



2019 Regional Member Forums

ROLL-UP
SUMMARY
REPORT

ASSOCIATION
MÉDICALE
CANADIENNE



CANADIAN
MEDICAL
ASSOCIATION

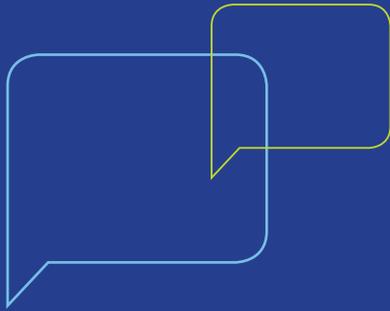


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2019 Regional Member Forums

EXECUTIVE SUMMARY

Listen, Learn, Act:
Executive summary, regional member forums 2019

In early 2019, the Canadian Medical Association (CMA) held a series of four regional member forums (RMFs), to connect face to face with members across the country.

Regional Member Forums 2019

- Atlantic region –
Halifax, Jan. 26
- Quebec region –
Montréal, Jan. 28
- Western/Northern
region –
Edmonton, Feb. 2
- Ontario/Nunavut –
Ottawa, Feb. 4

Members who couldn't attend the sessions in person were also able to post their comments on the RMF discussions online, through the CMA's community engagement platform, until Apr. 1, 2019.

The forums were developed as way to listen to and learn from physicians and medical learners about the pressing issues facing the medical profession, how this affects their daily work and their care for patients, and their ideas for actions the CMA and its members could take to create change.

The CMA reached out to members to help shape the agenda for these full-day events, and based on this feedback, the forums were structured around two broad topics — physician workforce issues, and physician health and wellness.

This summary — and the attached report — highlight the key findings from the RMFs, based on the insights from participating physicians at each forum, and online. This summary also outlines the actions the CMA is taking to help address these issues, today and in the future.

EACH RMF SESSION INCLUDED:

- Context-setting presentations from the CMA president and staff/experts;
- Keypad voting questions, with results displayed in real time;
- Small group discussions, on specific sub topics, with each group capturing its key discussion points on a worksheet;
- Plenary dialogue where groups reported back on their discussions, providing an opportunity for all participants to share their views; and
- An “idea wall” and participant forms where members could share their individual ideas.

What we heard about physician health and wellness

- Reduce workload and workplace burdens on physicians
- Foster culture change to create safer and more supportive training and practice environments
- Provide wellness supports and accommodations
- Foster social connections, respect and civility
- Enhance control over profession and flexibility in practice
- Foster patient accountability and manage patient expectations

We heard from our members that physician health and wellness was a high priority. Members told us that a lack of control and flexibility in their practice, coupled with increasing workloads, are negatively affecting wellness. Members also told us the medical profession needs a culture change, to create more supportive practice environments that foster respect and civility and provide wellness supports.

Physician wellness and a vibrant profession is a priority at the CMA, and we’ve created a dedicated physician health and wellness department, headed by Dr. Caroline Gérin-Lajoie.

The CMA compiled the National Physician Health Survey in 2018, and the results provide the first national data set in Canada on issues such as physician burnout, depression and suicidal ideation. The first snapshot was released in October 2018 and we are building on this work in 2019, releasing new data sets and conducting a national scan on physician wellness supports and programs across Canada.

In 2018, we co-hosted the International Conference on Physician Health with the British, American and Australian medical associations, and in 2019, we are hosting the Canadian Conference on Physician Health. We have also launched a Wellness Ambassador Initiative to help support early-career physicians to attend these conferences.

At a policy level, the CMA’s statement on physician health and wellness supports physician health as a shared responsibility, to be addressed at an individual, institutional and system-wide level. Similarly, the CMA’s Code of Ethics and Charter of Shared Values and the creation of an equity and diversity policy are helping to build a more supportive medical culture.

CMA's affinity partnership with MD Financial Management and Scotiabank is prioritizing physician wellness initiatives. With \$115 million over the next 10 years to support physicians and the communities they serve, this partnership will make a significant contribution to physician health and wellness.

What we heard about physician workforce issues

Mismatch and career transitions

- Provide career transition supports
- Develop physician leadership and facilitate multistakeholder collaboration
- Enable greater career flexibility and mobility
- Recognize and address the unique needs and challenges of rural practice
- Recognize and value "generalism" and family medicine
- Complement provincial/territorial health human resource (HHR) planning with a national perspective
- Provide more practice management supports and training

Diversity and equity

- Enable equal access to the profession for individuals from low-socioeconomic and diverse backgrounds
- Work with Indigenous communities to address their needs and the underrepresentation of Indigenous peoples in medicine
- Revise recruitment and admission processes to be broader and more inclusive
- Develop and support the leadership of women in medicine
- Recognize generational differences in career perspectives and foster respectful intergenerational dialogue

HHR strategies and technologies

- Develop and facilitate access to secure and interoperable technology platforms for communication and collaboration
- Facilitate physician mobility through a more flexible licensure model
- Facilitate the deployment and adoption of technology in physicians' practice by addressing barriers
- Address electronic medical record (EMR) challenges
- Educate physicians and patients on the "rules of engagement" for virtual care
- Prepare the profession for the disruption of medicine by technology

We heard from our members that they want to practise medicine differently, to leverage the potential of new and emerging technologies, such as virtual care, artificial intelligence and electronic medical records.

To set the stage for this shift, the CMA recently helped create the Virtual Care Task Force, partnering with the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. The task force will identify the regulatory and administrative changes needed to support virtual care and the broader use of technology. Issues of licensure will also be reviewed, which may help address the locum and relief issues facing many rural and remote physicians.

The task force will also provide an update on their work at the CMA Health Summit in August and invite physicians and other participants to bring forward their perspectives as part of the General Council policy session.

At our first-ever CMA Health Summit in 2018, we provided a forum for physicians and patients to discover and discuss emerging health care technology, and we will continue these discussions at our 2019 Health Summit, Connected in Care. CMA subsidiary Joule also awards annual Innovation grants — to help fund physician innovators developing software and technology to improve communication in the health care system.

The CMA also produces data to help shape its advocacy work and policies and to ensure health care institutions and governments make informed decisions about how physicians work today. Our 2019 physician workforce survey, currently in the field, will provide valuable metrics on topics such as workload, remuneration, wait times and employment, to support accurate and timely HHR planning.

We heard from our members that physicians want more control over their work, health policies and how they practise medicine.

The CMA's role is to support physician leadership and bring the physician voice to national policy discussions. As part of its advocacy work, the CMA amplifies its members' perspectives on a range of issues, such as diversity in medicine, cannabis, pharmacare and seniors' care. The CMA also intends to be active in the upcoming federal election campaign, to ensure that all parties recognize the importance of health care to both physicians and Canadians. At the individual level, we help physicians develop their leadership skills through the CMA Ambassador program and Joule's Physician Leadership Institute courses and by sponsoring their attendance at events such as SingularityU and the Canadian Conference on Physician Leadership.

In 2019, the CMA also built a community engagement platform to enable physicians to connect and take leadership on issues that matter to them. Canada's geography can make collaboration difficult; the platform is a way to help physicians stay engaged with peers from coast to coast.

We heard from our members that diversity and equity in the medical profession is important and must be supported.

Through our communities of interest (COI) program, the CMA is providing funding and support to several communities supporting diversity in medicine: the community of interest on Creating an Inclusive and Equitable Medical Community, and the community of interest on Indigenous Health. We've also released a joint discussion paper with the Federation of Medical Women of Canada, *Addressing Gender Equity and Diversity in Canada's Medical Profession*, and the feedback we received from members is now being used to develop our equity and diversity policy.

CMA president Dr. Gigi Osler is a committed leader on equity issues, speaking candidly to local, national and international audiences about the importance of diversity in medicine. She will be bringing this message to the international Women Deliver conference this spring, where the CMA will be presenting a session on building women's capacity as medical leaders.

Our work in creating a Charter of Shared Values has also helped frame a national discussion about respectful interaction within the medical profession.

Introduction

The Canadian Medical Association (CMA) held a series of four full-day, in-person Regional Member Forums (RMFs) in early 2019: Halifax (Jan. 26), Montréal (Jan. 28), Edmonton (Feb. 2) and Ottawa (Feb. 4).

