CANADIAN JOURNAL OF
Volume 10 Number 2
Summer 2024

Physician Leadership

THE OFFICIAL JOURNAL OF THE CANADIAN SOCIETY OF PHYSICIAN LEADERS

In this Issue

Conference proceedings: 2024 Canadian Conference on Physician Leadership

How coaches can engage clients to empower performance

Cost is not a four-letter word: focus on what you can change

CSPL Canadian Society of Physician Leaders
SCLM Société canadienne des leaders médicaux

Contents

37 **EDITORIAL: Conference proceedings and more**
Abraham (Rami) Rudnick, MD, PhD

CONFERENCE PROCEEDINGS: Keynotes

38 **Condition critical: rebuilding medicare for the next generation:** keynote speech by Andre Picard
Colleen Galasso

40 **Inventing the future: the possibility of an island**: keynote speech by Zita Cobb
Sorya Gaulin

42 **Health system leadership: what got us here won't get us there**: keynote speech by Dr. Verna Yiu
Colleen Galasso

43 **CONFERENCE PROCEEDINGS: Panel session**
Michelle Ward, MD

45 **CONFERENCE PROCEEDINGS: Plenary workshops**
Colleen Galasso

51 **CONFERENCE PROCEEDINGS: Workshop abstracts**
Colleen Galasso

58 **CONFERENCE PROCEEDINGS: 2023-24 Canadian Certified Physician Executives (CCPE)**

60 **CONFERENCE: 2024 Chris Carruthers Excellence in Medical Leadership Award**

62 **COACHING CORNER: How coaches can engage clients to empower performance**
Debrah Wirtzfeld, MD, MBA

64 **HEALTH ECONOMICS: Cost is not a four-letter word: focus on what you can change**
Jeffrey S. Hoch, PhD, and Carolyn S. Dewa, MPH, PhD

69 **BOOK REVIEW: Health for All: A Doctor's Prescription for a Healthier Canada**
Jane Philpott, MD
McLelland & Stewart, 2024
Reviewed by Johny Van Aerde, MD, PhD

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

ISSN 2369-8322

EDITORIAL

Conference proceedings and more

Abraham (Rami) Rudnick, MD, PhD

On May 24 and 25, 2024, over 240 physicians and learners gathered in Montréal for the 2024 Canadian Conference on Physician Leadership (CCPL), sponsored by the Canadian Society of Physician Leaders (CSPL). For the first time, the proceedings of this annual conference are included in this issue of the *Canadian Journal of Physician Leadership* (*CJPL*). This year's theme, Shifting the Paradigm, was highlighted using an innovative format that encouraged attendees to rethink established norms, challenge traditional structures, and engage in bold conversations on reforming our healthcare system. The goal was to continue to shift from a reactive position to being proactive and visionary.

The conference proceedings published in this issue of *CJPL* include summaries of the keynote presentations delivered by André Picard, Zita Cobb, and Verna Yiu, prepared by CSPL executive director Colleen Galasso, who was an active listener during the conference; a panel session that unveiled intricate realities of our healthcare system from physician, patient, and policy perspectives; high-level findings from two interactive plenary workshops; and abstracts from the 15 unique workshops that were offered. By publishing these proceedings, we aim to enrich *CJPL* by informing its readers who did not attend the conference and by providing conference presenters a platform to showcase their insights. We're committed to publishing this annual conference's proceedings in *CJPL* every year.

In addition, *CJPL* continues to publish general articles as well as special sections, such as Health Economics and Health Informatics, and a series on Coaching. The plan for the special sections is to provide continuity, so that future articles leverage past and present ones in the same section using a curriculum-like approach as much as possible, while ensuring that each article also stands alone. From a format perspective, administrative staff continue to work with me to enhance *CJPL*'s readability.

This issue also marks the 10th anniversary of *CJPL*. Over the past decade, we've strived to provide you with advice and tips on leadership, along with insightful articles on Canada's healthcare system. As we celebrate this milestone, we remain committed to providing you with the knowledge and tools you need to be successful in your leadership roles.

As we continue to evolve, we're eager to receive your input on *CJPL*'s content, process, style, and format. Please don't hesitate to share your thoughts and suggestions with me or any of the *CJPL* team members. Your feedback is invaluable in shaping the direction of our journal.

Author

Abraham (Rami) Rudnick, MD, PhD, FRCPC, CCPE, CPRRP, MCIL, DFCPA, mMBA, is editor-in-chief of *CJPL* and professor in the Departments of Psychiatry and Bioethics and the School of Occupational Therapy, Dalhousie University, Nova Scotia.

Correspondence to: **Abraham.Rudnick@nshealth.ca**

Condition critical: rebuilding medicare for the next generation

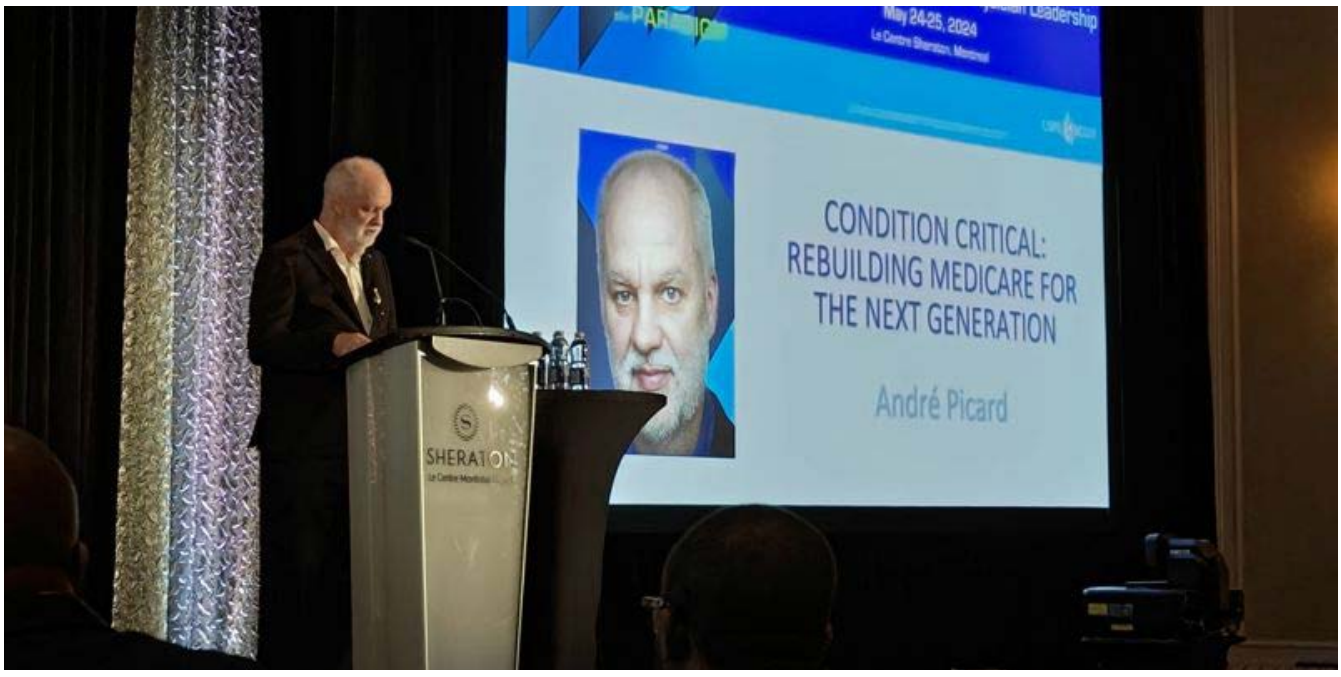
Colleen Galasso

André Picard, a well-known journalist with over 40 years of experience covering healthcare, delivered a compelling opening keynote address at the 2024 Canadian Conference on Physician Leadership (CCPL2024), held 24-25 May in Montreal. He shed light on the current state of Canadian healthcare and advocated for significant reforms that aligned with the conference theme: Shifting the Paradigm. Mr. Picard highlighted the urgent need to address the systemic issues plaguing the nation's healthcare system and presented an optimistic vision for the future. His address set the tone for the entire conference.

Mr. Picard began by stating, "The house of medicare is crumbling." He emphasized that cracks in the foundation are visible daily, both in the news and in medical practices. He cited several alarming statistics and anecdotes:

1. 6.5 million Canadians lack a family doctor.
2. Emergency rooms are closing frequently, with patients sometimes waiting 24, 48, or even 72 hours in hallways before hospital admission.
3. Long waits for diagnosis and surgery are common, leading to minor health issues becoming disabling and treatable cancers becoming fatal.
4. Ambulance response times are excessively long, especially in rural areas, sometimes up to eight hours.
5. Drug shortages and inconsistent coverage have become routine.
6. Patients are being discharged to nursing homes against their will and facing $400 daily fines if they refuse.
7. Government is interfering in transgender patient care by dictating treatment guidelines.
8. Income support for people with disabilities is inadequate, condemning them to poverty.
9. Burnout is prevalent among doctors and nurses, with many leaving the profession.

Mr. Picard declared, "There is indeed a crisis in Canadian healthcare, a long-simmering one that's boiling over in the pandemic era." However, he emphasized that despite these grim realities, his overarching message is one of optimism. "What I want to talk about is not just our failures, but our potential," he said, pointing out that healthcare has dramatically improved over the past 40 years, with medicine and approaches to health becoming more sophisticated.



He noted, "The challenges we face today are much greater than they were 40 years ago. Our expectations are far greater." According to Mr. Picard, the gap between rising expectations and the ability to meet them is the crux of the issue, but he views this as a challenge to be embraced. "Everything is fixable," he assured the audience of close to 240 physicians, residents, and medical students, stressing the need for a comprehensive blueprint, priorities, budget, and timetable for healthcare reform.

He pointed out that the health system, designed in the late 1950s and early 1960s, has not kept pace with changing demographics and medical advancements. "Today, the average age in this country is 47 and life expectancy is 82. The vast majority of care is chronic care," Mr. Picard said, emphasizing the need for the system to adapt to the aging population's needs.

Addressing the current state of Canadian healthcare, Mr. Picard remarked, "The system has, for as long as I can remember, lurched from crisis to crisis." He criticized the comparison to the United States healthcare system, advocating instead comparisons with European and Scandinavian systems. "The pandemic did not break healthcare. It was already broken. But COVID-19 brutally exposed the longstanding weaknesses," he said.

Mr. Picard identified five major problem areas that need urgent attention:

1. Primary care: "About one in four or one in five Canadians does not have a primary care provider," he stated, underscoring the importance of a strong primary care foundation.
2. Community care: He advocated for treating people where they live, focusing on interdisciplinary care and continuity.
3. Drug coverage: "We need to extend universal health coverage to prescription drugs," he emphasized, noting the lack of progress in this area.
4. Social determinants of health: He called for investment in prevention efforts and recognition of the broader socioeconomic factors that affect health.
5. Human resources: "Health should be a hands-on, people-centred business," he said, stressing the need for better recruitment and retention of healthcare workers.

On the topic of healthcare funding, Mr. Picard pointed out that Canada spends a significant amount on healthcare but gets little value for money. "We are obsessed with costs rather than results," he remarked, highlighting the inequities in the system.

Looking to the future, Mr. Picard discussed the impact of technological advancements and consumerism on healthcare. He noted the rise of telemedicine during the pandemic and the potential of AI and wearable technology to revolutionize medicine. "Medicine, and family medicine in particular, will never be the same, and that's not a bad thing," he said.

Mr. Picard emphasized the need for healthcare delivery to shift from being building-centred to people-centred. "Bring the care to them, not force them to come for the care," he advocated. He also highlighted the importance of continuous, holistic care, with primary care providers serving as the hub of the system.

In closing, Mr. Picard reiterated the philosophy of medicare: "No one should be denied essential care because of an inability to pay." He urged bold action to fix the crumbling system, stating, "This is no time for cynicism, nor for nihilism. After three years of pandemic living, people want some hope."

Mr. Picard's message was clear: although Canada's health system faces significant challenges, it is fixable. With the right reforms, Canada can create a system that reflects its values and meets the needs of its people. "We owe that to ourselves, to our children, and our grandchildren," he concluded.

