2020 Member Forums

ROLL-UP SUMMARY REPORT
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In early 2020, the CMA hosted six Member Forums across Canada, in Rouyn-Noranda, Quebec City, Calgary, Saskatoon, Vancouver and Thunder Bay, to engage and consult with members on three topics: access to care, physician health and wellness, and visioning the future.

Eight in-person forums were scheduled but the last two (London and Fredericton) were cancelled following the World Health Organization’s declaration on Mar. 11 and the rapidly evolving COVID-19 pandemic.

Members were engaged through interactive polling, small group activities, plenary discussions, and dialogue with CMA board members. In addition to these in-person events, the CMA also hosted a discussion on its online engagement platform.

Key Takeaways

**ACCESS TO CARE**

**WHAT WE ASKED**

“What are the root causes of the barriers impeding your ability to provide the best level of care to your patients? Why are the top attributes of a high-performing health care delivery model important?”

**WHAT WE HEARD**

Access to care is affected by a variety of factors, including but not limited to:

- **poor access to other medical services**, which reflects issues with the geographic distribution of health care providers across the country (particularly in rural and remote areas), a lack of health human resources planning, and communication and coordination challenges between providers due to enduring fragmentation across systems;

- **disparities in current remuneration models between jurisdictions**, specialties and organizations, and an inflexibility that does not allow remuneration to reflect the complexity of care and the full scope of practice; and

- **lack of integrated and standardized legacy digital tools/systems**, which has resulted in an inability to access health information.

**WHAT WE’RE DOING**

Virtual care is one way to help maintain and improve access to care and became vital during COVID-19.

The CMA:

- worked with medical experts to create a guide for physicians on offering virtual care services;

- collaborated with the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada on 19 key recommendations to pave the way for virtual care in Canada;

- commissioned a national poll illustrating Canadians’ satisfaction with virtual care services.
WHAT WE ASKED
“What changes would you make to improve patient-centred care at the system and practice levels?”

WHAT WE HEARD
To develop a patient-centred system, changes need to be made at both the system and practice levels. Three themes emerged, with actions that need to be taken at both levels:

- **patient engagement through partnership**, which recognizes the importance of patients being true partners in their care, needs to be implemented and patient feedback should be sought on how the system needs to change to improve patient outcomes and reduce costs;

- **multidisciplinary care delivery** needs to be supported, to improve outcomes through the provision of appropriate care (both type and level) and to improve communications between providers; and

- **digital transformation** needs to be embraced, to improve access for patients living in remote areas and to reduce the administrative burden for physicians.

WHAT WE’RE DOING
The CMA:

- works with [Patient Voice](#), a 12-member advisory board that lend their perspective to CMA’s policy and advocacy work;

- implemented a [patient engagement framework](#), to guide how we work with patients;

- worked with patient advocates and medical experts to create a [patient guide to virtual care services](#), as a compliment to the physician guide.
PHYSICIAN HEALTH AND WELLNESS

WHAT WE ASKED
“What aspects of the medical culture are important to preserve? What aspects of the medical culture would you like to see change?”

WHAT WE'RE DOING
Before the forums began, the CMA commissioned a national analysis of physician health and wellness services and resources. This analysis was informed by interviews and surveys with a wide range of stakeholders across Canada. We identified five potential pan-Canadian opportunities, and explored them through the Member Forums:
1. National standards, measurement and tools
2. Enhanced advocacy
3. Service awareness, availability and access
4. Medical profession transitions
5. Shifting the system’s culture

WHAT WE HEARD
• Through live polling, members identified compassion, empathy, respect, mentorship, professionalism and integrity as the most common aspects of the medical culture they would like to preserve.
• Hierarchy, stigma, bullying, paternalism and shame were identified as the most common aspects of the medical culture members would like to see change.

WHAT WE ASKED
“How could the identified pan-Canadian opportunities make a difference in your everyday practice?”

WHAT WE HEARD
Members believed the pan-Canadian opportunities that would have the greatest potential impact on physician health and wellness included:
• developing a standardized definition of wellness and national standards to measure wellness;
• ensuring physicians’ voices are represented in health care advocacy efforts;
• ensuring confidentiality and anonymity for physicians requesting mental health support;
• providing mentorship and dedicated supports (e.g., transition planning, skills training) for physicians in all career stages, particularly at key milestones; and
• promoting a culture shift away from “shame-based learning” towards a kindness and a coaching model.

WHAT WE'RE DOING
The CMA:
• introduced the Wellness Support Line, providing confidential 24/7 mental health support and counselling to physicians, residents, medical students and their immediate family and to ensure equitable access to wellness supports for physicians across Canada;
• created a physician wellness webinar learning series to help support physicians and their families in coping with the pressures posed by the COVID-19 pandemic;
• introduced The Wellness Connection, providing weekly virtual group support sessions and peer drop-ins for physicians and medical learners on a range of wellness issues;
• is building a Physician Wellness Hub, a consolidated library of the latest research, tools and resources on physician health and wellness, for physicians, medical learners and administrators. It will launch in September 2020.
**Visioning the Future**

Through open dialogue with the CMA board, members were asked to identify the most important disruptions that will impact health and health care in Canada in the next 10–20 years. These disruptions are categorized below into 10 themes:

1. **Changing medical profession**
   - Increase physician replacement with AI, robotics, etc
   - Declining interest in primary care
   - LGBTQ+ medicine

2. **Medical training**
   - Increasing student debt
   - Silo-based curriculum
   - Technical literacy

3. **Population health management**
   - Health literacy and access to data
   - Varied patient expectations (Millenials vs. aging population)
   - Interprofessional care and integration with allied health