The RMFs were designed to achieve three objectives:

- **Listening:** gathering physicians' input on pressing issues affecting the profession and patients;
- **Learning:** learning from physicians' experience on the ground to identify possible solutions; and
- **Acting:** identifying concrete actions, big or small, that CMA and its members can take together to affect change.

The RMF discussions were also posted online for comments, available on the CMA's community engagement platform from Jan. 24 to Apr. 1, 2019. A total of 78 comments were received on the discussion topics.

This report summarizes the key findings from participants' discussions at all four RMFs, based on an analysis of the data captured during each of the events, as well as the feedback received online.



Participants at Montréal RMF

PARTICIPANTS

In total, 280 CMA members participated in the RMFs.

The participant profile across the RMFs included a variety of perspectives:

- **Career phase:** Slightly more than one-third (35%) were in the "First Fifteen" years of their career (students, residents, >6 years of practice).
- **Gender:** Participants were nearly evenly split between female (51%) and male (47%), and 2% non-binary/prefer not to say.
- **Practice status:** Excluding students and residents, approximately two-thirds (68%) were family physicians/general practitioners (FPs/GPs) and 38% were other specialists.
- **Practice location:** Most participants practised in an urban/suburban setting (75%). Additionally, 22% practised in a small town/rural location and 2% in remote/geographically isolated areas.
- **Province/territory:** All provinces and territories were represented except the Northwest Territories and Nunavut.

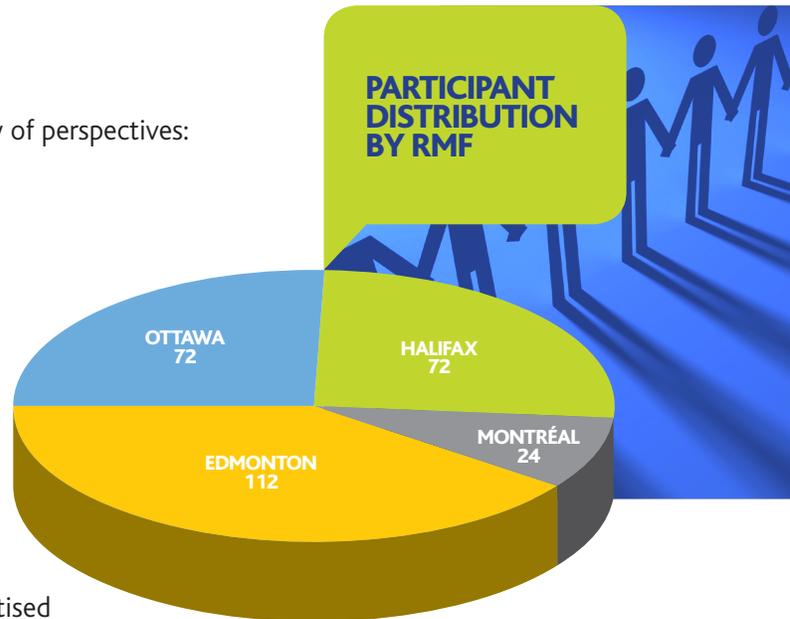
See Appendix A for the comparative demographic results across the four RMFs.

SUMMARY OF DISCUSSION

The RMFs focused on two broad topics:

1. Physician workforce issues
2. Physician health and wellness

Additionally, each RMF included an open dialogue with CMA board members, where participants had the opportunity to ask questions and bring forward other priority issues for the CMA.



Participants at Montréal RMF



Participant completing Post-it note for the "Idea Wall"

The process for each RMF included:

- context-setting presentations from the CMA president and staff/experts;
- keypad voting questions, with results displayed in real time to help get a sense of perspectives in the room;
- small group discussions, with tables assigned to discuss specific subtopics and participants completing a table worksheet to capture their key discussion points;
- plenary dialogue for groups to report back on their discussions and provide the opportunity for all participants to share their views with everyone; and
- opportunities to share individual ideas on Post-it notes on an "idea wall" or on individual participant comment forms.

1. Physician Workforce Issues

This discussion focused on three specific issues:

- **Mismatch and career transitions:** Addressing the mismatch between graduating physicians and practice opportunities/societal needs, as well as the lack of support for physician career transitions.
- **Diversity and equity:** Supporting and leveraging the changing gender composition and diversity of physicians and in practice/training environments and for patient care.
- **Health human resource (HHR) strategies and technologies:** Adapting HHR strategies to leverage the full potential of new and emerging technologies, such as virtual care, artificial intelligence and electronic medical records.

MISMATCH AND CAREER TRANSITIONS

Keypad Voting Results on Perspectives and Experiences

- **Responsibility of medical profession:** Most participants (ranging from 83% to 94%) felt that the medical profession has a responsibility to ensure that the supply, distribution and specialty mix of physicians is aligned with population health needs.
- **Canadian Resident Matching Service (CaRMS):** Over two-thirds (63-76%) knew a Canadian medical graduate who went unmatched through the CaRMS process.
- **Physician underemployment/unemployment:** Roughly half knew a physician who has been under- or un-employed for a period of time over the last two years. The highest proportion of participants was in the Ottawa RMF (67%).

See Appendix A for the comparative results on these keypad questions across the RMFs.

Key Findings from Table Discussions and Plenary Dialogue

Physician Workforce Issues:

MISMATCH AND CAREER TRANSITIONS



Provide career transition supports



Develop physician leadership and multi-stakeholder collaboration



Enable greater career flexibility



Recognize the unique needs and challenges of rural practice



Recognize and value "generalism" and family medicine



Add a complementary (to provincial/territorial) national approach to HHR planning



Provide more practice management supports and training

Provide career transition supports: Participants discussed the importance of having a variety of supports designed to help physicians transition through different phases in their career. This could include career mentorship for younger physicians; consulting with mid-career physicians on how best to manage their workload and for future planning purposes (e.g., transitioning from high-demand roles into other clinical duties, reducing on call as they get older); and exit supports/strategies for physicians later in their career. The latter could include reducing work schedules, providing supports for selling or transferring a practice and encouraging mentorship and teaching opportunities. Participants also called for supports to help physicians through transitions resulting from significant personal/life changes, such as accommodating a gradual return to work after being on maternity/parental or sick leave. More broadly, participants felt physicians could benefit from supports that could help them plan and navigate career changes at any stage of their professional journey, such as having a career manager or coach.

Develop physician leadership and facilitate multi-stakeholder collaboration: Participants felt there is a need for greater collaboration among physicians to help “unify the profession” and that physicians (not just politicians) should have a greater role in planning and decision-making at the institutional and system levels. This, they

“There can be high personal and career costs to make transitions in your practice.”

Ottawa participant

argued, can be advanced by supporting leadership development and fostering collaboration among individual physicians and by uniting the profession to strengthen the voice and influence of physicians (with many participants looking to the CMA to play this role). In addition, they called for greater collaboration with key stakeholders across health systems, such as with health authorities, colleges, medical schools, provincial governments and patients, to help better understand and plan for community needs.

“Collaborate between entities, not just with ourselves ... so we can come together to say these are the needs of the population. Right now there is mismatch and no integration.”

Edmonton participant

Enable greater career flexibility and mobility: Participants highlighted that the lack of career flexibility and mobility can pose significant challenges and undue stress for many physicians throughout their careers. For example, they cited the case of medical students who are required to make decisions with long-term consequences about residency early in medical school and of practising physicians who often face significant barriers if they want to change their location (e.g., to help meet a specific community’s needs), career path or lifestyle. As a result, they argued that medical students need greater flexibility to explore options or move across programs or specialties, and practising physicians need more options to be retrained. Flexibility was also discussed in terms of working hours, as many

younger physicians are seeking more part-time and job-sharing opportunities. Additionally, many participants discussed how national/general licensure could help address the supply-demand mismatch by helping to facilitate the movement of physicians across the country and between specialties, including for locums. Greater career flexibility and mobility is especially attractive to medical students and younger physicians.

"It's difficult to forecast what you want to be doing 20–40 years down the road."

Ottawa participant

Recognize and address the unique needs and challenges of rural practice: Participants expressed their frustration with the challenge of recruiting and retaining physicians in rural and isolated communities that continue to be underserved and discussed the pressures this places on those physicians who do choose to practise in these communities. Participants felt that this could be supported in several ways, such as "longitudinal recruiting" of local rural high school and college students, providing medical students with more exposure to and specialized training in rural medicine, providing more distributed/decentralized medical education opportunities (e.g., Northern Ontario School of Medicine's model), offering return-for-service agreements/contracts and allowing for greater regional autonomy over workforce and resource planning. Additionally, participants suggested building networks for rural physicians to help foster collaboration and provide opportunities for peer support, mentorship and role modelling.

