Creating Space for Doctors to be Doctors: A Cumulative Impact Lens on Physician Demands

A policy paper by the Council on Health Economics and Policy (CHEP) at Doctors of BC

December 2022

doctors of bc

Better. Together.

Doctors of BC's Council on Health Economics and Policy reviews and formulates policy through the use of project-oriented groups comprising practising physicians and professional staff.

Doctors of BC Council on Health Economics and Policy Membership 2018-2022

Dr Jessica Otte, Chair – Family Practice, Nanaimo
Dr Ali Abdalvand – Emergency Medicine, New Westminster
Dr Casey Chang – Internal Medicine, Burnaby
Dr Ernie Chang – Family Practice, Vancouver
Dr Karan D'Souza – General Surgery Resident, Vancouver
Dr Sharon Dodd – Family Practice, Richmond
Dr Lisa Gaede – Family Practice, North Vancouver
Dr Jennifer Leavitt – Family Practice, Vancouver
Dr Tommy Gerschman – Pediatrics, Vancouver
Dr Jaspinder Ghuman – Family Practice, Surrey
Dr Dan Horvat – Family Practice, Prince George
Dr Gordon Hutchinson – Family Practice, 100 Mile House
Dr Inderveer Mahal – Family Practice, Vancouver
Dr Thomas McLaughlin – Pediatrics, Vancouver
Dr Don Milliken – Psychiatry, Victoria
Dr Goldis Mitra – Family Practice, Surrey
Dr Tracy Monk – Family Practice, Vancouver
Dr Lloyd Oppel – Emergency Medicine, Vancouver
Dr Stephen Roome – Family Practice, Victoria
Dr Elliott Weiss – Rehabilitation Medicine, Vancouver
Dr Elizabeth Zubek – Family Practice, Maple Ridge

Doctors of BC Support Staff

Ms Deborah Viccars – Vice President, Policy, Planning & Law
Ms Helen Thi – Manager, Policy
Ms Katie Bowers – Manager, Planning
Mr Jorgen Harink – Senior Policy Analyst
Mr Colin Bowbrick – Policy Analyst
Ms Manvir Gill – Policy Analyst
Ms Crystal Wang – Senior Administrative Assistant

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Physicians in British Columbia are feeling pressured by numerous competing demands on their time. While physicians fully understand that medicine by nature is a fast-paced, multi-faceted field, the increasing volume of tasks not directly connected with patient care can become a burden and end up weighing heavily on physicians. Urgent action is needed to alleviate some of the burdens doctors, and other health care professionals, face everyday to protect the sustainability, and quality and continuity of care of BC's health care system.

Since early 2019, Doctors of BC has been engaging with members in an effort to find tangible solutions to this long-standing and complex issue. Feedback from BC physicians shows they are hitting the point of burnout and feel overwhelmed by mounting demands. They are concerned that the time spent on certain tasks is duplicative, unnecessary, and not based in evidence. Tasks such as paperwork, charting, and EMR management take away from valuable time spent tending to patients, teaching medical students, researching, and other meaningful work activities.

As a broad spectrum of factors continues to put pressure on the health care system, BC physicians are feeling the additional strain. In early 2021, we published a policy statement on this topic that found that physicians are experiencing escalated stress driven by the COVID-19 pandemic, staffing issues, and changing patient expectations.

Urgent action is required. The 2022 Physician Master Agreement (PMA) has built into it relief from administrative burdens that includes establishing working groups to make recommendations that simplify special authority forms, modifies the payment schedule to address re-referrals, and changes how patients are contacted for health authority managed programs, among other burdens.

Outside of the PMA, Doctors of BC is calling for an immediate, sustained, and coordinated approach involving all stakeholders, including the Ministry of Health, regulatory bodies, health authorities, and all other parties involved in health care delivery. Detailed information is found on our Fact Sheet.

Cumulative Impact Lens

A key recommendation to secure the future stability of our health care system, is for all organizations involved in the sector to examine tasks they assign to clinicians using a cumulative impact lens. No single task is the ultimate cause of a problem, but when many tasks accumulate over time, significant stress is often the result. Viewing through this lens, tasks can be examined across organizations, to avoid adding duplicative, unnecessary, or burdensome tasks to a clinician's plate.

Burdens Solutions Tool

Along with a more fulsome look at our policy recommendations and organizational commitments, the policy paper introduces the Burdens Solutions Tool—a framework or pathway designed to identify solutions to any new or changing demands that may be perceived as a burden by doctors and other health care professionals. Doctors of BC is committed to using the Burdens Solutions Tool in our work, and calls on all healthcare care stakeholders to do the same. It is only through collaboration that innovative solutions to these issues can be developed. We look forward to working together with physicians, health care stakeholders, and other clinicians across the country to address these demands, and make positive, lasting change to our health care ecosystem—change to benefit us all.

DOCTORS OF BC POLICY

Recognizing the well-intended but cumulative impact of mounting demands on physicians, and the associated impact on access to care, Doctors of BC makes the following recommendations and commitments aimed at reducing the number and impact of demands on physician time:

Recommendations

Doctors of BC recommends:

- That the Ministry of Health (MOH), Ministry of Children and Family Development (MCFD), health authorities, regulatory bodies, insurance companies, and other stakeholders who create demands on physicians use the Burdens Solution Tool—and consistently engage physicians in this process—when considering new/changing demands and evaluating existing demands.
- The development of an accountability structure, approval requirement, or legislated limitations on the ability of third parties who are not involved in the delivery of health care or social services to unilaterally impose administrative burdens, such as assessment, signature, or form completion requirements on physicians without seeking input from physicians on their medical necessity.
- That physicians be meaningfully engaged in the development of BC's digital health ecosystem governance, and the ongoing development of standards, planning, design, implementation, evaluation, and training associated with electronic record-keeping systems.
- That the Ministry of Health, Ministry of Advanced Education, Skills & Training (MOAEST), and health authorities consider options to support the training and expansion of clinical and administrative support staff, in all health care settings.
- That the BC College of Physicians and Surgeons (CPSBC) continues its commitment to apply and communicate how the principles of right-touch regulation are being used in the development of proposed standards, guidelines, and policies (or revision thereof).

Commitments

Doctors of BC commits to:

- Educating staff and members conducting business on behalf of the Association on the Burdens Solution Tool to ensure it is consistently embedded in our work.
- Continuing to work with the MOH, primarily through the Joint Collaborative Committees (JCCs), on identifying further opportunities to support the provision of longitudinal primary and specialty care.
- Supporting efforts to expand team-based care, with the intention of contributing to high-performing teams, whose members are empowered to work to the full depth of their scope of practice.
- Continuing collaboration with the MOH and other key stakeholders to establish new—and improve existing—compensation models, to help physicians manage demands and ensure they are compensated for additional work.
- Working with the CPSBC and other key stakeholders to improve clarity and transparency in their communications, and supporting those stakeholders measuring the impact of improved communication efforts, thereby identifying opportunities for further improvement.

INTRODUCTION

In response to growing concerns from doctors about feeling overwhelmed, burdened, and increasingly experiencing burnout, Doctors of BC sought input from physicians across BC via an online member engagement project in 2019.

Our intention was to understand the types and range of demands on doctors in BC, the burdens arising from those demands, and potential solutions. The findings from this engagement, in addition to global research on physician burnout, informed the development of a policy paper that was to include specific commitments and recommendations to alleviate burdens impacting BC physicians.

This policy work was near completion in March 2020 when the global COVID-19 pandemic started, which led to significant disruptions across the health care system. Due to the considerable level of change that ensued, Doctors of BC postponed publication of this paper, as our specific commitments and recommendations would quickly be out of date. We also did not want to increase pressure on an already strained system. However, the considerable value in highlighting the cumulative nature of demands during a period of rapid change soon became clear, and in February 2021, Doctors of BC published a *policy statement* on Physician Burdens.

The statement defines a 'burden' as a demand that is duplicative, unnecessary, or not clearly evidence-based, or when the volume of demands is so great they cannot be reasonably accomplished within existing workflows. It then describes how demands on physicians can accumulate to a point where they feel burdensome, and highlights the need to examine demands in a cumulative context, rather than in isolation, to allow full understanding of their impact on physicians. Finally, the statement provides a simple 'cumulative-impact lens' we recommended be used, to assess an existing or new demand and identify when it might become burdensome. (See Appendix A for the full policy statement.)

As BC moves out of the initial phase of the pandemic, Doctors of BC has taken the opportunity to reassess our recommended approach to managing burdens. The pandemic highlighted that in a complex, growing, and ever-shifting health care system, new burdens will continually emerge while others will subside. Recognizing this, we have built on the principles described in the Physician Burdens policy statement.