4. **Political shifts**
   - Political polarization and instability
   - National pharmacare
   - Universal basic income
   - Political mobilization of vulnerable populations

5. **Personalized medicine**
   - Precision medicine
   - Genomic science

6. **Physician health and wellness**
   - Physician burnout
   - New attitudes to work-life integration
   - Physician resource planning

7. **Social determinants of health**
   - Multi-cultural population
   - Income inequity, homelessness
   - Progressive social isolation

8. **Health system design and sustainability**
   - Private medical practices
   - Increasingly expensive personalized treatments
   - Alternative uses for dated health care facilities/equipment

9. **Emerging global threats and diseases**
   - Pandemic and novel infectious diseases
   - Climate change: climate refugees and population migration
   - Anti-vaccination attitudes

10. **Digital health**
    - Telemedicine and virtual care
    - Artificial intelligence
    - Internet of things integration
    - Patient data privacy

As next steps, the CMA will incorporate this member feedback into ongoing strategic initiatives:

- ideas shared on access to care will serve as a foundation for the CMA’s access to care strategy;
- opportunities and inputs shared on physician health and wellness will be used to further refine the recommendations of the Physician Health and Wellness national analysis; and
- disruptions identified in the sessions on visioning the future will inform the CMA’s longer-term strategic planning.
The agenda for the full-day Member Forums (see Appendix A) focused on three main topics: access to care, physician health and wellness and visioning the future.

- **The dialogue on access to care was an opportunity to explore** — a national call to action on addressing access to care was introduced, with an initial focus on care delivery models. Members were engaged in discussions to understand the barriers and to think about important attributes of care delivery models. It was also an opportunity to inform a national conversation, which has been delayed as a result of COVID-19, and identify strategies to improve care delivery models at the system and practice levels.

- **The dialogue on physician health and wellness was an opportunity to validate** — to listen to the experiences of members at the Member Forums and to confirm the call to action for culture change. It was also an opportunity to inform future recommendations that will move the dial on this issue and drive practical and meaningful impact for physicians.

- **The dialogue on visioning the future was an opportunity to listen** — for members to imagine the disruptions over the next 10 to 20 years and for CMA board members to listen to and understand the views of members that will shape the CMA’s future strategy.

The Member Forums were CME accredited and designed to be informative and highly interactive. Ideas and perspectives were gathered through live polling, small group activities and plenary discussions. Member feedback was gathered through comment cards and an evaluation form at the end of each session.

The 2020 Member Forum discussions were also posted online for comments and were available on the CMA’s community engagement platform from Feb. 7 to Apr. 13, 2020, for members to share their thoughts. Information that was made available for the online platform discussions included the context-setting presentations for the key topics presented at each forum, the polling questions, the discussion questions and highlights from each of the six in-person Member Forums.

This report summarizes the key findings from participants’ discussions at all six Member Forums as well as the feedback received online.
In total, 276 members attended the six Member Forums in person. These six Member Forums were held in Rouyn-Noranda, Quebec City, Calgary, Saskatoon, Vancouver and Thunder Bay between Feb. 7 and Mar. 6, 2020. (Note: The Member Forums originally planned for London and Fredericton were cancelled because of COVID-19.) The following is a high-level snapshot of the participant profile of members in attendance.

**Practice status:**
In total, 107 medical students and 17 medical residents were in attendance, representing 45% of attendees. Ninety-nine (36%) attendees were practising general practitioners or family physicians and the remaining 53 (19%) were practising specialists. The 2020 Member Forums saw an increase in participation from medical students (there were almost two times more medical students than at the 2019 Regional Member Forums).

**Length of practice:**
Of the 55% of attendees who were practising physicians, 9% had less than 6 years in practice, 30% had 6–20 years in practice, 25% had 21–30 years in practice and 36% had more than 31 years in practice. The 2020 Member Forums had a higher attendance from physicians with more than 31 years of practice than the 2019 Regional Member Forums.

**Province/territory:**
As illustrated to the right, most of the Member Forums drew their audiences from several provinces. The representation from different jurisdictions enriched not only the dialogue but also the member experience in networking and learning from colleagues.

The members at the above Member Forums were from:
- Quebec
- Ontario
- Manitoba
- Newfoundland & Labrador
- British Columbia
- Alberta
- Saskatchewan
- New Brunswick
- Nova Scotia
- Prince Edward Island
- New Brunswick
The member forums and online engagement focused on three topics:

- Access to care – delivery models of care
- Physician health and wellness
- Open dialogue with the board: visioning the future

1. Access to care – delivery models of care

Dr. Sandy Buchman, CMA president, Dr. Gigi Osler, CMA past president, and Dr. Abdo Shabah, CMA board member, provided context-setting presentations at the Member Forums, with a focus on:

- why access to care is being prioritized as a flagship issue;
- the CMA’s role and objectives in starting a national conversation on care delivery models; and
- results of the Member e-Panel Survey conducted in January 2020.

Results of the live poll

The top five impeding factors and attributes selected by members in the live polls conducted at the Member Forums and on the CMA’s online engagement platform are summarized below.

<table>
<thead>
<tr>
<th>Top impeding factors</th>
<th>Top attributes</th>
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<tbody>
<tr>
<td>Poor access to other medical services (24%)</td>
<td>Coordinated (20%)</td>
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<tr>
<td>Current remuneration models (14%)</td>
<td>Timely access (18%)</td>
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<tr>
<td>Lack of digital health integration (12%)</td>
<td>Appropriate care (16%)</td>
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<tr>
<td>Lack of national pharmacare (11%)</td>
<td>Patient-centred (14%)</td>
</tr>
<tr>
<td>Administrative burden (11%)</td>
<td>Efficient (9%)</td>
</tr>
</tbody>
</table>

Note: Results of the poll represent the opinions of the members who voted during the Member Forums and on the platform, and not those of the entire CMA membership.