"If a physician has to leave the community it leads to increased demands and expectations [on those who remain]."

Halifax participant

Recognize and value "generalism" and family medicine: Given the gaps and pressures in primary care, participants reiterated a pressing need to attract and retain more family FPs/GPs. This, they suggested, must begin by doing more to recognize and value their role and contribution: they noted that the professional culture tends to value specialization over "generalism", from the early stages of medical education through to remuneration, which eventually contributes to a mismatch between supply and demand (e.g., unfilled FP CaRMS positions versus a shortage of certain specialty positions). As a result, they argued that there is a need to rethink training and career pathways for physicians, especially early in their career. For example, some argued that medical students and residents would benefit from greater exposure to family medicine and general specialties (e.g., through rotating internships) and providing incentives (e.g., dedicated time and compensation) for more FPs to teach and take on students in their practice.

"We can't force people into specialties. Have rotating internships so people don't have to decide so quickly."

Ottawa participant

Complement provincial/territorial HHR planning with a national perspective:

Participants recognized that data play a critical role in informing workforce planning and are therefore critical to addressing the physician supply/demand mismatch. This, they argued, requires improving how data on health and health care needs are gathered, disseminated and used at all levels — local, regional, provincial/territorial and national. Moreover, in addition to supporting systems planning within jurisdictions, this would also help current and future physicians better understand the needs and practice opportunities across the country. Finally, some suggested that such national data could also help address what they described as “skewed metrics”: for example, when planning decisions are made on the basis of criteria such as physician-to-patient ratios that do not account for relevant patient demographics (e.g., average age of the population). Currently, this type of data is either not collected and aggregated or is not easily available, particularly for medical students and residents.

“In terms of knowing exactly what regions need and who is underemployed — the data are not available.”

Halifax participant

Provide more practice management supports and training:

Beyond the clinical issues they may be dealing with, some participants highlighted that many physicians struggle with the business and financial aspects of their practice. Recognizing that many physicians are in effect small business owners, participants saw value in more education and training on practice management.

“[Practice management] is overlooked in our training and should be included from day one in med school. ... As small business owners I do think it is key to our training.”

Ottawa participant

DIVERSITY AND EQUITY

Keypad Voting Results on Perspectives and Experiences

- **Gender:** The gender diversity among participants was generally close to 50% female, 50% male. Only a few participants identified as non-binary or preferred not to say.
 - According to 2018 data, 42% of all physicians in Canada are female.
- **Location of medical training:** Most participants (75%–88%) completed their undergraduate medical training in Canada, with the remainder having trained in the United States (2%–3%) or other countries (ranging from 9% in Ottawa to 23% in Halifax).

See Appendix A for the comparative results on these keypad questions across the RMFs.

Key Findings from Table Discussions and Plenary Dialogue

Physician Workforce Issues:

DIVERSITY AND EQUITY



Enable equal access to the profession for individuals from low-socioeconomic and diverse backgrounds



Work with Indigenous communities to address their needs and the underrepresentation of Indigenous people in medicine



Revise recruitment and admission processes to be broader and more inclusive



Develop and support the leadership of women in medicine



Recognize generational differences in career perspectives and foster respectful inter-generational dialogue

Enable equal access to the profession for individuals from low-socioeconomic and diverse backgrounds: Participants highlighted that individuals from low socioeconomic and diverse backgrounds face many barriers to entering the medical profession, from the high costs of medical school to admissions requirements that include extracurricular activities, volunteer work and standardized testing results — all of which are often more difficult for those who work part-time jobs, cannot afford certain activities and do not have access to role models and supports (e.g., mentorship). Participants suggested that reducing these barriers and providing more equal access to the profession could involve making medical school

"Students that don't have economic means have to put themselves through school. Their journey is much more challenging than those who have really strong support."

Edmonton participant

more affordable, reconsidering where and how medical school applicants are recruited and assessed, reserving more first-year medical school positions for these individuals and offering financial assistance. However, they also pointed out that the necessary first step is for these individuals to know

and believe that a medical career is indeed possible for them, which requires targeted recruitment, role models, mentorship and awareness of leadership opportunities.

Work with Indigenous communities to address their needs and the underrepresentation of Indigenous peoples in medicine:

The significant underrepresentation of Indigenous people in the physician workforce is concerning to participants. They highlighted the lack of opportunities available to Indigenous peoples in terms of education, practice, mentorship, role models and representation in leadership. While they recognized that some medical schools are making strides in this area, participants stressed that more needed to be done and suggested setting aside more first-year medical school positions, creating matching opportunities for Indigenous people and undertaking more targeted recruitment efforts for both students and mentors.

Some also suggested including more diverse perspectives, such as Indigenous elders, on medical school selection committees. Others stressed that continuing medical education should help promote culturally sensitive care for Indigenous peoples across the country.

In addition to representation issues, participants also noted the shortage of physicians serving Indigenous communities across Canada, which is contributing to disparities in health outcomes for Indigenous peoples. They suggested that access to better data could help address this issue by building greater awareness and understanding of these communities' specific needs.

"There are so many health disparities with the Indigenous population — we don't have any choice but to prioritize this population."

Ottawa participant

Revise recruitment and admission processes to be broader and more inclusive: Participants pointed out that the admissions processes for medical school effectively limit the diversity of the physician workforce. Beyond addressing financial barriers to access, participants suggested that rather than focusing solely on competencies and factors that may screen out those from lower socioeconomic backgrounds (e.g., extracurricular and volunteer activities), medical schools should broaden their approach to value more diverse life and personal experiences (e.g., working with different populations/communities) and soft skills, such as empathy, compassion and self-awareness.

They proposed that ensuring greater diversity among those in administrative positions and on selection committees; facilitating a broader dialogue on issues like identity and fairness; and including an assessment of personality traits and lived experience could help make admissions processes more inclusive. Again, participants also stressed that these skills and competencies should also be maintained and valued throughout a physician's career.

"There is diversity of identity [but also] diversity of experiences."

"As a student who will be facing CaRMS, we are not taught ... that empathy is highly regarded vs. our clinical or research experience."

Ottawa participant

Develop and support the leadership of women in medicine:

While gender representation in the physician workforce has improved, participants pointed out that women continue to be underrepresented in leadership and management positions, as well as within some areas like surgical specialties. They argued that beyond creating more opportunities for women in these areas, we must address the barriers that prevent or discourage women from seeking such positions: for example, providing "family-friendly" working conditions (e.g., parental leave policies, part-time work options) and addressing harassment and discrimination through effective policies, reporting mechanisms and supports. Having strong role models and mentorship were also cited as important.

"After talking with my female colleagues, I find that I am not alone [in not having a private space for pumping breast milk]... We need to provide better support to mothers in the workplace so they can focus their energy on patient care."

Online participant

Recognize generational differences in career perspectives and foster respectful intergenerational dialogue:

Participants acknowledged that younger and older physicians may have very different perspectives, needs and aspirations on matters of work ethic and work-life balance. They stressed that there were no "right" or "wrong" views, but that it was important to explore and reconcile these differences, for example, through mentorship and other opportunities for dialogue. From a workforce management perspective, this would be beneficial both to physicians entering the workforce and to older ones, as they transition out.

"A lot of older physicians think younger people don't work as hard. We challenge that — they just work differently."

Halifax participant

HHR AND TECHNOLOGY

Keypad Voting Results on Perspectives and Experiences

- Virtual visits: Less than one-third of participants indicated that their patients can visit with them virtually. The regional results ranged from 13% in Edmonton to 30% in Ottawa. Additionally, those practising in other specialties were more likely to answer this question positively than practising GP/FPs.
 - By comparison, only 6% of respondents in the 2018 Canadian Physicians Survey (Canada Health Infoway) indicated that virtual visits are possible.

- Provincial/territorial licensing: Up to a quarter (11%–23%) were licensed to practise in more than one province or territory.
 - This is compared with 10% of respondents to the CMA e-Panel Survey on National Licensure (2018).

See Appendix A for the comparative results on these keypad questions across the RMFs.

