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MEDICAL PROFESSIONALISM IN BRITISH COLUMBIA

Working Together: An Exploration of Professional Relationships in Medicine

A Policy Paper by BC's Physicians

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BCMA
BRITISH COLUMBIA MEDICAL ASSOCIATION

The BCMA Council on Health Economics and Policy (CHEP) reviews and formulates policy through the use of project-oriented groups of practising physicians and professional staff.

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Executive Summary

Physicians strive for professionalism in every aspect of their daily working lives. It is the cornerstone of their relationships with patients, one another, other health care providers, and society.

The Canadian Medical Association (CMA) defines three key elements of medical professionalism: ethics of care, clinical independence, and self-regulation. These elements have a long history in medicine and resonate strongly with physicians. In addition, physicians take pride in their profession's longstanding traditions of altruism, use of scientific evidence, and the social contract.

Despite this inherent pride, in recent years many doctors and other health professionals feel burnt-out, fatigued, and skeptical about the future of health care. There is a sense that professionalism is eroding. Perspectives on the root causes of these problems vary among physicians, specialties, and practice locations. Rather than attempting to identify every challenge physicians face or redefine medical professionalism, the British Columbia Medical Association (BCMA) has taken a more pragmatic approach and explored how professional relationships are being influenced and what opportunities exist to improve and strengthen these relationships.

Physicians do not practise medicine in isolation. Health care is delivered through a complex network of relationships. These relationships are influenced by individual behaviour, as well as society and the political environment. As a result, changes in society or the health care system can present challenges to professionalism. For example, while advancements in technology, both in medicine and in communication, have increased access to, and the type of, health-related information that is now available, this has also inadvertently increased demand for health resources and altered the physician-patient relationship.

This paper provides a review of the literature on theories of medical professionalism, including its past and present challenges. To ground these theoretical principles and provide a practical examination, a behavioural and systems framework was used to identify professional relationships in the British Columbia medical system. These relationships were explored through evidence collected from a stakeholder forum and a BCMA membership survey. The key findings were used to direct the commitments and recommendations, which are intended to foster an environment where professionalism is encouraged and supported.

These findings include:

- Increased access to health information has changed the way patients and physicians interact. Quality care includes patient empowerment through health education and increased health literacy.

- The differences between the systems within which physicians, other health care providers, and administrators operate strains professional relationships by creating barriers to communication and discouraging collaboration.

- Physicians feel responsibility for the economic sustainability of the health care system is being assigned largely to them. However, they have insufficient support to balance this with quality patient care. These conflicting priorities and expectations lead to discord between physicians, health authorities, and government.

- Physicians report positive relationships overall with patients and other health care providers. In comparison, they rate relationships with health authorities and government as "fair" or "needs improvement."

Integral to physicians' pride in their professionalism is the understanding that they are ultimately responsible for expressing it in their own individual relationships. The BCMA has identified a number of commitments made to support professional relationships. These are made with the understanding that physicians are not alone in providing health care but work closely with others. To that end, recommendations are identified that reflect that spirit of partnership between physicians and others. These recommendations are intended to encourage a sense of cooperation and improve these relationships.

British Columbia is well served by doctors whose jurisdictions encompass urban and rural, clinician and administrative, family physician and specialist, focused practice and full-scope, academic and scientist, learner and teacher. In choosing to uphold the virtues of professionalism and by holding one another accountable, physicians can enhance their professional satisfaction, the patient experience, and provide the highest standard of health care.

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Ways to Work Together

The BCMA's exploration of professionalism identifies opportunities to improve professional relationships between physicians and others. The following commitments and recommendations are intended to provide opportunities where the virtues of professionalism can be fostered and displayed. Please refer to Part 4, on page 32, for an in-depth explanation.

I. Commitments

1. **To Patients**
   The BCMA will continue the pursuit of optimal patient experience. This includes empowering patients through health education, health literacy, and the best use of online health-related information.

2. **To Physicians**
   The BCMA will work to improve the provider experience. This includes supporting mentorship and teaching of medical trainees, opportunities for collaboration at the local physician level, and recruitment and training of physician administrators.

3. **To Other Health Care Providers**
   The BCMA will work with other health provider associations to improve mutual understanding of scope of practice and roles with the intent of improving communication, patient care, and provider experience.

4. **To Health Authorities**
   The BCMA will support improved professional working relationships between health authorities and physicians, and will make improvement of these relationships a priority.

5. **To Government**
   The BCMA will continue collaborating with government through joint committees.[a] In addition, the BCMA will highlight the outcomes of this work throughout BC with the intent of encouraging collaboration down to the individual physician level.

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[a] The Physician Master Agreement includes funding for joint committees between the Ministry of Health and the BCMA for the purpose of improving patient and provider experience in BC. The joint committees include the Joint Standing Committee on Rural Issues, the General Practice Services Committee, the Specialist Services Committee, and the Shared Care Committee. The joint committees represent the interests of rural care, FP/GP care, specialty care, and FP/specialist collaborative care.

II. Recommendations

1. **To Patients**
   Patient interest groups participate in the development and promotion of patient education tools in cooperation with the BCMA and other stakeholders.

2. **To Physicians**
   BC physicians continue to support their colleagues at all career stages. This may include modeling professional behaviour to others, teaching and mentoring medical trainees, and supporting physicians who take on administrative roles.

3. **To Other Health Care Providers**
   Health care provider associations facilitate, in cooperation with the BCMA, an understanding of the scope of practice and role parameters among health care providers.

4. **To Health Authorities**
   Health authorities foster an environment that promotes professional working relationships between themselves and physicians. In addition, health authorities and the BCMA should continue to collaborate in the ongoing evaluation and pursuit of quality patient care and experience.

5. **To Government**
   The Ministry of Health continue to collaborate with the BCMA on joint committees. In addition, the Ministry should promote the success of this collaboration to the public, health authorities, and other health care providers with the intent of replicating the positive results throughout the health care system.

Acronym Legend

CMA – Canadian Medical Association

BCMA – BC Medical Association

AMA – American Medical Association

FP/GP – family physician/general practitioner

MOH – Ministry of Health

Introduction

Medicine and the world around it is changing more rapidly than ever before. In addition to advancements in treatment, there are other changes, both societal and within the health care system, that impact physicians.

Though the effects may be unintended, both large and small-scale changes can alter the environment in which physicians practise. These shifts do not occur in isolation and can change relationships between physicians and others. This can present significant challenges to the profession and resonate through the health care system.

While the world has evolved since the Hippocratic Oath was created in 500 BC, some features of medicine have transcended time. For instance, the medical profession's commitment to patient care has remained consistent and this will continue into the future. This altruism, along with the use of evidence and the social contract, has helped to uphold the profession over time. Along with these constants, though, the practice of medicine has unquestionably changed. This policy paper illustrates how technology, professional interactions, and economics have altered established patterns in medicine. These changes, along with shifts in physician demographics, an evolving society, and adjustments to the health care system structure, have widespread impacts. The purpose of this paper is to examine consistent features of the profession, as well as changes both within and outside medicine, in order to identify how professional relationships between physicians and others have been affected.

The responsibility for examining these changes and their impact on professionalism rests with physicians. Exploration of medical professionalism has already taken place in several jurisdictions. The Canadian Medical Association (CMA) released its *Charter for Physicians* in 1999[1] and an updated policy statement on medical professionalism in 2005.[2] In its policy statement, the CMA identified three tenets for defining medical professionalism: ethics of care, clinical independence, and self-regulation. These are widely accepted by Canadian physicians as essential elements of professionalism.

In addition to the CMA's work, in 2005 the UK Royal College of Physicians released *Doctors in Society*, a report that spelled out a new definition of professionalism, discussed its implications, and made further policy recommendations.[3] Perhaps the most widely known contribution to the exploration of medical professionalism is the Medical Professionalism Project's *Charter on Medical Professionalism* produced through a collaboration between the European Federation of Internal Medicine, the ACP-ASIM Foundation, and the American Board of Internal Medicine Foundation.[4] The *Charter on Medical Professionalism* describes the core values of medical professionalism, such as respectful relationships, integrity and accountability, excellence, and stewardship of health care resources.[5] These definitions were developed in response to changes in health care systems that were seen as potential challenges to professionalism. The values outlined in each charter and policy statement present a shared vision and unify the core beliefs of the profession. However, while the resulting definitions appeal to a wide audience of physicians, they are principle based. As a result, it can be difficult to apply such ideals to every professional interaction between physicians and others.

The goal of this paper is to examine relationships between physicians and others, not to redefine medical professionalism or dictate standards to others. Using a framework founded on traditional definitions of professionalism, these relationships are reviewed to get a better understanding of the challenges each faces. Then, specific and achievable steps are identified to help create an environment where professional behaviour is encouraged. Physicians in BC are committed to the provision of quality, evidence-based care in an evolving health care environment. Enhancing professionalism goes a long way toward supporting this commitment.

Physicians in BC are committed to the provision of quality, evidence-based care in an evolving health care environment.

Features of Medicine and Challenges to Professionalism

The modern understanding of the medical profession emerged in the mid-19th century with the first standards of ethics and practice. Since then, the social contract concept has shaped the profession: physicians act as guardians of a body of specialized, evidence-based knowledge and act in the best interests of patients and society. In return, they are granted a special role, autonomy, other privileges, and the right to self-regulation.