Question #1: Based on your experience, select the top factor that impedes your ability to provide the best level of care you would like to provide to your patients.

Question #2: Based upon your experience, please select the most important attribute of a high-performing health care delivery model.
Question #1: Top factor that impedes your ability to provide the best level of care (n = 248 respondents)

- Poor access to other medical services: 24%
- Current remuneration models: 14%
- Lack of digital health integration: 12%
- Lack of national pharmacare and coverage for other uninsured services: 11%
- Administrative burden: 11%
- Poor access to other health services: 10%
- Patient population factors: 8%
- Ministry of Health/Health authority regulations: 8%
- Absence of national licensure: 3%

Question #2: Most important attribute of a high-performing health care delivery model (n = 249 respondents)

- Coordinated: 20%
- Timely access: 18%
- Appropriate care: 16%
- Patient-centred: 14%
- Efficient: 9%
- Universal access: 8%
- Comprehensive: 6%
- Sustainable: 6%
- Provider wellness: 3%
What were the most commonly discussed impeding factors at the different Member Forums?

While poor access to other medical services ranked first or second across all Forums, current remuneration models ranked among the top three impeding factors in the Forums held in western Canada (Vancouver, Saskatoon and Calgary). Administrative burden and lack of digital health integration were the other two most commonly recognized impeding factors in the polling across the Member Forums.

What were the most commonly discussed attributes at the different Member Forums?

While coordinated and appropriate care were among the top three attributes in five of the six Member Forums, the attribute timely access was among the top three in all the Member Forums, except the Forums in Quebec. Another attribute that was identified in several of the Member Forums was patient-centred care.

Using the top results from the live polling, participants worked in small groups to discuss the root causes of the impeding factors and the importance of the top attributes. The key discussion themes for the most commonly discussed impeding factors and attributes are summarized below.

What are the root causes of the top impeding factors?

- The inequitable geographic distribution of health care providers, particularly in rural and remote areas, and in accessing specialists was discussed by participants. Transportation to and from treatment, limited adoption of virtual care, and system factors, including organizational silos, inappropriate referrals and system inefficiencies, were seen as exacerbating poor access.
- The lack of health human resources and long-term resource planning, including an increase in “overspecialization” of physicians, and inequities for rural/remote and First Nation communities were also discussed.
- Team-based care, along with communication between physicians and other health care providers, is a gap in current care delivery models. Poor communication stems from existing silos, lack of an integrated electronic medical record (EMR), language barriers and inappropriate referrals. Inappropriate referrals result from a lack of guidelines for referral (e.g., one provider/specialist referral system).
- Other root causes are limited funding for services (e.g., uninsured services, prescribed medications, diagnostics, long-term care), a lack of incentives for improving efficiency in care delivery or preventive care services and a lack of awareness of services available.
### Current remuneration models

- Overall disparities among the remuneration models for the various provinces/territories, specialties and organizations, as well as specific issues such as the lack of financial incentives for underserved specialties and the adoption of digital tools/practices (e.g., EMRs, virtual care), were discussed.
- The fee-for-service model incentivizes “quantity over quality” of patient consults and promotes a time-based model of care. It was also expressed in some Member Forums that the current remuneration models are inflexible and do not account for the complexity of care required for the patient. This has made the delivery of team-based care challenging and is leading to physicians “cherry picking” subspecialties.
- Other root causes include the fact that current remuneration models do not capture a physician’s true scope of practice and are based on volume rather than the quality of care delivered, and there is a lack of effective evaluation of the various remuneration models; in some Member Forums it was also indicated that there is a gender disparity in physician income.

### Lack of digital health integration

- The inability to access health information from other providers in a patient’s circle of care because of limited integration between health information systems used by providers across the different settings of care (i.e., limited integration between the electronic health records [EHRs] used in hospitals and the EMRs used by community-based physicians) was discussed. This also leads to practice management and care delivery inefficiencies.
- Lack of standardization (e.g., different systems, different methods of data collection) can limit the ability to integrate the systems, resulting in fragmented communication between providers (e.g., community organizations and hospitals).

### Administrative burden

- Physicians balance multiple roles (including managing their practice and fulfilling their teaching obligations). At times, when dedicated resources are not available, care coordination becomes an added responsibility for physicians.
- Shortages of administrative staff proficient in digital tools (e.g., EMRs), outdated administrative technology (e.g., fax machines) and lack of centralized health records training and technical literacy have increased the administrative burden on physicians.
Why are the top attributes important?

Coordinated care

- Primary care physicians, as the “gatekeepers” of the health care system, can facilitate better communication with other providers to reduce errors, improve patient safety, facilitate more seamless patient transitions between provider settings across the continuum of care, and enhance information exchange.

- Coordination through multidisciplinary collaboration (including digitally) was seen as beneficial in promoting prevention and wellness programs and improving system efficiency (including quality and cost of services) and patient outcomes. It was also indicated that multidisciplinary teams could decrease physicians’ administrative burden.

- Digital tools/platforms that facilitate information sharing and remote care delivery (e.g., telehealth, virtual care) were noted as key enablers of coordinated care. The digital tools could also enable population health management through better use of health data.

- Leading practices of integrated care delivery, such as a patient/medical home model with patient navigators to facilitate stronger communication (including digitally) between key stakeholders, could support an easier patient journey with better outcomes.

