

Condition critical: rebuilding medicare for the next generation

Colleen Galasso

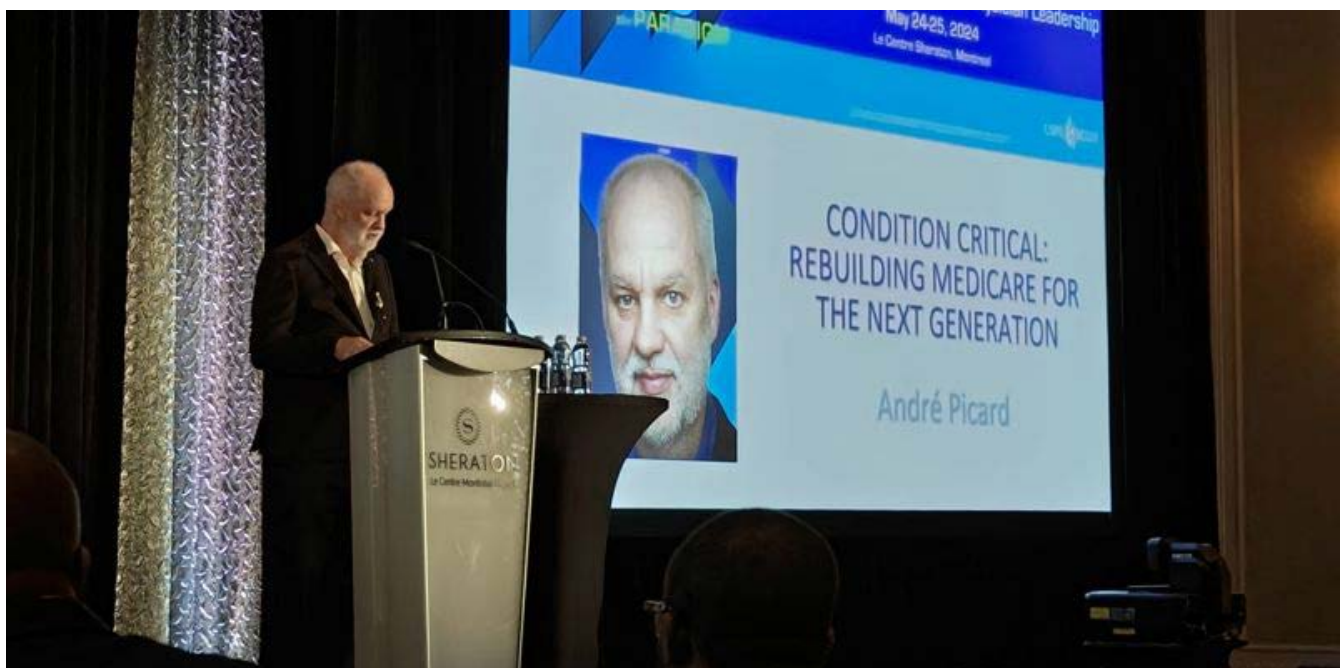
André Picard, a well-known journalist with over 40 years of experience covering healthcare, delivered a compelling opening keynote address at the 2024 Canadian Conference on Physician Leadership (CCPL2024), held 24-25 May in Montreal. He shed light on the current state of Canadian healthcare and advocated 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.

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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*.

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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.

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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.”

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SAVE THE DATE

2025 Canadian Conference on
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The Hyatt Regency Hotel
Vancouver, British Columbia

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.”

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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.

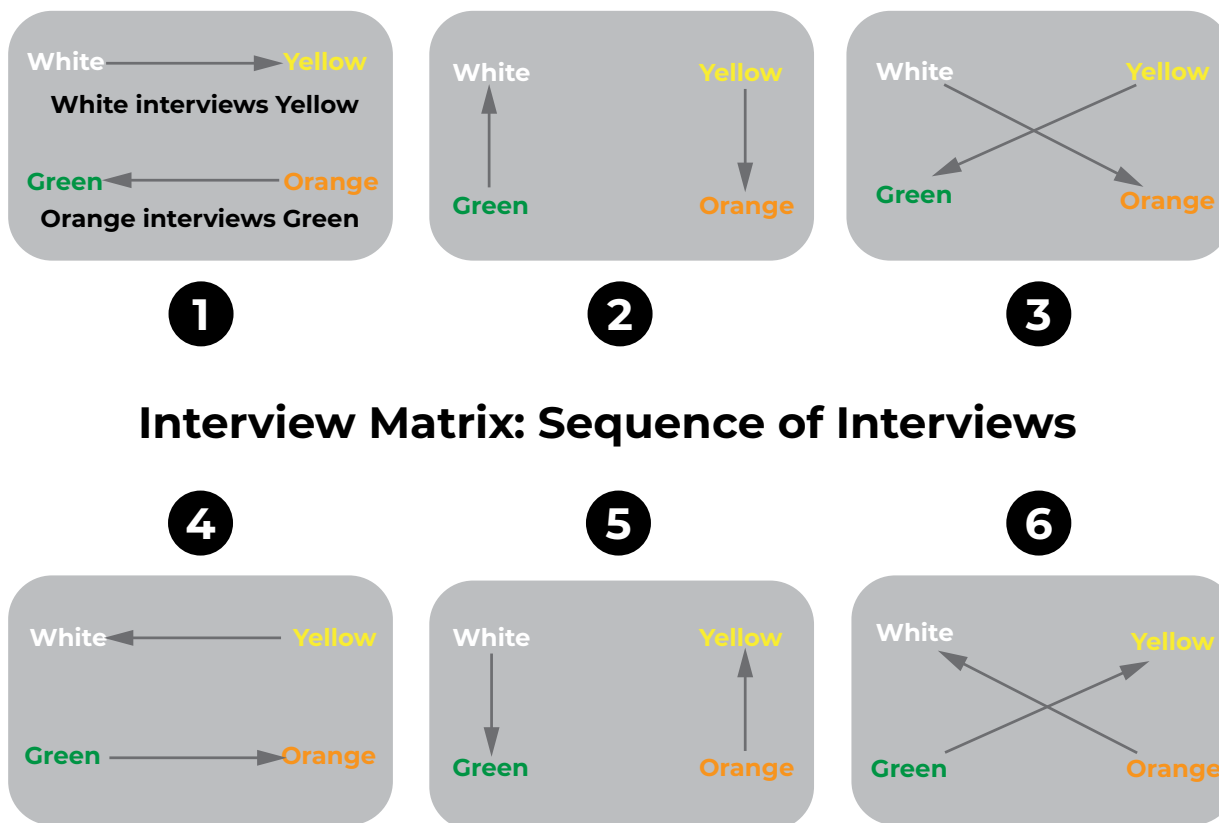
This involves increasing transparency and being open about how and why decisions are made. Practicing authentic listening and creating safe spaces for honest communication allow stakeholders to feel comfortable sharing their thoughts and concerns. Seeking alignment on shared values and goals and making 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.