Author

Colleen Galasso, executive director, Canadian Society of Physician Leaders, was a key listener at the 2024 Canadian Conference on Physician Leaders. With the speakers' agreement, she summarized this and other keynote presentations for *CJPL*.

Correspondence to: **colleen@physicianleaders.ca**

Inventing the future: the possibility of an island

"Each snowflake in an avalanche pleads not guilty."
– Stanislaw Lem

Sorya Gaulin

Zita Cobb, the CEO and founder of Shorefast and innkeeper at the world-renowned and award-winning Fogo Island Inn, was the opening keynote speaker on the second day of the Canadian Conference on Physician Leadership (CCPL).

Her message championing a holistic view of leadership resonated with the audience and complemented the essence of other speakers' addresses: to bring about systemic change, we must achieve greater collaboration between the various stakeholders, and the community must be at the table as it is the true unit of change. Leaders who recognize this and create the conditions for a holistic mindset to thrive, one that considers all parts of the whole, stand the best chance of succeeding in bringing about real change.

Ms. Cobb's personal story of growing up on Fogo Island without electricity or running water, followed by her meteoric rise in the business world as one of the highest paid executives in America and culminating in her return home to establish the Canadian charity Shorefast, offered a powerful overarching narrative for the conference's leadership theme.

After the near collapse of the fisheries, the main economic engine on Fogo Island, its population was almost resettled, as were many other outport communities in Newfoundland. The trajectory of Fogo Island was shaped by an art project by the National Film Board of Canada, called The Fogo Process. A film crew interviewed residents and engaged them in discussions with each other, capturing the interactions in 27 short films. One important outcome was the decision by Fogo Islanders to form a cooperative to manage the fisheries, which still exists to this day.

Years later, Ms. Cobb returned home to put her money to good use and create ways to add another leg to the economy of Fogo Island. Initially, the notion of building a luxury inn was met with resistance. When the proposal was sent to the various levels of government for funding assistance, one response was that it was "not normal, practical, reasonable or rational."

"But it's exactly what we need!" thought Ms. Cobb. This is the mindset she said physician leaders need to assume as they take up the challenge of providing innovative solutions to reform Canada's healthcare system. Her vision and perseverance motivated others to join in and contribute to making the Fogo Island Inn a reality. In 2023, the award-winning inn celebrated 10 years of operations.

In healthcare, as in economic development, this ability to envision a different way and bring people along to realize it, is the very definition of leadership. As Ms. Cobb said, "A systemic tilt is required to integrate communities into the economy and into systems planning…. We are all, each and every one of us, responsible for the ongoing creation of our communities… what matters is what we do. Everything everyone does matters." How leaders choose to lead is critical.

Shorefast and Fogo Island Inn are modeling a regenerative approach to community economic development that carefully considers all stakeholders in the decision-making process. This concept of collective leadership is what is needed for the future. A shared, inclusive, and visionary leadership model is essential for sustainable progress in both community and healthcare settings.

Author

Sorya Gaulin is chief marketing officer at Shorefast (**shorefast.org**).

Correspondence to: **soryagaulin@fogoislandinn.ca**

Health system leadership: what got us here won't get us there

Colleen Galasso

Dr. Verna Yiu, a distinguished leader in the healthcare field for over two decades, served as president and CEO of Alberta Health Services for six years before returning to academia where she now holds the position of provost and VP academic at the University of Alberta. She delivered the conference's final keynote address on the importance of leadership in healthcare systems.

In her address, Dr. Yiu emphasized that effective leadership is crucial for navigating the complex challenges faced by healthcare systems. She highlighted the importance of cohesive leadership, noting that the COVID-19 pandemic exposed both strengths and weaknesses in the system, including fragmentation in care transitions, communications, and data management, which led to poor outcomes.

One key issue brought to light by the pandemic was the entrenchment of pre-existing inequities, disproportionately affecting marginalized communities, including those in poverty, migrants, refugees, ethnic groups, and Indigenous communities. Health inequities related to chronic illnesses, mental health, seniors, and the homeless were exacerbated, underscoring the need for leadership to address these disparities.

Other issues that surfaced were the adverse effects of misinformation and politically motivated statements made during the pandemic. Claims such as "COVID-19 is a hoax" and the promotion of unproven therapies created public confusion and partisan differences, leading to the mistreatment of healthcare professionals, healthcare worker burnout, and influencing public perception of health measures like vaccination and mask-wearing.

Dr. Yiu proceeded to highlight numerous achievements that occurred during the pandemic in her home province of Alberta. Over 30 500 people were admitted to hospitals, with 4400 requiring ICU care. ICU bed capacity was doubled, and at the peak, COVID testing exceeded 23 000 tests a day. The staff for contact tracing expanded from 50 to over 3000, and Healthlink calls increased by 157%. Virtual care visits surged from 60 000 annually pre-COVID to 60 000 a month during the pandemic. In addition, the backlog of surgeries was successfully addressed before the fourth wave.

Many physicians were called on or "tapped on the shoulder" to take on leadership roles during the pandemic. Most held the position that "I'm first a doctor. That's what I went into healthcare for. It wasn't for leadership"; some even perceived medical leadership as "the dark side."

So why are physicians reluctant to lead? Drawing on insights from various studies, leaders face three kinds of risks: interpersonal risk (potentially harming relationships with colleagues), image risk (fear of being viewed negatively), and the risk of being blamed if leadership efforts fail. Physicians also cite financial differences, lack of training, fear of loss of autonomy, and job security issues as reasons for not becoming a leader.

Despite these challenges, effective leadership in the healthcare system has been shown to improve staff engagement, patient safety, operational management, overall credibility, and the ability to better manage physician issues. Studies reveal that medical leaders in healthcare systems achieve higher business performance, improved quality of care, and better patient outcomes. Dr. Yiu identified ways in which you can support your leadership journey to help make it a more positive experience, including joining organizations like the Canadian Society of Physician Leaders, engaging in leadership

development programs, and finding mentors.

Dr. Yiu went on to discuss the concept of "collective leadership," which involves seeing the larger system, fostering reflection, and shifting the focus from reactive problem-solving to co-creating the future. She underscored the importance of placing patients at the centre of their healthcare journey, promoting transparency and health literacy, engaging with communities to reimagine what the healthcare system can look like, and fostering innovation. This approach of collective leadership is essential for the future, as it harnesses the strengths of diverse perspectives and encourages collaborative efforts to address complex health system challenges. Moving forward, this model of leadership will be crucial in creating sustainable, patient-centred healthcare systems that are resilient and are able to adapt to emerging needs.

In closing, Dr. Yiu noted that, "We are the stewards of our healthcare system. It's been 40 years since medicare was established, and we need to commit ourselves to another 40 years and to change for the right reasons with the right outcomes. Who best to know this but physician leaders."

Author

Colleen Galasso, executive director, Canadian Society of Physician Leaders, was a key listener at the 2024 Canadian Conference on Physician Leaders. With the speakers' agreement, she summarized this and other keynote presentations for *CJPL*.

Correspondence to: **colleen@physicianleaders.ca**

Panel session: health system realities unveiled

Michelle Ward, MD

Values. Integrated systems. Brutal facts. These were some of the themes that emerged when three healthcare leaders weighed in on the Canada Health Act (CHA) and the state of Canadian healthcare at the Canadian Conference on Physician Leadership (CCPL) panel, Health System Realities Unveiled.

Moderated by journalist André Picard, the panel featured Nadia Salvaterra, a family physician and member of the board of the Canadian Society of Physician Leaders, Bill Tholl, former CEO of the Canadian Medical Association, of HealthcareCAN, and of Heart and Stroke Canada, and senior official at Health and Welfare Canada involved in framing the *Canada Health Act* and Adrienne Zarem, patient partner at Healthcare Excellence Canada.

The panel began by focusing on the CHA and questioning whether it has lived up to its five core principles. Mr. Tholl said, "We never expected the CHA would survive 40 months, let alone 40 years, without amendments…. We never expected that it would not be changed."

Mr. Tholl explained that the intent was that medically required services would be covered, not that it would focus solely on physicians and hospitals. He described how the legislation was "rushed through" in 3 months in 1984 and that it lacks specificity on many issues, including how hospitals and community health organizations should work together. "We might have been a bit more courageous," Mr. Tholl said, when asked what could have been done better. More detail would have been helpful, he said, but it was intended that this would be worked out over time.

Mr. Tholl described recent data from the Organisation for Economic Cooperation and Development, showing Canada ranked 31st among

38 developed countries in terms of number of physicians per capita and countries such as Norway and Australia graduating three times as many physicians (per capita) annually as Canada. "This is not by accident… it's by design," he said of these "brutal facts."

Ms. Zarem added that more support is needed from elected officials to fix the healthcare system. She reflected on the vulnerability that comes with believing that medical organizations can solve the issues on their own. She noted that legislation and the system ought to enable clinicians to do their work, not create barriers.

Dr. Salvaterra noted that barriers to care are a result of many factors including physical infrastructure, human resources, information sharing, time pressures, and the burden of being a gatekeeper to system resources. She noted that many issues are beyond the control of physicians. "I spend more of my time identifying things I cannot do for patients than things I can do for patients," said Dr. Salvaterra.

With the challenges of the Canadian healthcare system in mind, all three speakers focused on integration of services as a key driver for future success. Mr. Tholl pointed out that Canada's Ministry of Health and Welfare was split into two ministries in 1993, essentially "diminishing the political power" of the Ministry of Health and limiting its ability to "broadly and inclusively" consider all factors related to health, such as social determinants of health. Currently, Mr. Tholl noted, the federal government is focused on housing policy. However, there is no link to health policy, despite the knowledge that people experiencing homelessness are twice as likely to be admitted to hospital.

"Bridges don't exist," said Mr. Tholl, "There are very few ways to move money around between ministries."

Ms. Zarem noted that hospital stays are longer for those with no one to care for them at home. She stated that housing, education, food concerns, and appreciation of caregiving by family and friends requires integration within health policy at all levels.

Emphasizing this point, Mr. Tholl said that one of the ways to fix the current healthcare system is not to do what has been done before – create silos. He also sees recent calls for a separate health act or companion legislation for mental health as misguided.

With so many challenges to healthcare in Canada, the panelists were asked whether the system was "fixable."

Dr. Salvaterra replied, "I have to believe it's fixable." She said that being a clinician and physician leader helps with this, as when she is faced with a clinical problem she can't solve, she can "zoom out" and look at it at a system-level, and vice versa. She emphasized, "What we keep and what we change – the basis is our shared values." This will help determine whether the system needs a renovation, a rebuild, or a cosmetic fix, she said.

Ms. Zarem joked that she was not interested in cosmetic fixes, but agreed that the fix starts with understanding values. She highlighted the role of

reaching out to underserved communities to co-create solutions. "Get rid of the table – we need to go to them [patients]. Use the privilege that we have… to create space for people who we don't usually invite to the table."

Mr. Tholl reflected on whether the Canadian public's values align with the CHA from 40 years ago, with individualism being more prominent now as compared to the more common philosophy of communitarianism then.

Mr. Tholl also highlighted values, stating, "If we stick to our values… we can face those brutal facts and fix the system."

The panel's messages were echoed by some members of the audience. Dr. Jean-Christophe Carvalho, a cardiologist and CEO of the Centre intégré de santé et de services sociaux de Bas-Saint-Laurent, said that the panel made him reflect on his work related to integration in primary care services across his region. For example, a new model, Le Gap, allows telephone contact with a nurse to triage concerns and refer directly to primary care providers, pharmacists, physiotherapists, social workers, occupational therapists, and other healthcare providers for patients without a family physician.

Anthony King, program manager at the Medical Council of Canada, stated that he reads patient feedback daily and is struck by how often messages convey full satisfaction with their physicians. "It's the infrastructure they're not happy with, not the doctors," he said. He also emphasized patient involvement.

Dr. Angie Hong, family physician and executive coach, stated, "Everyone is fairly clear on all the problems that exist… I'm not sure we're yet talking about a lot of solutions."