Key Findings from Table Discussions and Plenary Dialogue

Physician Workforce Issues:

HHR AND TECHNOLOGY



Develop and facilitate access to secure and interoperable technology platforms for communication and collaboration



Facilitate the deployment and adoption of technology in physicians' practices by addressing barriers



Educate physicians and patients on the "rules of engagement" for virtual care



Facilitate physician mobility through a more flexible licensure model



Address EMR issues



Prepare the profession for the disruption of medicine by technology

Develop and facilitate access to secure and interoperable technology platforms for communication and collaboration: Participants pointed out that while powerful communications and collaboration tools and technologies exist today, their application in the health system continues to be fragmented and inconsistent. This, in turn, perpetuates the “silo” model. They argued that physicians would benefit greatly from solutions (e.g., standardized, secure communications platforms and processes) that could facilitate or enhance how they communicate and collaborate with each other, as well as with patients. They also sought solutions that were integrated, or at least interoperable, with their broader practice environment (e.g., not having to enter multiple passwords into multiple systems “that don’t talk to one another”).

“Some of the bold innovation doesn’t require catastrophic change. We don’t need new technology. We can use what we already have.”

Halifax participant

Many suggested that the solution may reside in making better use of existing technology, such as secure email platforms and FaceTime/Skype. They pointed out innovative approaches that are already being deployed in the medical field (e.g., “virtual rounds”) and suggested that lessons might be learned from innovations in other sectors where security and privacy are a priority (e.g., how sensitive financial transactions are conducted online using smart-phone based apps; how the Correctional

Service of Canada is using remote video technology for inmate visits and court appearances).

Some participants suggested conducting a comprehensive environmental scan to better understand what technology is currently being used by physicians in various settings and to identify emerging solutions. While concerns related to privacy and misuse were raised, the benefits of technology for facilitating professional collaboration and providing more accessible patient care were seen to outweigh the risks, especially with regard to enabling greater access for rural/remote communities and other underserved populations.

Facilitate physician mobility through a more flexible licensure model: Licensure was identified as a barrier for those who could or wish to practise physically or virtually in multiple jurisdictions. In their perspective, it is too expensive and administratively burdensome to be licensed in multiple jurisdictions, which then limits physicians’ ability to practise outside their province or territory. This was seen as an impediment to addressing access issues in rural and remote regions, as well as for specific populations (e.g., nonmobile seniors, youth who prefer online interactions).

“It’s very expensive to be licensed in every location, and there is quite a lot of paperwork involved.”

Edmonton participant

Participants were therefore supportive of licensure models that would help improve physician mobility (physical or virtual), with options including a single national licensure, a national locum licence, reduced or pro-rated licensure fees and the development of a common framework for physician collaboration across jurisdictions. In discussing national approaches, some cautioned against the potential unintended consequences of such models and in particular the risk of worsening recruitment and retention challenges in jurisdictions that are seen to be “not as competitive” and are currently underserved.

Facilitate the deployment and adoption of technology in physicians’ practices by addressing barriers:

Participants cited a wide range of policy, process, cost and infrastructure barriers that effectively limit technology adoption and use by physicians. In addition to the aforementioned licensure issues, many participants emphasized the need for national licensing to help them serve a broader patient base. In their perspective, it is too expensive and administratively burdensome to be licensed in multiple jurisdictions, which makes it difficult to use technology to work with patients. This is especially problematic as technology can help address access issues in rural and remote regions, as well as for specific populations (e.g., nonmobile seniors, youth who prefer online interactions).

“Technology is the future of medicine, and we have to take this into consideration.”

Montréal participant

Compensation models were also cited as a key barrier to the widespread use of technology in

health care. Participants noted that many jurisdictions do not have billing codes for the delivery of online/virtual or telemedicine services, and where such codes exist, their application is often limited or administratively burdensome. They argued that virtual care comes with its own unique set of requirements and processes (e.g., login into different systems, managing privacy issues), which must be accounted for and compensated. Some suggested that alternative payment models, such as blended payment or salary, might allow physicians more flexibility in how, and how much, they include virtual care in their practice. Participants also raised concerns about the cost of acquiring and maintaining technology (e.g., upfront investments in infrastructure to support its implementation), whether in physicians’ offices or health care institutions. Other barriers include the lack of interoperability with existing systems, change management challenges (e.g., lack of training and tech support) and patients’ limitations with respect to access to and use of technology.

Address EMR challenges: In discussing the role of technology in their practice, many participants focused on the challenges related to electronic medical systems/records (EMs/EMRs), and how these contribute to physicians’ workload and stress. Chief among these was the lack of interoperability across systems within and across institutions and jurisdictions. Many called for “a single, national

“EMRs are a huge problem for me. It’s an unbelievable amount of work to get reports. It’s an inhibitor of efficient practice.”

Ottawa participant

EMR” or at least, for national standards that would ensure interoperability. Participants also expressed their frustration with the amount of time, often unremunerated, they are required to spend on the EMR rather than on delivering patient care. Given these challenges, participants want EMRs that are easier to use and therefore less time-consuming; are more effective in providing information on patients; and are designed to facilitate communications between health care professionals, but also between physicians and their patients.

Educate physicians and patients on the “rules of engagement” for virtual care: Participants warned that although technology offers many possibilities, it should not hinder or undermine physician-patient relationships. To fully reap the benefits of virtual care, they felt it will be necessary to create shared “rules of engagement” to align the expectations of physicians and patients and ensure accountability for both parties. For example, some expressed concerns that physicians would be expected by their patients to be “on” and “available 24/7.” To address this, they suggested solutions such as patient education and virtual triage by nurses. Additionally, participants noted that all physicians will need to adapt care for their patient’s individual needs, recognizing that not everyone is skilled or comfortable with using technology.

“We need a strategy to educate and engage physicians and patients together. ... If we’re changing how we interact we need to have the same expectations.”

Edmonton participant

While data privacy and access concerns were raised and recognized as being paramount, several participants felt that these are generally overstated and often act as barriers to the adoption of technology, especially given how widely technologies are used in other sectors, such as in finance and the military. However, physicians still need to seriously consider data security and privacy when integrating technology into their practice.

Prepare the profession for the disruption of medicine by technology: Some participants shone a light on the exponential changes to be expected in the practice of medicine given the pace of technological advances, particularly in the realm of artificial intelligence (AI). Current examples include the use of AI for cognitive behavioural therapy and radiation oncology, but they noted that AI could be leveraged in health care systems more broadly to help simplify patient management for physicians. For example, they discussed how AI might enable innovative solutions that could minimize non-necessary interactions with physicians (e.g., AI-driven prediagnostic system). However, they cautioned that the profession must be proactive in understanding how technology will revolutionize the practice of medicine, so physicians can help shape that future rather than be defined by it.

“We need to embrace, learn more and engage. ... There are lots of opportunities for us to influence how technology is used. We need to lead this as opposed to suffering from it.”

Edmonton participant

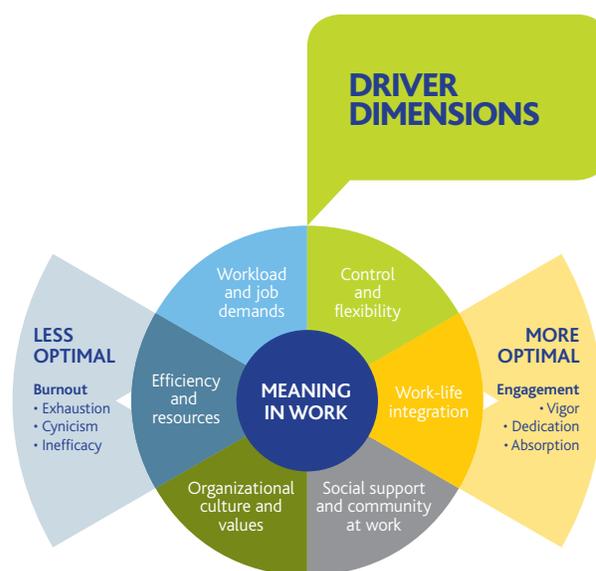
2. Physician Health and Wellness

Keypad Voting Results on Perspectives and Experiences

- **Concern with physician health and wellness:** On a scale of 1 (low) to 5 (high), most participants indicated a high level of concern (4 or 5) about physician health and wellness. The regional results ranged from 68% in Montréal to 83% in Halifax.
- **Mental health stigma:** Most participants stated that they would be comfortable (77%–89%) with a colleague approaching them for help with their mental health issues. In contrast, the majority would be uncomfortable (73%–84%) discussing their own mental health issues with a colleague.
- **Drivers of physician health and wellness:** When asked to identify what had the greatest impact on physician health and wellness, participants' top three drivers were:
 1. **Level of control and flexibility in their practice**
 2. **Workload and job demands**
 3. **Organizational culture and values**

See Appendix A for the comparative results on these keypad questions across the RMFs.