Since the mid-19th century, medicine has also been defined by explicit professional standards and codes of ethics. These documents reference the profession's values, ideals, and expectations of its members. In the face of societal changes, medicine consistently examines and re-examines the role of the profession in society. These examinations have produced defining documents including:

- The *CMA Charter for Physicians*.[1]
- The UK Royal College of Physicians report on professionalism.[3]
- The American Board of Internal Medicine's Charter on Medical Professionalism.[4]

Historically speaking, these definitions of medicine are recent but many of the elements they refer to have remained inherent in medicine since its inception, including the use of evidence, altruism, and the social contract. Understanding these elements helps to understand current relationships in medicine and the challenges they face.

I. Select Features of Medicine

Use of Evidence
The medical profession is devoted to exploring new knowledge and discarding what is less effective. Claridge and Fabian[8] trace the evolution of science-based medicine from medieval to modern times. The history of evidence-based medicine can be traced to the 12th century when students would use their mentors' successes as evidence for the correct course of treatment. Textbooks were produced by practising physicians who worked to identify and replicate successful treatments that they later recorded.

It would take approximately 600 years for medicine to begin the next stage of developing evidence-based care. Dr. John Clark, a junior surgeon in the British Army, observed that his patients lost consciousness when treated with "copious bleeding." Instead, Dr. Clark began using Peruvian bark, even though it meant challenging the surgeon-in-chief, and established "best practices." He recorded evidence from both successful and fatal cases, not wishing to show bias. This would later become a standard for clinical trials.

The late 19th century ushered in the transitional era of evidence-based medicine and increased use of randomized controlled (or clinical) trials. In the 1930s, studies described "blinding" patients and physicians as to their placebo/treatment assignment, and tossing a coin to assign groups. In the 1940s, the United Kingdom's Medical Research Council conducted a randomized clinical trial of streptomycin in pulmonary tuberculosis. This era was also marked by Dr. Ernest Amory Codman's work. Dr. Codman recorded the details of each operation, as well as preoperative and postoperative care, and reviewed results to compare treatments and patient outcomes.

The analysis of the history of evidence-based medicine demonstrates that, since the 12th century, medicine has been united by a commitment to use evidence to optimize patient care. The profession has evolved by recording successful treatments, establishing and sharing best practices, challenging the status quo to develop new evidence, and then incorporating new knowledge to ensure the best care for patients. This devotion to evidence-based care defines the profession.

Altruism

Physicians are acutely aware that their profession is based on providing service to others. At the core of this service to others is altruism, which is expressed when physicians put the best interests of patients above their own.[6] Altruism is strongly associated with the notion of "professionalism" in medicine. The desire to help others is a frequently cited reason for entering a career in medicine.[7,8] Many physicians report being "called" to medicine, referring to moral motives and a sense that the work serves a greater societal purpose.[9] In fact, physicians who view medicine as their "calling" also report greater professional satisfaction.[10] The altruistic nature of medicine is well-understood within the profession.

"Evidence-based medicine is the way of the present and the future."
– BCMA member, survey respondent

Prioritization of patient needs is highlighted in standards of ethics and definitions of medical professionalism and modeled to students. It elicits trust in patients and so must be upheld by all of the members of the profession. Patients must be able to trust that their health is the priority of their physician.

The Social Contract

While the concept of the social contract originated in the Enlightenment period, it flourished in the 19th century. At that time, professionals were granted prestige, status, and financial rewards, with the mutual understanding that their work would address the principal concerns of society in an altruistic manner. While in many ways the social contract and the responsibilities and rights or privileges for each party (Figure 1) is implicit, this general understanding underpins professional standards of conduct and definitions of medical professionalism.

Medicine, as a profession, is referred to as a noble calling because of the sense that the profession serves a greater societal purpose.[9] The work requires extensive knowledge, and as part of their responsibilities, physicians act as trustees of this body of specialized and evidence-based knowledge. The profession is responsible for maintaining the integrity of that knowledge and using it altruistically for the benefit of patients and society.

In return, society grants physicians a special role, financial and non-financial rewards, autonomy in practice, and the privilege of self-regulation. In theory, society has the right to withdraw or modify these privileges if physicians do not fulfill their responsibilities.

The profession is responsible for maintaining the integrity of specialized knowledge and using it altruistically for the benefit of patients and society.

FIGURE 1	The Social Contract in Medicine: Obligations and Expectations	
Party	**Obligations**	**Expectations**
Physicians	• Act altruistically • Promote the public good • Assume responsibility for the integrity of their unique knowledge base	• Special role in society • Self-regulation
Society	• Place trust in physicians • Offer monopoly powers to the profession in certain areas	• Right to withdraw or modify professional status if the profession fails in its duties

The Social Contract and Definitions of Professionalism

Since first emerging in the mid-19th century, ethical and practice standards have included reference to elements of the social contract.[11] The concepts formed the basis of the 1847 Code of Medical Ethics of the American Medical Association (AMA) and the CMA's first Code of Ethics developed in 1868.[12] The CMA's first code outlined the duties of physicians:

- To their patients, and of the obligations of patients to their physicians.
- To each other, and to the profession at large.
- To the public, and of the obligations of the public to the profession.

These responsibilities of the profession to society continue to be upheld in the AMA and CMA's revisions. Even today, the social contract is still upheld in medical documents and definitions, including charters of the Royal College of Physicians of London[3] and the American Board of Internal Medicine.[4] Some elements, like the responsibilities of society, remain tacit in modern documents. Regardless, medicine has sustained the contract, nurtured its obligations and values in its students, and modelled them to society.[13] As the wider world continues to evolve, the social contract adjusts.[13]

II. Questioning Medical Professionalism in the 20th Century

The mid-20th century saw a marked shift in the relationship between physicians and society. Social scientists began questioning the value of putting professionals on pedestals because they felt they were not fulfilling their end of the social contract. These accusations began to undermine the public trust in physicians and their commitment to the physician-patient relationship. While also levelled at other professions, there was indisputable damage to the social contract between physicians and society.

Even today, the social contract is upheld in medical documents and definitions.

In the 1960s, academics began challenging some of medicine's core features. Social scientists outside the profession questioned the altruism of physicians, accusing them of putting their personal welfare above that of society and thus violating the social contract.[14] Critics argued that the profession manipulated its rights to self-serving ends, using self-regulation to protect incompetent members. Further, medicine had become more profitable and the profession was accused of exploiting the service demand for profit.[13] The suggestion that physicians would create and exploit a demand for services was an assault on both the profession and individual physician values and work.

While the tide of criticism against physicians began to decrease by the 1990s,[15] medicine had already lost some control as many governments began increasing their role in health care management. In response to the earlier criticism, Canada began implementing health team-based initiatives[16] which significantly changed how health care is provided to Canadians.

"Today's doctors are required to be better collaborators with their patients, better communicators with other allied health professionals and stewards of scarce health care resources."
– BCMA member, survey respondent

The impact of these developments is undeniable. Sullivan[15] suggests that "deflation of medicine's earlier pretensions" in the 20th century holds the key to the future of the medical profession. It is apparent that medicine is not finished adapting. While societal changes challenged professionalism in the last century, more recent changes like the rapid exchange of information and the recent economic downturn continue to impact health care. With these changes, there is a need to re-examine professionalism and how it is expressed in relationships between physicians and others.

An Exploration of Professionalism Using a Behavioural and Systems Framework

Physicians and health care systems are interdependent and, as a result, professional behaviours and the organizational environment are equally shaped by one another. Just as individuals can learn, enhance, or adopt professional behaviours, so too can the larger systems in which they work.

The provision of quality health care in BC relies on a complex network of relationships, and the theory of relationship-centred care suggests that good care for patients depends on quality relationships within this network.[17] Thus, there is value in exploring professional relationships to identify areas for improvement, with the goal of ensuring the best quality of care.

Traditionally, definitions of medical professionalism have been principle based because they represent the core beliefs and values of a wide audience of physicians. Not surprisingly, applying theoretical definitions to a practical exploration of physician relationships is challenging. These definitions, however, are an ideal foundation for a framework that outlines how individual behaviours and the larger health care system shape professionalism in each other. This is considered a behavioural and systems view of these relationships.

I. Complementing Traditional Views of Medical Professionalism with Behavioural and Systems Views

Definitions of professionalism have been developed at various critical points in history. For instance, the Hippocratic Oath was created to distinguish physicians from charlatans, the Medical Professionalism Project's Charter on Medical Professionalism[14] was developed in response to changes in health care systems that challenged physician professionalism,[18] and the CMA's policy[2] on professionalism was designed to create a shared vision for the profession. Current definitions of medical professionalism describe the core beliefs and values that guide physicians.[19]

These traditional views of professionalism assume that professional behaviour is based on innate characteristics.[19] Even within the profession, it is difficult to judge other physicians' expressions of professionalism, to create rules that respect individual nuance and are universally applicable, or even to apply such rules fairly.[19] Thus, definitions intended to unite the profession are idealistic but challenging to apply to practical explorations of professionalism.

Lesser et al.[18] suggest that a behavioural and systems view of professionalism does not contradict traditional definitions, but uses them as a foundation. The Charter on Medical Professionalism,[4] for example, describes four core values of medical professionalism:

I.   Compassionate, respectful and collaborative orientation, with a focus of "being in service" of the patient.
II.   Integrity and accountability.
III. Pursuit of excellence.
IV.   Fair and ethical stewardship of health care resources.