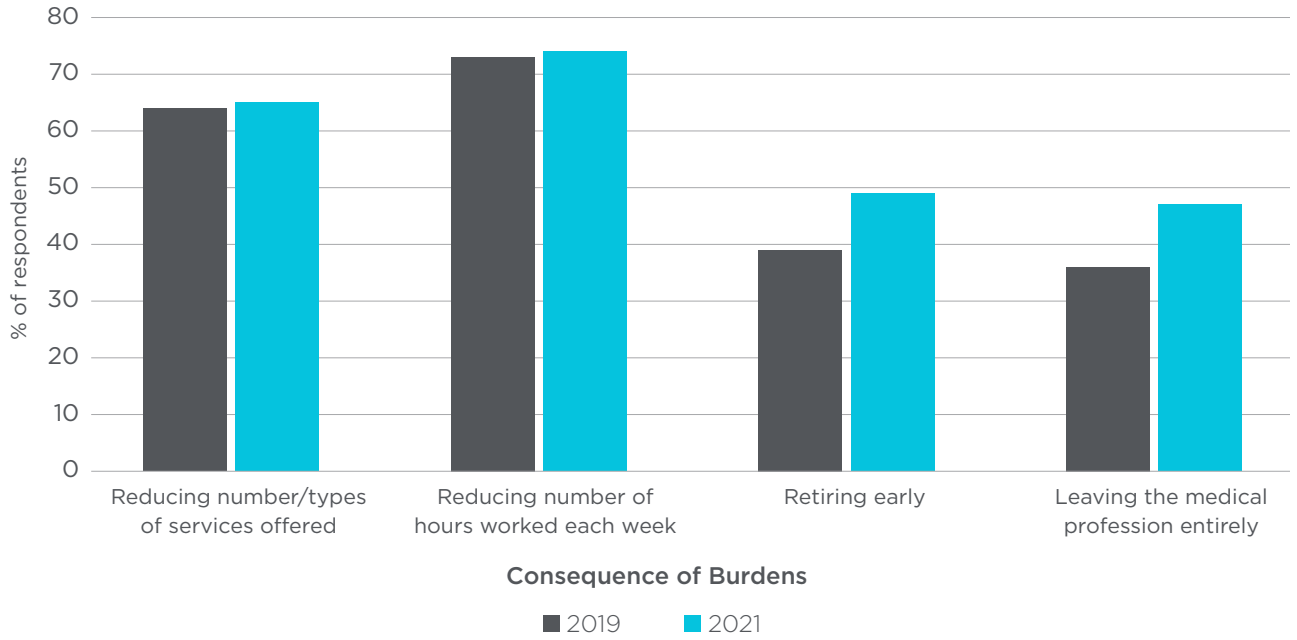
In this policy paper, we outline a process to determine the appropriate type of solution to prevent new or eliminate existing demands that do not support quality care, or increase efficiency in the provision of quality health care services.

WHY DOES THIS MATTER?

In 2021, Doctors of BC re-engaged with members, revisiting questions asked in 2019 to assess potential long-term changes driven by the COVID-19 pandemic.

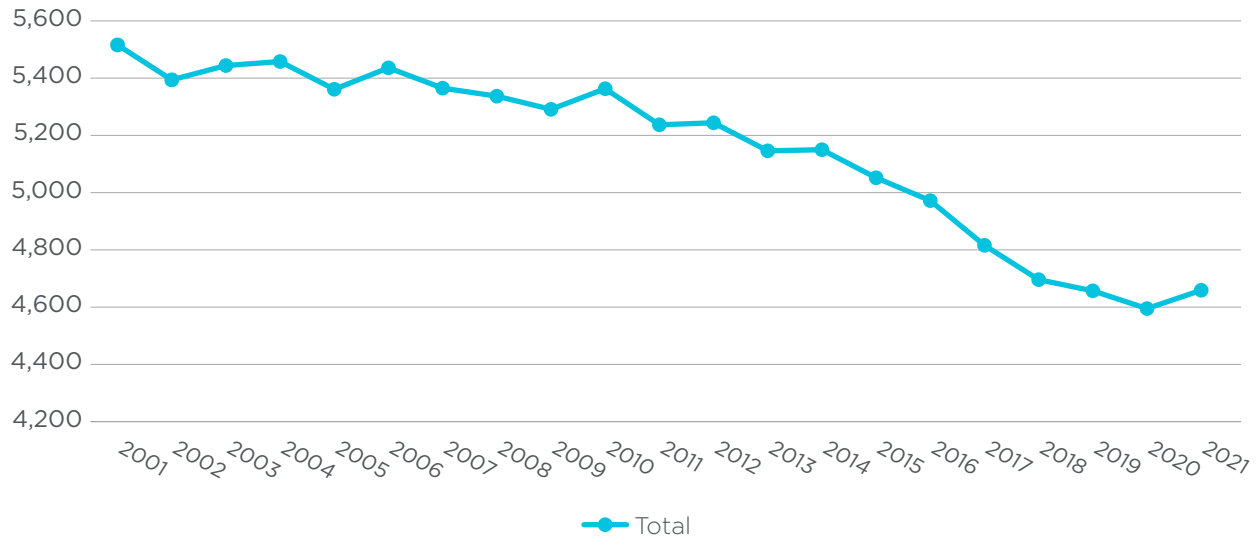
While the types of burdens impacting doctors the most (paperwork, documentation, technology, and health system growth) remained consistent, pressures related to patient expectations and staffing issues increased substantially. Respondents also felt significantly more burdened than prior to the pandemic, due to compounding stressors associated with providing care in challenging circumstances for an extended period. Decreasing job satisfaction, poor work/life balance, and increased burnout rates were similar to those pre-pandemic. Doctors also indicated that they are reducing the number of hours they work and services they offer, as well as considering retiring early, leaving the medical profession, or moving to other jurisdictions at a similar or greater rate than prior to the pandemic.

Impact of Burdens on Access to Care 2019 vs. 2021



Responses from physicians when asked "As a result of demands, have you ever done or considered any of the following (multiple options provided)?" is 2019 and 2021.

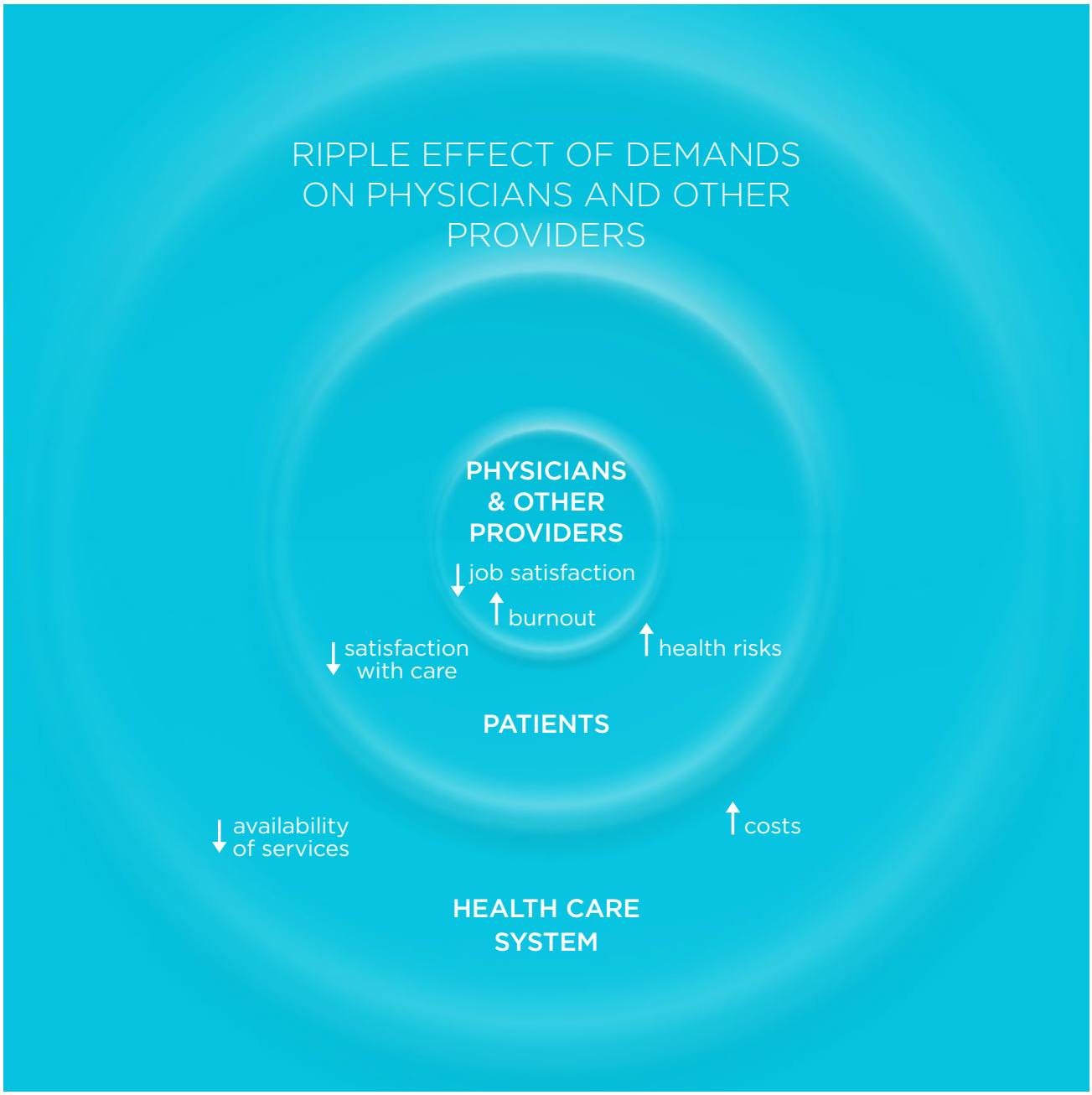
Average Number of Services Per Family Per Doctor



MSP data confirm that between 2001 and 2021, the average number of billable services provided per family doctor declined by approximately 15%. While there are likely several factors that contributed to this decline, it is reasonable to assume that increasing administrative burdens played a significant role.