A framework¹ that includes seven interrelated key drivers for physician health and wellness was used to facilitate the discussion on physician health and wellness. These drivers include workload and job demands, level of control and flexibility in practice, work-life integration, sense of meaning in work, social support and community at work, organizational culture and values, and system efficiency and resources. This led participants to identify a number of priority areas for intervention as it relates to physician health and wellness.



¹ Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clinic Proceedings* 2017;92:129–46.

Key Findings from Table Discussions and Plenary Dialogue

Physician Workforce Issues:

PHYSICIANS HEALTH AND WELLNESS



Reduce workload and workplace burdens on physicians



Provide wellness supports and accommodations



Enhance control over profession and flexibility in practice



Foster culture change to create safer and more supportive training and practice environments



Foster social connections, respect and civility



Foster patient accountability and manage patient expectations

Reduce workload and workplace burdens on physicians: In discussing physician health and wellness, one of the participants' prevailing concerns was workload and the related feeling of loss of control. Many participants focused on the significant resource challenges facing health care systems, and how physicians are directly affected by institutional and system-level resource shortages. Some cited the lack of "backup capacity" as an example: physicians leave their practice or community and are not replaced, thus creating additional work and pressure for remaining physicians. Similarly, some physicians

"Physicians have to do a lot of work that is only tangentially related to health. There is an overload of administrative tasks that could be delegated to other professionals or staff in the health care system."

Montréal participant

"We only get rewarded for one CanMEDS role, although there are eight."

Halifax participant

don't feel they are able to take time off when they are sick because there isn't anyone to cover for them. Participants also expressed their concern that such situations not only were detrimental to physicians but also directly affect patient care and safety.

Participants want to see pressing shortages addressed, such as through training and retaining more FPs/GPs and generalists (as discussed earlier) and creating more residency positions in certain specialties (e.g., psychiatry). Some also noted that integrated, collaborative team-based care and the support of allied health care professionals (e.g., nurses, physician assistants) could help alleviate physicians' workloads.

Participants also valued any solution that could help minimize the administrative burden on physicians. The high level of administration (especially for those running their own practice) effectively takes time away from patient care, but participants suggested that many tasks (e.g., data entry, paperwork, IT issues) could be performed by others. Greater use of technology could also support physicians in this area, particularly if EMRs were improved to be more efficient and coordinated. Additionally, some suggested that physicians' workloads could be relieved by educating and empowering patients to distinguish between necessary and unnecessary appointments.

Many participants also viewed physician workload issues through the prism of remuneration challenges. For example, they noted that physicians are not compensated for fulfilling other roles/responsibilities, such as research and advocacy, while also working full-time clinically. Additionally, physicians managing their own practice are "only paid so much," even if their staffing demands or overhead costs increase. As a result, many discussed how new compensation models are needed to better accommodate different types of practices and approaches to care, including those that encourage technology use (e.g., virtual care) and recognize physicians' administrative time.

Foster culture change to create safer and more supportive training and practice environments:

Many participating medical students, residents and physicians struggle with the culture of their profession, which was characterized by high performance, perceived "invincibility," acceptance of being overworked, minimization of health issues and reluctance to seek help out of fear of professional repercussions. This, they said, leads many physicians to burn out because they feel like they will be judged by others for not working hard enough or that they are "not cut out for medicine."

"We don't talk about saying 'no thanks' or asking for things we need in order to take care of ourselves."

Ottawa participant

Participants want to see greater emphasis on self-awareness, openness, empathy, compassion and collegiality among physicians. They also argued for zero tolerance of “toxic behaviour” and stressed the need to destigmatize burnout and mental health issues. This, they said, is key to creating training and practice environments that are supportive, offer psychological safety and where everyone has colleagues they can trust, confide in and seek help from — without shame — if they are experiencing challenges.

Collaboration also plays an important role in building a more positive culture and sense of community among physicians. Many recognized that engendering culture change will require both individual- and system-level change: physicians must become more self-aware and adept at recognizing, and addressing, their own symptoms of stress; physician leaders and system administrators must model supportive attitudes and behaviours and “walk the talk” of wellness, and more work needs to be done to help change patients’ expectations of physicians, allowing them more time to “disconnect” and practise self-care.

Provide wellness supports and accommodations:

In addition to addressing issues related to physician culture, participants noted a variety of measures that could help promote wellness within the profession. Many focused on strategies that would give physicians increased control and flexibility over their work schedules and practice and allow them to establish healthier and “more realistic” schedules. This includes regulated maximum limits to working hours (e.g., 37.5 practice/duty hours per week); shorter shift lengths (e.g., moving away

from 24-hour call); more part-time and shared work opportunities; “built-in” sick/mental health/personal days (“that don’t bleed into your vacation days”); mandated vacation days; subsidized sabbaticals; and longer, non-consecutive parental leave. Several participants discussed how physicians are allowed to work long shifts without rest periods, while in other professions (e.g., airline pilots) this would be considered unsafe. Medical students and residents reported experiencing similar stress with a lack of flexibility with their schedules. Additionally, several online discussion participants identified the need for more benefits for physicians, specifically the development of a pension plan. They viewed this as fundamental to their health and wellness, suggesting that physicians would not feel they have to work as much or as long if they had greater financial security over the long term.

Other wellness supports include building parent-friendly working conditions and providing access to gyms/exercises classes and nutritious food. According to participants, these types of initiatives would help promote physician health and reduce burnout, thereby improving patient safety. However, it was also recognized that these types of supports and accommodations require a more positive culture that acknowledges the importance of self-care (e.g., being encouraged to take a day off), as previously discussed.

“We’re human beings first, surgeons and doctors second. We’re not machines.”

Ottawa participant

Foster social connections, respect and civility:

Many participants discussed how they benefit from regular interaction with their colleagues and suggested that physician health and wellness could also be supported by meaningful opportunities for peer support and collaboration throughout one's career. Having more collaborative spaces and forums, such as physicians lounges, could help facilitate networking, learning and consultation between colleagues. While some emphasized the importance of having shared physical spaces, others discussed the need to explore digital options to help colleagues connect. Additionally, participants discussed the need for social groups and events to bring colleagues together — both within and outside of the work environment. Overall, they said this could help reduce isolation by facilitating meaningful connections between colleagues. Participants also highlighted the importance of mentoring, which could help promote reflexive practice and expose younger physicians to a wide range of career paths and practice approaches.

"I really appreciate the experience of different physicians in different parts of their career."

Edmonton participant

Enhance control over profession and flexibility

in practice: As previously noted, the feeling of "loss of control" was a recurring theme for participants. In addition to stresses related to workload and schedules, participants also discussed the challenges they faced in tailoring their practices to their needs and interests. Several participants discussed how

the increasing centralization and oversight of their profession by health authorities and provincial governments in effect limits physicians' ability to determine where, how and when they practise. They argued that physicians must be engaged early in planning and have a voice in decisions that affect them and their patients. To this end, participants saw the need for more physicians in leadership roles, but they suggested that for this to be possible, physicians would benefit from leadership training and compensation for time away from their practice (e.g., if they need to forgo shifts or close their practices to participate).

As noted in the earlier discussion on career transitions, participants also discussed control in terms of having greater flexibility and/or mobility in their practice throughout their career. Recurring themes included delaying when students need to make critical career decisions regarding residency; re-establishing "rotating internships" and providing more episodic (rather than longitudinal) work opportunities; and opportunities for re-training later in one's career.

"The issue seems to be that we have the knowledge of what needs to be done; however, as a profession, we do not have the authority to bring in needed changes or enforce them."