Lesser et al. associate specific actions with these core values at the individual and systems levels. For instance, at the individual level, a physician who values "integrity and accountability" will maintain patient confidentiality.[18] At the systems level, a health authority that values "integrity and accountability" may collaborate with physicians in the development of clear and stringent policies regarding conflict of interest and the maintenance of patient confidentiality.[18] For a complete description of the behavioural and systems framework, please refer to Appendix A.

At the individual level, a physician who values "integrity and accountability" will maintain patient confidentiality.

II. Practical Application of the Behavioural and Systems Framework

The behavioural and systems view of professionalism suggests that professionalism is an expression of values that can be conveyed by individuals or at the system level. At the centre of the framework is the idea that professionalism requires skills which can be learned, enhanced, or adopted. The framework suggests that individual behaviours and the health care system shape each other; both can encourage or discourage professionalism in the other. This also means that behaviours can be expressed in such a way that they resonate throughout the health care system.

Professionalism is an expression of values that can be conveyed by individuals or at the system level.

Expressions of Professional Behaviour

BC Physicians

Individual Relationships
• Patients

Individual Relationships
• Other Physicians
• Other Health Care Professionals

Organization-Level Relationships
• Administration
• Health Authorities

System-Level Relationships
• BC Medical Association
• Joint Committees
• Government/ Ministry of Health

Influences on Professional Behaviour
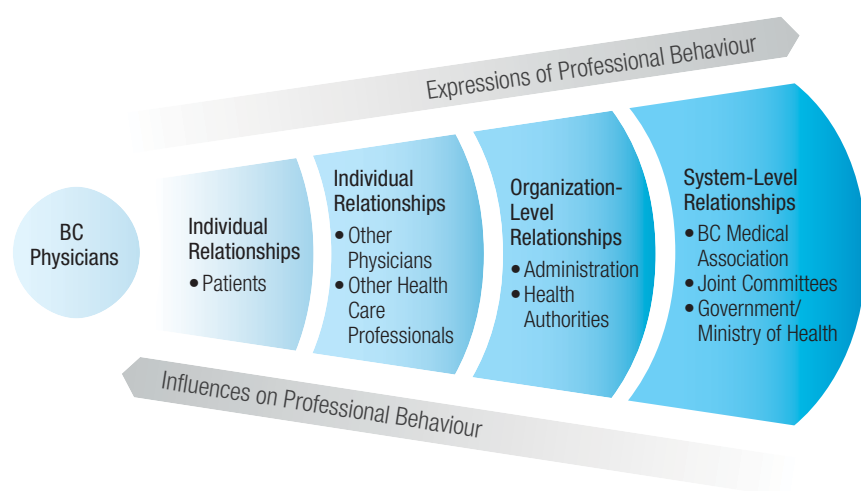
Adapted from: Lesser CS, Lucey CR, Egener B, Braddock CH, 3rd, Linas SL, Levinson W. A behavioral and systems view of professionalism. JAMA. 2010 Dec 22;304(24):2732-7

Using this framework to explore relationships in BC allows for a practical examination of relationships between physicians and others. It also helps to demonstrate how relationships can impact each other. When examined in this way, professionalism in relationships become less abstract, and opportunities to improve are more easily identified.

Professional Relationships in Medicine: Evidence from BC

The BC health care system is explored using the behavioural and systems view of medical professionalism. Evidence collected from a stakeholder forum and a survey of the BCMA membership confirms that there are opportunities to support professional relationships between physicians and others.

A review of the literature on medical professionalism identified many factors that could impact professional relationships. From this review, three areas were chosen for further examination:

- Widespread and rapid access to medical information.
- A shift to more collaborative care models in medicine.
- An increased concern with the long-term sustainability of the health care system.

To examine how these changes may have affected professional relationships in BC, specific physician relationships were identified. Then, evidence about relationships in the BC health care system was gathered in a May 2012 stakeholder forum and an August 2012 survey of the BCMA membership. The following evidence and summary findings were used to develop specific commitments and recommendations.

I. BC Physician Relationships

Clinically independent, physicians work in collaboration with others but act as autonomous agents. In contrast, the health care system is structured and hierarchical. These differences contribute to challenges to collaboration between physicians and others. Within the complex system of health care provision in BC, the following physician relationships were identified for examination:

Individual Relationships

I. Physician-Patient
II. Physician-Physician
III. Physician-Other Health Care Providers

Organizational Relationships

IV. Physician-Administrators
V. Physician-Health Authority

System-Level Relationships

VI.   Physician-BC Medical Association

VII. Physician-Joint Committees

VIII. Physician-Government/Ministry of Health

II. Results from a Stakeholder Forum

On May 15, 2012, the BCMA held a stakeholder forum in Vancouver, BC (Appendix B lists the forum attendees). The purpose of the forum was to obtain feedback from stakeholders on the current state of physicians' professional relationships and to identify specific areas for improvement. Using a series of fictional anecdotes, stakeholders explored professionalism, including its causes, shortfalls, and solutions. Facilitated small- and large-group discussions provided participants the opportunity to engage in open and honest dialogue. The following summary of the forum results directed this paper's commitments and recommendations. A complete version of the vignettes and associated discussion questions are available in Appendices C-E.

Vignette 1 – Democratization of Knowledge

The introduction of the Internet is seen by many to have spurred the democratization of knowledge. Access to a vast amount of medical information is changing the way patients relate to their physicians. While remaining focused on evidence, quality care, and patient experience, physicians are turning their attention to understanding how technology may be changing the physician-patient relationship. In a large group discussion, participants shared their personal experiences of how widespread and rapid access to information affects their practice or work.

Quality of Internet Resources

Physician participants reported that exposure to vast amounts of medical information is a challenge in their practice. Historically, physicians have faced external competition from "old wives tales" or local healers, but never before has the information had such a gloss of authenticity as it is presented on the Internet. The use of stock imagery, such as stethoscopes and white coats, suggests a level of validity which can be deceptive. External resources can present a challenge in the physician-patient relationship.

Democratization of Knowledge

In northern Italy, research scientist Dr Paolo Zamboni reported a correlation between blocked neck veins and multiple sclerosis. He pioneered a radical treatment called liberation therapy. A small research paper published the results online.[20] The response from traditional and social media was explosive, and the study was quickly shared internationally.

As patients elected to get the treatment in private clinics, Internet video testimonies showing miraculous improvements appeared. While a few Canadian clinics began to investigate the treatment, the Canadian medical establishment was reluctant to proceed with an unproven treatment that had not followed proper research protocol.

Understandably, patients were torn between a sense of caution and the lure of a cure, but many began travelling out of the country for the procedure and paying for their own treatment, often without telling their physicians.

VIGNETTE 2

Care Team Relationships

During morning rounds in the hospital, the entire medical team stood in Patient Brown's room. A test result was late, and Patient Brown, jokingly asked Dr Black whom he should yell at. Turning and pointing at the nurse, Dr Black replied, "If you want to scream at anyone, scream at her." Dr Black was asked if he could be quoted. "Sure," he answered. "It's a time-honored tradition — blame the nurse whenever anything goes wrong."[21]

Later, Dr Gray overheard two residents discussing the story. "Oh, he's the worst," one said. "He's always yelling at me in front of patients and blames me for his own mistakes." "I can't believe he still teaches, I mean he doesn't know anything about modern medicine and everyone thinks he's a total joke," the other student replied.

Upon hearing this conversation, Dr Gray is at a complete loss. While the students' conversation somehow seems inappropriate, he hesitates to intervene lest he appear to support Dr Black's behaviour.

Patient Health Literacy

Stakeholders suggested that the presence and popularity of medical information websites indicates they are filling a patient need. Patients have a right to autonomy when making decisions about their health, and in fact, patients with greater health literacy are healthier.[22,23] The challenge to physicians is how to discuss and collaborate with patients about the information they have found, and how to help them discern between their right to treatment and their demand for a specific treatment. Part of the physician role includes balancing patient autonomy with the physician's medical knowledge.

Patient Empowerment

Stakeholders reported that physicians have a responsibility to empower their patients through education. Physicians must balance between processing information presented by patients, listening to patient needs, educating patients, and endorsing treatment options. Balancing and managing these elements is part of the art of treatment by physicians, which ultimately empowers the patient.

> **Key Finding:** *Increased access to health information has changed the way patients and physicians interact. Quality care includes patient empowerment through health education and increased health literacy.*

Vignette 2 – Inter- and Intra-Professionalism

A key component of medical professionalism, self-regulation, has a different meaning for various stakeholders. Despite the fact that physicians are clinically independent, some stakeholders believe that physicians are responsible for the behaviour exhibited by their colleagues. In small group discussions, participants shared their opinions on inter- and intra-professional responsibility for upholding professional behaviour. They also considered the role of the health care system in encouraging or discouraging unprofessional behaviours, and discussed the effects and evolution of these behaviours.

Reporting Structure and Challenges to Professional Relationships

Health care requires a group approach to ensure that patients' needs are met. Most of the challenges that participants reported can be linked to the variations of the reporting structures for different members of health care teams. Physicians work closely with others to provide care. While they are team members, physicians are also clinically independent from other physicians and other team members. In contrast, other health care providers work within structured hierarchical systems with clear reporting lines. These differences can present a challenge to cohesive teamwork.