While these findings reflect the experience of participants in our online engagement only, and do not reflect the plans of all BC physicians, if even close to a third of physicians left practice, it would be catastrophic to BC's health care system.

Our findings align with broader health human resource trends. For example, the most recent (2022) National Physician Health Survey conducted by the Canadian Medical Association (CMA) found that 53% of Canadian physicians are experiencing burnout, and 46% are considering reducing their clinical workload in the next two years.[i] Similarly, a survey conducted in February 2022 found that approximately one-third of nurses were likely to leave their role by the end of the year. Of those, 44% said burnout was their primary reason for considering leaving their job.[ii]



This diagram demonstrates how seemingly small demands on physicians can ripple through the health care system to have significant impacts on quality and access to care across the entire health system.

Low job satisfaction and high burnout continue to ripple through the health care system, decreasing access to and quality of care. The accelerated trend of health care workers considering leaving the system is a critical concern, and highlights the urgent need for action to alleviate unnecessary pressures on physicians and other clinicians to ensure continued patient access to high-quality care.

Identity factors such as gender, race, ability, etc. may further contribute to these negative consequences. A 2017 survey by the Canadian Medical Association on equity and diversity in medicine found that female physicians experience higher rates of burnout and lower rates of job satisfaction as a result of gender inequity.[iii] These challenges may also be increased for women who identify with other factors of inequity (e.g., racial minority, low socioeconomic level, religious views, LGBTQ2+, disability).[1]

While this paper is based on the physician experience, Doctors of BC recognizes the similar experiences among all health care professionals, including nurses, pharmacists, and allied health professionals. The pandemic increased pressures at all points in the health care system, and highlighted many long-standing system challenges. The move toward team-based care brings opportunities to address some of these, including time constraints and the very real tension between finite hours in a day and rapidly accumulating demands on those hours. The recommendations and commitments focus primarily on addressing burdens specific to physicians, however, the principles and framework proposed are likely applicable to other health care clinicians. To reflect this, the paper uses the term 'clinician' when speaking to broad principles that could be applied physicians, and other health care professionals.

The current state is unsustainable and jeopardizes the quality of, access to, and experience of care in British Columbia. An immediate, sustained, and coordinated approach by Doctors of BC, other clinician associations, the Ministry of Health, health authorities, regulatory bodies, and any other parties that may impose burdens on clinicians is needed. They must collaboratively review new and existing demands and implement appropriate solutions to reduce the cumulative impacts they are having on patients, clinicians, and the health care system.

1 While Doctors of BC recognized the impact identity factors have on how individual physicians experience burdens, exploring the breadth of this issue is outside the scope of this paper. More information on this can be found in Doctors of BC's policy statement on Gender Equity in Medicine.

APPLYING THE CUMULATIVE-IMPACT LENS

Most demands on clinicians are well-intentioned and aim to support quality care. However, when the volume of demands is too great or they are unnecessary, duplicative, or not clearly evidence-based, they become burdensome.

In some cases, demands may limit a physician's clinical autonomy, thus reducing their ability to provide quality care. As demonstrated in the Physician Burdens policy statement, unnecessary burdens have negative system-wide consequences that impact individual clinicians, quality of and access to care for patients, and the long-term sustainability of the health care system.

Doctors of BC calls on stakeholders to consider each new and existing demand in the context of an accumulation of demands that physicians and other clinicians have consistently made clear they cannot meet if they are to maintain patient care access and quality in BC. This paper outlines an approach to applying a "cumulative-impact" lens to each new, existing, or changing demand of clinicians. This approach can mitigate potential negative impacts, reducing burdens and thereby sustaining health care quality, access, and efficiency. That approach is detailed in the **Burdens Solution Tool**.

While Doctors of BC hopes that the Burdens Solutions Tool can be applicable to other clinicians, it was developed based on physician data and experience. Doctors of BC is committed to working with other clinician groups to further refine and develop the tool so it can be used as a broad advocacy framework, supporting the collective interests of clinicians across the health system.

Burdens Solution Tool

This tool includes a series of potential questions for stakeholders/decision-makers—always in consultation with health care clinicians—to consider before implementing a new/changing demand. The tool is intended to help identify the most appropriate solution(s), to ensure that the new/changing demand actively supports the provision of quality patient care. The solutions are presented in a sequence such that if the first solution does not reduce the potential burden, the next step should then be considered. Further, the tool may present multiple solutions to reduce potential burden associated with a demand. This tool can also be used to review and assess existing demands on health care clinicians. The overall intention of the tool is to ensure decision-makers actively reduce burdens on clinicians every time they consider a new or changing demand. Solutions should support clinicians' ability to complete demands that are critical to the provision of quality health care, without impeding their clinical decision making.

Engaging Clinicians

Engaging clinicians at each step is critical to ensure that the cumulative-impact lens is applied effectively to new, changing, or existing demands. Their clinical perspectives are needed to fully gauge and understand whether a demand may contribute to, or detract from, quality of and access to patient care; and to identify the most appropriate solution to promote efficiency and reduce unintended consequences. Effort should also be made to ensure clinicians in rural and remote areas are included in engagement projects, as they face unique challenges when it comes to addressing burdens.

Identifying the Appropriate Solution(s)

1. **Eliminate** – Consider if and how the new/changing demand supports quality care. If this cannot be clearly demonstrated, the demand should be eliminated entirely. If the demand does support quality care, then consider removing other, less important tasks from the clinician's existing workload to offset the impact of a new demand.
2. **Simplify** – If a demand does support quality care, consider whether the task is streamlined to be as efficient as possible. There are many ways to simplify a demand ranging from reducing the amount of information collected so that the demand only considers clinically relevant information or implementing a technologic solution that automates a demand.
3. **Collaborate** – If a demand cannot be simplified, then collaboration across the health care team may help. Consider what type of information and expertise is needed to address the demand, and work with the most appropriate member(s) of the health care team (this may include clinical and/or administrative staff) to incorporate the demand into their workflow.
4. **Resource** – If the demand cannot be eliminated, simplified, or managed through collaboration, consider providing additional resources, be it compensation, staffing or time, to ensure that the clinician has sufficient means to complete the demand without detracting from their other responsibilities.
5. **Communication** – Once the most appropriate solution(s) have been identified, consider how and when the new or changing demand will be implemented and communicated. Avoid introducing a new or changing demand at the same time as other significant health system changes, and develop clear, simple communications that explain why the change is necessary, and how clinicians will be supported to implement it.

To support quality of and access to care by reducing unnecessary burden on physicians, Doctors of BC commits to:

> **Educating staff and members conducting business on behalf of the Association on the Burdens Solution Tool to ensure it is consistently embedded in our work.**
>
> **and:**
>
> **Doctors of BC recommends that the Ministry of Health, Ministry of Children and Family Development, health authorities, regulatory bodies, insurance companies, and other stakeholders who create demands on physicians use the Burdens Solution Tool; and consistently engage clinicians in this process when considering new/changing demands, and evaluating existing demands.**

Burdens Solutions Tool

ADDRESSING THE ISSUE – FOCUS ON IMPROVEMENT EFFORTS

In BC, where many health care stakeholders use the Institute for Healthcare Improvement (IHI) Triple Aim framework for quality improvement, Doctors of BC and the Ministry of Health have taken this to heart, as discussed in depth in our policy paper Improving BC's Health System Performance.

These partners consider *Experience of Care* to include both patient and clinician experience as key dimensions of quality. In other jurisdictions, the term Quadruple Aim is used, which features clinician experience as an additional fourth pillar. Regardless of how it is expressed, it is critical to recognize clinician experience as a key dimension of quality.

Through our member engagement efforts, BC doctors have identified specific opportunities to improve efficiency and quality of care and reduce burdens. In this paper we highlight how improvement efforts in these areas can allow physicians to focus on activities that support the provision of quality care, and thereby heighten their positive experience of care.

While the examples and solutions discussed target challenges identified by physicians, many will likely reduce burden on other clinicians, too. They also demonstrate how the Burdens Solution Tool can be applied in a real-world setting to support quality care.

1. Eliminate Existing and Prevent New Demands that Do Not Support Quality Care

Doctors of BC believes that unless a demand actively supports the provision of quality patient care, it should not be implemented or remain in place. The Burdens Solutions Tool will support stakeholders/decision-makers to review and assess proposed and existing demands on physicians, but limiting who can create and generate demands will also be important.

Through our member engagements, doctors identified a number of groups that generated a large volume of administrative tasks, including: insurance companies, employers, schools, private businesses; and other third parties who are not directly involved in the delivery of health care or social services. These tasks included completion of insurance paperwork, return to work/play requests, and sick notes. Members noted these among the most burdensome of demands as they lead to duplication of work, seek information that is not clinically relevant or is outside physician expertise, and are often uncompensated. With no regulations guiding who can place demands on physicians, the scope and content of these types of requests varies significantly. Their number continues to increase, with no regard as to the impact those requests have on access to–and quality of–care.