“\textit{When services are coordinated, we save time, resources and costs while improving access.}”

- Member Forum participant

Timely access

- Timely access is a critical attribute of high-performing health systems in delivering optimal patient outcomes, improving patient quality of life and reducing systemic costs associated with burden of illness. Conversely, long wait times, especially for diagnostic results and treatment, can increase patient distress, lead to poorer outcomes and increase systemic costs associated with illness left untreated.

- Strategies to remove administrative constraints — by hiring sufficient human resources, adopting digital tools to streamline access (e.g., eConsult, virtual care) and enhancing coordination between care providers — were seen as key enablers of timely access.

- Ensuring timely access to preventive care and mental health and addictions services, including access to digital tools, can help improve the overall health and wellness of the population and facilitate a shift toward a wellness-based model of care.
“There is a pressure to reassure patients that waiting [for treatment] is okay, when really, it’s not.”
- Member Forum participant

| Appropriate care                                                                 | • Appropriate care is viewed as the “right care at the right time in the right place to meet a patient’s needs” and should consider quality over quantity (this was brought to life by a quote from one of the members: "more care does not equal better care").

• Leading practice guidelines or standards defining appropriate care (and differentiating between appropriate care and medically required care) can help reduce overtreatment of patients, improve patient outcomes and experiences and reduce complications and the cost of care.

• The delivery of appropriate care can reduce duplication of care (e.g., getting a second opinion), improve care coordination across the continuum and improve the effectiveness of the use of system resources.

• There is a relationship between appropriate and coordinated care, such that providing appropriate care should necessitate that providers work within their scope of practice and, potentially, as part of a holistic care team, where each provider has clear roles and responsibilities.

| Patient-centred care                                                            | • Empowering and partnering with patients is a core principle for delivering patient-centred care. Engaging patients in their care delivery through co-design and providing patients with accountability for managing their care (including education and digital access to their information) can increase trust, increase buy-in and improve patient outcomes.

• Patient-centred care will improve patient experiences, patient–physician relationships and health system value.

• Additional system-wide structures and services to support patient-centred care include national pharmcare, health education for various populations and culturally sensitive care. |
Ideas to improve patient-centred care

Building on the discussion on impeding factors and attributes, the members were engaged on ideas for change. At the Member Forums, breakout groups were provided with a patient journey poster (see below) illustrating a patient’s interactions with the health system at different points in the continuum of care.

The graphic below illustrates a patient’s interactions with the health system at different points along their continuum of care.

The members were asked to identify both system- and practice-level strategies to improve patient-centred care. At the Member Forums, each group was asked to share one idea for change at the system level and one idea for change at the practice level. The same was asked of members through the online engagement platform. The following is a summary of the themes that emerged from the ideas shared by the members.
What changes would you make to improve patient-centred care at the system level?

**Patient engagement and empowerment**

- Incorporating patient feedback on how the system needs to change and ensuring that patients are "engaged," "empowered," and "educated" in their care can help to improve outcomes and reduce costs.

- Improving patient health literacy, through tools such as multilingual supports, can help patients navigate the health system. Patient education should include health promotion and prevention and providing digital access to their health information through various channels (e.g., online platforms, patient portals).

- Physicians are resource stewards on behalf of the health system. While patients’ preferences for their care are key elements of feedback that providers should consider, patients’ choices should also respect resource stewardship.

- Engagement with patients, both through formal avenues such as patient and family advisory councils (PFACs) as well as through informal avenues, is a critical opportunity to receive feedback on services that patients need and identify ways to improve patient-centred care.

**System integration and support for technology**

- There is a need for integration among EMRs, EHRs and other health information systems and a support structure for telemedicine/virtual care (including provincial funding, infrastructure, etc.). The members also expressed an interest in the use of artificial intelligence for population health management.

- It was recognized that the integration of health systems would provide one view of a patient’s health record across their continuum of care. It would also provide access to a patient record for all the providers in the patient’s circle of care (including the patient) and enable communication among physicians and other providers.

- Other advantages of an integrated health information system are less duplication of data, reduction of the administrative burden on physicians, and support for more efficient care transitions between siloed care environments (ensuring patients don’t “fall through the cracks”).
“When someone shows up at a hotel, the hotel knows how the customer would like his/her room and other preferences. Why can’t we do this in health care, where we capture the patient’s health information?”

- Member Forum participant

Integration with other providers to deliver holistic care

- Integrating care with public health and allied health professionals to deliver holistic care could create a “one-stop shop” for patients and support the development of preventive care services to support population health management.

- Delivery of holistic care through multidisciplinary care teams in “health-hubs” can better support patient-centred care. These teams should be physician led so that family physicians can keep a pulse on the patient’s care. These teams will also help improve family physicians’ access to and communication with specialists, and other health care providers (helping reduce unnecessary referrals and wait times).

- Alternative funding models to support integrated care could include capitation, funding allocations direct to patients (e.g., providing patients with a dollar amount that they can allocate as they see fit) and programs that incentivize family support and navigation services.

Adoption of innovative models of care (e.g., patient medical home or “community first” model)

- A coordinated care experience through a “patient medical home” was discussed. This would be a place where patients can access required services in their home and community.

- The “patient medical home” model was also referred to as the “community first” model. A key attribute of this model is a multidisciplinary care team that consists of family physicians, social workers and other providers. This model could help reduce emergency department visits by enabling better care for specialized groups (e.g., LGBTQ, people with mental health conditions, people with chronic illnesses) through access to appropriate services and supports.

