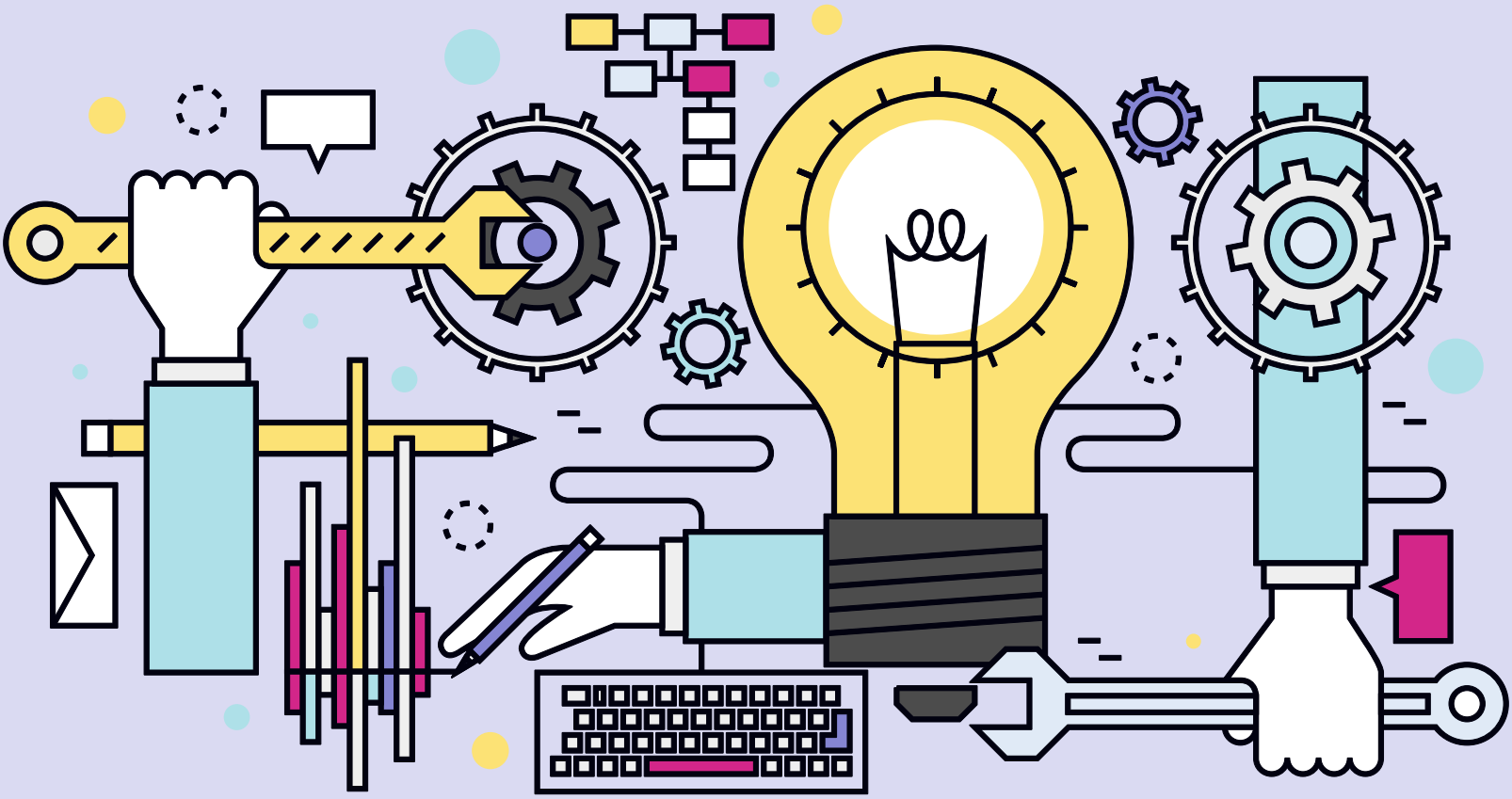


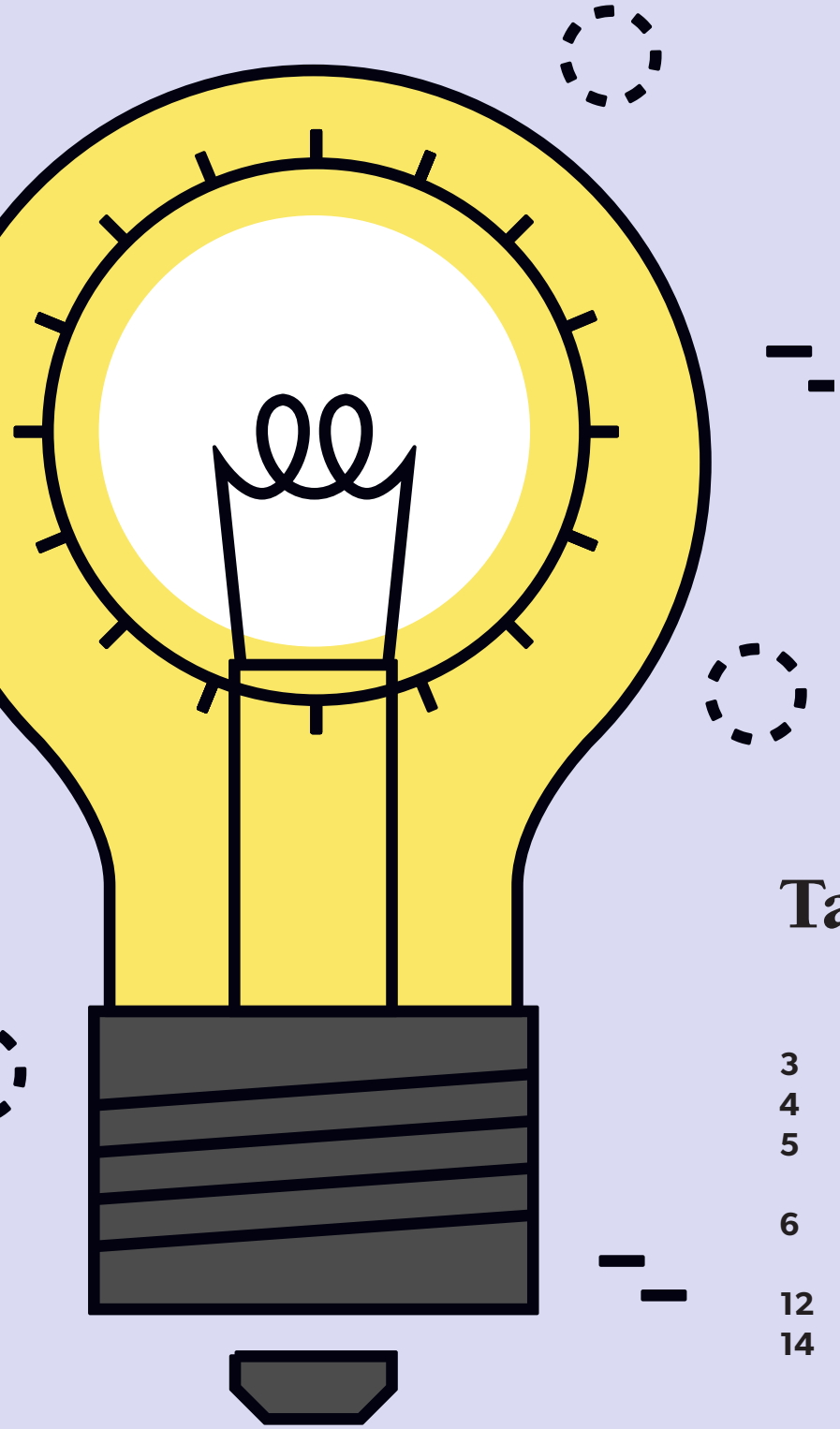
Healing Nova Scotia

Part Two

Supporting the academic physician mandate

Doctors Nova Scotia | July 2018

Doctors Nova Scotia



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Message *from the Board of Directors*

In fall 2017, Doctors Nova Scotia (DNS) published *Healing Nova Scotia: Recommendations for a Thriving Physician Workforce*. This comprehensive report featured feedback gathered from physicians during a provincial tour. Association representatives met with 235 family physicians and rural/regional specialists in communities across Nova Scotia to learn about the challenges they face.

In late 2017 and early 2018, DNS representatives met with academic physicians practising primarily in the Halifax Regional Municipality. Most of these physicians work under clinical/academic funding plan (C/AFP) contracts, while a minority work within the fee-for-service (FFS) model. Association representatives also consulted the C/AFP Department Heads to learn about the issues academic physicians are facing.

On behalf of the DNS Board of Directors, we would like to thank the physicians who contributed their perspectives. This report synthesises their feedback and recommends ways to improve tertiary and quaternary health-care in Nova Scotia.