In the scenario discussed by participants, one physician is unsure of how to respond to his colleague's behaviour. This is not uncommon in physician relationships because generally, as independent contractors, they have no authority over one another. In the small group discussion, some participants noted that there is a lack of clarity about physician responsibility for their colleagues. One group candidly reported that most physicians would do nothing in the situation presented in the vignette, likely because there is no existing process for intra-professional feedback.

Impact of the System on Care Team Relationships

When asked to describe how the health care system discourages or encourages unprofessional behaviour, stakeholders remarked that there is a power imbalance in the relationships between physicians and others. Historically, the traditional physician-nurse relationship has a marked power differential. Physicians and nurses have different training and are expected to act independently and collaboratively when caring for patients. Participants noted the lack of a firm understanding of one another's training, values, and methods of providing care. The health care system currently promotes a care team approach, yet because of independent administration, each member of the team has a different pay structure, work schedule, and varying levels of support from the system itself. The result is different methods of communication, expectations, and expressions of professionalism. These differences pose a significant challenge to maintaining professionalism in the care team.

"The profession has changed … in its approach to patient care and now has a much more collaborative atmosphere both in its interactions with patients as well as colleagues from across disciplines. There is more emphasis on team approaches and knowledge sharing between professionals with different areas of expertise."

– BCMA member, survey respondent

Importance of Respectful Relationships

A respectfully engaged workforce is associated with increased sense of professional satisfaction. For physicians, who may spend extensive hours in their work environment, this can be essential. Stakeholders agreed that losing a sense of team could be very destructive.

The effects of unprofessionalism on the teaching environment were seen by participants as particularly destructive. Unprofessionalism is considered a learned behaviour. There is an assumption that students who choose to enter the profession of medicine have an innate sense of professionalism toward each other and other care team members. However, participants noted that any negative behaviour modeled to students, such as poor professional relationships or communication, could become learned behaviour for students.

It was also noted that there was a sense of a decline in professional and respectful communication between physicians. The effects of unprofessionalism manifest in numerous ways: through patients' perceptions of all physicians, by the loss of professional confidence among physicians, through the loss of confidence in the physician by other health care team members, and by pressure on administration to respond to circumstances over which they have little or no control.

Changes to the Health Care System

Participants reported a decline in professionalism over time. It was noted that physicians' status as independent contractors has had a negative impact on solidarity within the profession. Physicians reported feeling isolated because of the fragmentation of care resulting from reduced hospital privileges, increased numbers of walk-in clinics, and the loss of physician lounges. In addition, physicians stated that "scope creep" and lack of input at the administrative level undermine their sense of responsibility to the larger care team and the health care system.

Some relationships, such as the patient-physician relationship, have been prioritized in the last decade. This may be because medical schools now place increased emphasis on training in this area. In contrast, the cumulative effects of job dissatisfaction and unprofessional workplace relationships have decreased physician engagement within health authorities and hospitals, and with other physicians. Participants reported dissatisfaction with their professional relationships with specific physician specialties, health authorities, and the state of the system.

A respectfully engaged workforce is associated with increased sense of professional satisfaction.

VIGNETTE 3

Vignette 3 – Impact of Economic Climate on Professional Role

The Charter on Medical Professionalism[4] considers social justice, including the fair distribution of health care resources, as one of its three fundamental principles. While this does not necessarily imply physician responsibility for health care sustainability, it suggests that physicians are being held responsible for costs and spending. In small group discussions, participants shared how increased demands for health resources and economic challenges have changed their professional role, their perception of the physician's role in system sustainability, and perception of appropriate solutions.

Balancing Competing Needs

The physician participants reported that they face competing needs from patients, who have increased expectations of care and access, and the desire of administrators to control costs and temper spending. Physicians reported that patient expectations have increased with their awareness of treatment and diagnostic options. They reported that patients will use emergency rooms or other inappropriate resources if they feel their needs are not being met. This fragmentation of care can mean a loss of control by primary care providers.

Each specialty also drives spending. As a result, there are competing responsibilities between using any means necessary to diagnose and treat a patient, and exercising control over costs. Health authority administrators may only see an increase in costs and attribute them to physicians. However, they may not see the association between increased patient visits and, for example, promotion of the benefits of vitamin D by an influential talk show host.

Economic Impact

Administrator Smith is at his wit's end. He is looking at the budgets and is overwhelmed by the over-utilization of radiological imaging by just one physician, Dr Spendy. Over lunch, he vents to Mr Jones, the Chief Financial Officer. "It's not that I don't like Dr Spendy," he says. "It's just that he's so passionate about every patient that he'll go to the ends of the earth to find a diagnosis." CFO Jones agrees, "And he worked so hard to get us that grant last year, which was great for the hospital."

"Maybe it would be less of a problem if I thought he needed to order so many tests, but he's so at variance from the other doctors' practice patterns that most of the time I think he's just confirming his own diagnosis," says Administrator Smith.

"You really can't do anything about it you know," the CFO laments. "Did you hear about that study in *Archives of Internal Medicine*? They showed hospital physicians the price of every test before they could order it and it didn't change a thing.[24] We'll have to find savings somewhere else."

Physicians reported that they feel challenged to balance their sense of personal responsibility for each patient, for whom they want to exhaust every avenue of treatment and diagnosis, with their sense of responsibility for the long-term sustainability of the health care system.

Health Care System Sustainability

Overall, participants felt that physicians possess a sense of responsibility and obligation to society. Physicians reported that they feel challenged to balance their sense of personal responsibility for each patient, for whom they want to exhaust every avenue of treatment and diagnosis, with their sense of responsibility for the long-term sustainability of the health care system. Participants recognized the challenge that physicians face when balancing the needs of the patient with health care system sustainability, and that tension would be likely as health authority administrators try to exert power over costs and patient needs. In the corporate world, organizations direct their staff through policies and protocols to instill in their workers a sense of responsibility to the entity itself. In contrast, health authorities and hospitals do not have complete power to implement policies and protocols over physicians because they are clinically independent.

Overall, participants perceived a lack of understanding of costs and long-term sustainability among physicians, patients, and administrators. They reported that poor communication is a barrier to physicians trying to support long-term health care sustainability. There is a sense that physicians must be increasingly accountable, but to whom and how has yet to be defined.

> *Key Finding: Physicians feel responsibility for the economic sustainability of the health care system is being assigned largely to them. However, they have insufficient support to balance this with quality patient care. These conflicting priorities and expectations lead to discord between physicians, health authorities, and government.*

Additional Themes Identified From the Forum

A request to identify the challenges and barriers to inter-professional relationships elicited a great deal of constructive dialogue from forum participants, including identification of ways to improve the system.

Participants noted that in other sectors professionalism and performance are related, and that corporate success is associated with increased power and remuneration. For physicians, who operate as private contractors within the health authorities' "corporate" system, it can be

frustrating to work toward improving the system while being excluded from major decision-making processes. At a systems level, physicians are responsible to their patients, their institution, health authorities, and society. At the individual level, physicians have fewer interactions with their colleagues and increasing professional isolation. This trend challenges physician connection to the health care system and others, and erodes the sense of responsibility to improve the health system.

Many participants reported that poor communication is the main inhibitor of professional relationships. In addition, patients, other members of the health care team, government, and administrators have little knowledge about physician training and culture. Participants recommended increased support, including recruitment and training, for physicians who take on administrative responsibilities, to ensure their success and to improve working relations with health authorities.
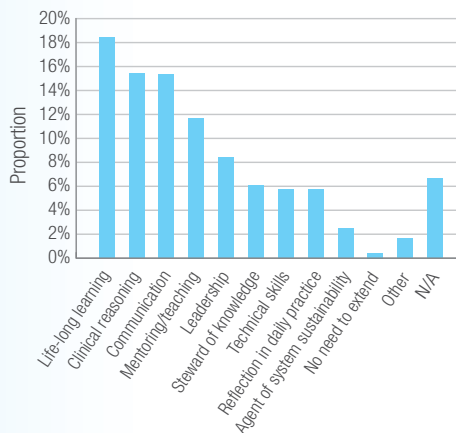
Finally, in a few of the forum discussions, there was a call for physician "accountability." In response, one stakeholder noted that medicine is self-regulating and the profession must continue to define its own standards. The perception exists that, by suggesting physicians are not accountable, health authorities are attempting to exert control over physicians. Accurate or not, these comments and discussions highlight the contentious nature of the physician-health authority relationship.

III. Results from a Survey of BCMA Members

In August 2012, the BCMA membership received a survey about medical professionalism. The BCMA membership includes approximately 12,000 physicians across the province. Responses were submitted by 1,809 physicians who were active, retired, or in training. Despite the survey's length and breadth, 77% (n=1387) of all survey respondents completed the survey in its entirety. The 1,387 completed responses were identified for analysis. A complete copy of the survey is provided in Appendix F.

The membership was represented by a diverse set of respondents. There was almost equal representation of general practitioners (n=608) and specialists (n=599), and a minority chose not to self-identify (n=180). Of note, 155 respondents identified themselves as medical trainees. The gender distribution of respondents was 55.9% female (n=775) and 40.9% male (n=567); 3.2% (n=45) did not identify their gender.

In your opinion, which of the following qualities also define medical professionalism?

Bar chart with y-axis "Proportion" ranging from 0% to 20%, showing categories: Life-long learning, Clinical reasoning, Communication, Mentoring/teaching, Leadership, Steward of knowledge, Technical skills, Reflection in daily practice, Agent of system sustainability, No need to extend, Other, N/A

Qualities of Medical Professionalism

As noted earlier, the CMA has identified three essential elements for defining medical professionalism: ethics of care, clinical independence, and self-regulation. Respondents to the BCMA survey were asked to choose additional defining elements. Life-long learning, clinical reasoning, communication, and mentoring/teaching were identified as qualities that define medical professionalism.