Across Canada, there have been a range of advocacy efforts in this area. The Canadian Medical Association (CMA) states that third parties requesting forms from physicians should only require them when there is a clear need for medical information about a patient. Third parties should also engage physicians in form development and design to ensure that they are necessary, do not disrupt workflow, and physicians are compensated appropriately.[iv]

Similarly, Doctors of BC, other provincial and territorial medical associations, and the CMA have been advocating since 2014 to end the use of sick notes in human resource practices.[v] Nova Scotia

agreed to temporarily prohibit employers from asking for sick notes for short-term illness at the onset of the COVID-19 pandemic.[vi] This was well-received by physicians and is currently undergoing further evaluation to determine if it will become a permanent change.

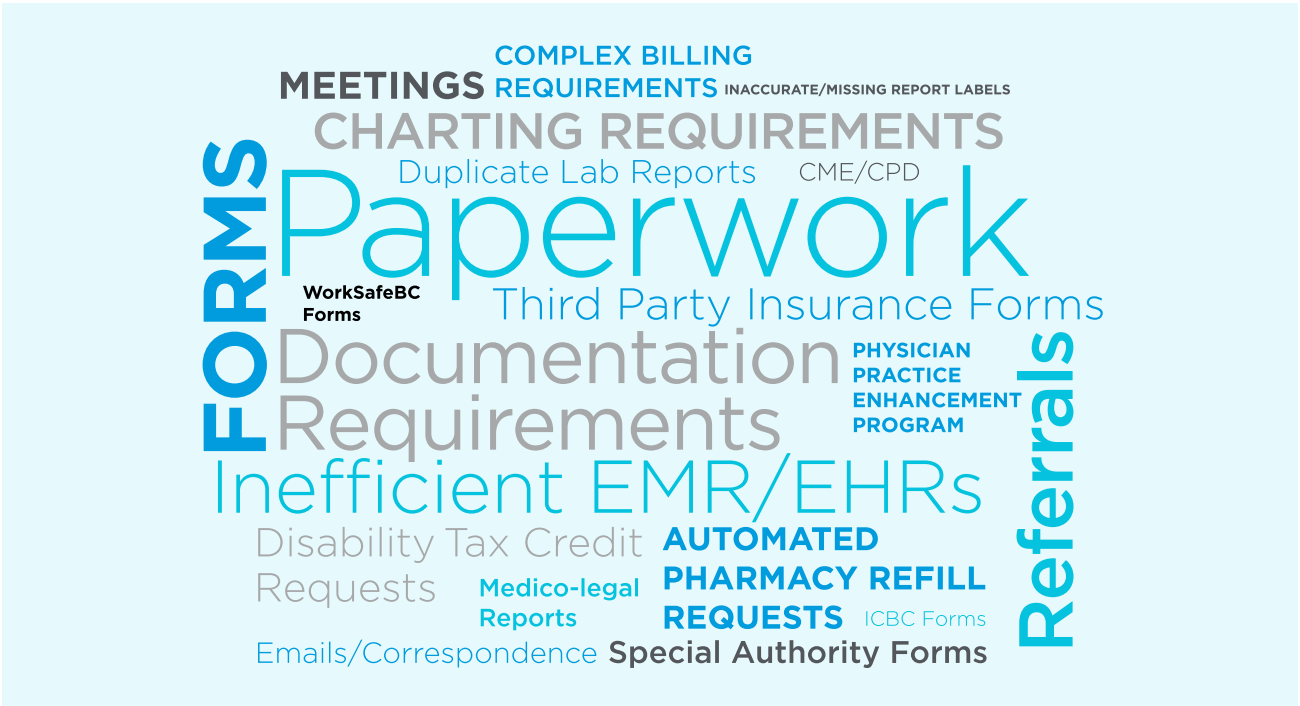
In BC, the Provincial Health Officer, Dr Bonnie Henry, and the Minister of Health, Adrian Dix, communicated to the public that employers should not ask employees for sick notes for short term illness to reduce strain on health care clinicians during the COVID-19 pandemic. Unlike Nova Scotia, this communication was not supported by any enforcing policy or legislation, allowing some employers to continue requiring sick notes. Anecdotally, physicians in BC report that many employers continue to ask for sick notes, particularly for people returning to their workplaces.

In order to limit the ability of third parties to unilaterally impose administrative burdens on physicians:

Doctors of BC recommends the development of an accountability structure, approval requirement, or legislated limitations on the ability of third parties who are not involved in the delivery of health care or social services to unilaterally impose administrative burdens (such as assessment, signature, or form completion requirements) on physicians, without seeking their input regarding their medical necessity.

2. Simplify Demands to Support More Efficient Delivery of Health Care Services

When a demand has been shown to support quality patient care, Doctors of BC believes that stakeholders/decision-makers should consider how to simplify and streamline the task for efficiency (e.g., ensuring only clinically relevant information is required, removing unnecessary steps from a process, facilitating a more seamless flow of information, etc.). Through our member engagements, BC doctors have identified administrative tasks and technology as the two areas in greatest need of simplification and increased efficiency.



The most commonly discussed administrative burdens that were highlighted by doctors in the first round of engagement with Doctor of BC members on physician burdens in 2019.

Administrative Tasks

While physicians recognize that administrative work is a necessary part of medical practice, they report that the increase in the overall volume of administrative tasks is unsustainable, reducing their face time with patients, and significantly encroaching on their personal time. The most recent CMA Physician Health Survey found that respondents spent an average of 10.0 hours a week on administrative work.[vii]

BC doctors report paperwork (primarily forms) and charting as the most burdensome demands, with more than 80% of participating BC physicians feeling more burdened by it than they did five to ten years ago. Administrative work associated with regulatory compliance (e.g., privileging and credentialing requirements), meetings, and the volume of correspondence required by complex referral systems were also noted as significant and rapidly increasing administrative demands.

Some physicians refer to the extra time they spend completing administrative tasks outside of clinic hours as 'pajama time'. After dinner or putting the kids to bed, physicians will sit down to complete their administrative work for the day, which can amount to several additional hours of work. In our engagements with doctors, many stated that they are committed to supporting their patients, but often feel that it comes at the expense of their personal time, and that it impacts their families and friendships.

> ***From a personal perspective, it's very difficult to balance family (spouse and young children) and my own needs with work in medicine. It's impossible to get work done within regular working hours so I'm forced to choose between sub-optimal performance, or limiting time with family or doing things for myself, which is a big source of stress.***
>
> — Physician participant in the Phase 1 engagement

These findings are not unique to BC, with national and international literature indicating that increasing administrative burden is one of the most significant factors contributing to low job satisfaction and burnout.[viii, ix, x]

While there have been some successful efforts to reduce burden associated with administrative tasks in BC (see the below text box describing Doctors of BC's work with ICBC and WorkSafeBC on administrative tasks), a coordinated effort to simplify administrative tasks that support quality care is needed to increase the efficiency of health care delivery. This would include reviewing existing administrative tasks asked of clinicians using the Burdens Solutions Tool, and the ongoing application of the tool to any new or proposed changes to administrative tasks.

Reducing ICBC-Related Administrative Challenges

To help physicians reduce the administrative burden of navigating the system while providing care to patients with injuries covered by ICBC, Doctors of BC worked closely with ICBC on new enhanced care coverage regulations. ICBC acknowledges the importance of reducing administrative hurdles in the system and will be implementing training and service design changes in response to physician feedback.

Improving WorkSafeBC Billing Processes

Surgeons have expressed frustration with the labour-intensive and time-consuming billing process for WorkSafeBC cases. Both they and their MOAs (Medical Office Assistants) have said that searching for information on eligibility, waiting for approvals for expedited surgical premiums, and waiting again for WorkSafeBC follow up is overly time-consuming. In response, Doctors of BC is working with WorkSafeBC to create summary dashboards so physicians can see what they are eligible for, what has been approved, and what has been rejected.

Doctors of BC successfully requested that WorkSafeBC increase the time allowed to bill for expedited surgical premiums from 20 to 40 days. To further ease the challenges faced by physicians when billing WorkSafeBC, Doctors of BC is creating billing tips based on WorkSafeBC's quarterly data reports. These tips will help physicians and MOAs reduce workload, and avoid common billing mistakes.

This type of work is already happening in Canada. In 2019, Doctors Nova Scotia signed a Physician Master Agreement with their provincial government that included the creation of a pilot project "to identify and implement measures to reduce administrative burden on physicians and their patients".[xi] The provincial Office of Regulatory Affairs and Service Effectiveness, in partnership with physicians and other key stakeholders, is conducting a review of administrative burdens. As of 2022, they have seen improvements such as working with the Department of Community Services to improve income assistance forms.[xii]

Beyond an external review of administrative tasks, Doctors of BC also recognizes the impact of our own administrative requests of our members. Internally, staff have begun work to identify potential opportunities to simplify the administrative requests we make of our physician members, such as processes related to honoraria and sessional payments. Using technology and guided by a value-irritant matrix, we aim to eliminate administrative burdens that are unnecessary, while simplifying and automating necessary administrative processes.[xiii] This will allow us to focus on engaging our members on important topics, while reducing the volume of requests from Doctors of BC.

Technology

With the rise of electronic medical record keeping systems, technology is closely intertwined with administrative work, and leads to many of the same challenges for physicians.