Online participant

Foster patient accountability and manage

patient expectations: Participants discussed how patient demands can contribute to physician stress and burnout: patients now have access to more —

but not always accurate — information (e.g., “Dr. Google”) and expect to receive instant access to care at their convenience (“Uberization of health care”). Some spoke of patients coming to them with too many complex health issues to manage in a single appointment (“foot in the door phenomenon”); others shared that patients accost them “in line at the grocery store”, expecting answers and test results; yet others struggled with patients who do not follow their advice (e.g., not getting prescribed tests or taking their medication) but require multiple visits or complex care. Participants emphasized that the physician-patient relationship is a two-way street and called for strategies to educate and empower patients to be more accountable as partners in their own health and care, with a focus on reducing unnecessary consultations and following through on physicians’ advice.

“We have to find a system to hold patients accountable or partially responsible for their own care to cut down on wait lists. ... We also have to make sure that visits are relevant, both virtual and in person.”

Montréal participant

OPEN DIALOGUE: OTHER IDEAS

Key Findings from Post-it Notes and Dialogue

The following provides a summary of additional ideas and issues shared by participants on the “Idea Wall” or in their individual comment forms. All ideas and comments relating to the physician workforce and to physician health and wellness that arose in this context have been incorporated in the relevant preceding sections.



“Idea Wall” from Edmonton RMF

Issues facing the profession

- Improve the public perception of physicians
- Unify the profession
- Focus on advocacy/government relations for 2019 federal elections (e.g., seniors care, access to care, resource issues, health care costs)
- Advocacy for patients and physicians under federal jurisdiction
- Address medico-legal concerns for physicians (e.g., “legal challenges”)
- Engage medical students and develop their advocacy capacity
- Promote and enable interdisciplinary care and collaboration
- Explore benefits/pensions for physicians
- Support building a culture of innovation within the profession
- Depoliticize the profession and health more broadly (e.g., unions, governments)
- Ensure greater accountability across the profession
- Explore fee relativity (across specialties, jurisdictions)
- Promote judicious choices (e.g., Choosing Wisely)

System issues

- Develop a position to inform national pharmacare discussions and address concerns with pharmaceutical industry (e.g., drug shortages and prices, insurance)
- Inform discussions on the future of medicare/universal health care
- Address resource issues (e.g., “primary care crisis”) and reduce silos in the system
- Learn from the experience of physicians who have worked abroad, in blended public-private health care systems or in virtual care models (e.g., Babylon in BC)

Health issues

- Focus on health promotion/healthy living and social determinants of health
- Take action on climate change, sustainability and environmental factors affecting health
- Act on the global stage/global health
- Address mental health issues, especially for youth
- Support denuclearization
- Address the growing burden of chronic diseases
- Explore universal basic income
- Focus on medical assistance in dying (MAiD)/end-of-life care
- Address gaps in child/youth health

Patient needs

- Engage patients more regularly and in more meaningful ways
- Address the needs of our aging population/seniors’ care
- Meet the needs of patients with developmental disabilities
- Advocate for patients (and physicians) falling under federal jurisdiction (e.g., Transport Canada; Health Canada; Correctional Service of Canada; Industry Canada; Veteran Affairs; Canadian Armed Forces; Innovation, Science and Economic Development Canada; Immigration, Refugees and Citizenship Canada)
- Redefine the physician-patient relationship and help both adjust to new realities and possibilities

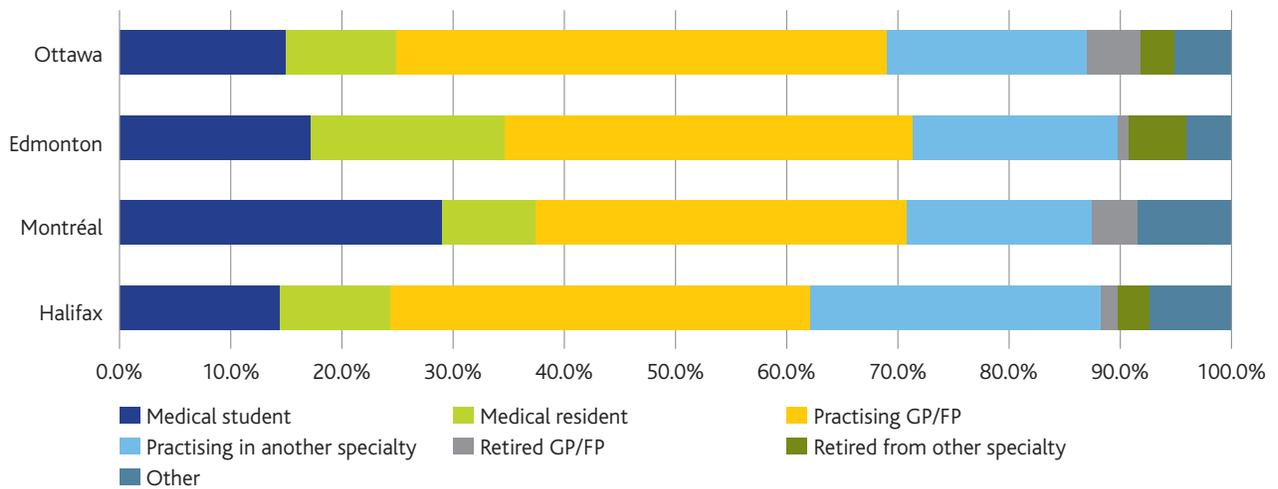
CONCLUSION

Through the RMFs, the CMA gained valuable insights into several key issues facing a diversity of physicians in Canada. Ensuring that there are meaningful opportunities to hear from members firsthand is part of the CMA’s ongoing commitment to leverage engagement and collaboration to drive its work as the national association representing physicians. Across all RMFs, most participants rated their experience as highly positive. Additionally, many shared comments about wanting to see the CMA host such dialogues more regularly.

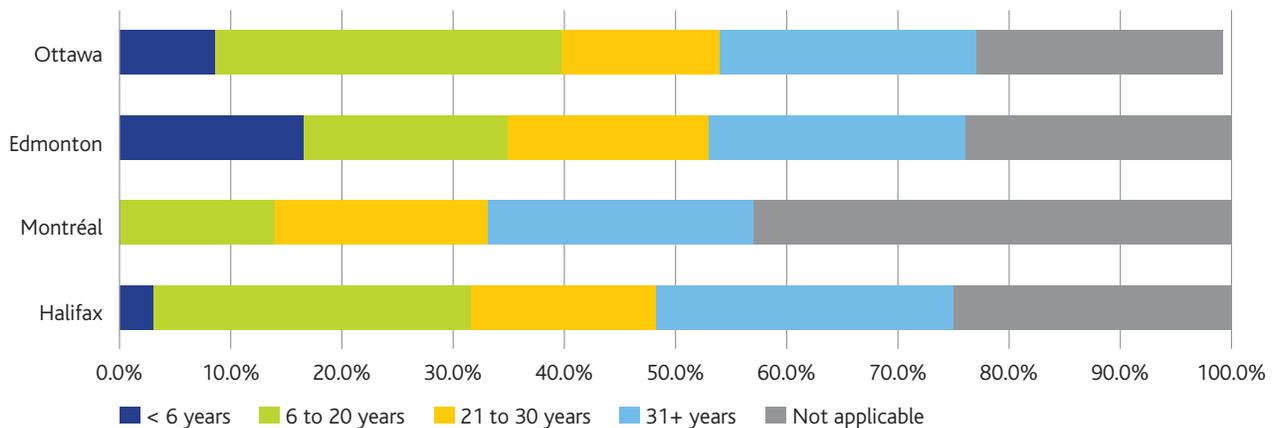
The key findings outlined in this report will be shared with participants and used to help inform the CMA board’s discussions on how the organization can help address these issues moving forward.