Nova Scotia's academic physicians share many of the frustrations of their colleagues with FFS, hourly or alternative payment plan (APP) contracts. Academic physicians faced challenges following the amalgamation of the health authorities in 2015. They have also noted the province's issues with recruiting and retaining primary care physicians are having a significant impact on their work, especially when they are faced with patients who don't have family physicians to provide follow-up care, or patients who present later in the course of their disease due to delayed access to care.

A shortage of resources means that C/AFP physicians are increasingly challenged to work to their optimum scope of practice. Ever-increasing workloads mean that physicians must work harder to keep up with their clinical and academic caseloads, with little time left for innovative pursuits. For many academic physicians, the option of practising in other provinces is becoming more appealing. Physician recruitment and retention is not a problem reserved for family physicians and rural/regional specialists.

In the first *Healing Nova Scotia* report DNS made several recommendations for ways the province's health-care stakeholders could strengthen the physician workforce. Some of that work is underway.

While academic physicians share many of the challenges experienced by their colleagues in primary and secondary care, some of their concerns are unique. This report is meant to focus on these unique issues, continuing the conversation between physicians and key health-system leaders, including those within the Department of Health and Wellness, the Nova Scotia Health Authority, the IWK Health Centre and the Faculty of Medicine at Dalhousie University, which began with the publication of *Healing Nova Scotia.*

The work has just begun, and much more needs to be done. We believe it is critical that all stakeholders come together to address the issues that affect physicians. Doctors Nova Scotia is prepared to do its part. We invite our partners to work with us to create a better future for our health-care system, for the sake of all Nova Scotians.

Sincerely,

André Bernard, MD, MSc, FRCPC
Board Chair

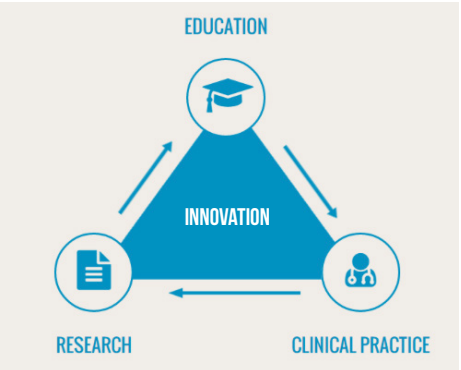
Tim Holland, MD, CCFP(EM)
President

On behalf of Doctors Nova Scotia's Board of Directors

Acknowledgments
We thank academic physicians from the following departments and divisions for their input:
Anesthesia
Critical care
Diagnostic imaging (IWK)
Diagnostic radiology
Emergency medicine
Family medicine
Gynecologic oncology
Medicine
Obstetrics and gynecology
Ophthalmology
Pathology
Pediatrics
Psychiatry
Radiation oncology
Surgery
Urology

Executive *summary*

> It's time to work together to ensure **physicians can provide optimal health care** for Nova Scotians.



WHAT IS AN ACADEMIC PHYSICIAN?
Many of Nova Scotia's physicians are involved in teaching and mentoring the next generation of physicians. For purposes of this report, "clinical/academic physician" and "academic physician" refer to physicians working within one of the Dalhousie Faculty of Medicine academic departments, either on a fee-for-service basis or as part of a clinical/academic funding plan (C/AFP).

Academic physicians play a unique role in health care. In addition to providing specialized clinical care to patients with complex health conditions, they conduct research that drives innovation and clinical practice. They also educate medical students on how to apply best practices in patient care. And they work with health-care leaders to influence decision-making in an effort to improve the health-care system. Academic physicians typically work at academic health science centres (AHSCs). In Nova Scotia, academic physicians are affiliated with Dalhousie University's Faculty of Medicine, and practise at the QEII Health Sciences Centre, the IWK or other hospitals within the Halifax Regional Municipality. A limited number of academic physicians practise outside of Halifax.

This report outlines priority issues identified by academic physicians, with preliminary recommendations on how to address them. Mirroring the findings of Doctors Nova Scotia's (DNS) initial report on the state of health care in Nova Scotia, the issues identified are complex, systemic issues, beyond the association's ability to resolve independently. As the issues affect all health-system stakeholders, it is a prerequisite that our partner stakeholders commit to working together to critically evaluate these issues and collaborate on resolving them.

