Understanding physician leadership in Canada: overview of a CSPE/CMA/CHI study

by Johny Van Aerde, MD

Abstract
Physician leadership is necessary for the transformation of the Canadian health care system because physicians have a unique knowledge of that system. However, many physicians are not compensated for their leadership roles, receive little support in terms of training or resources, and may be viewed with suspicion by colleagues.

The rapidly changing environment of the health system requires physicians to become engaged as leaders.1,2 Physician leaders can play a significant role in innovation and transformation within the health care system.3-5 Physicians can truly influence the value equation: value equals quality divided by cost.6 However, to optimize participation of physicians as leaders in the health care system, one needs to understand the factors that may help support those who wish to take a more active role in health care reform.7 Given that their training focuses on clinical preparation, many physicians lack effective leadership skills; however, they must not only know what is needed to work in the system, they must also learn what is required to work on the system.8

To determine the demographics of Canadian physician leaders and to better understand the needs of physicians who take on leadership roles, the Canadian Society of Physician Executives (CSPE), in partnership with the Canadian Medical Association (CMA) and the Centre for Healthcare Innovation (CHI) at the University of Manitoba, conducted a study on physician leadership with the following objectives:

- To develop a baseline of demographic data on formal and informal leadership roles of physicians in Canada
- To understand the factors that enable and deter physicians from taking on leadership roles
- To gauge the current level of satisfaction and dissatisfaction of physicians with their leadership positions
- To determine ways for organizations to increase physician engagement in leadership

Data were gathered using a large electronic survey (689 responses for a 17% response rate) and semi-structured interviews (15). Some highlights of the results follow.

Profile of the physician leader
Physician leaders tend to work well beyond what is strictly required in their formal roles. In more than 50% of cases, they work in a wide variety of settings by taking on several formal and informal leadership roles simultaneously. Among survey respondents, 1 in 14 of those in formal leadership roles are not paid and 18% receive a stipend only. In general, rural physicians work more unpaid hours in leadership roles than urban physicians.

On average, respondents spend 38–81 hours a month on voluntary activities, for which half receive no support while the other half receive recognition, support for education, or office/administrative support. It was noted that two
thirds of all leadership learning is acquired through the CMA’s Physician Leadership Institute (PMI) courses and the annual Canadian Conference on Physician Leadership cohosted by the CSPE and CMA. Most of the remaining third is acquired from courses offered by their organization or from advanced courses and degrees pursued by individual physicians on their own initiative.

Although respondents reported that leading other physicians is both satisfying and dissatisfying depending on the circumstances, overall, they described it as “herding cats.” Dissatisfaction with their current role comes from dealing with bureaucracy, which is often perceived as ineffective and impeding change. Work was portrayed as increasingly complex: long and sometimes unpaid hours without recognition, and a struggle to maintain work–life balance.

Challenges and opportunities to engage physicians as leaders in health organizations

The biggest challenges for physicians taking on medical leadership roles are the demands on personal time and the impact on their financial welfare. Structural issues include the ongoing and peripatetic regionalization of local and regional health care organizations and irregular and inconsistent characterizations of the formal physician leadership role.

Culturally, there is still a negative attitude emanating from practising physicians, who often view physicians who take on leadership roles as having “gone to the dark side.” According to survey respondents, the negative attitude toward medical leaders is present throughout the entire medical system — from medical school through residency to clinical practice — and it is a limiting factor for physicians who want to develop leadership skills and take on leadership roles.

The lack of training in leadership skills was identified as a strong barrier to physician leadership. Respondents recommended the introduction of such learning at all stages of a physician’s career and throughout the entire health system. Organizations were encouraged to optimize the chance to engage physicians in leadership roles by implementing succession planning and talent management and by providing financial remuneration or other rewards and recognition.

In addition to appropriate leadership training, respondents suggested
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that physicians would also benefit from coaching and from promotion based on performance improvement and related accountability. Standardized evaluation and accreditation, such as the Canadian Certified Physician Executive (CCPE) credential, was noted as a method to improve the credibility of physician leaders among their peers and among administrators. Although maintaining a clinical practice appears to be important for credibility among peers, it seems less important for physician leaders with longer clinical experience or for those who need to spend more time on increasingly demanding senior leadership activities.

Conclusions

The findings of this study imply that health system transformation toward improved patient care requires physicians to engage in life-long leadership development, for which the system will have to find resources. The identified need for learning and for attitudinal changes toward physicians who want to engage in leadership activities constitute a large void that can be filled by the combined efforts of the CSPE and CMA’s Physician Leadership Institute. The question is whether the health care system and the organizations within it are willing to make the structural and cultural changes required to make this happen and to free up the necessary time and finances.

References


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This paper has been reviewed by a panel of physicians.

Book review

Bending the cost curve in health care: Canada’s provinces in international perspective

Gregory P. Marchildon and Livio Di Matteo

University of Toronto Press, 2015

Reviewed by Johny Van Aerde, MD

With a title like that and authors who are experts in economics, most physicians would not even look at this book’s table of contents, let alone its 480 pages. However, if you are interested in health care systems and their links with politics, economics, and some of the non-medical determinants of health, the book will hold your interest from beginning to end. More than two dozen Canadian and international authors address the past, present, and future of health care based on demographic, financial, and political evidence, adding reasonable projections where possible.

The sustainability of public health care spending is central to any policy debate in Canada. Unfortunately, this debate usually generates more heat than light, and there seems to be no general agreement on what sustainability in health care actually means. Bending the Cost Curve uses many different lenses to approximate that meaning.

Part I deals with general considerations on how to “bend the cost curve” (i.e., reduce the rate of