Appendix A: Comparative Keypad Voting Results

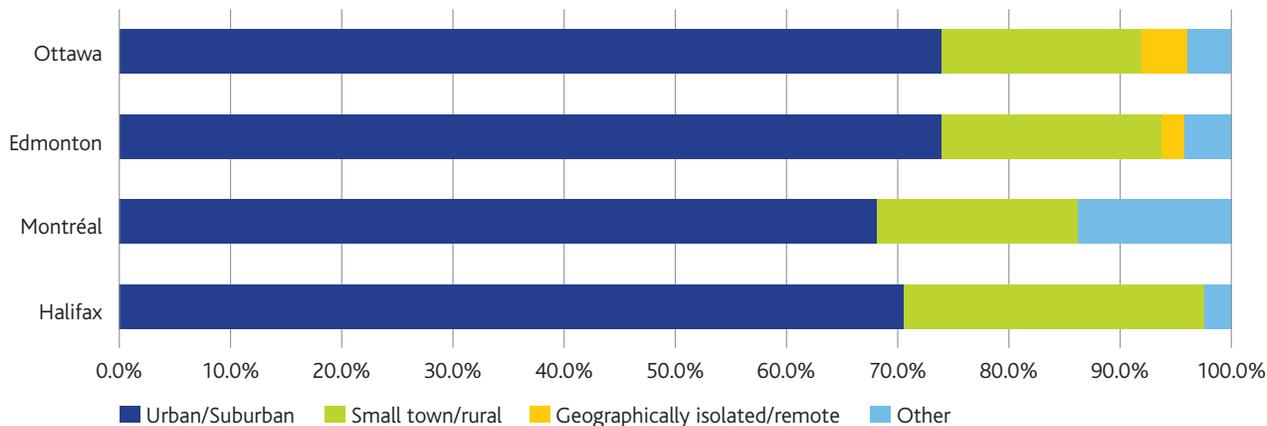
Which of the following best describes your practice status?



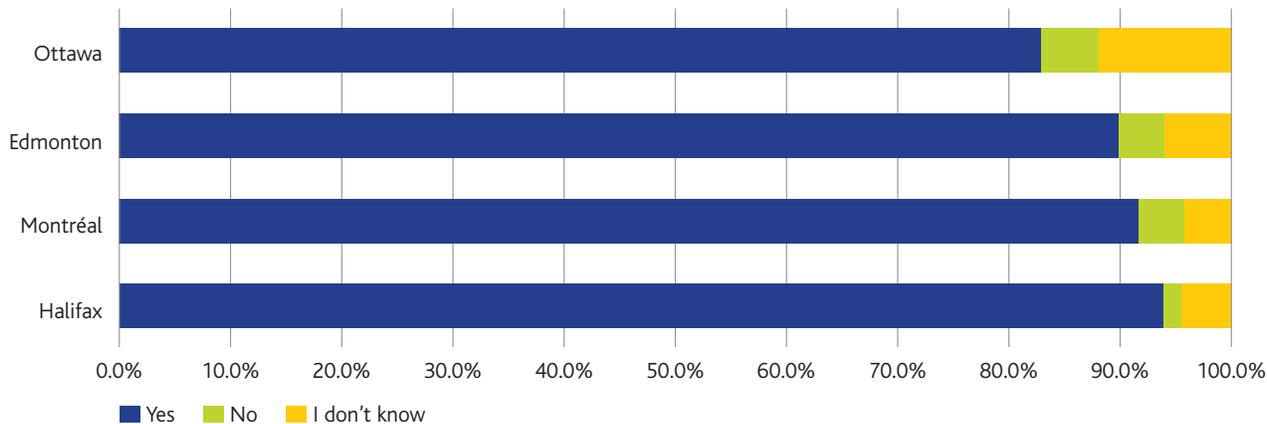
How long have you been practising medicine (excluding your years in residency)?



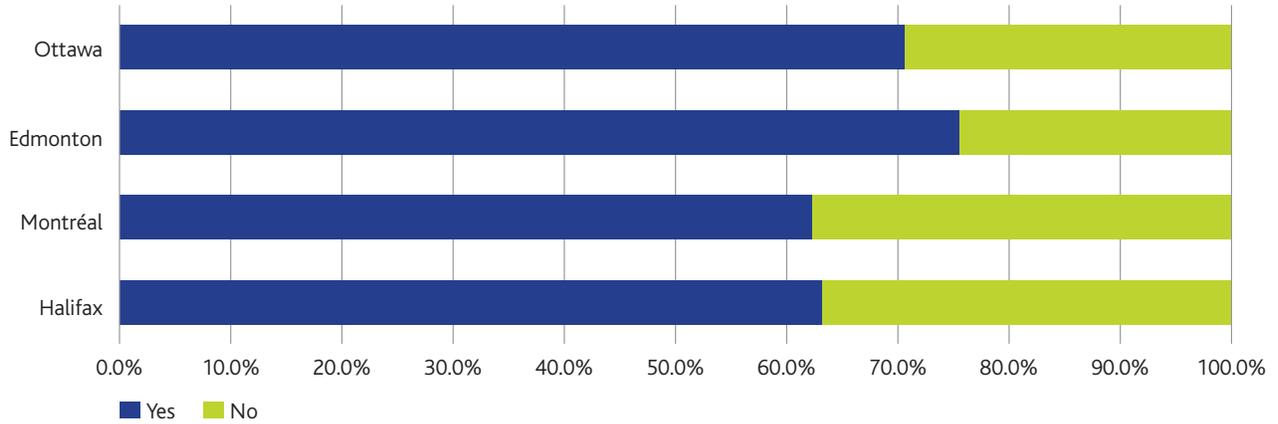
Which best describes where your primary practice is located?



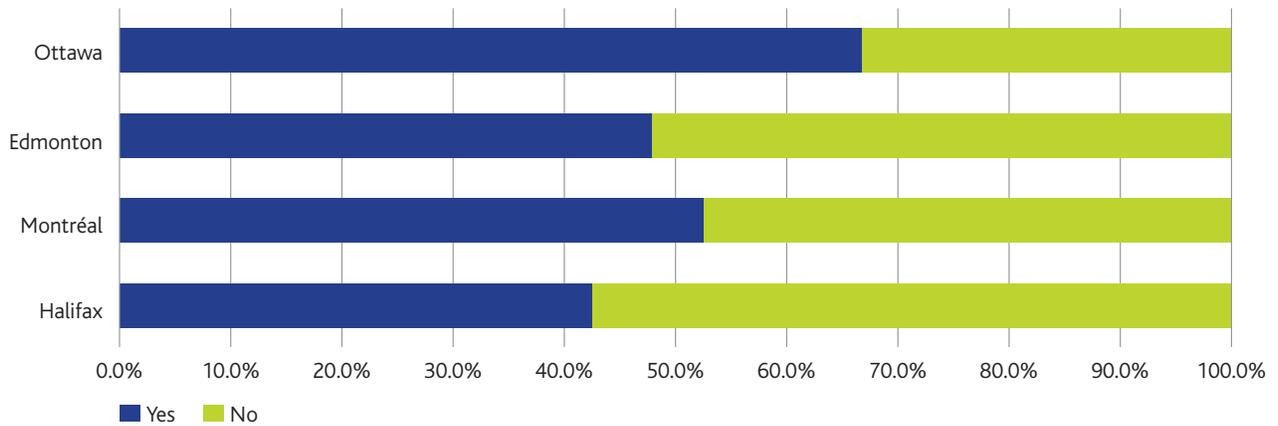
Does the medical profession have a responsibility to ensure that the supply, distribution and specialty mix of physicians is aligned with population health needs?



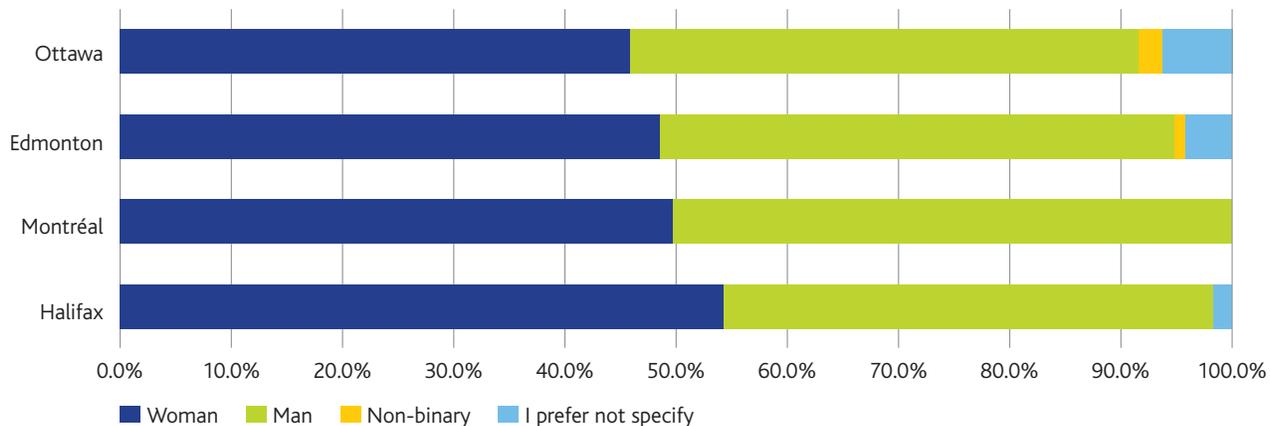
Do you know any Canadian medical graduates who went unmatched through the CaRMS process?