Author

Michelle Ward, MD, is a is a health communications consultant, journalist, pediatrician, and associate professor at the University of Ottawa.

Correspondence to: **michellegkward@gmail.com**

Interactive plenary workshop sessions

Colleen Galasso

At the heart of healthcare transformation lies the need for fresh perspectives and innovative approaches to address our systems' complex challenges. To this end, the conference departed from its traditional format of offering concurrent workshops in the morning and afternoon of the first day and, instead, hosted plenary workshops. The goal was to infuse the conference with a new level of engagement and liveliness, expanding the opportunity for dynamic interactions and collaborative dialogue among participants.

Plenary workshop 1: Setting the stage for action

The morning workshop used an innovative facilitated "interview matrix"[1] approach (figure 1). Participants engaged in six rounds of brief interviews, alternating between roles as interviewer and interviewee. The room was divided into four quadrants, each with its own question. These questions were designed to build on the information and insights shared by Mr. Picard in the opening keynote presentation and the subsequent panel session, providing participants with new perspectives on our complex healthcare system. The questions were colour-coded, allowing participants to easily identify interview partners by holding up and waving their coloured sheets. Below is the sequence of interviews conducted during the session and a high-level summary of the responses.

Question 1: The healthcare system is all about relationships (e.g., patient–physician, physician–physician, physician–organization, organization–government). ***How can we redefine these relationships to enhance trust and better serve all stakeholders?***

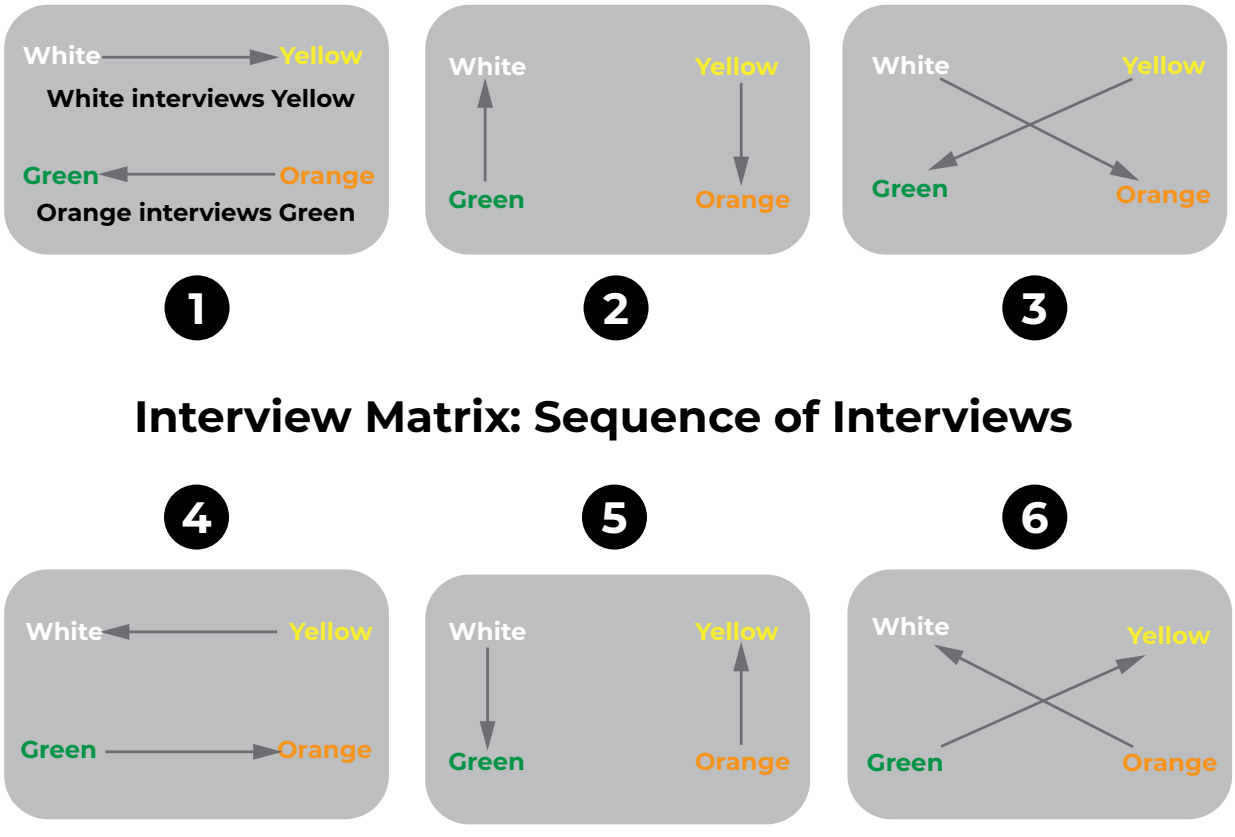
Participants emphasized that redefining relationships in healthcare to enhance trust hinges on clear communication and accountability among all stakeholders: patients, caregivers and families, physicians, hospitals, the public, and governments.

This involves increasing transparency and being open about how and why decisions are made. Practicing authentic listening and creating safe spaces for honest communication allow stakeholders to feel comfortable sharing their thoughts and concerns. Seeking alignment on shared values and goals and making commitments to address concerns are also essential. Above all, prioritizing patient-centred care ensures that the focus remains on what is best for the patient.

Question 2: We heard that meaningful involvement of the public, patients, and caregivers in healthcare transformation efforts is often hindered or lacking. ***How can we ensure inclusivity and that diverse perspectives are present around the transformation table and considered in the decision-making?***

Participants stressed that achieving inclusivity and diverse perspectives in decision-making requires engaging stakeholders on their terms and respecting their identities. Implementing an ongoing process for continuous engagement is crucial in fostering long-term relationships. Authentic engagement means addressing personal bias and involving stakeholders and their diverse perspectives from the outset, not just soliciting feedback. Providing education, resources, and fair remuneration for community representatives will support their active involvement and create safe dialogue spaces. Reviewing and refining inclusivity within the *Canada Health Act* is essential to promote co-ownership of solutions and drive real change.

Figure 1: Six rounds of interviews allowed participants to engage with others as interviewer or interviewee



Question 3: Physicians often highlight issues beyond their control and overlook those within their sphere of influence. Health professionals, in particular physicians, have power and can influence, yet sometimes this power can result in advocating more for professional needs than for the good of all. ***How can we advocate for systemic changes that address healthcare disparities and ensure that all communities have access to quality healthcare?***

Participants emphasized that engaging with underserved communities is essential for understanding their needs and avoiding assumptions. They highlighted the importance of forming diverse partnerships and broad coalitions involving not just communities but not-for-profit organizations, patients and their families/caregivers, providers, and allies to amplify unheard voices. Using data to identify disparities and support advocacy messaging was also stressed.

Inclusive leadership should support advocacy efforts, focusing on transparency, accountability, and interdisciplinary collaboration. Leveraging technology, such as virtual care and artificial intelligence (AI), can help reduce geographic access barriers. Addressing healthcare disparities also requires tackling social determinants of health through upstream thinking and prevention. Finally, integrating leadership and advocacy skills into the formal medical education curriculum is crucial for sustaining these efforts.

Question 4: Despite ongoing discussions about healthcare transformation over the years, substantial changes have yet to materialize. ***What actions can physician leaders take now, within their spheres of influence, to initiate the necessary changes in the healthcare system, and how do we create a sustainable change movement?***

Physician leaders should build authentic relationships and foster ongoing dialogue with patients, community leaders, and other stakeholders. Strategic leadership, anchored in a clear and shared vision encompassing diverse perspectives, is essential for creating a consensus-driven approach that embraces bold, courageous actions and political engagement. Start with manageable initiatives and build on these successes to drive meaningful, incremental change. Leveraging data to support evidence-based decisions and ensuring accountability through measurable outcomes will assist in sustaining progress. Continuous education, empowerment, and holding leaders accountable for progress will help sustain long-term change.

The *Setting the stage for action* session provided attendees with a platform to engage in thought-provoking discussions, emerge with fresh perspectives, and identify innovative options to address key challenges facing our healthcare system.

Plenary workshop 2: Pathways to health system reform

The afternoon plenary workshop used the dynamic Open Space[2] facilitation approach, placing participants at the heart of the discussion by allowing them to generate the topics themselves. This engaging process starts with a theme or "sentence stem" without a predetermined outcome. For our conference, the sentence stem was: "*In order to manage the polarity of continuity and transformation of the Canada Health Act, we need to pay attention to…*"

The room was arranged with circular rows of chairs surrounding a central table (Figure 2). Participants completed the stem sentence with their topic and placed it in the Market; 35 topics were identified. Following this, there were three rounds of 30-minute conversations where participants self-selected the

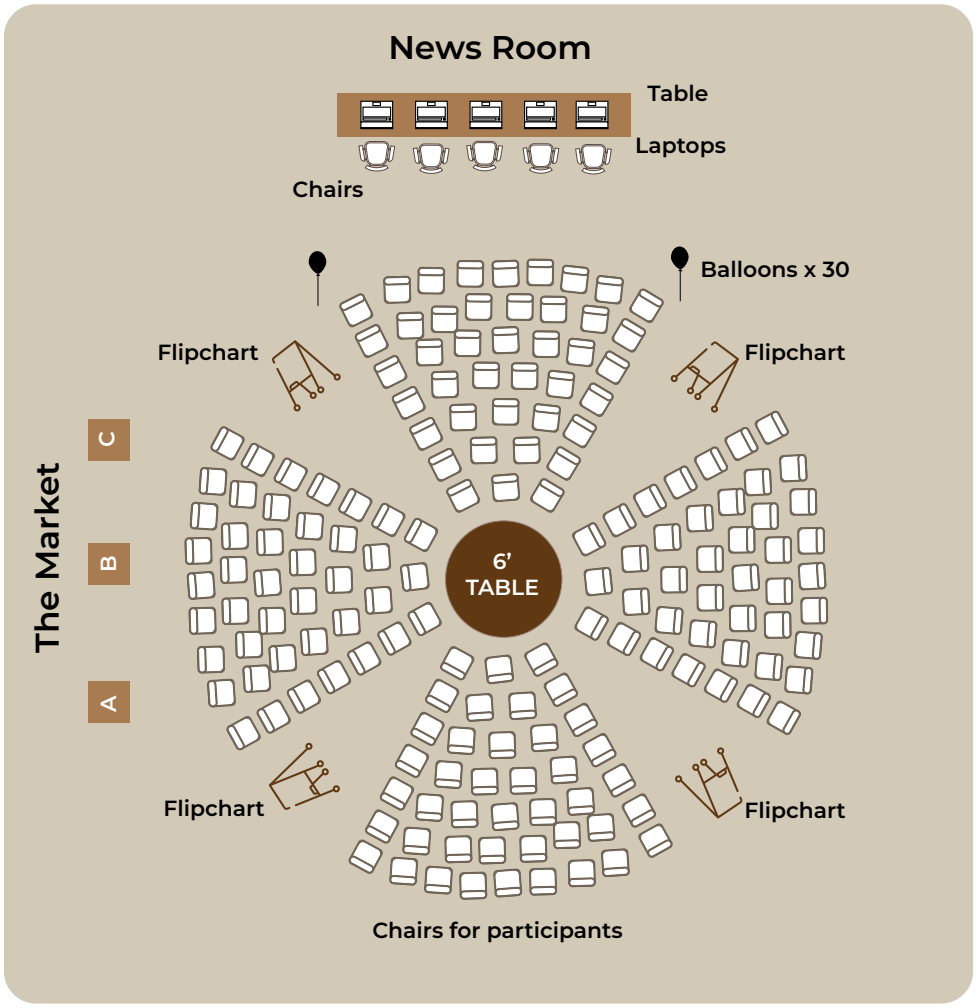


Figure 2. Layout for the Open Space forum

topics they were most passionate about and joined others for a lively exchange of ideas and discussion. After the three rounds, each participant received the same, specific budget of $1.85 in denominations of $1.00, $0.50, $0.25, and $0.10, and was asked to allocate the entire amount to the topics they deemed most important. This allowed participants to prioritize which topics to focus attention and resources on.