The priority issues identified by academic physicians in Nova Scotia fall into the following themes:

1. ***Access to primary care***
2. ***Support for the clinical/academic mandate***
3. ***Decision-making and engagement***
4. ***Relationships and professional satisfaction***
5. ***Resources and work environment***
6. ***Retention and recruitment***

Doctors Nova Scotia has identified several recommendations to address these concerns and improve the practice environment for academic physicians and health care for Nova Scotians. They include:

1. ***Improve access to primary care*** *for both patients and physicians.*
2. ***Provide greater support for the clinical/academic mandate*** *by creating an environment conducive to innovation and ensuring enough funding is available to support academic and clinical work.*
3. ***Clarify and streamline decision-making*** *and reinstate meaningful physician engagement in health-system decision-making.*
4. ***Rebuild and reinforce collaborative relationships with health-system stakeholders,*** *and ensure physicians are treated as part of the solution, not part of the problem.*
5. ***Provide the necessary financial, human, infrastructural and technological resources*** *so that physicians have what they need to accomplish their clinical/academic mandate and meet patient needs.*
6. ***Improve academic physicians' professional practice environment*** *by working with health-system stakeholders to make Nova Scotia's AHSCs appealing workplaces.*

Doctors Nova Scotia looks forward to continuing the work it began in the fall of 2017 in collaboration with physicians and other key health-system stakeholders to address these issues and recommendations. It's time to work together to ensure better practice environments exist for all physicians, so they can thrive in their profession and provide optimal health care for Nova Scotians.

Context
Issues in primary and secondary health care

Doctors Nova Scotia (DNS) represents the collective voice of all physicians in Nova Scotia and works on their behalf. Following the implementation of the 2015 C/AFP Agreement and Master Agreement, DNS reached out to its members to learn about the challenges they face on the front lines of health care in Nova Scotia.

Over 18 months, DNS representatives talked to physicians across the province, listening carefully during community meetings and day-to-day discussions with members and carefully reading members' responses to association surveys. These conversations revealed that physicians have very serious concerns about their ability to effectively practise medicine, properly advocate for their patients and maintain a healthy work-life balance in the current health-care environment.

The initial results of that outreach project were published in a report called *Healing Nova Scotia: Recommendations for a thriving physician workforce*, in September 2017. That report focused on the experiences of family medicine and regional specialist physicians across the province, outlining the challenges and frustrations they deal with as they work to provide health care for Nova Scotians. Five themes arose:

1. ***Fragility of the physician workforce***
2. ***Loss of professional autonomy and satisfaction***
3. ***Erosion of comprehensive family medicine***
4. ***Unsustainability of rural specialty services***
5. ***Lost opportunities to leverage technology***

The report also identified a number of recommendations for ways that DNS, physicians and other health-care stakeholders could begin to repair damaged relationships, rebuild trust and improve health care in the province. The chief recommendation was to form a Health System Physician Coordination Council, which would provide all parties the opportunity to work together to act upon the report's recommendations and create the best possible health-care system for all Nova Scotians.

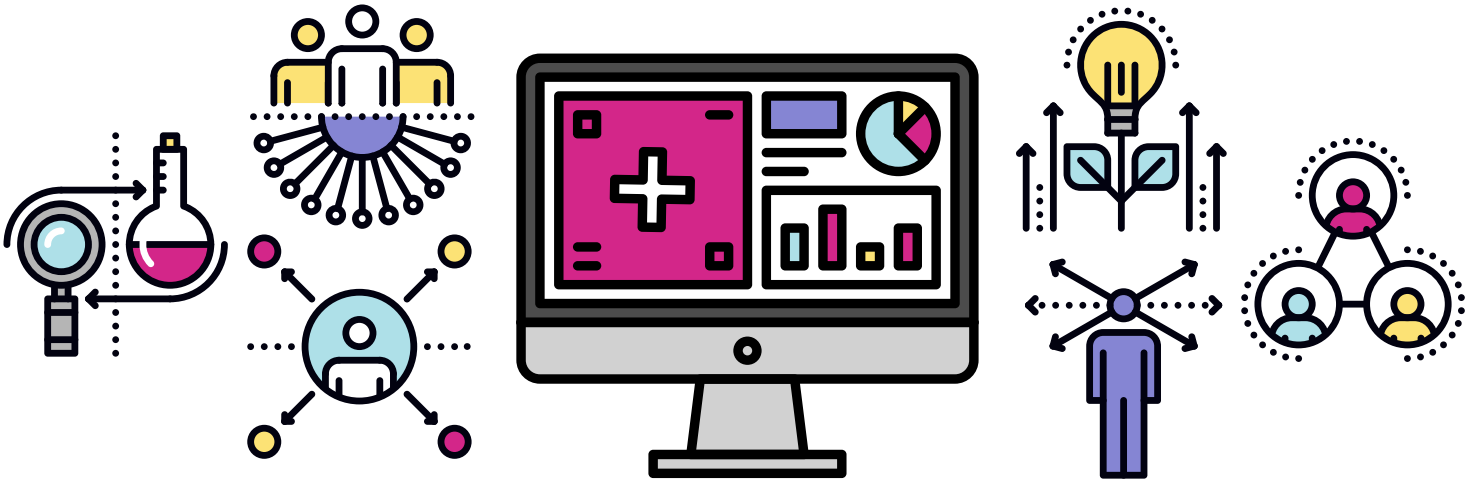
The other recommendations were to:

1. ***Improve and restore local decision-making and engagement of physicians***
2. ***Integrate existing recruitment initiatives to improve recruitment outcomes for physician supply in Nova Scotia***
3. ***Decrease the burden of unsustainable workloads***
4. ***Revive full-scope comprehensive family medicine***
5. ***Maintain rural specialty services***

Healing Nova Scotia was a comprehensive assessment of the state of primary and rural specialty care in Nova Scotia, but it did not include feedback and perspectives from the academic physicians practising primarily in Halifax (and Dartmouth and Cape Breton, to a more limited extent). In fall 2017 and early 2018, in an effort to learn more about the issues affecting academic physicians, DNS representatives attended meetings with the academic physicians representing the 12 C/AFP departments: anesthesia, critical care, diagnostic imaging (IWK), emergency medicine, family medicine, gynecologic oncology, medicine, pathology, pediatrics, psychiatry, radiation oncology and surgery. The DNS representatives also met with the four FFS academic physician departments: urology, ophthalmology, diagnostic radiology and obstetrics gynecology, as well as the Committee of C/AFP Department Heads. Their feedback is summarized in the following pages.

> Mirroring the association's findings on primary and rural specialty care in Nova Scotia, **most of the issues identified here are complex, systemic issues.** Resolving them will require concerted, collaborative efforts from all health-system stakeholders.

Issues *in tertiary and quaternary care, and their impact*



The issues academic physicians identified with the health-care system have been grouped into six themes. The overlap between these themes and the 2017 *Healing Nova Scotia* report demonstrate that physicians in Nova Scotia are facing insufficient resources, burnout, poor engagement and challenging decision-making processes.

1 Access to primary care

Nova Scotians' lack of access to primary care is compromising patient safety and quality of care, and, in some cases, forcing specialists to practise outside their specialty and/or scope of practice.
More info, page 7.

2 Support for the clinical/academic mandate

Insufficient resources and unnecessary obstacles within the practice environment are undermining the clinical/academic mandate.
More info, page 8.

3 Decision-making and engagement

Lack of physician engagement, layers of bureaucracy and cumbersome decision-making processes are resulting in delayed and/or ineffective solutions to health-system issues.
More info, page 9.

4 Relationships and professional satisfaction

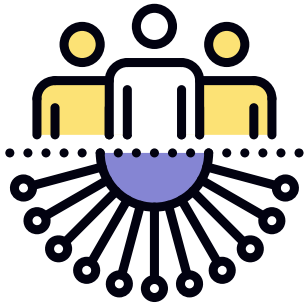
Academic physicians are faced with strained relationships and low morale, which compound recruitment and retention challenges.
More info, page 10.

5 Resources and work environment

Ongoing scarcity of financial, human, infrastructural and technological resources means academic physicians are burning out and at increased risk of being unable to meet patient needs due to delays in access or turnaround time.
More info, page 10.

6 Retention and recruitment

Many academic departments are at significant risk of specialists leaving the province to work in more attractive practice environments. The lack of resources is also contributing to recruitment issues in many C/AFP departments.
More info, page 11.