Though electronic record keeping systems were once promised to improve efficiency, most physicians report significant increases in their administrative workload as a direct result of their system. This explosion of administrative work is the result of automated processes that lead to frustrations. These include mandatory fields generating unmanageable volumes of data; multiple copies of laboratory reports; changing norms around documentation (sometimes referred to as 'note bloat'); requirements to copy and paste the same information into different systems (sometimes referred to as 'swivel chair'); and inappropriate or inaccurate descriptive labels on reports from facilities. Participants in our member engagements reported spending increasing time on data entry and data review and, consequently, less time on direct patient interaction. These tasks also cause significant disruptions to their personal lives. In the most recent CMA Physician Health Survey, 49% of respondents said they spent a moderately high or excessive amount of time on their EMR at home.[xiv]

Similar to physician feedback on other administrative tasks, both the data from our member engagements and international literature suggest that electronic record keeping systems are significant contributors to physician burnout, as doctors spend an increasing amount of time on technology-related administrative tasks during clinic hours, and in their personal time. Accordingly, any administrative work generated by an electronic record keeping system should be evaluated as all other administrative burdens, using the Burdens Solutions Tool. For example, one solution that would help simplify technology related burdens is to ensure physicians are able to access all programs and information necessary to providing care from within their EMR, rather than having to log into multiple different programs.

There are also opportunities to increase the efficiency of these systems to improve quality of care for specific patient populations, and better align with patient-centred care and physician workflow.

Whether they practice in a facility or the community, physicians report that the most significant technology-related challenge is lack of interoperability between the various electronic record keeping systems in BC. The governance of BC's digital health ecosystem is currently limited. The standards vendors must comply with are minimal, and there is no enforcement of these standards. This has myriad impacts, including many vendors with varying system capabilities. As of 2022 in BC, there are nine different electronic medical record (EMR) vendors providing 30 different products and services to community-based physicians, five different electronic health record (EHR) systems operating across the regional health authorities, and potentially hundreds of acute care systems (e.g., laboratory and diagnostic information systems).

Because each system operates and records information differently, there is limited ability for clinicians to effectively share patient information between different parts of the health care system. Under the current structure, the health system must rely on vendors to create unique solutions to IT challenges, which often results in increased costs and workload. As a result of this complexity, physicians must find alternative–often technologically regressive–ways to share important clinical information. Slowing down the flow of clinical information can impact patient safety, delay care due to missing information, and lead to duplicate testing.

Further development of the governance of BC's digital health ecosystem is required to increase interoperability between different electronic record keeping systems. Clinician input on strategic direction and guidance, accountability mechanisms, prioritization of projects, and compliance standards for vendors will be critical to the development of this governance structure. The governance structure should consider how changes to BC's digital health ecosystem will be implemented, and ensure adequate change management strategies are put in place to support physicians through any necessary amendments. Its establishment will support progress on information-sharing and flow between clinicians at the point of care, efficient provision of care, and patient safety.

To provide opportunities for physicians, both in the community and facilities, optimize the efficiency of electronic record keeping systems and support increased interoperability:

> **Doctors of BC recommends that physicians be meaningfully engaged in the development of governance of BC's digital health ecosystem; and the ongoing development of standards, planning, design, implementation, evaluation, and training associated with electronic record keeping systems.**

3. Collaboration with Patients and Clinicians to Support Longitudinal Team-Based Care

All health care systems, including BC's, are increasingly more complex. Advances in clinical understanding of diseases, diagnostics, and treatments as well as social determinants of health play a role in this as do many other contributors. While clinical complexity itself offers professional satisfaction (e.g., helping patients manage complex conditions, the potential to improve individual and population health), a corresponding increase in demands on physicians, many of which may be outside their expertise (e.g., completing forms for social housing), poses challenges. Doctors of BC recognizes that simplifying some demands may not be possible, and believes the best way to address them, while supporting quality patient care, lies in cross-team collaboration.

Fortunately, health system growth provides opportunities for increased collaboration and sharing of expertise. Doctors of BC's policy paper Working Together: An Exploration of Professional Relationships in Medicine explores the importance of medical professionalism in supporting the crucial relationships required in an effective health care system. The following section of this paper builds on the principles of medical professionalism to highlight how better collaboration with patients, clinicians, and administrative staff can support more effective delivery of health care services.

Improving the Physician-Patient Relationship

In 2019, 82% of participants in our member engagement said that patient expectations have increased in the past five to ten years. Identified contributors to this increase were the perception that physicians should be available at all times, misleading or inaccurate online health information, the consumerization of medicine, and a lack of understanding of the health care system. As a result, many physicians feel like they are losing valuable face time with patients to manage misinformation, and that there is an overall decline in trust between patients and doctors.

The COVID-19 pandemic further contributed to the widening gap between patient expectations and physicians' ability to provide care. In our 2021 engagement, patient expectations was the area where participants felt the most significant change over the course of the pandemic. This was largely due to patient perceptions regarding the availability and appropriateness of virtual care services, increased circulation of misinformation, and strained personal and professional relationships.

There is an increasing need to recognize that patient education is a critical role physicians and other clinicians play in supporting patients. Physician workflows and compensation structures should support their ability to take the time to educate patients. Research from Australia suggests that patients are more likely to report having unmet expectations or file a complaint against a physician with whom they do not have a trusting relationship.[xv] Conversely, when a patient has a longitudinal relationship with a clinician, they are more likely to show a high level of trust, and see improved health outcomes.[xvi] Physicians are best able to develop stronger, long-term relationships with patients through longitudinal primary and specialty care.

To support stronger relationship between patients and physicians:

> **Doctors of BC commits to continuing to work with the Ministry of Health, primarily through the Joint Collaborative Committees, on identifying opportunities to further support the provision of longitudinal primary and specialty care.**

Supporting High-Functioning Health Care Teams

While a poorly functioning team may contribute to a sense of burden, evidence suggests that high-performing health care teams reduce demands and improve the well-being of all team members.[xvii] The qualities of a high-performing team include: shared goals, clear role definition, psychological safety, effective communication, and measurable outcomes.[xviii] These qualities, particularly clear role definition, reduce burdens by harnessing the training and expertise of all team members to allow for the most appropriate and efficient division of tasks.

In turn, this supports longitudinal, patient-centred care. For physicians, this allows them to focus on direct patient care to the full depth of their scope of practice.

While the changing scopes of practice of health care clinicians across Canada often refer to expansion of *breadth* of scope, Doctors of BC encourages supporting all members of the health care team to work to their full *depth* of their scope. The former can contribute to duplication of care and reduced clarity of role definition, while the latter supports coordinated quality team-based care. In cases where there is sufficient evidence of training and demonstrated expertise, Doctors of BC supports changes to health professionals' scopes of practice, provided the proposed changes are ethical, appropriate, consistent with the best scientific evidence, and protect quality of care and patient safety.

If implemented in a collaborative manner, team-based care can improve the quality of health care services, by connecting patients to the care they need quickly and efficiently. High-functioning teams require resourcing to all for team-building and development in key areas such as interprofessional communication, shared decision-making, and understanding the scope of practice of their team members.

To support high-performing teams within the context of team-based care:

> **Doctors of BC supports efforts to expand team-based care with the intention of contributing to high-performing teams whose members are empowered to work to the full depth of their scope of practice.**

Example: Applying the Cumulative-impact Lens to Social Assistance Forms

Burden: Physicians recognize that social assistance supports are often the most effective intervention to support an individual's health; however, completing social assistance forms feels burdensome because they require considerable detail beyond physician expertise, and require considerable time to complete.

Applying the Burdens Solution Tool:

- ☒ Eliminate – Social assistance forms support quality care so they should not be eliminated.
- ☒ Simplify – There may be some limited opportunities to simplify these types of forms, depending on the type of information they require.
- ☑ Collaborate – It is within the scope of practice for a social worker to support patients in accessing social services that support their needs.

Solution: A high-functioning health care team should work together to develop a pathway for the social worker to interact directly with patients who may require social assistance supports. This will allow the social worker to more appropriately conduct a full assessment to better understand the patient's needs, and allow the physician to focus on providing medical care, when and if it is required. Clarifying the role of each team member, and creating clear processes to ensure team members can fulfil these roles reduces burdens and improves the overall quality of care the patient receives.

The introduction of physician assistants (PAs) could further strengthen health care teams. In addition to supporting existing health care clinicians to integrate into high-performing teams, PAs can work in any clinical setting to extend physician services and perform any clinical duties delegated by physicians. In our 2013 policy statement on *Physicians Assistants*, Doctors of BC indicated our support for the establishment and deployment of PAs in BC as a regulated profession.[xix]

Well-trained non-clinical or administrative support staff are another critical component of high-functioning teams. Challenges retaining administrative staff and/or difficulty finding those with appropriate training were highlighted in our member engagements, and worsened significantly during the COVID-19 pandemic. Conversely, physicians who work with administrative staff with higher-level training report increased productivity and fewer retention challenges. Doctors of BC believes there are potential opportunities to provide administrative staff with training to bolster their professional skill-set, and improve their productivity in physicians' practices.

Having medical scribes support physicians and other clinicians, including nurses, with administrative work is one option (a popular one among our engagement participants). With scribes entering information into medical records during patient consultations, physicians can focus on delivering patient care, and reduce the volume of administrative work. The medical scribe role is well established in the US, particularly among specialists, where studies show they can increase productivity and physician satisfaction.[xx, xxi] To date, the use of medical scribes in Canada has been limited. However, one study conducted in an Ontario emergency department showed an increase in the number of patients seen per hour,[xxii] suggesting that medical scribes would likely be an effective addition to Canadian health care teams.