In each conversation, participants were asked to identify at least two things that we are doing right related to the topic and two or more things we could do to improve on the topic. In addition, they had the opportunity to provide their contact information, indicating their willingness to participate in reform activities related to the topics they were passionate about. This information was recorded in the News Room for further analysis. Below is a high-level summary of the top seven topics in order of priority based on the budget participants allocated to each.

1. Public health determinants ($18.60)

Doing well:
a. Recognizing the crucial role of public health in Canada
b. Vaccination programs are protecting children from infectious diseases

Needs improvement:
a. Committing sufficient resources and providing long-term stable funding at the local, provincial, and national levels
b. Shifting policy priorities to public health with corresponding changes to the legal framework

2. Team-based care ($14.95)

Doing well:
a. Piloting team-based care delivery models, including networks, clinics, and system-level initiatives

b. Integrating patient partners as active members of the care team, contributing valuable perspectives that improve patient outcomes

Needs improvement:
a. Interprofessional collaboration between physicians, registered nurses, and case managers
b. Establishing clear delineation of responsibilities and accountability within the team, including scope of practice
c. Addressing geographic barriers that hinder access to team-based care

3. Accountability and enforcement ($13.85)

Doing well:
a. Quality of care is generally excellent
b. Ensuring care is portable across the country

Needs improvement:
a. Accountability in how federal health transfers to provinces and territories are spent
b. Applying and enforcing the rules (principles) consistently across Canada

4. Primary care ($12.95)

Doing well:
a. Socializing the population about the critical role that primary care plays in the healthcare system
b. Training family physicians
c. Expanding team-based care
d. The concept of a patient's medical home is working well in some jurisdictions
e. Increasing funding to the community

Needs improvement:
a. Creating a system to transition patients to a primary-care team in their community/area.
b. Funding primary care teams as an essential service using a standardized model that is national in scope and includes measures of accountability
c. Socializing the population to non-primary care providers
d. Scaling up and increasing the use of successful models

5. Technology ($10.90)

Doing well:
a. Increasing awareness and governance of artificial intelligence over the past four years
b. Including stakeholders from the technology sector at the table
c. Artificial intelligence is helping to address inequality and accessibility in the healthcare system
d. Integrating virtual care into the healthcare system

Needs improvement:
a. Clarifying the role of technology in relation to the *Canada Health Act* – funding (who pays, what is covered), accountability, access, connectivity, laws, and regulations
b. Scaling up technology across the country, keeping in mind ethical balance
c. Measuring technology as it relates to the *Canada Health Act* (e.g., evaluating and assessing how technological advancements and implementations align with the principles and objectives outlined in the *Canada Health Act*)

6. Quality of care ($9.30)

Doing well:
a. Family physicians leading team-based care
b. Accrediting acute/patient care

Needs improvement:
a. Ensuring all care providers, clinics, and teams are accredited, including alternative providers and evidence-based quality outcomes
b. Recognizing the link between quality of care and healthcare provider wellness
c. Defining quality from the patient perspective using research-based criteria
d. Balancing access, continuity, and quality considerations
e. Improving data collection related to healthcare teams to improve quality and address accountability

f. Using outcome measures and key performance indicators (KPIs), including patient-reported outcome measures (PROMs)
g. Incorporating more patient voices in healthcare decisions

7. Retention ($6.70)

Doing well:
a. Integrating and engaging physicians and their families in their communities
b. Increasing awareness of the retention problem with good intentions to improve
c. Increasing exposure related to this issue in medical school
d. Supporting physicians in rural areas

Needs improvement:
a. Ensuring that the care team is well-supported with adequate personnel and financial resources
b. Understanding and addressing reasons for staff turnover and mitigating human resource shortages, feelings of isolation, and costs related to family medicine
c. Recognizing and addressing the retention problem by assuming responsibility for payments, recruitment processes, and providing compensation and benefits.
d. Increasing staff and support for physicians to alleviate unsustainable workloads
e. Fostering a good working environment by addressing hierarchical issues, empowering leadership, implementing time-off policies, and addressing toxic work environments
f. Ensuring the community pays attention to job and life satisfaction for physicians and their families
g. Embracing electronic health records and new technology to enhance patient care and personnel care

Other topics that were suggested and received a share of the budget included: healthcare costs, licensing of international medical graduates, letting the data speak (i.e., making decisions and drawing conclusions based on objective evidence), social prescribing, national culture and values (i.e., collective beliefs, customs, practices, and social behaviours that characterize a particular country or society), modernizing the *Canada Health Act* and the consequences of changing it.

The *Pathways to health system reform* plenary workshop showcased the impact of collaborative engagement in tackling the complexities of health system reform. The Open Space facilitation technique allowed participants to engage in inclusive dialogues to identify the priority topics and brainstorm solutions.

The insights gained from this session will be compiled into a comprehensive report, which will be disseminated to key stakeholders, including policymakers, healthcare administrators, medical associations and organizations, medical professionals, and community leaders. The goal is to guide these stakeholders toward implementing reform measures within the identified topic areas so that the evolving needs of patients, the public, and healthcare workers are effectively addressed. The findings will be shared through various channels, such as CSPL's website, e-newsletters, *CJPL* and workshops to ensure widespread accessibility and engagement.

References

1. O'Sullivan T, Tracey S, Cornell W. Structured interview matrix (SIM): facilitators' guide. Ottawa: EnRiCH, University of Ottawa, LIFE; 2022. Available: **https://ruor.uottawa.ca/server/api/core/bitstreams/619661a6-8bde-43f1-b0de-f95baf04a5a4/content**
2. Herman M. What is Open Space technology? Open Space World; 2024n.d. Available: **https://openspaceworld.org/wp2/what-is/**

Author

Colleen Galasso, executive director, Canadian Society of Physician Leaders, was a key listener at the 2024 Canadian Conference on Physician Leaders.

Correspondence to: **colleen@physicianleaders.ca**

Workshop abstracts

Creating success from our differences and opportunity from conflict: the Team Optimization for Physicians (TOP) initiative

Amanda J. Brisebois, MD, FRCPC, FACP, AoDI, PCC(ICF), CCPE

The TOP program was introduced by sharing case studies that exemplify how this program can ensure operational and team successes. The program brings structure to working together to solve problems and creates space for teams to heighten their communication and integration skills.

The TOP program promotes the model "B Better 2 B Free." Success is achieved by managing differences in the moment and facing concerns and conflicts with a clear process based on mediation principles. These principles honour individuals within teams and teach participants strategies to ensure that differing opinions are embraced.

Participants in this workshop were expected to leave with concrete examples to transform their workplaces into environments where open communication is welcome, our differences are turned to successes, and conflict is seen as an opportunity.

Learning objectives:

- Recognize how the current focus on "well" workplaces can be transitioned into action.
- Master the "B Better 2 B Free" processes for turning in-the-moment differences into successes and creating opportunity from conflict.
- Recognize the power of the TOP program to transform workplaces by identifying individuals and teams who need support, working through issues with process, and creating a team playbook focused on customized issues that a team is facing.
- Use the success of programs in Alberta to start to plan local initiatives to support practitioners and teams in the workplace.

Managing disruptive behaviour in the healthcare workplace

Heather Murray, MD, MSc, FRCPC; Liisa Honey, MD, FRCSC; Armand Aalamian, MDCM, CCFP, FCFP

Unprofessional behaviour in the healthcare workplace undermines working relations and team dynamics. The current climate of resource scarcity, access to care challenges, and provider stress and burnout are likely contributing to workplace incivility. The impacts of these unprofessional behaviours can have significant negative effects on patient safety, staff morale and retention, and increased organizational costs. Physicians who exhibit unprofessional behaviour may have concurrent challenges with stress and mental health.

Leaders who have structures in place to identify these events can compassionately debrief involved staff, offer staff exhibiting unprofessional behaviour insight into their impact, and connect them with supports and strategies for behaviour change. The Canadian Medical Protective Association (CMPA) offers a course to members who are also physician leaders, entitled *Strategies for Managing Unprofessional Behaviour*. This case-based workshop was based on key elements of that course. Participants left with insights into the causes, contributing factors, and impacts of unprofessional behaviour in healthcare workplaces. The importance of a fair, procedure-based approach, using examples of existing institutional and provincial policies to discuss the management of representative cases, was reviewed. Incorporating a structured framework, a step-wise approach to identifying, debriefing, and remediating distressed individuals who are exhibiting unprofessional behaviour was applied. Physician leaders with new insights into unprofessional behaviour and an approach to managing it are better equipped to "do things differently" in their institutions.

Learning objectives:

- Define unprofessional behaviour and list outcomes for patients, staff, teams, and organizations.
- Understand the role of procedures and procedural fairness in responding to reports of unprofessional behaviour.

- Summarize a stepwise approach that can be used to intervene and remediate unprofessional behaviour.

Trust in me: using trust to transform health teams and systems

Michelle Ward, MD

Recent research shows that public trust in the healthcare system has declined, patients trust their physicians less than in the past, and trust issues within teams negatively impact collaboration and productivity.

This workshop focused on trust as a core element of healthcare leadership and its ability to transform the health system from individual interactions to team dynamics to public messaging. It examined the elements of trust, strategies to build and convey trust as a leader, and how to navigate trust dynamics in a group.

Following illustration and analysis of trust elements, small-group game-play (with assigned roles) was used to practice skills and evaluate trust dynamics. Reflection and large-group feedback was used to enhance learning.

Learning objectives:

- Describe the elements of trust and their role in medical leadership.
- Demonstrate communication skills that convey trustworthiness.
- Identify practical strategies to incorporate greater trust in one's work.
- Analyze trust dynamics within a group.

From allyship to co-disruption: leadership training for an inclusive workplace

Mamta Gautam, MD, MBA, FRCPC, CCPE, CPE; Ming-Ka Chan, BSc(Psych), MD, MHPE, FRCPC

Allyship training for leaders is essential to cultivate a safe and accountable workplace that removes barriers to access and enhances participation of teams. With increasing recognition of the need to advance equity, access, and participation, healthcare organizations have initiated policies and programs to promote the representation and participation of diverse groups of individuals, of various identities including and not limited to age, race, ethnicity, ability, disability, gender, religion, culture, and sexual orientation.

Research shows that the right policies alone cannot shift workplace culture. It is imperative that leaders behave and step up as allies and co-disruptors to leverage their power and privilege, take action, and demonstrate commitment to the cause. Allies inspire others to act as change agents in creating a healthy culture of belonging and support. Such healthcare cultures will then have positive downstream impacts on patients', caregivers', communities', and planetary health.

Through a combination of learning and development, storytelling, small and large group discussions, scenarios, and skill acquisition, this workshop provided new ways to foster critical dialogue about differences and equity and share concrete, actionable tools to empower employees and leaders to advocate for themselves and others. It addressed how to recognize and intervene in learning and workplace marginalization, feel empowered to speak up when inequities appear, and respond when microaggressions occur. This workshop aimed to position leaders to model and establish positive allyship behaviours in the workplace, co-create collectively, and work in solidarity.

Learning objectives:

- Define allyship and associated core concepts.
- Identify one's accountabilities as a leader and potential allies.
- Describe how to tangibly practice allyship in the healthcare workplace.

Understanding change roles — aligning people for success

Shayne Taback, MD, FRCPC, CEC

Physician leaders need a solid understanding of change dynamics to achieve results (LEADS framework). In his 1992 book, Managing at the Speed of Change, Darryl R. Conner initially introduced four change roles: change advocate, change sponsor, change agent, and change target, and this framework

has been refined since then. Leaders with knowledge of these roles and their best practices can gain improved clarity around the authorization of people involved in the change and the ability to diagnose and treat alignment issues.

This workshop was intended for anyone interested in being more successful at bringing about change inside their organization.

Learning objectives:

- Classify individuals involved in a planned change by their change roles.
- Construct a map of these individuals.
- Select strategies to improve alignment of people in the system.

