making are the work of the team, the facilitator must create the necessary conditions for team members to share the information that is important to them. This information includes facts and data, but these rarely fully inform decision-making. Also part of team decision-making are the biases, values, assumptions, and beliefs of the team members. The role of the facilitator includes making it safe for people to share these as well, so that the team can make a decision to which everyone is committed.

The practice of facilitation does not require the use of a sophisticated set of skills. Rather, facilitators can be tremendously useful in helping the team achieve its goal by paying attention to, and enabling mechanisms for, three important meeting processes: time keeping, gate keeping, and recording the team's dialogue.

Time keeping helps to ensure that the dialogue stays on track and gets the task completed. Gate keeping refers to interventions the facilitator undertakes to help balance participation, ensuring that all team members have an opportunity to contribute both their expertise and other perspectives that are important to them. Finally, the facilitator must ensure that a process is in place for capturing the team's dialogue as it goes about its work of accomplishing its goal.

Basic and developmental facilitation

An important distinction in the practice of facilitation is between basic and developmental facilitation. A person who is engaged in basic facilitation is helping a team for a limited period; the facilitator takes a lead role in managing the group process so that the team's goal is achieved. Developmental facilitation has a different purpose: to help team members manage themselves and their meeting processes with the goal of eventually becoming unneeded.

Key facilitation skills

Effective facilitators require knowledge and skills in

- designing engaging and productive meetings
- keeping the discussion on track
- types of decision-making and discerning best fit
- managing the behaviour of challenging team member

This is the first in a series of five articles on facilitation. In upcoming issues of the CJPL, we will focus on each of these key facilitation skills.

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This article has been reviewed by a panel of physician leaders.

CSPE member describes long-term project and continuing passion

Salybia Mission Project: a student initiative creates a living legacy

Sylvia F. Marcos, MD, DABIM, FRCPC

Abstract

After visiting a rural clinic in the remote Kalinago Territory on the island of Dominica, a group of medical students envisioned an organization that would improve the delivery of health care services to the last remaining indigenous population of the Caribbean. In March 2002, they initiated the Salybia Mission Project. Since its inception, the project has continuously staffed and supplied the clinic in the Kalinago Territory. It couples the need for health care services with stipended clinicians and aspiring medical physician volunteers from the neighbouring Ross University School of Medicine. It also participates in cultural and educational initiatives, as it believes that a community's health needs extend beyond the clinic's walls. Because of its vision and spirit of collaboration, Salybia Mission Project has become a nationally recognized non-profit organization and continues to play an integral role in the clinical education of students as well as the community it serves.

"Look not at the condition of the facilities, focus on the patients.... They will guide you.... They will teach you." These are the words of Dr. Worrel Sanford, a physician, a mentor, and a member of the Kalinago people. Our paths crossed early in my medical education during a visit to a remote clinic where he volunteered his weekends providing free care to this sole surviving indigenous community in the Caribbean. Shortly after our arrival in 2002, we quickly learned that Dominica's geographic remoteness translates into limited resources for all its citizens, especially for those in the Kalinago Territory.

Our small group of freshly minted medical students was disturbed by the dearth of medical supplies and medications, so we resolved to change that situation. Our efforts marked the inception of the Salybia Mission Project (SMP), an organization whose vision is to help provide medical care to the indigenous people of Dominica. What started as a student-run association that provided clinic volunteers, solicited donations, and held fundraisers to finance the venture matured into a nationally recognized nonprofit organization charged with doing the same. To demonstrate our commitment

to the Kalinago people, our first collaborative project was to enhance the existing clinic and its services. In addition to importing basic equipment and pharmaceutical supplies, our group of founders made structural improvements by painting, tiling, and installing plumbing to provide clean running water. When the original clinic was irreparably damaged by an earthquake, SMP collaborated with the Kalinago Council, the Church of the Nazarene, the Canadian Fund for Local Initiatives, and other community supporters to finance and build a new one that opened its doors in March 2010. In the interlude, SMP worked to convert an early childhood centre into a functional clinic and provide volunteer and stipended staffing so that the community's biweekly services were not interrupted.