- Either of the models would need an increase in funding for community-based services (to provide coverage for allied health, social care and public health services), broader adoption of standardized patient pathways and navigation services and provision of remote care services (e.g., virtual care).
Making family medicine an attractive career choice

- Family medicine is becoming a less popular choice among medical students, and the need for primary care is rising. This is creating a critical gap in addressing patient-centred care models.
- It was identified that there is a need to promote family medicine as a specialty — informally through mentorship and formally through training reforms (e.g., a one-month rotation in university) — to ensure Canadians across all geographies have access to a family physician.
- The members also identified a bold future — "every Canadian has a family doctor" — underscoring how critical family medicine is in the Canadian health system.

Engage in multidisciplinary care delivery

- There was a clear understanding among members that multidisciplinary care delivery, such as through a co-location or team-based delivery model, is a leading practice that could improve the patient experience with greater access to services across the continuum of care, including specialist care, preventive care and mental health care.
- The members also indicated that multidisciplinary care could improve outcomes by providing the appropriate type and level of care and facilitating better communication between providers, including through technology-enabled means (e.g., integrated EHR/EMR).
- The role of a care coordinator to support triage, navigation and communication between providers was seen as an important element of multidisciplinary, patient-centred care. The members discussed the facilitation of this by providing patients with a primary contact throughout their care journey, reducing the administrative burden on providers.

What changes would you make to improve patient-centred care at the practice level?

- There was a clear understanding among members that multidisciplinary care delivery, such as through a co-location or team-based delivery model, is a leading practice that could improve the patient experience with greater access to services across the continuum of care, including specialist care, preventive care and mental health care.
- The members also indicated that multidisciplinary care could improve outcomes by providing the appropriate type and level of care and facilitating better communication between providers, including through technology-enabled means (e.g., integrated EHR/EMR).
- The role of a care coordinator to support triage, navigation and communication between providers was seen as an important element of multidisciplinary, patient-centred care. The members discussed the facilitation of this by providing patients with a primary contact throughout their care journey, reducing the administrative burden on providers.
Patient empowerment through partnership

- The delivery of patient-centred care requires that patients be **empowered to participate in their health care journey** — from sharing goals to providing feedback — and equipped with the knowledge to **meaningfully participate** (e.g., through having access to their data). This would help physicians to gain a better understanding of a patient’s social determinants of health and to deliver culturally sensitive care.

- The members identified that these changes would require a **shift toward engaging patients in the design of their care**, incorporating their feedback into care delivery and measuring patient satisfaction and experiences to measure the effectiveness of care delivered.

- It was shared that **physicians need to build strong relationships with their patients to build trust** (e.g., through listening and elevating the patient voice through advocacy), educate them (e.g., about navigation services) and manage expectations for their care.

“**At the practice level, we [as physicians] need to empower patients to take a more active role in their health**”

- Member Forum participant

Embracing digital transformation

- The members recognized that as physicians, they could **play a critical role in the success of digital transformation initiatives**. They encouraged fellow physicians to “**be a voice**” for change and indicated that, as physicians, they not only need to advocate for system-level change but also need to “**be engaged**” and become “**a part of the change**” at the practice level.

- Physicians could be encouraged to support digital education and empowerment efforts by **educating patients on their right to request access to their health data** and become more engaged in their care, **adopt telehealth to improve access for their patients** in remote areas, and provide virtual follow-ups.

- The members also identified that adoption of **integrated digital tools** (e.g., EMR, eReferral, eConsult) could **reduce administrative overhead** (e.g., faxes).
2. Physician health and wellness

Dr. Caroline Gérin-Lajoie, executive vice-president of physician health and wellness (now physician wellness and medical culture), and Dr. Gigi Osler, CMA past president, provided context-setting presentations at the Member Forums, with a focus on:

- key results of the National Analysis of Physician Health and Wellness Services and Resources;
- the top drivers identified for physician health and wellness at the 2019 Regional Member Forums;
- the potential pan-Canadian opportunities; and
- the CMA’s role and objectives regarding this issue and its primary focus areas.

Results of the live poll

Note: Results of the poll represent the opinions of the members who voted during the Member Forums and on the platform, and not those of the entire CMA membership.

Question #1: Over the last 12 months, have you seen a physician or trainee in your environment suffer from a health condition that you believed was related to the work environment or medical culture?

Question #2: What aspects of the medical culture are important to preserve?

Question #3: What aspects of the medical culture would you like to see change?

Question #1: Across all Member Forums and on the online engagement platform, **81% of members indicated YES**, highlighting the relevance of this discussion to the audience.
**Question #2:** The responses from the Calgary, Saskatoon, Vancouver and Thunder Bay Member Forums generated the word clouds below (the member discussions at the Rouyn-Noranda and Quebec City Member Forums are summarized in the blue boxes below). Based on the relative size of the words, compassion, empathy, respect, mentorship, professionalism and integrity were the most common aspects of the medical culture that participants would like to preserve.

- **Rouyn-Noranda**
  - The pleasure of helping people
  - Physicians’ dedication to their patients
  - Mutual aid in teaching
  - The patient at the centre of our concerns
  - Autonomy of thought and action

- **Quebec City**
  - Collaboration
  - Professionalism
  - Continuous learning
  - The patient at the centre

- **Calgary**

- **Saskatoon**

- **Vancouver**

- **Thunder Bay**
Question #3: The responses from the Calgary, Saskatoon, Vancouver and Thunder Bay Member Forums generated the word clouds below (the member discussions at the Rouyn-Noranda and Quebec City member forums are summarized in the blue boxes below). Based on the relative size of the words, hierarchy, stigma, bullying, paternalism and shame were the most common aspects of the medical culture that participants would like to see change.