In many ways, these qualities are inter-related. For example, physician devotion to life-long learning aligns well with the awareness that the profession relies on development and dissemination of evidence for the best patient care. Physicians are known for staying current with new treatment developments and continuing medical education, as well as reading and contributing to medical journals. The devotion to life-long learning is also reflected in daily practice, as the best physicians also learn from listening to their patients. Finally, the profession supports their own learning and that of future physicians through mentorship and teaching. By encouraging the spirit of life-long learning and clinical reasoning in students, the profession is able to continuously grow and improve.

Societal Changes Impacting Medicine

Change Over Time

The provision of medicine has changed over time.[25] In particular, the past 20 years has seen dramatic changes including advancements in treatment and, in particular, the rapid exchange of information. As a result, there are multiple generations of physicians working alongside each other who see the world and their individual practice of the art of medicine in different ways. The survey asked respondents whether such changes have affected the core definition of the physician professional, and, if so, how.

Approximately 51% of all survey respondents, regardless of age, agreed that the core definition of the physician professional has changed, while only 26% of respondents thought that it had remained stable. The three most common reasons for the change in the definition of the physician professional were increased expectations of collaborative care provision, a significant change in the expectations of care style, and technological advances changing the practice of medicine.

Internet and Media

Survey respondents concurred that increased speed and access to information in the last 20 years has influenced the provision of medicine. In the past, physicians were the stewards of medical knowledge and this accorded them an associated status. Now, with patients' access to the Internet and widespread access to medical information, patients are more likely to question their physician, present their own information, and seek a collaborative relationship. Increasingly, physicians contextualize information and try to educate their patients instead of dictating to them, which was the trend in the past.

In addition, patients have increased exposure to the media, which may sensationalize treatments and health care. Physicians recounted having to talk patients out of treatments and diagnoses. The change in the information that patients are exposed to, while not necessarily a negative change, denotes a shift in the physician-patient dynamic.

Respondents were closely divided in their perceptions of their patients' increased access to information and its influence on their relationship. Only a narrow majority of physicians surveyed believe that the Internet poses a challenge to their professional role with their patients. This was not perceived as a challenge to physician authority or disrespectful on the part of patients. Instead, respondents expressed concern that patients are accessing websites or sources that provide poor quality information and that this could lead people to make poor decisions about their health. Physicians also noted that appointment times are so short that it is challenging to address issues, and review and discuss misinformation.

Changes Within the Health Care System that Impact Medicine

System-Level Barriers to Professionalism

Many forum participants, including physicians and administrators, noted that the differences in employment contracts, as well as hierarchies and reporting structures, introduce barriers to communication and accountability. As this was a significant point raised in the forum, survey respondents were asked to propose solutions.

Over 63% of survey respondents agreed that the structure of the health care system creates or acts as a barrier to professional relationships between physicians and others. Those who agreed with the statement presented in the survey provided a wide range of thoughts on how the system creates a barrier.

The most common response was that the system contributes to "misaligned goals" or "silos" between physicians and others. One respondent stated that the Ministry of Health supports other health care workers in the provision of services similar to those of physicians but at a greater cost, while increases in health care costs are often attributed to physicians. Confirmation of the factual basis of this statement is beyond the scope of this paper. However, these responses illustrate how perceptions can be destructive to collaborative efforts.

Economic Sustainability

Recently, there has been a great deal of media focus on the long-term sustainability of the Canadian health care system. Over 70% of survey respondents agreed that physicians are increasingly being held responsible for the system's sustainability, as compared to 20 years ago. Of those respondents who felt that economic sustainability of the health care system is increasingly being attributed to physicians, 59% (n=666) thought this was not appropriate.

Self-Regulation and Quality Control

Self-regulation is an essential component of medical professionalism.[2] This does not mean, however, that physicians do not include others in the regulation process. The Canadian Medical Protective Association notes there is a history of non-physicians, including laypeople and stakeholders, on College councils. Recently, some BC health authorities have introduced Statements of Expectations and peer reviews. These documents and processes have been perceived as challenges to independent self-regulation because of a lack of collaboration in their development. This perception may also be due to the already contentious nature of the relationship between physicians and health authorities.

The BCMA membership was asked whether non-physician participation in defining the standards of patient care and experience is an encroachment on self-regulation or an opportunity for greater collaboration. Over 42% of respondents said there is an opportunity to collaborate on self-regulation. Many physicians commented, though, that if physicians do not execute and control this collaboration, it has the potential to be a serious encroachment. Some physicians (18%) felt it is a serious encroachment. In their open-ended comments, several also stated that only physicians can understand the complexity of their responsibilities and regulate each other accordingly.

Are physicians being held more responsible for health care system sustainability?

41%

59%

■ Yes and this is not appropriate
■ Yes and this is appropriate

Physician Relationships

The survey asked respondents to rate the status of physicians' relationships with specific parties, specify the primary challenge in each relationship, and suggest ways to improve it.

The survey also asked respondents to rate the status of their relationship with the College of Physicians and Surgeons of BC (the College). When asked to elaborate on their rating and to identify what they or the College could do to improve their relationship, most respondents noted they did not expect or need the College to change because the structure of the relationship was well defined. Further, respondents suggested that those who were dissatisfied should take personal responsibility by getting involved with the College, or by educating themselves on proper procedure so that the College would be less likely to interfere with their practice. Overall respondents expressed satisfaction with the physician-College relationship so no further analysis was necessary.

Relationships: Physician-Patient

Generally, the survey responses were as diverse as the individuals who provided them. However, nearly 75% of respondents rated their relationship with their patients as positive.

Regardless of whether a respondent was a family physician(FP)/general practitioner (GP) or specialist, the most frequently identified challenge with patients was the limitation to appointment times. Physicians felt that they simply do not have enough time with their patients. This trend was observed by physicians who identified both fee-for-service and alternative payment plans as their primary method of payment, which was unexpected. Small numbers of physicians suggested solutions such as changing the way care is provided by delegating to other members of the care team, focusing on patient experience and reducing paperwork, training more physicians, and privatizing health care.

Confounding the problem of limited appointment time, respondents stated that trying to balance conflicting patient-health care system needs was presenting a challenge. Respondents noted that patients, like physicians, face daily demands on their time. As a result, patients may see their physician less frequently and hope to address multiple health issues in one appointment. Physicians recognized both the patient needs and limitations of the health care system but reported that this introduces a challenge to the physician-patient relationship. Suggested solutions included:

Overall, how would you rate physician relationships with PATIENTS?

Legend:
- Needs improvement
- Fair
- Very good
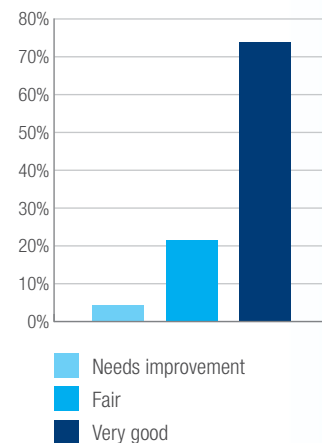
- Helping patients to better understand the parameters and limitations of the current appointment system.
- Adjustment to the payment or billing structure to allow for longer appointments.

Only a few respondents reported that it is the physician's responsibility to structure appointments to ensure patient needs are met within the allotted time. While physicians understand that they are ultimately responsible for providing patient care no matter what the circumstances, respondents suggested that the physician-patient relationship could be enhanced with increased understanding. Respondents suggested that some challenges could be minimized if patients were empowered through increased health literacy and had a greater understanding of how physicians are limited by the current appointment structure.
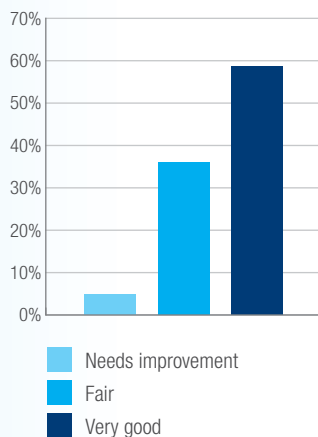
Relationships: Physician-Other Health Care Providers
Overall, respondents rated their relationship with other health care providers as being positive. Approximately 75% of physicians surveyed rated their relationships with other health care providers in the range of 6 to 9 (on a 9-point Likert scale).

While respondents reported many different challenges in their relationships with other health care providers, the most common related to "scope or role creep" (27%), time constraints limiting communication (21%), and a lack of respect (14%). These responses were consistent between FPs/GPs and specialists, although FPs/GPs were more likely to report time constraints limiting communication as an issue.

Respondents favoured two suggestions to improve relationships between physicians and other health care providers. As their roles are complementary, physicians suggested that identifying defined and structured communication guidelines, including associated reimbursements, could improve the quality of their communications. Physicians also suggested that they collaborate, where appropriate, with other health care providers in order to outline and define the scope of practice and role expectations, and thus reduce ambiguity.

Relationships: Physician-Health Authorities and Government/Ministry of Health
In contrast to how they rated the status of their relationship with patients and other health care providers, respondents negatively rated their relationships with health authorities and government/Ministry of Health (MOH).