The clinic's supplies continue to be procured and donated primarily by SMP, which finances its ventures through student membership drives and a variety of fundraising events. However, SMP believes that its role extends beyond replenishing supplies and has, therefore, broadened its efforts to help cultivate a sense of communal self-sustainability. In the past decade, SMP has managed a Nursing Scholarship Fund that was established by its pioneers. To date, it has financed the education of six nursing graduates, who now form the pillars of the front-line community health services in the territory. These nurses not only staff the clinic, but also make regular house calls and spearhead community educational activities and public health initiatives.

The Kalinago people, once a great tribe that welcomed Christopher Columbus to its shores on a Sunday (hence the name Dominica), now consists of approximately 2200 people, who live on a 1500-hectare parcel of land in a corner of the island. To help discern the social elements that affect these inhabitants' lives, the Kalinago Community Health Assessment Report[1] was commissioned and published in December 2012.

When the original clinic was damaged by an earthquake, SMP helped build a new one that opened in March 2010.

This two-year project marked a collaboration of the Kalinago Council, the Dominican Ministry of Health, SMP, the University of Manitoba, and Ross University School of Medicine. The data from the resulting report highlight the importance of the SMP's expanded initiatives that focus on building housing, providing transportation, and supporting educational programs in the community. SMP is currently in the process of securing supplies and volunteers to build a home for a family whose precarious circumstances keep them from fully integrating into the community.

What continues to fuel SMP's success is the unwavering commitment of those who nurture its vision by making it their own. Literally, thousands of Ross University School of Medicine students have carried on the work of the SMP's pioneering members and, in so doing, have left their own indelible marks. What was once a fledgling organization is now recognized as one of the largest student groups associated with the island's American offshore medical school.

On my recent trip to Dominica, I worked alongside students who exude the same passion for the work that we did as founders. Over the past decade, SMP has proven to be as beneficial to the development of the medical students as it is to that of the community it serves. Coincidentally, Ross University School of Medicine recently established a community clinical requirement as part of its basic sciences core curriculum, a requisite element of its clinical sciences courses that mirrors the patient–student engagement that is central to SMP's clinics.

SMP takes great pride in the fact that its programs are devised and implemented by its membership. Its student-directed organizational structure, coupled with the guiding hand of its advisor, Mr. John Hawley, fosters the development of strong, independently minded and very successful student leaders. While I was chief resident of one of the largest internal medicine residency programs in New York, I enjoyed listening to candidates passionately describe how their experiences with SMP enriched their personal and professional lives. These lifetime members readily deploy their skills throughout their residency training and in their careers. Some use their exposure to tropical medicine in cities that are hubs of immigrant communities. Others use their knowledge in rural medicine to work in underserviced and geographically remote areas. And then, there are those like my fellow cofounder, Dr. Challie Minton, who used SMP's model to establish a clinic in rural North Carolina.

When I embarked on my educational quest, I decided that my passion for practising medicine superseded the location where I would do it. Choosing an unconventional path meant I would face challenges not encountered by my domestic counterparts. What I could not have fathomed was that I would find myself in an environment that would become the wellspring for SMP. As I reflect from my home in Toronto, I recognize that this circuitous journey has molded me into the physician that I am today. Each day, I continue to look to my patients for guidance during our encounters, irrespective of the country or context that we find ourselves in.

If you wish to know about Salybia Mission Project, please visit us at www.salybia.org.

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This article has been reviewed by a panel of physician leaders.

Book review

The Path to Health Care Reform: Policy and Politics

André Picard
Conference Board of Canada, 2013

Reviewed by Johny Van Aerde, MD, MA, PhD, FRCPC

In *The Path to Health Care Reform*, André Picard analyzes the Canadian health care system in an historical, political, and reflective context. Throughout the entire monograph, the health journalist highlights the fact that we cannot address the "how" questions without first answering "what." What is it that we want from our health (care) system and what is that system supposed to be anyway? Surprisingly, there is no concrete description of Canadians' expectations and, because there are no precisely defined goals or outcomes, we have not seen substantial changes or improvements for decades. What business or organization would be successful and feel good about itself without goals and objectives?

Many of today's difficulties are embedded in the history of the health care system and in Canadian culture, as evidenced in the first six chapters of the book, which look back as far as the 17th century when health care was established in Quebec. Picard comes to the conclusion that many promises have been left unfulfilled, resulting in a health care system today that simply reflects political and policy choices made over the last half century. Many inquiries and commissions have been struck, many documents have been written, but very limited action has resulted, not least because health care system reform takes longer than the short election cycles or the high turnover rate of health ministers.