<table>
<thead>
<tr>
<th>Rouyn-Noranda</th>
<th>Quebec City</th>
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<tbody>
<tr>
<td>• The constant pressure</td>
<td></td>
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<tr>
<td>• Working in a silo</td>
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<tr>
<td>• The military hierarchy</td>
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<td>• Lack of recognition</td>
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<td>• Low error tolerance</td>
<td>• Work overload</td>
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<td>• Peer and supervisor/boss pressure</td>
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<tr>
<td>• The competition</td>
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<tr>
<td>• Harassment</td>
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<tr>
<td>• The feeling of invincibility</td>
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Rouyn-Noranda:
- The constant pressure
- Working in a silo
- The military hierarchy
- Lack of recognition
- Low error tolerance

Quebec City:
- Work overload
- Peer and supervisor/boss pressure
- The competition
- Harassment
- The feeling of invincibility
Making a difference: pan-Canadian opportunities

During the Member Forum discussions and on the online engagement platform, members shared ideas on how the five pan-Canadian opportunities emerging from the National Analysis can make a difference in their everyday practice.

- National standards, measurement and tools
  - There is a need for a standardized definition of wellness, standardized metrics that measure wellness (capturing all facets of wellness, not just hours worked) and national work standards for payment scales, work hours, safety and time off. These standards could serve as guidelines and help improve equity across disciplines and provinces/territories.
  - There is an interest among members in measuring the wellness of physicians to establish a baseline across Canada and in conducting annual wellness surveys/audits to track physician wellness. It was also identified that this national-level measurement of physician wellness could be performed by the CMA.
  - The significance of national licensure for ease of physician movement across Canada was also highlighted, especially to improve credentialing, protect pan-Canadian trainees, enhance physicians’ ability to try different specialties and support virtual care across jurisdictional boundaries.
  - Other ideas included the incorporation of a wellness curriculum in medical schools, mandatory physician wellness check-ins conducted by colleges and an annual check-up for every physician with their family doctor (i.e., every physician has a family doctor).

- Enhanced advocacy
- Service awareness, availability and access
- Medical profession transitions
- Shifting the system’s culture

The key themes from member discussions are summarized below.
“Physician wellness should be a right, and built into the work environment — it should be a key performance indicator for the health care system.”

- Member Forum participant

**Enhanced advocacy**

- A need for physician-led advocacy was recognized, especially at the system level, to advocate on key issues (e.g., pay scales, work conditions) and the importance of “physician unity” and a peer network to increase solidarity, support and collegiality among physicians. This would also help create an environment where everyone feels supported and respected.

- Destigmatizing the need for mental health supports for physicians was widely discussed as a critical component for improving physician wellness. It was also recognized that there is a need for additional support to reduce empathy burnout and the workload of physicians, including funding for therapy, counselling and/or coaching.

- Physicians need to be comfortable asking for help, and there is a need to increase patient awareness on the issue of physician burnout. Today, physicians are also at risk of experiencing empathy burnout, which not only will affect their personal life but also will have cascading effects on their ability to deliver culturally sensitive care. Increasing patient awareness on this will help increase patient–physician trust.

“A healthy physician equals healthy patients.”

- Member Forum participant
Service awareness, availability and access

- Given the emotional difficulties physicians may face stepping into a patient role, members acknowledged a need for services to be **confidentially** and/or **anonymously accessible** if desired.
- There is a need for developing **safeguards** and a **centralized repository** ("one-stop shop") of information and resources on health and wellness. Members also recognized the importance of early education (at the student level) on the resources available.
- Other ideas shared by members included **24/7 physician and family support services** with routine follow-ups, **peer support clinics** to help physicians to manage stress and eliminate stigma, **mental health counselling for physicians** and **virtual support groups** for physicians in rural areas.

Medical profession transitions

- There is a need for supports/mentorship to facilitate **healthy transitions** across all stages of a physician’s medical career, including family planning, management of the transition into retirement and advice on how to transfer the patient roster to other physicians or a successor at the time of retirement. A need for **dedicated supports and skills training to aid in transitions** during and into major career milestones (including medical training, financial planning) was also recognized.
- The members also discussed incorporating **business education and knowledge on managing a private practice into the curriculum** (hiring, billing, scheduling, taxes, investments) or, at minimum, clear and accessible supports on how to do so. Members agreed that such a skill set would assist physicians in effectively reducing their workload and administrative burden, helping reduce burnout.
- There is a need for facilitating mutual respect along the physician hierarchy through opportunities like “reverse-mentorship” between early-career physicians and mature physicians. The **use of digital tools** was an example of an opportunity for reverse mentorship.
- There is an opportunity to advocate for reform of the CaRMS interview process to reduce the **high stress/uncertainty** and travel (including environmental impacts of travel) associated with the process. This discussion also highlighted a need to advocate for support for unmatched residents and to create **enough residency spots to match the job market**.
Shifting the system’s culture

- There is a need for a system-level shift from the traditional culture of shame-based learning and “presenteeism” to a culture of kindness and a coaching model, where physicians are rewarded for their professionalism and respect for each other. In this model physicians “walk the walk” by modelling self-care and being kind to each other, helping physicians be compassionate with each other.

- It was recognized that to create a culture shift, it is important to inform physicians early in their education (at the student level) on the wellness resources available, to eliminate bullying and harassment of learners, to introduce the flexibility to switch specialties without being penalized and to reform historical practices like 24-hour on-call.

“Why not have trauma-informed medical training? Why not a ‘what happened to you?’ instead of a ‘what’s wrong with you?’ approach within the profession? I would like to see more emphasis on hope than resilience.”

- A member on the online engagement platform
3. Open dialogue with the board: visioning the future

The open dialogue was about the future. It was grounded in the ideas shared by members on the following question: What are the major disruptions that will impact health and health care in Canada in the next 10 to 20 years?