Mindful self-compassion for healthcare professionals

Kristy Williams, MD, CFPC; Victoria Pawlowski, MEd, RCC

Mindful self-compassion (MSC), rooted in evidence-based research, equips healthcare professionals with skills to effectively navigate distressing emotional situations in both their professional and personal lives. MSC has been shown to significantly reduce depression, stress, secondary traumatic stress, and burnout, while simultaneously enhancing self-compassion, mindfulness, compassion for others, and job satisfaction among healthcare professionals.

Through brief presentations, mindfulness activities, hands-on exercises, group dialogues, and at-home practices, this workshop provided participants with direct encounters with self-compassion and imparted practices that evoke self-compassion in their everyday routines and contribute to the development of strong healthcare leadership.

Learning objectives:

- Understand the evidence-based benefits of self-compassion.
- Apply the skills of mindful self-compassion to care for oneself and alleviate stress and symptoms of burnout for physician leaders.
- Practice self-compassion in relationships and caregiving.

Building Indigenous intercultural capacity

Lisa Abel, NVision Insight Group

Designed by NVision, a majority Indigenous-owned company, this workshop addressed a variety of Canada's Truth and Reconciliation Commission's calls to action. Participants built their Indigenous intercultural capacity – in areas such as adaptation skills, self-knowledge, attitude of respect, intercultural communication, and other attitudes and skills – to be anti-racist and strengthen relationships with Indigenous communities, organizations, and governments.

Learning objectives:

- Understand what race, racism, bias, and culture are.
- Identify Indigenous stereotypes and learn how to counter them.
- Develop skills in building Indigenous intercultural capacity.

Let's negotiate, docs!

Deepti Ravi, MD, FRCPC, FCAP, EMBA

Negotiations are an integral part of healthcare, from contract signing to securing funding. However, many healthcare professionals find these conversations uncomfortable and challenging. This workshop addressed the critical need for healthcare colleagues to confidently engage in negotiations, fostering an environment where they can advocate for what they deserve.

Participants were expected to gain enhanced negotiation skills, increased confidence in advocating for themselves, and a practical understanding of how negotiations can contribute to long-term career satisfaction and well-being.

Learning objectives:

- Understand and apply basic negotiation tactics in a systematic and timely manner.
- Integrate theory, evidence, and method related to negotiation into clinical and administrative practice to identify goals shared with colleagues.
- Engage in hands-on negotiation exercises to initiate practical skills development.

Living, learning, and earning longer: navigating career longevity and avoiding career burnout

Kelly Tremblay, PhD, FAAA, CEC, ACC

Many of us are going to live a decade or so longer than our parents and living longer presents challenges and opportunities. The United Nations describes longevity and population aging as one of the most significant social transformations of the 21st century because it will affect nearly every sector of society – including our own health and careers. Whereas our parents experienced a 40-year career span, our careers will likely span 60 years.

If living longer requires earning longer, and earning longer requires learning longer, then physicians, allied healthcare professionals, and administrators are at a particular disadvantage. Physician burnout is an epidemic in North America, with growing numbers of physicians, residents, and administrators reporting symptoms. These symptoms do not appear to be the result of being on the job too long because research suggests that practitioners and leaders with 20 years or less in practice are significantly more likely to be experiencing burnout than those late in their career.

In this workshop, we reviewed what research is revealing about the typical career span of physician and allied healthcare leaders and how to navigate the extra miles with burnout in mind. Specifically, peer-reviewed resources and tools, designed to enhance leadership capabilities and preserve health, were shared and practiced onsite and in real time.

Learning objectives:

- Create a personal career timeline that includes best practices for preserving health and career longevity.
- Recognize many symptoms of burnout and fatigue and their effects on people's minds and bodies.
- Comprehend peer-reviewed strategies for preserving health and career longevity.
- Apply peer-reviewed leadership and lifestyle strategies designed to prevent burnout.
- Identify available tools and resources for continued reflection.

Atomic transformation: creating an environment for positive and productive change in health systems

Nicole Boutillier, BSc, MD, CCFP, FCFP, CCPE; Govind Adaikappan, BASc Mechanical Engineering, MASc Industrial Engineering, EMSc, Health Economics, Policy and Management

As demands on healthcare systems continuously increase, the need for physician leaders to navigate complexities and drive transformational change has apparently never been higher. Over 70% of transformations fail; hence, we need to do things differently. "Every system is perfectly designed to get the results it gets" (Dr. W. Edwards Deming).

To pivot from the status quo, leaders should focus on two critical aspects: intentionally shaping the organizational environment by influencing structure and systems to guide transformation with an equal emphasis on what and how; and setting leadership behavioural norms – what are the expectations and how will they be lived?

This workshop explored key elements of an environment in which leaders are successful and provided practical steps to build such an environment.

Learning objectives:

- Share lessons learned from transformation efforts across a healthcare organization staffed by 25 000 people.
- Understand core elements required to build the environment for successful transformation.
- Recognize core leadership behaviours needed to drive transformation.

Building a community of practice for hospital chiefs of staff

Nancy Merrow, MD, CCFP(PC), FCFP, G(CEC), former chief of staff and vice president, Medical Affairs, Orillia Soldiers Memorial Hospital

Hospitals' chiefs of staff hold a pivotal leadership role with direct accountabilities at the highest level of the organization. Although long established in legislation and hospital bylaws, this role is often ill defined and poorly understood. This role's oversight of the recruitment, retention, performance, and engagement of physicians, midwives, nurse practitioners, and dentists who are not in an employment relationship with the hospital is complex and requires deft handling of relationships and incidents that directly affect patient care. Successful chiefs of staff sometimes say that they have a lot of responsibility with much less actionable authority. Nonetheless, the hospital's senior administration and its board of directors rely on the chief of staff to manage credentialed staff in a way that optimizes their engagement and minimizes related risk to the organization and to the patients it serves.

The chief of staff can benefit from creating a network of relationships and supports that accelerates their learning and sustains their energy in this role.

This workshop used an interactive game format to explore and practice collaboratively, using scenarios drawn from real-world experiences to create action plans using available resources.

Learning objectives:

- Enhance specific methods to communicate with impact, get results at meetings, and have high stakes conversations in the role of a hospital's chief of staff.
- Acquire an approach to identify one's knowledge and skill gaps and create a related development plan to thrive in leadership.
- Gain a network of colleagues across Canada who can continue to learn together and share experiences that expedite solutions to sticky situations.

Collectivism in medicine: a better model of excellence?

Eusang Ahn, MD, MSc(MedEd), Dipl. KSEM, FRCPC; Kaitlin Endres, MD; Jerry Maniate, MD, MEd, FRCPC, FACP, CCPE, CPC(HC)

In an era of unprecedented burnout among healthcare professionals, new solutions and strategies to strengthen their resilience and enhance their work life are of paramount importance. Collectivism, a holistic group-based mindset model for the well-being of both clinical care and healthcare professionals is novel in the western context. Collectivism may offer valuable lessons and a new perspective on how to approach the creation of better models of excellence.

This workshop aimed to explore likely applications and added value stemming from the adoption of collectivist principles in healthcare.

Learning objectives:

- Identify the individualist cultural aspects of the current models of "team-based" practice and their origins.
- Define and discuss collectivism and explore its application in cultural and professional contexts.
- Co-create novel strategies that use aspects of a collectivist approach for cultural change in participants' organizations and groups.

Change leadership: overcoming tribalism and embracing disruptive innovation

Tamara McColl, MD, FRCPC, MMEd; Eddy Lang, MDCM, CCFP(EM), FCFP, FCAHS, CCPE

Healthcare is delivered within complex systems, by a heterogeneous group of individuals with differing social identities related to their various departments and specialties. As a result, tribalism has developed between disciplines and has become a significant barrier to achieving a collaborative approach to patient care in a system under duress. Tribalism is defined as "loyalty to a tribe or other social group, especially when combined with strong negative feelings for people outside the group" (Britannica Dictionary).

Despite the shared goal of delivering effective patient care, healthcare professionals often work in silos and typically exhibit discordant views toward each other in terms of their level of contribution to patient care as well as the overall healthcare system. These biases

are deeply rooted and pose significant challenges as we collectively attempt to address a healthcare crisis that includes access restriction and massive staffing shortages. Healthcare providers have lost confidence in the ability of our current system to address these issues. We need a more comprehensive and collaborative approach to eliminating the silos between departments and specialties. This workshop provided practical strategies to foster collaboration.

Learning objectives:

- Address an approach for leveraging current crises in healthcare to improve provider engagement and outcomes.
- Develop strategies for reducing inter-specialty conflict and foster the development of a shared vision and collaboration.

LEADS-SAFER: an expanded LEADS framework to achieve safe, inclusive leadership

Jennifer Williams, BSc, MD, FRCPC; Jodi Ploquin, MSc, TIC, CWT, CHE; Johny Van Aerde, MD, PhD, FRCPC; Graham Dickson, PhD, Partner, LEADS Global

Eight out of ten physicians in Canada report experiencing bullying and harassment in the workplace. A third of female surgeons report being sexually assaulted by a colleague. There is mounting evidence of racism and microaggression impacting the well-being of physicians and medical learners. Anti-science has introduced new forms of patient-to-worker violence. Moral distress has been amplified by a post-pandemic backlog of care and workforce shortages.

These are all sources of emotional injury that threaten the well-being and performance of our providers. Many will look to their leaders and healthcare organizations for support. If their experience is dismissed, minimized, or shamed, it causes a second harm, known as sanctuary trauma or institutional betrayal. Repetitive exposure to trauma has exacerbated burnout, mental health issues, and challenges accessing mental health supports.

What does this mean in the context of a longstanding healthcare leadership framework like *LEADS in a Caring Environment*? We cannot assume that the healthcare environment is inherently caring. In fact, many healthcare providers do not experience a safe environment.

Our foundational leadership framework and embedded leadership behaviours need to extend beyond the focus of achieving results and systems transformation (LEADS) to proactively taking care of our people by creating safe and inclusive workplaces – SAFER. The domains of SAFER are: safety (cultural, psychological, and physical); awareness of sources of workplace trauma and impacts; foster voice and choice; embrace compassionate curiosity (shift from judgement to curiosity); restorative connections.

We proposed a novel expansion of the LEADS framework, to LEADS-SAFER. The SAFER domains explicitly build the "people side" of leadership, describing the capabilities needed in leaders to create safe, inclusive workplaces where healthcare providers can thrive.

Learning objectives:

- Clarify the call to action by healthcare leaders for a paradigm shift in healthcare.
- List evidence that most healthcare providers do not experience a workplace that is a caring environment.
- Explain the need for explicit expansion of the LEADS framework to achieve safe and inclusive leadership.
- List leadership attributes of the SAFER approach to shift the paradigm beyond a results-focused mindset to a people-first mindset.
- Identify two actions to apply SAFER principles in practice.

Strategic planning and execution

Callie Bland, BSc, BSN, Certified Professional Co-Active Coach (CCPN)

Strategic planning is an essential leadership skill that helps leaders focus and be proactive rather

than reactive and provides a sense of direction and vision with an actionable plan to achieve desired outcomes. Strategic planning improves decision-making, increases operational efficiency, enhances coordination and alignment between departments and stakeholder groups, and strengthens accountability. Providing physician leaders with strategic planning language, concepts, and skills can increase their confidence and effectiveness to engage with healthcare administrators and with the business function areas of an organization. Encouraging physician leaders to consider how their work connects to the vision, mission, values, strategic priorities, and objectives of their organizations can increase physician involvement in their organization's planning process.

This workshop focused on three phases of strategic planning that align with the CanMEDS competency to engage in the stewardship of healthcare resources and with the achieve results domain of the LEADS framework. It was also planned to help participants increase awareness of personal strengths they bring to strategic planning and empower them to fully engage with it so that they feel they belong in this planning process. Participants were equipped with a practical strategic planning framework that can help them implement their own planning processes and show them how to participate in the planning that already exists in their organization.

Learning objectives:

- Enhance awareness of the importance of strategic planning and its key components as well as concepts of a strategic plan.
- Explore three phases of strategic planning and the elements of each stage.
- Review important activities needed to execute a strategic plan successfully and ensure related accountability.
- Understand pitfalls that may compromise strategic planning.