Of the promises made in the 2004 health accord — *A 10-year Plan to Strengthen Health Care* — the only significant accomplishment was an improvement in access to cancer treatment, cardiac procedures, diagnostic imaging, joint replacement and cataract care, resulting in reduced wait times for those specific items. Politically, that was important, but the $41-billion price tag was huge and the system did not really become more efficient.

With supportive facts, Picard argues that the other nine promises in the accord were barely touched on, mainly because no clear measures and outcomes were defined at the onset. That is reflected in reports by the now-abolished Health Council of Canada, which, on one hand, shared information on innovation across the country but, on the other, did not have much to report on the implementation of the health accord.

Picard also highlights the positive points of the Canadian health care system. It provides jobs for 1.1 million people and is a stabilizer of the Canadian economy, especially during a recession. He acknowledges that medical care and new offerings have constantly improved; however, it is the structures used to deliver the care that have certainly not improved.

Lack of change to the system is attributed to the lack of political leadership, vested interests, and the cultural fear of change. The lack of political leadership is inherent in the system of short election cycles and the tendency of politicians to hide behind constitutional and legislative myths around prohibition of health care reform. The vested interests of hospitals and other players in the health care sector, combined with a lack of coordination between "silos," have led to inertia and the status quo. Finally, Canadians fear change, and that fear is further stoked by interest groups on a regular basis.

Picard raises several issues that need to be addressed: public versus private funding, drug costs, primary care, home care, health human resources planning, and the need to abandon the bickering between the federal and provincial governments that has resulted in

inequality of services delivered in different provinces and to transform that relationship into one of real coordination and collaboration.

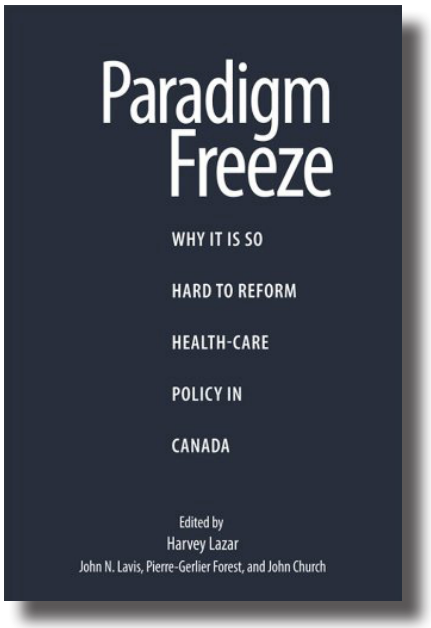
Picard argues that Ottawa has virtually withdrawn from any leadership role in health care and only contributes 20% of the costs for hospitals and physicians. Before we can accomplish any meaningful change or address barriers, some of the fundamental questions to be answered are the "what" questions: What is medically necessary? What is the evidence? What is not medically necessary? What do we mean by "sustainable"? What will we pay for? Once those questions have been addressed, we can ask "how": How will we pay for these services? How can the public purse support our medically necessary services and how can we supplement with private insurance and/or out-of-pocket options? How do we define that balance? How will we measure effectiveness and efficiency of the services delivered?

On several occasions, Picard mentions that the health system cannot be everything to everybody; a fair balance has to be struck between the needs of the individual and those of the population, including the socioeconomic need for health. Everything in the health care system is about balancing competing interests while keeping universality of necessary care central.

This monograph is a page turner; it can be downloaded electronically from the Conference Board of Canada's web site: (http://www.conferenceboard.ca/e-library/abstract.aspx?did=5863)

Paradigm Freeze: Why It Is So Hard to Reform Health-Care Policy in Canada

Edited by H. Lazar, J.N. Lavis, P.G. Forest, and J. Church
McGill–Queen's University Press, 2014



Reviewed by Johny Van Aerde, MD, MA, PhD, FRCPC

In *Paradigm Freeze*, Lazar and his team analyze 30 cases of health care reform in five provinces (Alberta, Newfoundland and Labrador, Ontario, Quebec, and Saskatchewan). They represent six health policy issues in four policy domains: regionalization (in the domain of governance); needs-based funding and alternative payment plans in primary care (both in the financial domain); for-profit delivery and wait times (both in the delivery domain); and drug cost coverage (program content domain). In essence, they compare the reforms that actually took place with the policy reform ideas and recommendations that had been set out in major, well-researched reports by government-appointed commissions, task forces, and advisory councils between 1990 and 2003. In a later chapter, they compare this era with the period from 2004 to 2011.