To support high-functioning teams with administrative tasks that are essential to the delivery of high-quality care:

> **Doctors of BC recommends that the Ministry of Health, Ministry of Advanced Education, Skills & Training, and Health Authorities consider options to support the training and expansion of clinical and administrative support staff in all health care settings.**

4. Provide Additional Resources to Support Increased Efficiency

If a demand cannot be eliminated, simplified, or managed through collaboration, the last option to consider is providing additional resources that would enable a clinician to adequately complete the demand, without detracting from their other responsibilities or encroaching on their personal time. While the primary intention of this paper is to increase efficiency of delivery of health care services, it is necessary to consider how the current allocation of resources may contribute to a sense of burden for clinicians.

The types of resources needed to support clinicians will vary by the degree of work associated with the demand, practice setting, how they are compensated, and other factors. For physicians, their compensation model is the most significant factor that could improve their ability to provide health care services more efficiently. Compensation and related financial pressures are a priority area of concern for physicians (ranked second by member engagement participants, in terms of specific burdens to address).

Feedback from our member engagements cites various challenges connected to compensation models having not kept pace with changes in the delivery and management of care. These include clinical complexity, growing patient populations, a perceived decline in business autonomy, and complexity of the health care system. This has resulted in significant financial pressures, including increasing costs due to new regulatory requirements, other spiralling costs (i.e., overhead, insurance, professional dues, continuing medical education, etc.), unpaid administrative work, and more.

Many physicians feel their ability to deliver quality care is limited by the rigidity of current compensation models. Challenges include increases in the amount of work associated with each patient visit, with no corresponding increase in compensation. Many physicians are spending increasing non-clinic hours managing electronic records, completing forms, charting, managing correspondence, and other indirect patient care tasks; thus impacting work-life balance, job satisfaction and access to/quality of care. Others feel unable to spend adequate time with individual patients, particularly those with clinically complex needs, due to the structure of their compensation model. Finally, some physicians feel that existing compensation models do not provide sufficient business autonomy or freedom to deliver care in the most efficient manner possible.

Currently, Doctors of BC and the Ministry of Health are working together to explore new compensation models to help address financial pressures. This includes considering the feasibility of expanding different payment models and new incentives through the General Practice Services Committee (GPSC). The goal is to support delivery of high-quality care while maintaining appropriate compensation and supporting physician job satisfaction.

As individual medical practices vary significantly based on clinician preferences, location, patient population, and many other factors, there is no

Business Cost Premium
The 2019 Physician Master Agreement established a new Business Cost Premium on fees for Consultation, Visit, Counselling and Complete Examination services to help cover the rising rent, lease, or ownership costs of a community-based office.

Community Longitudinal Family Physician Payment
In 2019, the GPSC announced introduction of the Community Longitudinal Family Physician (CLFP) Payment. This payment acknowledges the foundational importance of longitudinal care, and recognizes the additional non-clinical responsibilities required to provide ongoing, coordinated care for which fee-for-service physicians are not compensated.

single best compensation model to reduce physician burden and burnout. All compensation models are likely to have some benefits and some drawbacks; therefore, it is important to strike the correct balance of incentives to optimize both patient and physician satisfaction.[xxiii]

Doctors of BC believes that all physicians should have the ability to choose the compensation structure they feel best supports their practice. We also recommend that physicians be supported to transition to new compensation models, or to optimize existing ones that best support their clinical work. Currently, some physicians recognize the potential benefits of alternative payment models in alleviating the burdens they experience, but do not have access to these models under current funding arrangements. The intention of ongoing work between Doctors of BC and the Ministry of Health is to support physicians who want to move to a different payment model that would better support their ability to provide quality care.

Doctors of BC also believes that it is crucial to ensure all compensation models provide physicians with an appropriate degree of business autonomy. Business autonomy refers to the amount of control a physician has over the business management aspects of their practice, including decisions related to finances, staffing, workload management, scheduling, and internal communications. While individual physicians desire varying levels of business autonomy, there is consensus that doctors should be empowered to participate in this type of decision-making as it contributes to more efficient delivery of care, regardless of their compensation model.

To ensure compensation models support quality patient care, do not limit physicians' ability to address challenges, and maintain fair compensation for changing expectations in an evolving health care environment:

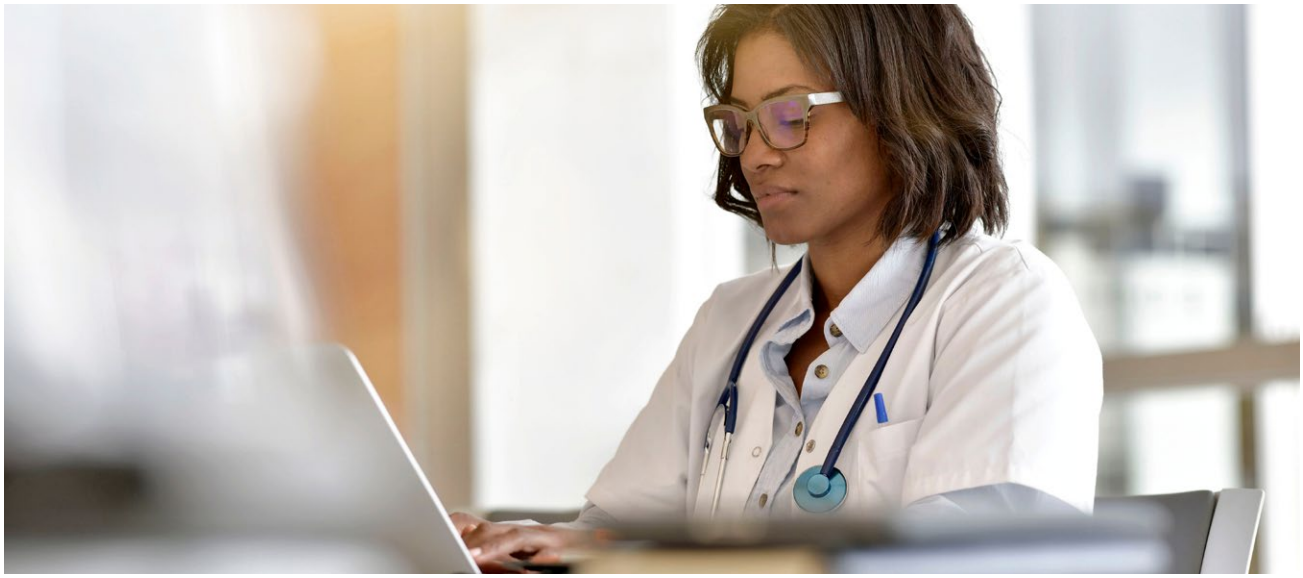
> **Doctors of BC commits to continuing to work with the Ministry of Health and other key stakeholders to establish new and improve existing compensation models, to help physicians manage demands and ensure they are compensated for additional demands.**

5. Timing & Communication

Once the most appropriate solution(s) have been identified, consideration must be given to the timing of how and when the new or changing demand will be implemented and communicated to clinicians. Using the cumulative impact lens, if too many changes occur at the same time, they become overwhelming and detract from quality of, and access to, care. As such, stakeholders/decision-makers should carefully consider when to implement new or changing demands, so they do not coincide with other changes in the health care system. This requires a broader awareness and coordination across the system to avoid multiple changes happening at the same time. It also may require a longer time horizon for implementation. It is also necessary to communicate all new and changing demands in a clear and simple manner that effectively explains why the change is necessary, and how clinicians will be supported to implement it through change management strategies.

The timing and communication of changes regarding practice requirements is an emerging concern for physicians. As licensed professionals, physicians recognize that practice requirements (e.g., regulatory requirements, policy and legislation) are necessary to ensure patient safety and uphold a standard of care. They expect a degree of change and updates over time. However, feedback from our member engagements indicate that the perceived volume and speed at which practice requirements are created or amended, and the manner, tone, and timing in which the changes are communicated, has led to physicians feeling overwhelmed. While policy and practice-related changes come from various sources, the College of Physicians and Surgeons of BC (CPSBC) was referenced most often during our engagements.

In absolute numbers, there has been a modest increase in the number of practice requirements physicians are expected to comply with. In 2018/19, the CPSBC created or revised a total of 6 practice standards and professional guidelines, 11 in 2019/2020, and 8 in 2020/21.[xxiv, xxv, xxvi] While many of these are revised rather than entirely new standards or guidelines, the physicians reported that pace of change, particularly while trying to manage



the challenge of adapting their practice to the COVID-19 pandemic in 2020, felt overwhelming and unmanageable.

Since 2017, the CPSBC has shifted to consulting with its registrants on *all* proposed revisions, new practice standards, and professional guidelines. As a result of this commitment, there has been a significant increase in the number of communications from the CPSBC to physicians. In addition, the CPSBC is responsible for communicating policy and legislative changes from both the provincial and federal governments that may impact physician practice. While the intention is to ensure physicians have full and timely access to changes that may affect their practice, both the consultation efforts and communication-relaying function contribute to a perceived increase in volume of new or amended regulatory requirements. Fear associated with these changes may be further exacerbated by anecdotes from other jurisdictions, where disciplinary action or malpractice litigation against physicians are more common than in BC.