2023-24 Canadian Certified Physician Executives

Dr. Jane Barron
Chair, Discipline of Laboratory Medicine, Faculty of Medicine, Memorial University of Newfoundland / Provincial Neuropathologist, Newfoundland and Labrador
St. John's, NL

Dr. Christy Bussey
Zone Medical Executive Director – Central, Nova Scotia Health / Hospitalist, QEII Health Sciences Centre
Halifax, NS

Dr. Paula Cashin
Vice Chair, CMA Board of Directors & Board Director, CMA Foundation / Council Member, Canadian Medical Protective Association
Gander, NL

Dr. Ken Farion
Provincial Medical Director for Hospital Services and Patient Flow, Health PEI / Past VP Quality, Strategy & Family Partnership, CHEO
Charlottetown, PE

Dr. Robert Green
Senior Medical Director, Trauma Nova Scotia / Director, Research in Medicine Program, Dalhousie University Medical School / Board, Trauma Association of Canada / Associate Editor, *Canadian Journal of Emergency Medicine*
Halifax, NS

Dr. Wael M. R. Haddara
Chair, Department of Medicine, Schulich School of Medicine, Western University / Department Head, Medicine, London Health Sciences Centre and Chief, Department of Medicine, St. Joseph's Health Center, London (Interim)
London, ON

Dr. Katrina Hurley
Chief, IWK Health Emergency Department / Head, Division of Pediatric Emergency Medicine, Dalhousie University
Halifax, NS

Dr. Heather Johnson
Medical Site Lead, South Shore Regional Hospital / Incoming Board Chair, Doctors NS
Bridgewater, NS

Dr. Kathie McNally
Chief Medical Officer, Health PEI / Family Physician
Charlottetown, PE

Dr. Nnamdi Ndubuka
Medical Health Officer, Northern Inter-Tribal Health Authority / Course Director, College of Medicine, University of Saskatchewan / Physician Advocate, Equity, Diversity and Inclusion, Saskatchewan Medical Association
Prince Albert, SK

Dr. Danielle O'Keefe
Vice Dean, Education and Faculty Affairs, Memorial University of Newfoundland (MUN) / Past Chair, Discipline of Family Medicine, MUN
St. John's, NL

Dr. Carmel Overli-Domes
Senior Medical Advisor, Quality of Care, College of Physicians and Surgeons of Saskatchewan (CPSS) / Past Senior Medical Advisor, Professional Conduct, College of Physicians and Surgeons of Alberta (CPSA)
Regina, SK

Dr. Mateen Raazi
Provincial Head, Anesthesiology, Saskatchewan Health Authority & College of Medicine / President & Board Member, Association of Canadian University Departments of Anesthesiology (ACUDA) / Board Member, Canadian Anesthesiologists Society
Saskatoon, SK

Dr. Cliff Sample
Chief Medical Officer, Covenant Health
Edmonton, AB

Dr. Grant Stoneham
Registrar and CEO, College of Physicians and Surgeons of Saskatchewan / Past Lead Area Chief of Staff – Saskatoon Area, Saskatchewan Health Authority / Past Associate Dean, Saskatoon Programs, College of Medicine, University of Saskatchewan
Saskatoon, SK

Dr. Todd Webster
Regional Academic Director, Grey Bruce Academy, Schulich School of Medicine and Dentistry, Western University
Owen Sound, ON

Dr. Sheldon Wiebe
Professor and Provincial Head, Department of Medical Imaging, Saskatchewan Health Authority and College of Medicine, University of Saskatchewan
Saskatoon, SK

Dr. Ben Williams
Vice-President Medicine, Quality, Research and Chief Medical Officer, Island Health / Co-Chair, Provincial Medical Services Executive Council
Nanaimo, BC

CCPE
CANADIAN CERTIFIED PHYSICIAN EXECUTIVE
MÉDECIN GESTIONNAIRE CERTIFIÉ DU CANADA

Dr. Curtis Johnston
Deputy Zone Medical Director, Edmonton Zone, Alberta Health Services

Dr. Curtis Johnston has made significant contributions to medical leadership throughout his career, leaving a profound impact on the healthcare systems across Alberta. Serving in various leadership roles, including hospital Site Chief of both Medicine and Critical Care, Facility Medical Director, and Deputy Zone Medical Director for the Edmonton Zone, Dr. Johnston has demonstrated exceptional leadership abilities and a steadfast commitment to the development of medical leaders.

As Facility Medical Director, Dr. Johnston prioritized the development of medical leaders through personalized coaching, physician leadership seminar series, and annual medical leadership retreats. These initiatives, acclaimed for their practicality and effectiveness, provided emerging and established medical leaders with valuable insights and skills to navigate the complexities of healthcare leadership, fostering a supportive environment for critical discussions and collaboration, and creating a community of medical leaders.

Dr. Johnston's commitment to enhancing his own leadership skills is evident through his extensive involvement in courses, conferences, and obtaining his Certified Executive Coach Designation. His leadership during the COVID-19 pandemic as the Senior Medical Advisor for the Provincial Emergency Coordination Center garnered widespread recognition, earning him the title of Physician of the Year by the Edmonton Zone Medical Staff Association and a Queen Elizabeth II Platinum Jubilee Medal.

Furthermore, Dr. Johnston's contributions extend beyond his immediate healthcare setting. He initiated a Virtual Medical Leadership Development series, initially offered to physicians in Edmonton, but due to its popularity is now open to physicians across the province. These sessions provide an invaluable opportunity to network with other medical leaders, discuss complex situations, and to learn from each other in a peer-to-peer, nonhierarchical environment. He launched a complementary "Critical Conversation Series," equipping physician leaders with strategies to effectively navigate challenging conversations.

In terms of cultivating leadership capacity, Dr. Johnston developed and delivers the New Physician Orientation program, compulsory for new physicians joining Alberta Health Services. Additionally, he offers individual coaching sessions to medical leaders, providing tailored support to address complex issues. This personalized coaching represents a unique and innovative approach to medical leadership development and growth.

Dr. Curtis Johnston's leadership journey is characterized by his unwavering dedication to advancing medical leadership, fostering collaboration, and driving positive change within the healthcare system. His achievements and contributions have left an indelible mark on medical leadership development in Alberta.

"Dr. Johnston is one of those rare leaders who has earned and engenders trust, embodies humility and compassion, and has steadfastly committed himself to the improvement of those he leads." – Dr. Kathryn Dong

Dr. Shannon Fraser, CSPL President;
Dr. Chris Carruthers, Dr. Curtis Johnston,
Dr. Rollie Nichol, Past president


Better
care
royalcollege.ca

How coaches can engage clients to empower performance

Debrah Wirtzfeld, MD, MBA

Wirtzfeld D. How coaches can engage clients to empower performance. *Can J Physician Leadersh* 2024;10(2):62-63
https://doi.org/ 10.37964/cr24782

The Canadian Physician Coaches Network (CPCN) is a not-for-profit organization whose coach members serve the needs of clients who are physicians. All members have previous experience working with physicians and recognize the unique challenges that come with being a member of the medical profession. Because engaging with a coach is an important aspect of achieving full leadership ability,[1-3] the CPCN has chosen to come together with the Canadian Society of Physician Leaders to produce a quarterly Coaching Corner. Each article explores a potential physician leadership challenge and how a coach might engage with a client to assist them in empowering their performance. This article uses a fictitious person in a realistic scenario with the author as the coach.

Physician leadership challenge: time management in a new leadership role

Scenario: Dr. X is a 47-year-old physician who became chief medical officer in a medium-sized healthcare authority six months ago. He feels overwhelmed and that he doesn't have enough time to be successful in his new role. He has held other leadership positions in the same organization and has always felt somewhat overwhelmed with leadership work, although not to this extent.

The following represents an approach that might be taken by an executive coach. The engagement is for six months, and not all the questions listed below would be asked in a single session. Much of the work would happen between sessions.

1. **What are the top three priorities of a leader in this position?**
2. **What three things currently take up your time?**
3. **Please rate on a scale of 0% to 100%, with 0% being no overlap and 100% being complete overlap, the degree to which the priorities of the position reflect where you spend time?**
4. **What one step could you take to better align where you spend time with the priorities of the position, even by 1–2%?**
5. **What do you need to give up?**

Dr. X had never considered priority setting. Quantifying the gap between where he is now (60%) and where he wanted to be (100%) helped him gain clarity around what activities he needed to keep doing, what he needed to take on, and what he needed to give up. Asking him to think about making it 1–2% better allowed him to start to think about small steps he might take to start improving things. It did not pressure him to be perfect or to take on more than he could manage. As he began to see success, he was able to consider more and move to what might make things 5–10% better. Asking him about what he would give up allowed Dr. X to consider what and to whom he could delegate to enhance impact.

6. **What strengths do you bring to this position?**
7. **Where might others bring greater strengths?**

Dr. X took almost two months to complete this exercise and begin to recognize that leadership is a team sport where greater influence can be achieved through supporting others' strengths. We used this information to develop a strengths matrix for the team, which allowed Dr. X to consider where and when there was opportunity for delegation.

8. **What aspects of this position are within your control?**
9. **Where do you have influence?**
10. **How do you set boundaries?**

In my experience working with physician leaders, they often assume they have more control than they

actually do. They often think they have control over others' thoughts and actions. In this case, it was eye opening for Dr. X to realize that the actions of others were beyond his scope of control. Conversely, what was under his control was active listening and setting boundaries around timelines and obligations. This was an area that Dr. X needed to consistently and consciously continue to work on.

11. **How do you determine what to delegate, when, and to whom?**
12. **How do you deal with urgent issues?**
13. **How does your team determine what activities should be eliminated from the portfolio?**

Dr. X took these questions to his team and continued to refine where responsibilities and accountabilities could be shared. He saw greater influence, even though he was spending less time in the role, and he felt more effective.

Dr. X was provided with some time-management tools to help him use his time more effectively.

Conclusion

The benefits of working with a coach with respect to time management include the ability to align efforts with the priority areas of a particular role or portfolio, achieving enhanced influence through appropriate delegation, allowing team members to speak to their strengths, and recognizing the power of setting appropriate boundaries. A coach can also help identify the contribution of other issues, such as working outside of one's scope of control or potential lack of resources. It is important to note that difficulty with time management may stem from issues that are outside the scope of practice of a coach. In this situation, a coach can work with the client to redirect them to more suitable resources, where appropriate, such as a mental healthcare provider.

How do I find an appropriate coach?
Many physicians find a coach through recommendations from others or word of mouth. The CPCN website (www.coach4md.org) lists the biographies and areas of interest of accredited coach members who have worked with physicians. It is readily searchable by those interested in finding a coach. You may reach out to any number of coaches and explore whether there is a potential match, either in person or more commonly through virtual options.

References

1. Benjamin B, Bharmal S. Unlocking leadership potential with coaching: finding the right match. London: Ivey Academy; 2024. Available: **https://www.ivey.uwo.ca/academy/insights/2024/05/unlocking-leadership-potential-with-coaching-finding-the-right-match-1/**
2. Paláez Zuberbuhler MJ, Salanova M, Martínez IM. Coaching-based leadership intervention program: a controlled trial study. *Front Psychol* 2019;10:3066. **https://doi.org/10.3389/fpsyg.2019.03066**
3. Halliwell PR, Mitchell RJ, Boyle B. Leadership effectiveness through coaching: authentic and change-oriented leadership. *PLoS One* 2023;18(2):e0294953. **https://doi.org/10.1371/journal.pone.0294953**

Author

Debrah Wirtzfeld, MD, MBA, PCC ICD.D, is the chair of the Board of Directors of the Canadian Physician Coaches Network.

Correspondence to: **chair@coach4md.org**

Cost is not a four-letter word: focus on what you can change

Jeffrey S. Hoch, PhD, and Carolyn S. Dewa, MPH, PhD

Hoch JS, Dewa CS. Cost is not a four-letter word: focus on what you can change *Can J Physician Leadersh* 2024;10(2):64-68
https://doi.org/10.37964/cr24783

In this second article in a series on health economics, we focus on cost concepts that are important for leaders who must decide how to spend scarce organizational resources like time and money. Building on the first article's focus on efficiency, this article delves into the important ideas of expected, fixed, variable, and marginal costs. Knowledge of these types of costs can help leaders successfully identify optimal courses of action. An understanding of these concepts can also help leaders communicate.