Each province has its own chapter, and the reading is fascinating for those of us who lived through the events in one or more of the five provinces. Because health care reform was a political priority in Saskatchewan, where medicare was born, and because of the fiscal crisis in the 90s, that province was the most successful in transforming policies into health care reforms between 1990 and 2003. Policy reform decisions on regionalization, needs-based funding, for-profit delivery, and wait-list management were made.

Although reform was also a priority for Alberta during the mid-90s and it was experiencing the same financial crisis, reform decisions there were limited to regionalization and needs-based funding. In Newfoundland and Labrador, where health care reform was not on the political agenda, very little, if anything, changed. During the same period, Quebec's main accomplishment was the comprehensive drug coverage policy. Policy reform in Ontario was slow, and the authors call it "more tortoise than hare."

For the second period, the analysis shows that the regionalization in

Alberta, accomplished during the first period, was abolished without forewarning or explanation — an aggressive reversal of the earlier policy decision. Progress was made on alternative funding plans. During that second period, Ontario sped up its reform of alternative payment plans, for-profit delivery, and wait times, with a modest shift in regionalization. Quebec implemented a policy on wait times.

Taking the five provinces as a whole, policy reform was meager. Although reform also occurred through the creative efforts of health care professionals and health systems managers, independent of the government, that is not the focus of this book. The insubstantial outcomes are explained more by health system rigidities than by a societal wish to protect a system that supposedly was doing well. This meant that the kind of reform experienced during 1990–2003 was aimed at strengthening the current model of hospital and medical services by improving performance of services, not transforming the system or inventing a new one. In other words, Canadians prefer the certainty of arrangements created half a century ago over the uncertain outcome attached to reform.

In terms of concrete results, the evidence shows that policy reform was absent or limited in 16 of the 30 cases. Only one case was deemed to be comprehensive (drug cost coverage in Quebec), one was at the border of comprehensive and significant (wait lists in Saskatchewan), and, in 12 cases, reform was moderate to significant compared with the original policy.

From that point, the book becomes even more interesting, as Lazar and his group use a mix of research methods to analyze the underlying reasons for the lack of policy reform. During 1990–2003, two independent facilitating variables had a major influence on reform decisions in the 30 cases: change in government or political leader after an election in which the platform had included health care reform (13/30) and a fiscal crisis or perception thereof (13/30). Barriers to reform were insider interests mainly of provincial medical associations (27/30), public opinion (9/30), and values as reflected in the medicare model or the *Canada Health Act* (16/30). The influence of media was weak by comparison (4/30). Knowledge from interjurisdictional learning and from the research community worked in favour of placing items on the reform agenda of the government, but did not necessarily influence the choice of that policy (12/30). Finally, depending on the policy, federal and provincial institutions influenced reform in both directions (11/30). For the 2004–2011 period, the same variables were at play with the following differences: the fiscal variable was less strong, the knowledge variable was no longer influential because the decisions had become more political and less technical, and, for Quebec, the justice system had some influence through the Chaoulli v. Quebec case.

Although the provincial medical associations, in general, have been an inhibiting force to health care transformation according to the research findings, the book mentions the contribution of the Canadian Medical Association (CMA) over the last few years. Using publications and recommendations resulting from public consultations and forums, the CMA has been urging real transformation of Canada's health care system, but it has not been able to find a government willing and able to act as a "dance partner."

The authors conclude by stating that there has been little fundamental change in Canadian health policy over the past four decades and the interplay of ideas, interests, and federal/provincial institutions has led to a paradigm freeze. The evidence in this book suggests that the chances of reform on a large scale, the type of transformational changes we need, are slim at best. Some conditions that might enable such transformational events are also ones that a majority of Canadians would not vote for if they had a choice. "Without some sort of insurmountable disruptive force, either a major shift in medical science or technology or a catastrophic economic or political crisis, fundamental health policy reform in Canada is unlikely."

Paradigm Freeze and The Path to Health Care Reform are worth reading, almost a must if you are interested in this aspect of the Canadian health care system. As this would involve reading in excess of 600 pages, this interpretive and summarizing review may be enough to satisfy your appetite.

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