In order to close the gap between the perceived and actual changes to regulatory requirements, communication to registrants must be clear and transparent. Along with this, timing these changes to ensure they do not coincide with other significant health system changes is necessary. This will ensure that physicians have adequate capacity to fully understand and implement them, without unintended consequences for access to or quality of patient care.

The CPSBC has undertaken work to improve the clarity and accessibility of existing practice standards and professional guidelines, by simplifying the language and consolidating documents where possible. They are working to make documents more accessible to physicians when they need them most, through simple technology updates such as searchable PDFs. The CPSBC has also recently undertaken efforts to provide more educational resources and supports to physicians. These include developing resources related to specific standards; hiring professional coaches who are free to registrants to support them in navigating a medical practice; application of standards and guidelines; and other opportunities to reduce regulatory related burdens. These efforts should be continued and expanded where possible.

To reduce physicians' sense of fear and being overwhelmed attributed to new and updated regulatory requirements that are increasing in volume and pace:

> **Doctors of BC commits to working with the CPSBC and other key stakeholders to boost clarity and transparency in their communications, and support those stakeholders to measure the impact of refined communication efforts to identify opportunities for further improvement.**

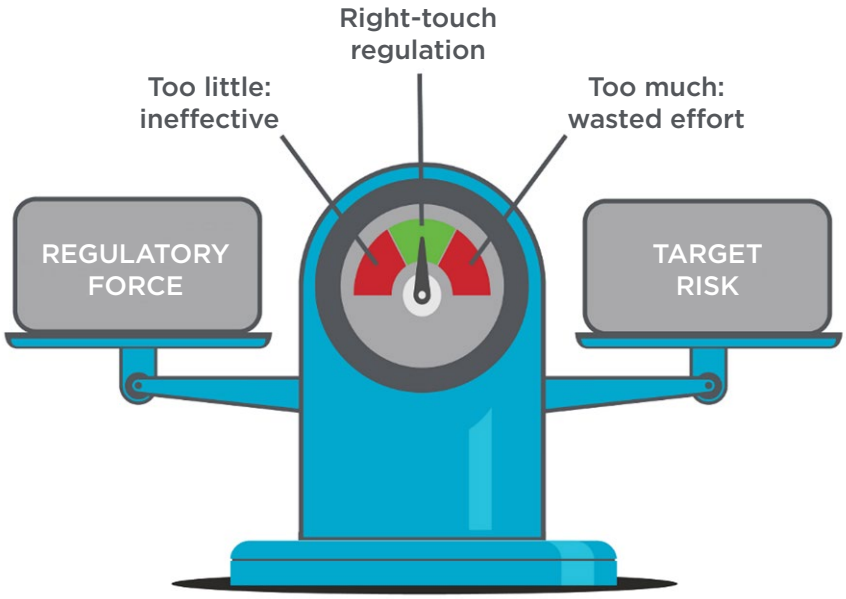
Another issue highlighted by members is that BC physicians feel that some practice requirements—specifically regulatory requirements–go beyond what is necessary to protect the public and contribute to: unnecessary administrative burden, inefficient use of physician time, and financial costs that exceed what current compensation structures can fund. According to the feedback, the impact of the regulatory requirement on physicians is not, in their view, matched to the degree of risk of potential public harm, or the underlying public-safety motivation. Consequently, some physicians fear they will be unable to comply with regulatory requirements, jeopardizing their ability to continue practicing in an efficient and patient-centred manner.

According to the CPSBC's strategic plan, *right-touch* regulation is one of the regulatory philosophies they use to guide their work.[xxvii] Right-touch regulation is a regulatory approach developed by the Professional Standards Authority in the United Kingdom that strives to ensure the level of regulation is proportional to the level of risk, and that the most up-to-date evidence is transparently applied to new regulations.[xxviii]

All new and amended practice requirements should demonstrate how the regulatory action matches the potential level of risk to the public. This information must be communicated to physicians in a clear and consistent manner that demonstrates how the regulatory action is proportionate to the potential risk to patient safety, along with a transparent analysis of the evidence used to support the regulatory change. Communications should indicate how practice requirements will be reviewed and respond to change over time, and how potential unintended consequences will be identified and addressed.

With an eye to upholding the principles of right-touch regulation, and ensuring clarity for physicians around how the new or revised requirement appropriately balances the level of risk to the public and the level of regulation imposed or advised: Doctors of BC recommends that the CPSBC continue to commit to apply and communicate how the principles of right-touch regulation are being applied in the development of each proposed standard, guideline, policy (or revision thereof).

THE RIGHT-TOUCH REGULATION FRAMEWORK



This image was adapted from the Right-touch Regulation framework developed by the Professional Standards Authority in the United Kingdom, www.professionalstandards.org.uk***.***

CONCLUSION

We are asking too much of health care clinicians without providing them the necessary support and resources to do their jobs well.

Some physicians say they no longer find joy in practising medicine while others say medicine is no longer a sustainable career. To support continued provision of and access to high-quality patient care, an immediate, sustained, and coordinated approach by Doctors of BC, other clinician associations, the Ministry of Health, health authorities, and regulatory bodies is needed. A review of new and existing demands lead to implementation appropriate solutions, reducing the cumulative impacts they are having on patients, clinicians, and the health care system.

APPENDIX A

Physician Burdens policy statement

POLICY STATEMENT

doctors of bc

Physician Burdens

Last updated: October 2020

Doctors of BC Position

Doctors embrace the inherently demanding nature of medicine. However, when the volume of demands becomes so great or the demands are perceived to be duplicative, unnecessary, or not clearly evidence-based, their accumulation becomes burdensome, resulting in negative impacts on quality and access to patient care, physician health and wellness, and health system sustainability. Doctors of BC calls on BC's health system stakeholders to explicitly consider the cumulative impact of new and existing demands on physicians to ensure they don't detract from physicians' ability to continue to deliver quality patient care.

Doctors of BC commits to:

- Using a cumulative impact lens to assess the necessity and impact on access to quality patient care of existing and proposed demands on physicians.
- Revising the mandate of all internal Doctors of BC committees and directives of Doctors of BC representatives sitting on external and joint collaborative committees to embed this lens in their work.

Doctors of BC recommends:

- That key healthcare stakeholders that create or revise demands on physicians, including Health Authorities, provincial and federal government ministries and the College of Physicians and Surgeons of BC, use a cumulative-impact lens to assess the necessity and impact on access to quality patient care of existing and proposed demands on physicians.

Background

In an increasingly complex health care system, physicians are faced with a growing number of demands that lead to unmanageable time constraints and expectations to deliver beyond what can reasonably be expected within a single day. There is no single, identifiable demand leading to this problem. In fact, physicians acknowledge that any particular demand, in isolation, would be manageable. Rather, it is the accumulation and compound effect of multiple, often seemingly minor, demands that are having an adverse effect.

To understand how and why demands on physicians are becoming overwhelming, an analogy can be drawn from the environmental sciences and their consideration of *cumulative impact*. Cumulative impact is a term used to describe "a change in the environment caused by multiple interactions among human activity and natural processes that accumulate across space and time."[1] For example, many factors have a negative impact on fish populations including: commercial fishing, tourism, coastal development, rising water temperatures, ocean acidification, and other factors. As none of these occur in isolation, it is impossible to determine the individual impact of each. It is the complex interactions between these factors that leads to a greater impact than any individual factor would have on its own, thus jeopardizing the sustainability of fish populations.[2]

Requiring a physician to complete an additional form or step in a regulatory process likely makes sense when considered in isolation. Applying the cumulative-impacts lens to a physician's work day assists in understanding that, alongside numerous other competing and increasing requirements, this single new task may be the straw that breaks the proverbial camel's back.

This lens can also help to demonstrate how and when demands accumulate to the point where they contribute to low job satisfaction and burnout. The sheer volume of work being asked of physicians and their offices, whether clinical or administrative, is the most significant demand they face and is quickly

Economics and Policy Analysis Department
doctorsofbc.ca/health-policy

T 604 638 2825
TF 1 800 665 2262 x2825

115 - 1665 West Broadway
Vancouver, BC V6J 5A4

becoming unsustainable. Spending hours of 'pajama time' completing work (often administrative) at home on evenings or weekends makes work-life balance impossible for many. For others, completing work during clinical hours often requires they limit time spent on direct patient care.

In addition to excessive workloads, demands become burdens when much of the work physicians are trying to complete makes inefficient use of their time and expertise, appears to contribute little if anything to quality patient care, is under- or un-paid, or is not transparently grounded in current evidence.

Analysis

For some, the expectation to deliver the highest standard of health care under so many time constraints is unbearable. An online engagement with BC physicians showed decreased job satisfaction (87%), burnout (68%), and a range of other impacts on their mental and physical well-being are the direct result of growing demands.[3]

Beyond the immediate impacts on individual well-being, literature demonstrates that low job satisfaction and physician burnout are associated with decreased patient satisfaction, increased medical errors, higher risk of patient mortality, decreased attention to patients, and decreased overall productivity.[4-10]

Low job satisfaction and physician burnout also pose a significant risk to the availability of health services. Participants in our online engagement reported decreasing the number of hours worked each week (73%) and reducing the number of services they offer (64%) in response to feeling over-burdened.[3]

Further, approximately one third of participants said they had considered or had already retired early, left the medical profession, or moved to another jurisdiction as a means of improving their job satisfaction or reducing burnout, thus posing a risk to the availability of physician health care services in BC. These findings align with literature that estimates that up to $213.1 million worth of health services are no longer available to patients due to physician burnout in Canada.[10]

Potential movement away from general practice and community-based practice is another significant systems-level risk. One theme that arose in the qualitative feedback from our online engagement was a trend of community-based physicians (especially full-service family physicians) leaving their practices to work in hospitals or shifting to locum work, thus reducing access to longitudinal care. Additionally, shifting care from community-based settings to facilities has the potential to increase health care expenditures by having more minor procedures conducted in facilities.