Overall, how would you rate physician relationships with OTHER HEALTH CARE PROVIDERS?

- Needs improvement
- Fair
- Very good

Unexpectedly, many respondents noted that they considered the two groups interchangeable. As a result, the following analysis includes references to both health authorities and the MOH.

The results of the survey echoed the findings in the forum in that the relationship with health authorities, government, or the MOH is contentious. More than 20% of respondents identified "budgets and/or funding" as being a challenge and reported that the funding these groups provide is insufficient to meet patient needs. In addition, 17% of respondents noted that physician, government, or MOH goals are misaligned: physicians are care focused, while other entities are fiscally focused. Again, this sense of conflicting values is consistent with feedback from the forum. Smaller numbers of respondents reported a lack of communication, collaboration, and mutual understanding as the source of challenges. It was also noted that health authorities and/or the MOH systematically discourage physician collaboration, for instance, by scheduling meetings during clinic hours or by reimbursing some meeting participants but not physicians.

Respondents reported that increased collaboration at the individual practitioner level would improve their relationships. For their part, some respondents believe their relationship with these groups would improve if physicians advocated for their needs in a public forum. This may be counter-productive, as good will toward collaboration could decline if physician groups advocated their needs to the public instead of communicating directly with health authorities, government, or the MOH.

Since 2002, when BCMA and government joint committees were outlined in the Physician Master Agreement, there has been a great deal more collaboration. More recently, physicians have successfully worked with health authorities through the Divisions of Family Practice. Some respondents acknowledged this work, but it is unclear whether those who requested increased collaboration and advocacy were unaware of these initiatives or dissatisfied with the results.

Key Finding: *Physicians report positive relationships overall with patients and other health care providers. In comparison, they rate relationships with health authorities and government as "fair" or "needs improvement."*

Overall, how would you rate physician relationships with HEALTH AUTHORITIES?
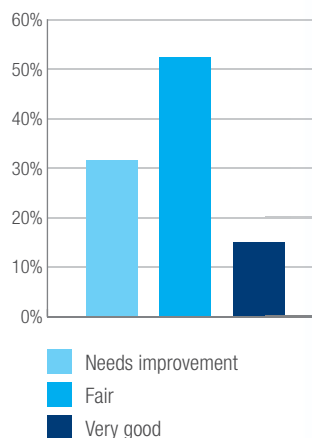
- Needs improvement
- Fair
- Very good

Overall, how would you rate physician relationships with GOVERNMENT/ MINISTRY OF HEALTH?

- Needs improvement
- Fair
- Very good
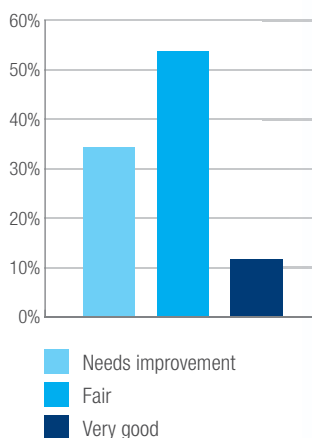
Conclusion: Toward Enhancing Professional Relationships in BC

Providing health care in BC involves an intricate network of relationships. Positive professional relationships within this network ensure that each stakeholder, including physicians, is able to focus on their part in ensuring the highest standard of health care.

With the intent of improving the current state of professional relationships, and with the awareness that improvement must be a joint effort, areas of concern are discussed and actions to overcome them are identified.

I. Commitments and Recommendations

Physician-Patient

Patients increasingly refer to online resources and look to discuss their findings with their physicians. There are concerns that unreliable resources can cause patient anxiety and that the current appointment structure does not allow adequate time for physicians to review every resource with patients. With both patients and providers appreciating a sense of partnership in the care relationship, physicians are ideally positioned to respond to this interest in increased health education. As part of patient education, physicians should be able to direct patients to the best resources. In addition to supporting a patient need, studies have shown that increased health literacy results in better health outcomes.[23]

The ideal professional physician-patient relationship is one in which the physician focuses on patient care and experience. The patient, in turn, understands his or her role in achieving good health, the physician's capabilities, and the limitations of the health care system overall.

> **Commitment 1:** *The BCMA will continue the pursuit of optimal patient experience. This includes empowering patients through health education, health literacy, and the best use of online health-related information.*
>
> **Recommendation 1:** *Patient interest groups participate in the development and promotion of patient education tools in cooperation with the BCMA and other stakeholders.*

Physician-Physician

In both the forum and survey, a general decline in respectful communication was identified as a concern. In the forum, it was also noted that collegial respect was deteriorating. For instance, a lack of support from physicians for those who took on administrative duties was noted, and physician administrators were generally seen as overcompensating for their new role to the detriment of their peers. There is a sense that taking on these responsibilities is a thankless task and that the profession does not adequately support physician administrators by identifying good candidates, providing them with training, or helping them succeed once in the role. Given the importance of having good quality physician administrators, it is to the profession's benefit to identify appropriate administrator candidates and support them in their work. In the survey, physicians highlighted the importance of life-long learning in the profession. This should be used to the profession's advantage by providing mentorship and training across the career continuum. For the profession to continue to flourish, it needs to be nurtured from within.

Inter-physician professionalism is expressed through collegial respect and communication. Professional satisfaction among physicians is achieved when respect and other virtues are expressed at all levels, from administrators to individual physicians, from physicians' first day of medical school until their retirement.

"Aside from being a medical expert, the physician of the 21st century needs to be an effective communicator, collaborator, and health system advocate to successfully deliver care."
– BCMA member, survey respondent

Commitment 2: *The BCMA will work to improve the provider experience. This includes supporting mentorship and teaching of medical trainees, opportunities for collaboration at the local physician level, and recruitment and training of physician administrators.*

Recommendation 2: *BC physicians continue to support their colleagues at all career stages. This may include modeling professional behaviour to others, teaching and mentoring medical trainees, and supporting physicians who take on administrative roles.*

Physician-Other Health Care Providers

The modern provision of patient care is increasingly team based. Challenges can arise, however, because the structure of the systems of team members are so different. For instance, simple differences in scheduling rotation can challenge how and when team members are able to communicate about patient care. This disconnect is also mirrored at a higher level when professions work to define, and sometimes expand, their scope of practice because it can create a sense of conflict. This tone filters down to the individual practitioner level. The professionalism in relationships between physicians and other health care providers should be modeled by professional associations with respectful communication. Thus, while differences remain outstanding, there are opportunities to align and mutually improve the quality of care, as well as the patient and provider experience.

Constructive relationships between physicians and other health care providers reflect a spirit of collaboration, a focus on care, and an appreciation of the expertise, skills, and education each brings to the relationship.

While differences remain outstanding, there are opportunities to align and mutually improve the quality of care, as well as the patient and provider experience.

Commitment 3: The BCMA will work with other health provider associations to improve mutual understanding of scope of practice and roles with the intent of improving communication, patient care, and provider experience.

Recommendation 3: Health care provider associations facilitate, in cooperation with the BCMA, an understanding of the scope of practice and role parameters among health care providers.

Physician-Health Authorities

The relationship between physicians and health authorities is complicated. Although they are independent, each is influenced by the other's actions. Data from both the forum and survey identified a significant level of mistrust between physicians and health authorities. Physicians and administrators must commit to improving these relationships.

The relationship between physicians and health authorities requires a better understanding of mutual expectations, roles, and responsibilities. At a minimum, increasing communication and mutual trust should become priorities for both groups. Physicians and administrators must also work in partnership to identify methods for defining mutual goals, as has begun with the Divisions of Family Practice. This type of successful collaborative model should be developed and made available to all physicians.

Commitment 4: The BCMA will support improved professional working relationships between health authorities and physicians, and will make improvement of these relationships a priority.

Recommendation 4: Health authorities foster an environment that promotes professional working relationships between themselves and physicians. In addition, health authorities and the BCMA should continue to collaborate in the ongoing evaluation and pursuit of quality patient care and experience.

Physician-Government/Ministry of Health
Physicians face an incredible challenge in trying to balance their primary focus on patient care and government's push for cost control. The membership survey highlighted how this contributes to the contentious tone of the physician-government relationship. Yet positive developments, in particular the continued success of the joint committees, have demonstrated that collaborative arrangements already in place are having constructive results. Opportunities to participate in these processes should be promoted to all BC physicians.

Professional relationships between physicians and the government or the MOH require each party to be thoroughly educated on the expectations, roles, and responsibilities of the other. Providing feedback, eliciting support, and establishing long-term collaboration will help to develop the mutual understanding needed for the foundation of a professional relationship.

Professional relationships between physicians and the government or the MOH require each party to be thoroughly educated on the expectations, roles, and responsibilities of the other.

Commitment 5: The BCMA will continue collaborating with government through joint committees. In addition, the BCMA will highlight the outcomes of this work throughout BC with the intent of encouraging collaboration down to the individual physician level.

Recommendation 5: The Ministry of Health continue to collaborate with the BCMA on joint committees. In addition, the Ministry should promote the success of this collaboration to the public, health authorities, and other health care providers with the intent of replicating the positive results throughout the health care system.

The innate passion within each physician to espouse professionalism suggests that it can be achieved, and as individual physicians demonstrate virtues such as respect and altruism, professionalism will resonate throughout the larger health care system.