Members were invited to post their ideas on a “Disruptions Wall” at the Member Forums and on the online engagement platform. These ideas have been categorized into 10 themes that reflect the disruptions viewed as most relevant to the members.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Details</th>
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<tbody>
<tr>
<td>Changing medical profession</td>
<td>• Increase physician replacement with AI, robotics, etc</td>
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<td></td>
<td>• Declining interest in primary care</td>
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<td></td>
<td>• LGBTQ+ medicine</td>
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<td>Medical training</td>
<td>• Increasing student debt</td>
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<td>• Silo-based curriculum</td>
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<td></td>
<td>• Technical literacy</td>
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<tr>
<td>Population health management</td>
<td>• Health literacy and access to data</td>
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<td></td>
<td>• Varied patient expectations (Millenials vs. aging population)</td>
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<td></td>
<td>• Interprofessional care and integration with allied health</td>
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<tr>
<td>Political shifts</td>
<td>• Political polarization and instability</td>
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<td></td>
<td>• National pharmacare</td>
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<td></td>
<td>• Universal basic income</td>
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<td></td>
<td>• Political mobilization of vulnerable populations</td>
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<td>Personalized medicine</td>
<td>• Precision medicine</td>
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<td></td>
<td>• Genomic science</td>
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<td>Physician health and wellness</td>
<td>• Physician burnout</td>
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<td></td>
<td>• New attitudes to work-life integration</td>
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<td></td>
<td>• Physician resource planning</td>
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<tr>
<td>Social determinants of health</td>
<td>• Multi-cultural population</td>
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<td></td>
<td>• Income inequity, homelessness</td>
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<tr>
<td></td>
<td>• Progressive social isolation</td>
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<tr>
<td>Health system design and sustainability</td>
<td>• Private medical practices</td>
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<tr>
<td></td>
<td>• Increasingly expensive personalized treatments</td>
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<tr>
<td></td>
<td>• Alternative uses for dated health care facilities/equipment</td>
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<tr>
<td>Emerging global threats and diseases</td>
<td>• Pandemic and novel infectious diseases</td>
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<td></td>
<td>• Climate change: climate refugees and population migration</td>
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<td></td>
<td>• Anti-vaccination attitudes</td>
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<tr>
<td>Digital health</td>
<td>• Telemedicine and virtual care</td>
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<tr>
<td></td>
<td>• Artificial intelligence</td>
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<td>• Internet of things integration</td>
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<td>• Patient data privacy</td>
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At the Member Forums, a version of these themes (specific to each of the Forums) was used as a backdrop for an open dialogue with a panel of CMA board members, who facilitated a discussion with members on these themes. The most common areas of discussion among members are summarized below.
Changing medical profession

- Members expressed the need for work–life integration to ensure that their time with patients is protected and that they have time to rest and recuperate. They shared comparisons with other industries, such as aviation, where it is illegal for pilots to fly after a standardized number of hours. The lesson learned was to ensure that physicians don’t burn out working 68–72 hours per week.
- The members also discussed the importance of improving resource allocation and sustainability to address distribution issues between rural and urban areas and help reduce patient volumes for late-career physicians who are transitioning to retirement. This improvement could be enabled through team-based/multidisciplinary models of care that help physicians work alongside allied health professionals to deliver high-quality care to patients.

Digital health

- The members expressed the view that even though technology is becoming increasingly prevalent in the delivery of care, “there is always going to be a role for the physician,” especially in building a human connection with the patient. It was stressed that digital tools should be used to augment rather than replace in-person care delivery by supporting continuity of care.
- It was recognized that as information becomes increasingly accessible and available online, physicians are no longer the gatekeepers of health care information, and patients will continue to become more knowledgeable about their health. This will improve patients’ ability to lead their care delivery in partnership with their physicians.
- While the members agreed that there are various benefits of digital health (e.g., artificial intelligence can improve clinical decision-making; virtual care can improve accessibility and break down silos between providers), they indicated that digital tools need to be ethically integrated to avoid issues such as inequities in access.
- The members also identified system-level and practice-level supports needed for physicians to successfully adopt digital tools and practices, such as leading practices guidelines for implementation and interoperability, regulations for effective use, funding for incentivizing adoption, and technical literacy for physicians. One of the areas where the CMA has shown leadership is the work done by the Virtual Care Task Force on identifying recommendations for scaling up the adoption of virtual care.
“Thirty years ago, doctors were the gatekeepers of health care knowledge and information for the patients, but today with digitalization, information is available online.”

- CMA board member

Social determinants of health

• To provide holistic and high-quality care, it is imperative to consider the social determinants of health, such as inequities in access to care due to income differences, stigma and bias against certain populations. It was indicated that failing to consider the effects in planning care could "set patients up to fail" and cause them to "lose trust" in their care.

• Partnership between physicians and allied health professionals (e.g., outreach workers) could improve care for patients with socially complex needs.

• The role of technology and its effects on social isolation were also discussed. For example, it has been witnessed that use of social media is increasing social isolation rather than improving social connectivity.

“I can help treat my patients’ addictions issues, but I don’t know how to fix the circumstance that made my patients users in the first place.”

- Member Forum participant
Health system design and sustainability

- Members expressed the need to **design a system that improves access** by breaking down silos (in system design and care delivery), embracing a “**primary care for all**” model and **integrating technology** to support the delivery of care.

- High-quality health system design should **address the social determinants of health**. For example, **preventive services/programs** should be made available, **community action groups** should be created to design innovative and holistic care solutions and **Indigenous and other marginalized populations should be engaged as partners** in system design and development.

- To make the health system sustainable, remuneration needs to be **transparent and equitable** based on the **type of service** provided and should allow physicians to address all of a patient’s concerns in one visit, as a part of a multidisciplinary team, rather than requiring the patient to visit multiple times.