KEY WORDS: leadership, costs, efficiency, health economics

The difference between physicians and physician leaders is the number of patients being treated at any one time. A waiting room may be filled with patients, but an examining room only holds one patient. Physicians consider the best course of treatment for the patient before them using their real-world expertise, their patient's preferences, and research evidence (see Table 1 in Schlegl et al.[1]). In contrast, physician leaders are responsible for the groups they lead. Their choices and policies affect everyone in the group; their focus is not on one individual. In a way, leaders "treat" the groups they lead. What is sacrificed to make one individual better off must be considered from the perspective of the group or "population." When leaders use data to inform their decisions, they keep track of the sacrifices related to the different options with information called "costs." These costs help clarify the sacrifices attending the decisions.

In this article, we describe various types of costs to offer physician leaders insights as they consider (or reconsider) their relationship with costs.

Understanding "cost"

A major misconception about cost is that it is merely a gauche monetary concept. In fact, there are many different types of costs that leaders must be aware of: reputational costs, time costs, and costs related to energy or effort. If you are a leader responsible for the stewardship of scarce resources – from beds, to nurses, to MRIs – the use of these scarce resources represents a cost for which you are responsible. In this article, we describe different costs and explain how leaders can avoid common mistakes related to them.

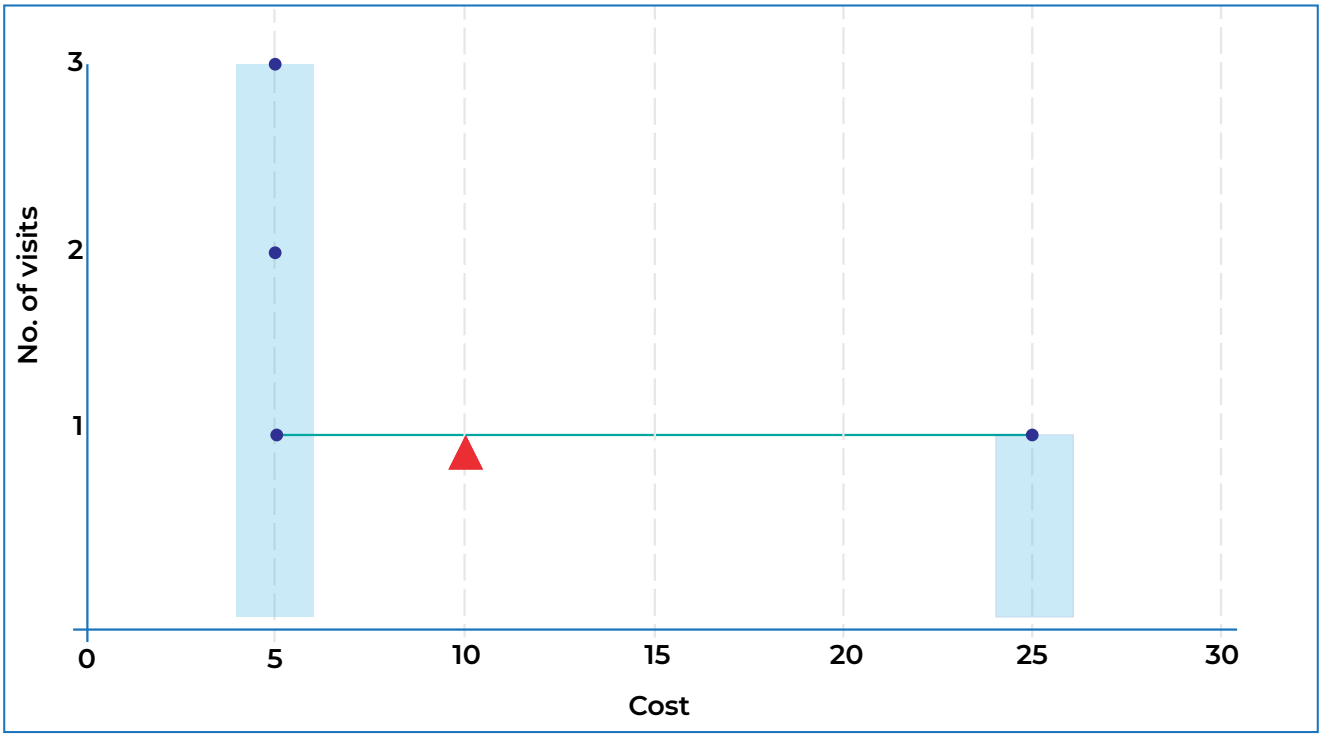
Expected or average costs

Expected cost is the average cost computed by taking the total cost and dividing it equally. For example, if your division generated overall costs of $40 in providing four visits, then the average or expected cost for each visit is $10. However, among the four visits, none may have cost the expected $10. Some visits may have been more than $10 and some less; overall, the entire set of visits cost $40. Spreading that cost equally over all four visits gives an expected cost of $10 per visit.

Figure 1 illustrates the four visits described above. With three that cost $5 each and the remaining one costing $25; no visit cost $10. The expected cost is equal to ($5 + $5 + $5 + $25)/4 or $10. The histogram in Figure 1 shows how the expected cost, indicated at $10 with a Δ, is like a balancing point. The expected cost is not, "the cost you should expect" per unit.

This can be important for budgeting. If you know the expected cost of providing a service, multiplying it

Figure 1: Costs ($) for four visits: three visits cost $5 each and one cost $25. The expected cost of the four visits is $10, which can be viewed as a fulcrum or balancing point Δ



by number of visits yields the total cost. This is useful for population-level planning. For example, assuming a new service will provide 600 visits and using the expected cost of $10 per visit (also assuming costs are not affected by the increase to 600 visits), total costs are expected to be $6000 (i.e., 600 x $10).

Fixed and variable costs

Fixed costs are the costs you incur even if you do nothing. For example, rent paid each month regardless of how many patients are treated is a fixed cost. Perhaps your organization has a professional on retainer (e.g., a lawyer, a pest removal service, or a health economist) and each month they are paid a fixed amount; that is a fixed cost too. A study published in 1999 found that, "the majority of cost in providing hospital service is related to buildings, equipment, salaried labor, and overhead, which are fixed over the short term.[2]

In contrast, *variable costs* change because they are dependent on the number of visits provided. The Conference Board of Canada studied healthcare cost drivers in Canada before and after COVID-19.[3] The report gives two examples where fixed costs would be larger than variable costs: "technology enhancements needed to support telehealth or virtual healthcare during the pandemic"; and "costs incurred to prepare hospitals and emergency rooms to handle COVID-19 cases" (page 35 of the Conference Board report).

Conversely, the Conference Board of Canada's COVID cost report[3] also noted examples where the variable costs were greater than fixed costs. The variable costs of COVID to organizations were dependent on the volumes and types of drugs and pharmaceuticals and personal protective equipment used (page 35 of the Conference Board report). This makes sense because, as more visits are used, visit cost should increase.

Using cost concepts

Table 1 provides data to help a leader decide the number of visits to provide. When there are no visits, fixed costs are $6. With each visit, costs increase by a variable amount. Total cost is the sum of variable and fixed cost. When the number of visits increases from 0 to 1, total cost increases from $6 to $10. This change in total cost ($4) is called marginal cost, the difference in total cost resulting from one more visit. Note, the marginal cost changes depending on the number of

Table 1: How costs and reimbursement ($) change with increasing number of visits (hypothetical data)

Number of visits	Fixed cost	Variable cost	Total cost	Marginal cost	Total reimbursement
0	6	0	6	–	–
1	6	4	10	4	5
2	6	7	13	3	10
3	6	9	15	2	15
4	6	10	16	1	20
5	6	12	18	2	25
6	6	15	21	3	30
7	6	19	25	4	35
8	6	24	30	5	40
9	6	30	36	6	45
10	6	36	43	7	50

visits; in this example, it ranges from $1 (when visits increase from 3 to 4) to $7 (when visits increase from 9 to 10).

In this example, we assume that the reimbursement for each visit is $5. So, how many visits should be provided to maximize the organization's profit if the marginal revenue from each visit is $5?

With no visits, the revenue is $0, but because the fixed cost is $6, the organization incurs a loss of $6. For one visit, the loss drops to $1. Only at three visits does total revenue equal total cost. Subsequently, revenue increases with each visit up to the 10 visits shown.

Table 2 summarizes the opinions of three managers about how many visits to "produce."

If maximizing profit is the goal, none of the Table 2 options achieves that. To maximize profit, the right answer depends on the cost that you can control. That is the variable cost (i.e., it changes by an amount equal to marginal cost when you change number of visits). In this example, profits are highest with eight visits. Profit is the highest when extra total cost of one more visit equals the extra reimbursement from that additional visit. In other words, when the marginal cost ($5) equals marginal revenue ($5), and this occurs at eight visits. The trick is to realize that fixed cost is something to ignore, as every option has the same fixed cost; thus, it does not bear on the optimal decision since you will always incur fixed costs.

Table 2: The right number of visits

	Manager A	Manager B	Manager C
Answer	0 visits	3 visits	10 visits
Rationale	Fixed cost is more than reimbursement; do not provide any treatments	Average cost equals reimbursement, so no money is lost.	Revenue is highest, so we are taking in the most money we can.

Table 3: How time costs and returns vary with increasing delegation of tasks (hypothetical data)

Number of delegations	Fixed cost	Variable cost	Total cost	Marginal cost	Total return
0	6	0	6	–	–
1	6	4	10	4	5
2	6	7	13	3	10
3	6	9	15	2	15
4	6	10	16	1	20
5	6	12	18	2	25
6	6	15	21	3	30
7	6	19	25	4	35
8	6	24	30	5	40
9	6	30	36	6	45
10	6	36	43	7	50

Each time you increase the number of visits by one, marginal cost changes depending on how much the variable costs change (however, marginal revenue is constant at $5). It makes sense to stop trying to earn $5 more when the cost of doing that is $5 or more. Increasing from 0 to 1 visit costs $4 more to earn $5 more. That means a profit of $5 − $4 = $1 and it makes sense to make the increase. Going from 3 to 4 visits costs $1 more to earn $5 more in revenue. Again, why stop there? However, increasing from 9 to 10 visits costs $7 more to earn $5, which does not support "profit maximization," because, to bring in $50 of revenue requires paying $7 more (in extra cost) for something worth $5 (in revenue gained).

This example highlights the differences between minimization, maximization, and optimization. Total costs are minimized at 0 visits. This is the right focus if there is no broader goal or objective than to cut costs (even at the expense of patient care). In contrast, total revenue is maximized at 10 visits. This makes sense when leaders want to treat as many patients as possible (even if it involves putting their organization at financial risk). Leaders interested in optimizing their objective compare the costs they can control (i.e., marginal costs) with the additional gain (i.e., marginal revenue). Often, the best action is not choosing the least or the most; cost minimization (0 visits) is different from quantity maximization (10 visits), and both often differ from optimization (e.g., maximum profit).

Non-monetary cost

Now, let's return to our earlier point that cost is not solely a monetary concept. Imagine you are implementing a new technique and have already invested six hours of time learning it (e.g., attending a training seminar). If you can delegate the task, you can save 5 hours each time you use the technique. However, it takes time to master the technique.[4] 'If we use the data in Table 1 where cost now represents hours of your time (Table 3), the fixed cost is the amount of time you invested learning the new way; this is time you will never get back (even if you never use the new skill/technique). The variable cost is the time you spend delegating (e.g., in communicating what you want done). Notice, the total time grows the more you delegate. The "return" is time you get back now that a task taking you 5 hours to complete is delegated to someone else; this is 5 hours per delegation.

If you delegate 10 times, you will spend 43 hours to

save 50 hours. However, if you delegate 8 times, you spend 30 hours and save 40 hours. You are managing your time better if you regain 10 hours by delegating only 8 times. The fact that you have already spent 6 hours learning the technique, does not oblige you to use the technique at all. The key insight is to focus on what you can change, and that is how much time you put into using the technique and the resulting gain (i.e., the time you save).