II. Summary

The world is evolving at a rapid pace, and so is medicine. Despite these changes, health care still relies on relationships between physicians and others. Professionalism in these relationships must continue to be upheld in order to provide the best quality care. Through the data collection for this paper, including a review of academic literature, a stakeholder forum, and a survey of BC's physicians, it is clear that physicians are passionate about their profession and have a strong sense of professionalism. This suggests a promising way forward. Of course, the paths toward more professional relationships will vary depending on where they start – some physician-stakeholder relationships are healthier than others. The innate passion within each physician to espouse professionalism suggests that it can be achieved, and as individual physicians demonstrate virtues such as respect and altruism, professionalism will resonate throughout the larger health care system. Using this foundation and with conscious effort and good will from others, the BC health care system is ensured of an environment that promotes professionalism.

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APPENDIX A: THE BEHAVIOURAL AND SYSTEMS FRAMEWORK

Lesser et al.'s behavioural and systems view of professionalism[18] can also be interpreted as a relationship framework. Lesser et al. propose that values of professionalism can be displayed as core competencies through interactions between physicians and other individuals. The authors also suggest that this professionalism must be understood within the context of the larger health care system, because individual physicians have a relationship with the system and work within it. Thus, professional behaviours expressed at the individual and systems levels are equally shaped by one another.

If medical professionalism is defined by ideals, then the behavioural and systems view allows us to evaluate professionalism in terms of specific, observable, and achievable behaviours expressed in physicians' relationships. A behavioural and systems view of professionalism is a framework through which to observe professionalism at a practical level.

Figure 2 shows that just as individuals can shape professional relationships at a systems level, the system can shape professionalism in the individual.

Behavioural View of Medical Professionalism

Lesser et al. suggest that professionalism is expressed through a physician's behaviours during interactions in relationships with patients, families, and other individuals.[18] Lucey and Souba[19] identify a number of teachable behaviours, such as self-awareness and self-control, situational awareness, alternative strategy development skills, crisis communication skills, communication, and peer coaching.

Physicians express professionalism by demonstrating behaviours in their relationships. With patients and their families, they display empathy, humility, and a commitment to deliver consistent and equitable care. In professional relationships, with colleagues or care team members, physicians display respect and participate in collaborative patient care. Lucey and Souba also suggest that emotional intelligence, reflective practice, and mindfulness are critical to nourishing professionalism at the individual physician level.[19]

Systems View of Medical Professionalism

A systems view of professionalism is founded on the understanding that the health care system is a network of relationships between various health care system agents with varying degrees of influence, and that professionalism is expressed through these interactions. Optimal professionalism requires that physicians effectively balance the needs and competing values of the patient, colleagues, stakeholders, and the health care system.[18] In addition, physicians have a professional responsibility to be engaged with each of these agents, and ensure quality patient care by driving change and promoting advocacy at the systems level. This is heightened if the structure of the system undermines the ability of physicians to meet their professional responsibilities at the individual level, particularly in their relationships with patients.

While the behavioural view of medical professionalism refers to behaviours exhibited by individual physicians, the systems view refers to behaviours exhibited when physicians work "between" different systems of health care. Cultivating behaviours for professionalism at the systems level includes advocacy training, engagement in ongoing education, development of internal review systems, engagement in the development of external reviews of the health care system, and support for organizational strategies that foster a specific culture of professionalism.[18] Simultaneously, when engaging with different systems, individual professionalism can be expressed through virtuous behaviours.

Professional behaviours and the organizational environment in which they are expressed are inextricably linked. Both are equally shaped by the other, and actions at each level, either by individuals or by organizations, can have long-term consequences.

FIGURE 2. Behavioural and Systems Views of Professionalism

Strategies to strengthen professionalism
- Develop individual competencies
- Promote physician leadership and supportive organizational culture
- Encourage physician advocacy and engagement in system reform

Source: Lesser CS, Lucey CR, Egener B, Braddock CH, 3rd, Linas SL, Levinson W. A behavioral and systems view of professionalism. JAMA. 2010 Dec 22;304(24):2732-7

APPENDIX B: STAKEHOLDER FORUM ATTENDEES

BCMA Medical Professionalism Forum
Tuesday, May 15, 2012 – Robson Square Conference Centre, Vancouver, BC

Facilitator
Dr Brian Evoy, Forum Facilitator

Presenters
Dr John Haggie, President, Canadian Medical Association

Dr Kerry Jang, Vancouver City Councillor and Professor of Psychiatry, UBC Medical School

Ms Kelly McQuillen, Executive Director, Primary Health Care and Specialist Services Branch, Ministry of Health

Participants
Dr Granger Avery, Executive Director, Rural Coordination Centre of BC

Dr Peter Barnsdale, President, Society of General Practitioners of BC

Dr Jeff Blackmer, Executive Director, Ethics, Professionalism and International Affairs, Canadian Medical Association

Dr Cathy Clelland, Executive Director, Society of General Practitioners of BC

Dr Bakul Dalal, President, Society of Specialist Physicians of BC

Dr Marjorie A. Docherty, President, College of Physicians and Surgeons of BC, Clinical Professor

Dr Lisa Gaede, President, BC College of Family Physicians

Dr Mark Godley, Member, BCMA Medical Professionalism Project Group

Dr Steve Gray, Vice President, Physician Compensation & Planning, Provincial Health Services Authority

Dr John Haggie, President, Canadian Medical Association

Dr Robert Halpenny, President & CEO, Interior Health

Dr Gordon Hoag, Medical Director, Laboratory Medicine, VIHA and Co-Chair, Shared Care Committee

Dr Arun Jagdeo, Board Member, Professional Association of Residents of BC

Dr Kerry Jang, Vancouver City Councillor and Professor of Psychiatry, UBC Medical School

Ms Cynthia Johansen, Registrar/ Chief Executive Officer, College of Registered Nurses of British Columbia

Ms Lynn Kelsey, Patient Partner, Patient Voices Network, ImpactBC

Ms Susan Lanyon, Patient Partner, Patient Voices Network, ImpactBC

Dr Trina Larsen Soles, Chair, BCMA Council on Health Economics & Policy

Ms Kelly McQuillen, Executive Director, Primary Health Care and Specialist Services Branch, Ministry of Health

Dr Gurdeep Parhar, Associate Dean, Equity & Professionalism, UBC Faculty of Medicine

Dr Alan Ruddiman, Chair, BCMA Medical Professionalism Project Group

Mr Greg Shepherd, President, BC Pharmacy Association

Ms Suzanne Solven, Deputy Registrar, College of Pharmacists of BC

Dr Shirley Sze, Member, BCMA Medical Professionalism Project Group

Mr Peter Toppings, Manager, Patient Voices Network, ImpactBC

Mr Kevin Warren, Director, Agreements and Negotiations, Ministry of Health

Dr Andrew Webb, Vice President, Medicine, Fraser Health Authority

Dr Carole Williams, Council Member, Canadian Medical Protective Association

Dr J. Galt Wilson, Deputy Registrar, College of Physicians and Surgeons of BC

Dr Joanne Young, Member, BCMA Medical Professionalism Project Group

BCMA Staff
Dr Jonathan Agnew, Executive Director, Practice Support & Quality (then Director of Policy)

Mr Jim Aikman, Executive Director, Economics & Policy Analysis

Ms Mary George, Policy Analyst

Ms Linda Grime, Administrative Assistant

Mr Rob Hulyk, Director of Physician & External Affairs

Dr Nasir Jetha, (then President of the BCMA)

Dr Dan MacCarthy, MD Consultant, Practice Support & Quality (then Executive Director, Practice Support & Quality) and Member, Medical Professionalism Project Group

Mr Allan Seckel, Chief Executive Officer, British Columbia Medical Association

APPENDIX C: MEDICAL PROFESSIONALISM FORUM VIGNETTE I

Large Group Discussion – **Democratization of Knowledge**

Introduction

Read the following Introduction aloud to the group.

Video clip from the *Nature of Things* http://www.cbc.ca/natureofthings/episode/ms-wars-hope-science-and-the-internet.html

The Internet has spurred a social network movement that is changing the doctor/patient relationship with repercussions for physician and institutions.

Vignette #1

Read the following narrative aloud to provide a situational framework for the group's discussion.

In northern Italy, research scientist Dr Paolo Zamboni reported a correlation between blocked neck veins and multiple sclerosis. He pioneered a radical treatment called liberation therapy. A small research paper published the results online.[20] The response from traditional and social media was explosive, and the research was shared internationally.

As patients elected to get the treatment in private clinics, Internet video testimonies showing miraculous improvements appeared. While a few Canadian clinics began to investigate the treatment, the Canadian medical establishment was reluctant to proceed with an unproven treatment that had not followed proper research protocol.

Patients were understandably torn between a sense of caution and the lure of a cure, but many began travelling out of the country for the procedure and paying for their own treatment, often without telling their physicians.

The example of liberation therapy demonstrates how the Internet is producing information faster than the health care system can respond, providing little guidance for the individual physician facing these challenges.

Discussion Guide

Use the following questions to guide the discussion. Try to keep the discussion centred around the Vignette and avoid the abstract or personal. Try to ensure each member of the group has the opportunity to participate.

A. Acknowledgement by stakeholders, including physicians, that the Internet, social media, and resulting challenges to professional authority are not going away.

B. Explore the appropriate place/role for information from sources other than a physician.

C. Explore the role of physician as coach and guide and how this contrasts with traditional roles.

APPENDIX D: MEDICAL PROFESSIONALISM FORUM VIGNETTE II

Small Group Discussion 1 – **Inter/Intra Professionalism**

Introduction

Read the following Introduction aloud to the group.