Solutions

As the research and physician feedback indicate, numerous small, discrete, or seemingly isolated demands interact to have a cumulative impact on physicians, patients, and the health care system. Fortunately, research also demonstrates that physicians who spend at least 20% of their time on work that is meaningful to them (such as direct patient interactions, research, or teaching), experience less burnout and higher job satisfaction.[12] For this reason, it is necessary to apply a cumulative impact lens to the consideration of each, seemingly unrelated, new "ask" of physicians.

Application of a cumulative-impact lens would see decision-makers at local, regional, provincial, and national levels carefully considering how any proposed change may ripple through the health care system, potentially impact quality or accessibility of patient care, as well as physician workflow. Further, when and if a change were implemented, decision-makers would consider how best to support physicians to continue providing quality patient care while they meet the new demand.

Using a cumulative-impact lens would also require decision-makers to assess and ask the following of any new demand (or modification in demand) on physicians:

- Is this necessary?
- How does it contribute to quality patient care?
- Is an off-setting reduction in 'ask'/demand required to ensure this can reasonably be accomplished?

These same considerations should apply to review of existing demands and processes.

FOR FURTHER INFORMATION

Please contact Julia Dreyer, Senior Administrative Assistant at policyandplanning@doctorsofbc.ca

POLICY STATEMENT doctors of bc

Further Considerations

In addition to these broad principles, more specific action needs to be taken to:

1. Implement short-term measures to help physicians manage the immediate impacts of burdens and physician burnout,
2. Enable more efficient delivery of health care by identifying specific solutions to reduce burdens related to practice requirements, administrative processes, and technology.
3. Address compensation structures to ensure that where demands are necessary and contribute to quality health care, physicians are compensated appropriately.
4. Better understand and address the emerging burdens associated with increased use of virtual care and working from home, particularly for parents and caregivers.

Doctors of BC is actively working to develop specific policy commitments and recommendations in these areas in a forthcoming policy paper that will expand on the research and concepts presented in this policy statement.

References

[1] Canadian Council of Ministers of the Environment. Canada-wide Definitions and Principles for Cumulative Effects. [August 28, 2020]. Available from: https://www.ccme.ca/files/Resources/enviro_assessment/CE%20Definitions%20and%20Principles%201.0%20EN.pdf

[2] Luders K. How can we assess human impacts on coastal ecosystems? Environmental Institute Blog [August 28, 2020]. Available from: https://blogs.adelaide.edu.au/environment/2018/01/29/human-impact-coastal-ecosystems/

[3] Doctors of BC. Physician Burdens – Phase 1 Engagement, 2019.

[4] Leiter MP, Maslach C. Latent burnout profiles: A new approach to understanding the burnout experience. Burnout Research 2016;3(4):89-100.

[5] Flanagan MD, Kuhn CM. Self-care as a professional imperative: physician burnout, depression, and suicide. Can J Anesth 2017;64(2):154-168.

[6] Dominici G, Girardi P, Innamorati M, et al. Burnout, hopelessness and suicide risk in medical doctors. Clin Ter 2010;161(6):511-514.

[7] Kumar S. Burnout and Doctors: Prevalence, Prevention and Intervention. Healthcare 2016;4(3):37-46.

[8] Card AJ. Physician Burnout: Resilience Training is Only Part of the Solution. Annals of Family Medicine 2018;16(3):267-270.

[9] Dewa CS, Loong D, Bonato S, et al. How does burnout affect physician productivity? A systematic literature review. BMC Health Services Research. 2014;14(325).

[10] Panagioti M, Panagopoulou E, Bower P, et al. Controlled interventions to reduce burnout in physicians: A systematic review and meta-analysis. JAMA Internal Medicine 2017;177(2):195-205.

[11] Dewa CS, Jacobs P, Thanh NX, & Loong D. An estimate of the cost of burnout on early retirement and reduction in clinical hours of practicing physicians in Canada. BMC Health Serv Res. 2014;14(254).

[12] Shanafelt TD, West CP, Sloan JA, et al. Career fit and burnout among academic faculty. Arch Intern Med, 2009;169(10):990-995.

History

October 2020: Approved by Board of Directors

FOR FURTHER INFORMATION

Please contact Julia Dreyer, Senior Administrative Assistant at policyandplanning@doctorsofbc.ca

REFERENCES

i. Canadian Medical Association & Ipsos. National Physician Health Survey. 2022.

ii. Incredible Health. Study: 34% of nurses plan to leave their current role by the end of 2022. https://www.incrediblehealth.com/blog/nursing-report-covid-19-2022/

iii. Canadian Medical Association and Federation of Medical Women of Canada. Addressing Gender Equity and Diversity in Canada's Medical Profession: A Review. 2017.

iv. Canadian Medical Association. CMA Policy: Third Party Forms. 2017. https://policybase.cma.ca/viewer?file=%2Fmedia%2FPolicyPDF%2FPD17-02.pdf

v. Canadian Medical Association. Maintaining Ontario's Leadership on Prohibiting the Use of Sick Notes for Short Medical Leaves: Submission to the Standing Committee on Finance and Economic Affairs. 2018.

vi. Office of Regulatory Affairs and Service Effectiveness. Project Status Report: Reducing Physician Administrative Burden. 2020. https://doctorsns.com/sites/default/files/2020-11/admin-burden-workplan.pdf

vii. Canadian Medical Association & Ipsos. National Physician Health Survey. 2022.

viii. Society of General Practitioners. Paperwork Survey for Family Doctors Research Findings. 2012.

ix. Doctors Nova Scotia. Physician burnout survey. 2017. https://doctorsns.com/news-events/surveys/physician-burnout

x. Kane L. Medscape National Physician Burnout, Depression & Suicide Report 2019. https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056#8

xi. Doctors Nova Scotia. Master Agreement. 2019. https://doctorsns.com/contract-and-support/master-agreement

xii. Office of Regulatory Affairs and Service Effectiveness. Project Status Report: Reducing Physician Administrative Burden. 2020. https://doctorsns.com/sites/default/files/2020-11/admin-burden-workplan.pdf

xiii. Price B & Jaffe D. The Best Service is No Service: How to Liberate your Customers from Customer Service, Keep Them Happy, and Control Costs. 2008. Jossey-Bass.

xiv. Canadian Medical Association & Ipsos. National Physician Health Survey. 2022.

xv. Avant Mutual Group Limited. Managing unrealistic patient expectations. https://www.avant.org.au/uploadedFiles/Content/Resources/Member/Risk-201005-Managing-Unrealistic-Patient-Expectations.pdf

xvi. Olaisen, RH, et al. Assessing the longitudinal impact of physician-patient relationship on functional health. Annals of Family Medicine 2020;18(5):422-429.

xvii. Welp A & Manser T. Integrating teamwork, clinician occupational well-being and patient safety – development of a conceptual framework based on a systematic review. BMC Health Services Research 2016;16:281.

xviii. Smith CD, Balatbat C, Corbridge S et al. Implementing optimal team-based care to reduce clinician burnout 2018. National Academy of Medicine.

xix. Doctors of BC. Physicians Assistants. 2013.

xx. Gidwani R, Nguyen C, Kofoed A, et al. Impact of scribes on physician satisfaction, patient satisfaction, and charting efficiency: A randomized controlled trial. Annals of Family Medicine 2017;15(5):427-433.

xxi. Bank AJ, Gage RM. Annual impact of scribes on physician productivity and revenue in a cardiology clinic. Clinicoecon Outcomes Res 2015;7:489-495.

xxii. Graves PS, Graves SR, Minhas T, et al. Effects of medical scribes on physician productivity in a Canadian emergency department: a pilot study. CMAJ 2018;6(3):E360-E364.

xxiii. Yan C, Kingston-Riechers J, Anderson C. Financial Incentives to Physician Practices: A literature review of evaluations of physician remuneration models. Alberta, Canada. 2009.

xxiv. College of Physicians and Surgeons of British Columbia. Annual Report 2018/2019. https://www.cpsbc.ca/files/pdf/2018-19-Annual-Report.pdf

xxv. College of Physicians and Surgeons of British Columbia. Annual Report 2019/2020. https://www.cpsbc.ca/files/pdf/2019-20-Annual-Report.pdf

xxvi. College of Physicians and Surgeons of British Columbia. Annual Report 2020/21. https://www.cpsbc.ca/files/pdf/2020-21-Annual-Report.pdf

xxvii. College of Physicians and Surgeons of British Columbia. Strategic Plan 2018-2020.

xxviii. Professional Standards Authority. Right-touch regulation. https://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation

115 - 1665 West Broadway
Vancouver BC V6J 5A4
doctorsof**bc**.ca

@doctorsofbc
@bcsdoctors
@doctorsofbc

doctors of bc
Better. Together.