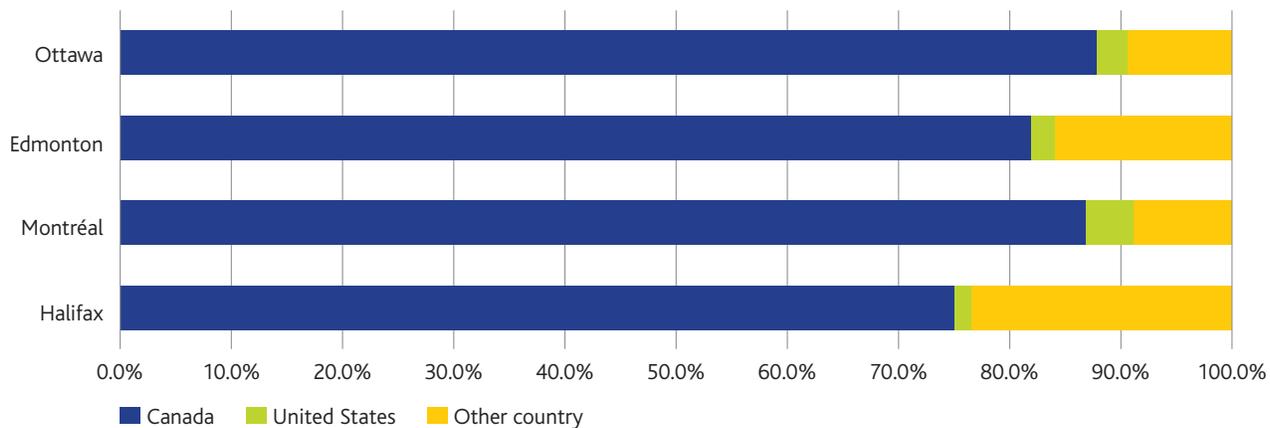
Do you know a physician who has been underemployed or unemployed for a period of time over the last 2 years?



"I identify as:"



Where did you complete your undergraduate medical training?



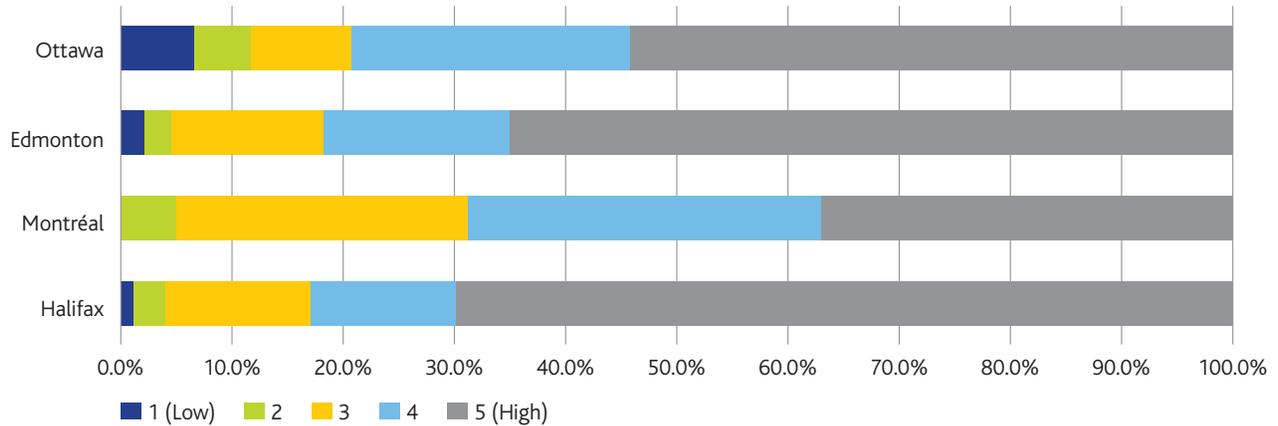
Can patients in your practice visit with you virtually (i.e., online by video)?



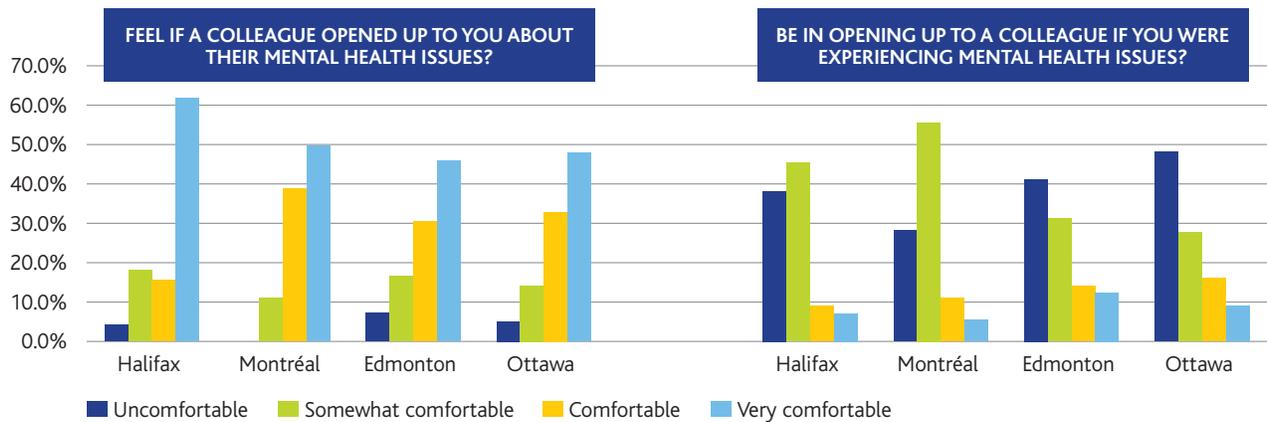
Are you currently licensed to practise in more than one Canadian province or territory?



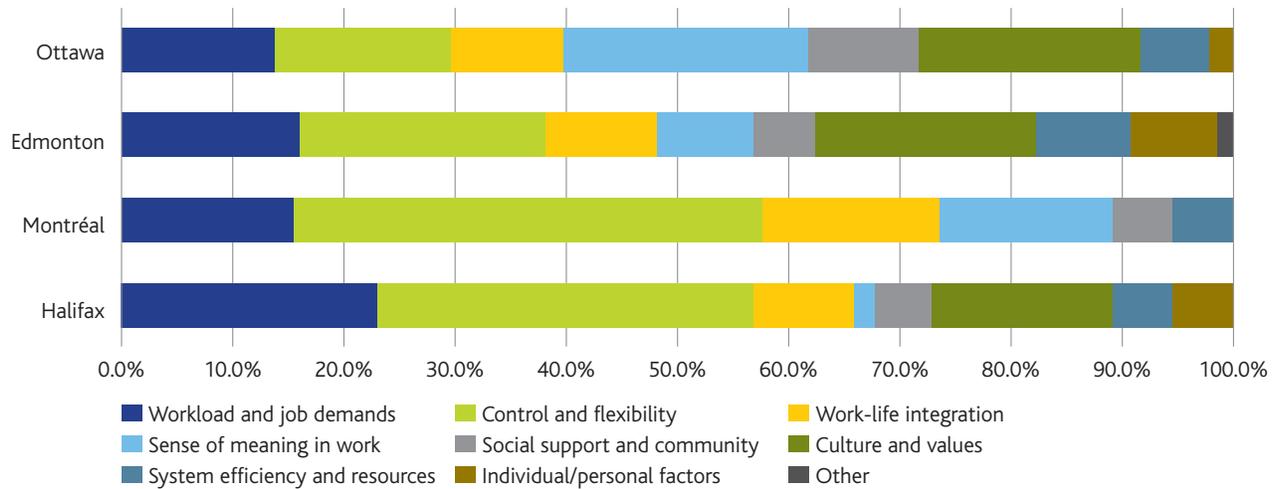
On a scale of 1 (low) to 5 (high), how much of a concern is physician health and wellness for you?



How comfortable would you...



Which driver do you believe has the greatest impact on physician health and wellness?



Overall, how would you rate your RMF experience?