Conclusion

As a leader, you are a steward of your organization's most precious resources. When you invest them, whether time or money, your choices are important. You purposefully choose to direct resources toward higher value alternatives. Understanding costs allows you do more with your organization's scarce resources to achieve its goals and fulfill its mission. Expected or average costs are useful for estimating total costs. Fixed costs are less important than variable costs for helping you decide on optimal actions. Fixed costs are "sunk" – once they are committed, there is no changing them, and they cancel out of any analysis. Variable costs are a lever you can change, which makes them worthy of your focus. Marginal cost shows you how variable costs change and can help your organization make optimal decisions. Focusing on the difference in costs (e.g., additional costs) will allow your organization to be efficient.

References

1. Schlegl E, Ducournau P, Ruof J. Different Weights of the Evidence-Based Medicine Triad in Regulatory, Health Technology Assessment, and Clinical Decision Making. *Pharmaceut Med*. 2017;31(4):213-6.
2. Roberts RR, Frutos PW, Ciavarella GG, Gussow LM, Mensah EK, Kampe LM, Straus HE, Joseph G, Rydman RJ. Distribution of variable vs fixed costs of hospital care. *JAMA*. 1999 Feb 17;281(7):644-9.
3. The Conference Board of Canada. Healthcare Cost Drivers in Canada: Pre-and Post-COVID-19. Ottawa: The Conference Board of Canada, 2020. Accessed on June 8, 2024 at **https://tinyurl.com/y9vcvs8z**
4. Landry L. How to Delegate Effectively: 9 Tips for Managers. Harvard Business School Online, 2021. Accessed on June 8, 2024 at **https://tinyurl.com/mvzzkd3a**

Authors

Jeffrey S. Hoch, MA, PhD, is a professor in the Department of Public Health Sciences at the University of California Davis (UC Davis). He is chief of the Division of Health Policy and Management and associate director of the Center for Healthcare Policy and Research at UC Davis.

Carolyn S. Dewa, MPH, PhD, is a professor in the Department of Psychiatry and Behavioral Sciences and the Department of Public Health Sciences at UC Davis.

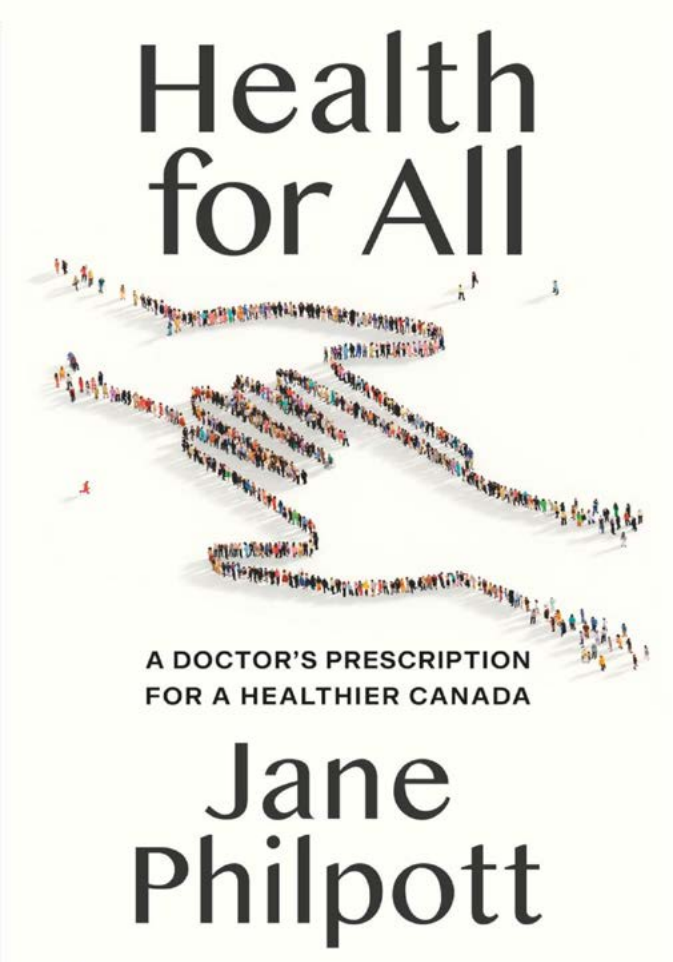
Correspondence to: **jshoch@ucdavis.edu**

BOOK REVIEW

Health for All: A Doctor's Prescription for a Healthier Canada

Jane Philpott, MD
McLelland & Stewart, 2024

Reviewed by Johny Van Aerde, MD, PhD



Dr. Jane Philpott is a servant-leader who has made a wide range of humanitarian contributions to the common good: from Médecins sans Frontières in Niger to the bedside in Ontario's long-term care facilities during the pandemic, from family physician to federal health minister, from evidence-based medicine to innovation in primary healthcare, from grieving mother to published author. This book is filled with narratives, experiences, reflections, and human emotions, as well as accomplishments and lessons learned from failure. The book makes it clear how and why those narratives and experiences informed the purpose of Dr. Philpott's life: to work for and fight for a fair world with health for everyone.

In *Health for All,* Philpott's mix of knowledge, evidence, learning, and innovation, interlaced with meditative reflections and narrative experiences is divided into four parts: clinical, spiritual, social, and political. The clinical and political parts are outstanding and deserve a reflective read.

In Part 1, Clinical, we gain insight into why primary and community care are poorly served in Canada: historically, because such care was never included in the 1966 *Medical Care Act* or in the 1984 *Canada Health Act*; politically, because the return on investment (i.e., being re-elected) is much higher for building a new hospital or giving more money to acute care than it is for investments in primary care or socioeconomic factors that influence health and wellness. To solve this conundrum, Philpott proposes an additional law, the *Canada Primary Care Act*. It would hold governments at all levels accountable for access to primary care, just as the *Canada Health Act* is meant to do for acute care.

Good examples of successful primary care and community health models can be found in Europe, mainly in Scandinavia and the Netherlands. The Dutch primary healthcare system is one of the best in the world, at the top for many health and healthcare indicators. The Netherlands is also an example of how keeping healthcare at arm's length from government, as in many European countries, works better than

in our country. Quoting Philpott's vision for primary care, "The operations and oversight of the [primary care] system would not reside within government but should be delegated to an arm's length health authority."

Philpott presents 10 conditions needed to create a successful system that brings primary team-based care into the community, conditions she learned from her two years as minister of health when she orchestrated integration of 25 000 Syrian refugees. One could argue that almost none of these 10 conditions is currently in place, but they give us a framework that healthcare professionals, the public, and politicians must bring to life to be successful.

As Philpott advocates decisive action, it is no surprise that she offers practical solutions in the form of pilot projects, showing what else is possible. Based on the principles of the Quintuple Aim and on the concerns and needs identified by patients and providers, the Periwinkle Model was co-created in Kingston. This multi-partner project is an adaptation of the patient-centred medical home for a geographically defined population, with patients attached to a whole team of healthcare professionals. Accountability is built into the model, similar to what Norway accomplished with its *Patients' Rights Act*. In the Periwinkle model, the workforce and services are expanded with learners, volunteers, and community partners. Care is provided long term and supported with a good EHR that makes it easy to access information, should the citizen move to a different but similarly structured municipality.

Because the shortage of family physicians will not disappear, even in a multidisciplinary team setting, Philpott is spearheading yet another innovative pilot project. Queen's University, where she is dean of health sciences, has launched a satellite campus devoted exclusively to training family doctors. These medical students are committed to family medicine from the start. Teaching is done by educators who themselves are entrenched in primary healthcare.

If you are short on time, skip Part 2, Spiritual. Although it gives insight into Philpott's stories and reflections, the four chapters lack evidence or references on which to base the content. The chapter on meaning is a mainly religious reflection triggered by a personal and very painful experience of losing a daughter, far from home while the parents were serving others. Sharing that personal and intimate pain with the reader shows the author's vulnerability and humanity and takes courage, something that returns many times in the book.

Part 3, Social focuses on the socioeconomic factors affecting health, as well as injustice. This topic is a fundamental element of this book but, as suggested by the author herself, a more complete picture on how socioeconomic inequity make us sick can be found in *The Health Gap* by Michael Marmot.[1]

In Part 4, Political, Philpott packs so much wisdom and insights into 50 pages that it deserves a slow read. She went into politics to improve people's health on a larger scale than she was able to do as a clinician. Starting with a stronger knowledge base in health and healthcare than the average career politician allowed faster initiation of and action on the projects during her short two years as minister of health, including the Syrian refugee program, naloxone for non-prescription use, the *Cannabis Act*, and MAID legislation. Those projects also prove that, "When people and circumstances are aligned, the machinery and the institutions of government can be used to make us a healthier nation." She demonstrated that, "a seat in the house should be a tool, not a target, and politics can be a force for good. Sadly, it is abused and misused to the point that its potential for public benefit becomes contaminated." Reading these words and seeing what she accomplished in such a short time, one wonders what our health system might have looked like had she stayed on as health minister for two or three election cycles.

In "Using clinical skills in politics," Philpott describes some of the clinical skills that health professionals are expected to master and then submits that politicians should learn a similar set of competencies. Those competencies should form the basis for politicians' behaviour if they have the best interests of the population at heart. Philpott claims that many people go into politics with values similar to those found

in medical professionalism and with the aspiration to display behaviours to match those values. Unfortunately, there is enormous pressure to act quite differently. Philpott ponders whether the Canadian parliament could function like a healthcare team where individuals arrive with different skills and are encouraged to work with each other to the full scope of those talents, offering constructive criticism and looking for the best ideas from all parties. Tasks are shared and shifted according to who is trained for the job. That section of the book is just brilliant and an eye opener.

The problems or solutions described in the book are not new to the world of health policy. The ideas are based on many reports written over decades. Yet health systems remain stuck. Health workers are exhausted, they work hard every day, but when they try to change or improve care, they struggle to make progress. They know what's not working and how the system could be changed, but they don't control the levers to do so. Power is held by a few in Canada and we, the voters, are the ones who are giving them that authority. We will never be a country with health for all unless our political leaders make it a top priority, exhibit the courage to make some tough decisions, and then painstakingly watch over implementation of a new coordinated national health system rooted in universal access to primary care. Voters must make it very clear that we expect this work to be done, as healthcare is consistently one of the top five concerns of Canadians. If we want Canadians – public, healthcare professionals, and politicians – to understand what work needs to be done and to co-create "what else is possible," then this book is a must read.

Reference

1. Marmot M. *The health gap: the challenge of an unequal world*. London: Bloomsbury, 2015.

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.

Correspondence to: **johny.vanaerde@gmail.com**

Rotman School of Management
UNIVERSITY OF TORONTO

Gain the leadership edge you need in a sector where the frontiers are always advancing.

15 months, 5 modules, 3 continents.

Incredibly flexible and immersive, the Rotman Global Executive MBA for Healthcare and the Life Sciences is a hybrid program that integrates a 50/50 model of in-person classes with live, online sessions.

Customized for the sector, this program is designed for mid-to-senior level working professionals from the Healthcare and Life Sciences industry: care providers, service delivery organizations, consulting firms, and public agencies.

Learn directly from industry experts with study tours spanning 3 continents, and gain a firsthand exploration of international health systems.

Invest in your potential

The return on investment for the GEMBA-HLS program is both personal and professional.

APPLY TODAY

www.rotman.utoronto.ca/GEMBA-HLS

#1 University in Canada

#18 of Top Universities in the World

Gain an exceptional network

"The program has provided me with the executive, stakeholder and team management skills to navigate new frontiers in healthcare."

Mohini Bhavsar, GEMBA-HLS Alumna
Chief of Staff and Director of Corporate Strategy, Grand Challenges Canada

Finance your Executive MBA

Apply early to be considered for merit-based and industry-specific awards, EDI scholarships, and travel bursaries. Other options include Professional Student Loan Plans, Employer Sponsorship, and more.

Tuition Fees

$116,080 CAD*, for 2025 entry year.

* Additional ancillary and incidental fees will apply. Subject to change.