Population health management

- Members recognized that with the rise of **“consumer-driven medicine” and the demand for patient-centred care**, there is a need to develop integrated care pathways that address the holistic health and social needs of patients. This would involve integrating mental health care, preventive care, allied health services and other social services into the models of care and digitally enabling the delivery of these services.

- Members also identified that the **aging population** in Canada requires a “**culture shift**” toward models of care that support out-of-hospital care (e.g., provision for palliative care). A critical success factor for addressing these generational differences will be the **effective training of physicians on the differing needs of each generation** (e.g., Baby boomers, Millennials, Gen-Z).
## APPENDIX A: AGENDA

<table>
<thead>
<tr>
<th>TIME</th>
<th>ITEM</th>
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<tbody>
<tr>
<td>8:00 – 8:30</td>
<td>Networking Breakfast and Registration</td>
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<tr>
<td>8:30 – 9:15</td>
<td>Opening and Introductions</td>
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<td></td>
<td>• Welcoming remarks</td>
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<td>• Overview of the day, introductions and warm-up exercise</td>
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<tr>
<td>9:15 – 9:35</td>
<td>Access to Care – Health Care Delivery Models</td>
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<td>• Context-setting presentation and overview of the topic from a CMA perspective</td>
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<td>9:35 – 10:05</td>
<td>Access to Care – Health Care Delivery Models</td>
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<td>• Break outs (30 min.): Discussion on key barriers to accessing care related to the current health care delivery model(s) and brainstorming the ideal attributes of delivery model(s) that support access to care for patients</td>
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<tr>
<td>10:05 – 10:20</td>
<td>Health Break</td>
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<tr>
<td>10:20 – 11:45</td>
<td>Access to Care – Health Care Delivery Models</td>
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<td>• Break outs (45 min.): Brainstorming strategies, at the system and practice level, for changing or introducing new delivery models of care to improve access to care</td>
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<td>• Report back (40 min.): Report back to the larger forum</td>
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<tr>
<td>11:45 – 12:00</td>
<td>Moving Forward</td>
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<td>• Summary of the discussion on access to care and CMA next steps</td>
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<tr>
<td>12:00 – 1:00</td>
<td>Lunch</td>
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<tr>
<td>1:00 – 1:20</td>
<td>Physician Health and Wellness</td>
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<td>• Context-setting presentation including data (CMA National Physician Health Survey) and an overview of the emerging results from the CMA National Analysis of Physician Health and Wellness Services and Resources</td>
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<td>1:20 – 2:45</td>
<td>Physician Health and Wellness</td>
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<td>• Break outs (40 min.): Brainstorming actions to promote and support positive and supportive training and practice culture</td>
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<td>• Report back (40 min.): Report back to the larger forum</td>
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<td>2:45 – 3:00</td>
<td>Physician Health and Wellness Open Dialogue: Preliminary Recommendations Stemming From National Analysis</td>
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<td>• Summary of the discussion on the preliminary recommendations for physician health and wellness and CMA next steps</td>
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<tr>
<td>3:00 – 3:15</td>
<td>Health Break</td>
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3:15 – 4:15 | Open Dialogue: Visioning The Future – Disruption And Opportunities
Facilitated plenary with regional CMA board members
• How will health care be disrupted in the next 10–20 years? What should the CMA be strategically planning for?
• How might we address the future disruptors? What is needed to do so?

4:15 – 4:30 | Close
• Summary of the day and next steps

Locations
The CMA hosted six one-day Member Forums:
• Rouyn-Noranda – Le Noranda Hotel & Spa on Friday, Feb. 7
• Quebec City – Delta Quebec Hotel on Monday, Feb. 10
• Calgary – Calgary Airport Marriott In-Terminal Hotel on Saturday, Feb. 22
• Saskatoon – Sheraton Cavalier Saskatoon Hotel on Monday, Feb. 24
• Vancouver – Hilton Vancouver Airport on Monday, Mar. 2
• Thunder Bay – Delta Hotels Thunder Bay on Friday, Mar. 6

Learning objectives
The group learning program has been certified by the College of Family Physicians of Canada for up to 5.5 credits.

This event is an accredited group learning activity (Section 1) as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada, and approved by the University of Ottawa’s Office of Continuing Professional Development. You may claim a maximum of 5.5 hours (credits are automatically calculated).

Overall learning objectives
At the end of the Member Forum, participants will be able to:
• identify factors that affect access to care and physician health and wellness;
• describe and advocate for practice- and system-level change to improve access to care delivery models and physician health and wellness; and
• compare their experience with that of other physicians in their region at both the practice and system levels.

Care delivery models learning objectives
At the end of the Member Forum, participants will be able to:
• identify and validate access barriers related to the current health care delivery model(s);
• define ideal attributes of delivery model(s) that support access to integrated delivery of care for patients; and
• develop strategies for improving care delivery models, at both the system and practice levels.
Physician health and wellness learning objectives
At the end of the Member Forum, participants will be able to:

• describe the landscape of physician health and wellness in Canada through both the data (CMA National Physician Health Survey [NPHS]) and the emerging results of the CMA National Analysis of Physician Health and Wellness Services and Resources;

• identify strategies for promoting and supporting physician health and wellness, with particular emphasis on professional culture, at the practice and system levels; and

• illustrate actions for practice- and system-level change in participants’ unique contexts.

Open dialogue learning objectives
At the end of the Member Forum, participants will be able to:

• identify and describe emerging health care disruptors that Canada will be facing in the next 10–20 years; and

• describe strategies to respond to the future emerging health care disruptors.