From the *New York Times*. Published: May 7, 2011. http://www.nytimes.com/2011/05/08/opinion/08Brown.html

While many hospitals have adopted anti-bullying policies, too few see it as a serious issue. Bullying pervades relationships through hospitals and care centres. Physicians can often be seen as bullies while simultaneously feeling victimized at any stage of their medical career. The process can be subtle and go unnoticed by other students and teachers. In its early stages, bullying can go unnoticed even by the victim.[21]

Vignette #2

Read the following narrative aloud to provide a situational framework for the group's discussion.

During morning rounds in the hospital, the entire medical team stood in Patient Brown's room. A test result was late, and Patient Brown, a friendly, middle-aged man, jokingly asked Dr Black whom he should yell at. Turning and pointing at the patient's nurse, Dr Black replied, "If you want to scream at anyone, scream at her." Dr Black was asked if he could be quoted. "Sure," he answered. "It's a time-honored tradition — blame the nurse whenever anything goes wrong."

Later, Dr Gray overheard two residents discussing the story. "Oh, he's the worst," one said. "He's always yelling at me in front of patients and blames me for his own mistakes." "I can't believe he still teaches, I mean he doesn't know anything about modern medicine and everyone thinks he's a total joke," the other student replied.

Upon hearing this conversation, Dr Gray is at a complete loss. While the students' conversation somehow seems inappropriate, he hesitates to intervene lest he appear to support Dr Black's behaviour.

Discussion Guide

Use the following questions to guide the discussion. Try to keep the discussion centred around the Vignette and avoid the abstract or personal. Try to ensure each member of the group has the opportunity to participate.

A. What are Dr Gray's individual responsibilities in this case? Should he do anything? If so, should he start by approaching Dr Black, the residents, or the nurse? What do the demands of professionalism require of him, if anything?

B. In what ways do the various parts of the health care system encourage or discourage the kinds of behaviours exhibited by Dr Black?

C. What are some of the effects of such unprofessional behaviour (i.e., on patients, physicians, other health care professionals, and administrators)?

D. Has the issue of unprofessional behaviour improved or worsened over the past 10 years? Why or why not?

APPENDIX E: MEDICAL PROFESSIONALISM FORUM VIGNETTE III

Small Group Discussion 2 – **Impact of Economic Climate on Professional Role**

Introduction

Read the following Introduction aloud to the group.

With computerized health systems, physicians can place orders more rapidly than ever before. Just a few clicks and your physician can purchase a panel of blood tests, futuristic imaging, and diagnostic procedures that will assist in confirming a diagnosis.

The balance between physician control of health care costs and its contradiction with their primary objectives is a dynamic issue. Beyond just the direct need for testing, there are so many other reasons tests are ordered: physicians feel a responsibility to do the most they can to make the patient better; they're scared a superior may berate them for not considering it; and the fear of malpractice always lingers. Is it unethical for physicians to consider costs or is it unethical to ignore the consequences of infinite spending?

Vignette #3

Read the following narrative aloud to provide a situational framework for the group's discussion.

Administrator Smith is at his wit's end. He is looking at the budgets and is overwhelmed by the over-utilization of diagnostic laboratory tests and radiological imaging by just one physician, Dr Spendy. Over lunch he vents to Mr. Jones, the Chief Financial Officer.

"It's not that I don't like Dr Spendy," he says. "It's just that he's so passionate about every patient that he'll go to the ends of the earth to find a diagnosis."

CFO Jones agrees, "and he worked so hard to get us that grant last year, which was great for the hospital."

"Maybe it would be less of a problem if I thought he needed to order so many tests, but he's so at variance from the other doctors' practice patterns that most of the time I think he's just confirming his own diagnosis," Administrator Smith reveals.

"You really can't do anything about it you know," the CFO laments. "Did you hear about that study in Archives of Internal Medicine?[24] They showed hospital physicians the price of every test before they could order it and it didn't change a thing.d We'll have to find savings somewhere else."

Discussion Guide

Use the following questions to guide the discussion. Try to keep the discussion centred around the Vignette and avoid the abstract or personal. Try to ensure each member of the group has the opportunity to participate.

A. Has physician-related spending changed with the increased availability of diagnostic tests and technology?

B. Has the economic challenge of sustaining the health care system changed the physician's professional role?

C. What is the appropriate role for the physician with respect to health care sustainability? Specifically, what would a completely professional relationship between physicians and administrators with respect to cost control look like?

D. If cost-consciousness among physicians is the goal, how can it be achieved? Or if cost-consciousness is not physician responsibility, how can they be removed from the issue?

APPENDIX F: MEDICAL PROFESSIONALISM SURVEY

Introduction

Changes in medical practice, public expectations, physician-patient relations, and the desires of newer medical graduates suggest it is time to re-examine what it means to be a "professional" in medicine. Many non-physician groups in health care have tried—and continue to try—to re-define medical professionalism, but it is the BCMA Board of Directors' belief that doctors themselves are best positioned to explore these issues.

In June 2011, the BCMA Board of Directors requested that the Council on Health Economics and Policy (CHEP) provide a detailed review of medical professionalism. As the projected group prepares the report, it is important that what is presented is representative of the opinion of the BCMA membership.

To that end, we are asking for your help in completing a brief survey. Your responses are vital to helping us identify specific policy recommendations that will be included in the final report.

Please take a few moments to complete this survey and, as a token of our thanks, you will be entered to win an iPad3 (draw entry is optional). Survey deadline is August 24, 2012.

Thank you in advance for your participation.

Definition

One definition of medical professionalism contains three essential elements:
- Ethics of care/Do no harm
- Clinical independence
- Self-regulation

1. In your opinion, which of the following qualities also define the medical profession? Please choose three.

Technical skills, agent of system sustainability, clinical reasoning, leadership, communication, mentoring/teaching, reflection in daily practice, steward of knowledge, life-long learning, other, no need to extend the definition.

Change over time

2. The past 20 years have seen remarkable advancements in research, treatment, and technology. For the first time, as many as four generations work alongside one another. Changes in personnel and technology have had varying impacts on how other professions are defined.

Do you think that the core definition of the physician professional has changed over the past 20 years? If so, how has the profession changed?

Structure

3. The structure of the health care system itself can create or act as a barrier to professional relationships between physicians and others including patients, administrators, other physicians, allied health care professionals or health authority employees.

Do you agree or disagree with this statement? If you agree, please explain how the health care system structure can create barriers between physicians and others.

Sustainability

4. The long-term sustainability of health care is being called into question. Whether appropriate or not, the media often portray physicians as responsible for increased health care spending. Are physicians being held more responsible for the economic sustainability of the Canadian health care system than they were 20 years ago?

If yes, please specify whether you believe this an appropriate facet to the definition of a medical professional or not.

Internet and media

5. Physicians we spoke to report that patients more frequently want to discuss medical information they have accessed through the Internet and media. Does this pose a challenge to your professional role with your patients? If yes, please explain.

Quality

6. Non-physicians are taking—and will continue to take—a greater role in defining the standards of patient care (for example, health authorities and patient groups). Is this an encroachment on self-regulation, or an opportunity for greater collaboration?

Specific relationships
Throughout their professional career, physicians develop and juggle relationships with many different groups. Sometimes, these relationships clash with one another and maintaining professionalism can be challenging. The next few questions ask about your impressions of relationship physicians have with each of the following groups:
- Patients
- Other health care professionals
- Health authorities
- The College
- Government

Answer questions 7 through 11 on a scale of 1-9, with 1 being "Needs Improvement" and 9 being "Very Good":

7. Overall, how would you rate the status of the physician-patient relationship?

8. Overall, how would you rate the status of physician relationships with other health care professionals, e.g., nurses, pharmacists, physiotherapists, et al.?

9. Overall, how would you rate the status of physician relationships with health authorities?

10. Overall, how would you rate the status of physician relationships with the College?

11. Overall, how would you rate the status of physician relationships with government?

Patients
12. What is the #1 challenge to the professional physician-patient relationship?

13. In your view, what, if anything, should physicians do to improve this problem?

14. In your view, what, if anything, should patients do to improve this problem?

Other professionals
15. What is the #1 challenge to the professional physician relationship with nurses and/or allied health professionals?

16. In your view, what, if anything, should physicians do to improve this problem?

17. In your view, what, if anything, should nurses and/or allied health professionals do to improve this problem?

Health authorities
18. What is the #1 challenge to the professional physician relationship with the health authorities?

19. In your view, what, if anything, should physicians do to improve this problem?

20. In your view, what, if anything, should health authorities do to improve this problem?

College
21. What is the #1 challenge to the professional physician relationship with the College?

22. In your view, what, if anything, should physicians do to improve this problem?

23. In your view, what, if anything, should the College do to improve this problem?

Government
24. What is the #1 challenge to the professional physician relationship with the government/Ministry of Health?

25. In your view, what, if anything, should physicians do to improve this problem?

26. In your view, what, if anything, should the government/Ministry of Health do to improve this problem?

Comments
27. Do you have any other comments or suggestions of medical professionalism?

Demographics
28. What is your age?

29. What year did you graduate from medical school?

30. Gender

31. General practitioner or specialist?

32. Would you specify your region of practice as urban or rural?

33. Within which health authority do you practice?

34. How would you describe your primary method of compensation?

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