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

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.





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.

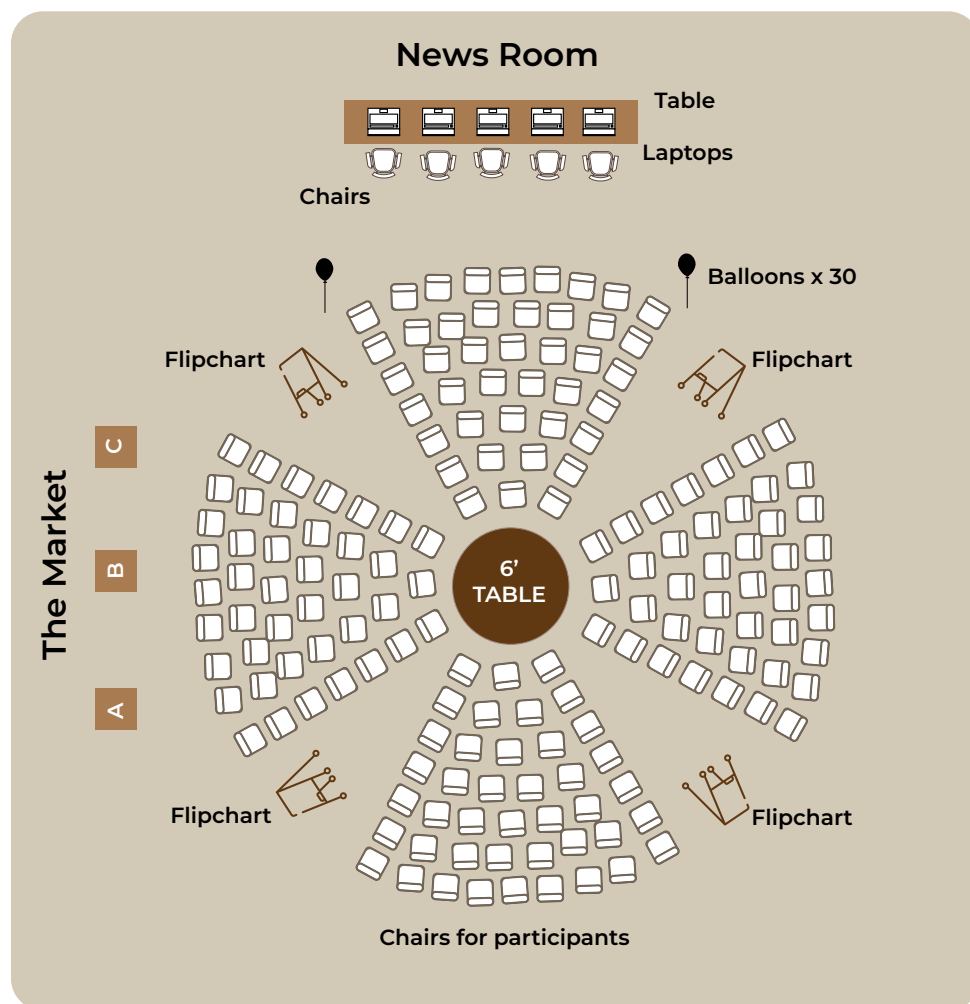
The *Setting the stage for action* session provided attendees with a platform to engage in thought-provoking discussions, emerge with fresh perspectives, and identify innovative options to address key challenges facing our healthcare system.

Plenary workshop 2: Pathways to health system reform

The afternoon plenary workshop used the dynamic Open Space² 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.

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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 Mellow, 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; Johnny 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.

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