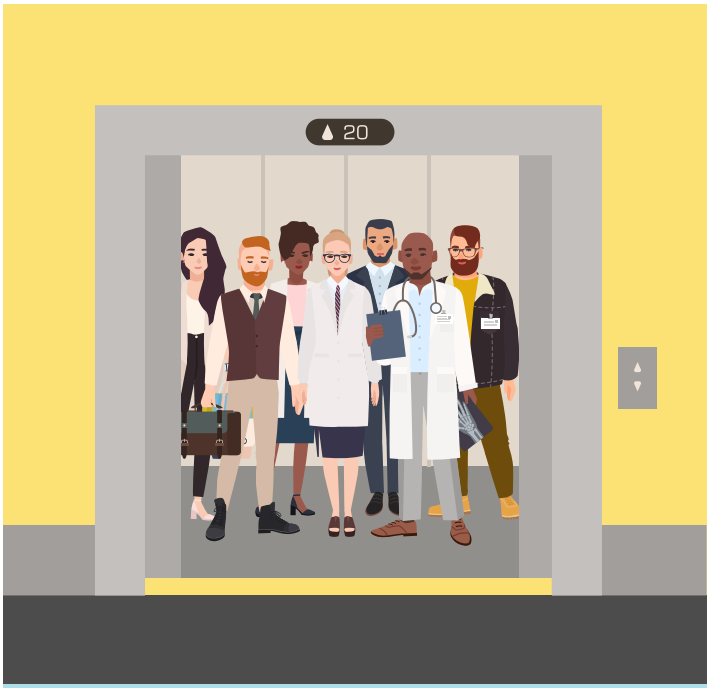


1 Access to primary care

Nova Scotians are lacking access to primary care, and that lack of access is compromising patient safety and quality of care. The ongoing issues in primary care are having a significant impact on the work of academic physicians. Too many Nova Scotians are facing long wait times to see their family physician, or don't have a family doctor at all, so they must seek care at walk-in clinics or their local emergency department. This lack of access to primary care means that by the time a patient is finally referred to a specialist, that patient's health condition is often more acute than it would have been had they been seen earlier by a primary care provider. These patients are often older people dealing with multiple co-morbidities, which can further complicate their health condition and make their treatment more challenging.

The lack of access to primary care also presents problems post-treatment. It is not unusual for patients to face delayed discharge from hospital, or to face uncertainty upon their discharge, because there is no family physician to oversee their primary care following their release. In many cases, specialists feel the need to take on this follow-up care. It is important to note that when academic physicians are providing care that should be provided by a family physician, including assessing post-op conditions and prescribing medications, they are working outside of their specialty scope of practice. This is an inefficient use of their time and expertise, but the real concern is that it creates greater potential for error, putting both the physician and patient at risk. Many academic physicians voiced concerns regarding the potential for increased College complaints and/or potential liability situations by continuing to provide care outside their scope of practice, but say they feel compelled to support patients who are without a primary care physician.

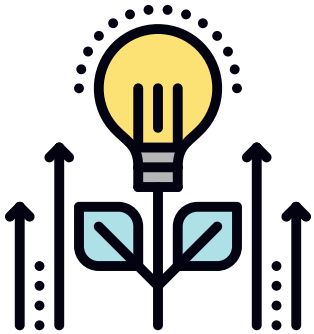
Finally, the lack of access to primary care is also affecting academic physicians in their personal lives. Preliminary polling of academic physicians indicated that about one in five do not have a family physician for themselves or their family. The health and well-being of academic physicians is also at risk due to the lack of access to primary care in Nova Scotia.



THE SAME…BUT DIFFERENT

As you will see in the pages that follow, academic physicians experience many of the same system issues that affect their family physician and rural/regional specialist colleagues, including the tenuous state of primary health care, challenging relationships with the government, the Nova Scotia Health Authority and MSI, and a difficult work environment where professional burnout is endemic.

However, just as academic physicians' work mandate differs from that of their colleagues in primary and secondary care, so do the problems they experience in the health-care system. Academic physicians face added pressures as they struggle to meet ever-increasing demands on their time from patients who require more involved care, students/residents who require additional oversight, and ever-increasing bureaucratic requirements. Meanwhile, departmental funding has flat-lined, making it challenging for physicians to fund their research projects, recruit new colleagues and fulfil their innovation mandate.



2 Support for the clinical/academic mandate

The purpose of academic departments is to support an innovative health-care system in which physicians provide integrated, comprehensive, longitudinal care, inclusive of academic, administrative and research activities. Academic physicians benefit from the opportunity to diversify their careers and experience beyond purely clinical patient service, while the health-care system benefits from the teaching, research and administration services that academic departments deliver.

Academic physicians identified a number of factors that create obstacles to providing innovative, high-quality and efficient services. These factors include inadequate funding, a lack of meaningful accountability metrics, increasing academic requirements without additional resources or support. These factors are negatively impacting academic physicians' ability to fulfill the C/AFP mandate of health-care innovation.

Many AHSCs in Canada offer some form of funding to support recruitment and retention, utilization increases, innovation and succession planning, and incentive funding to support quality and productivity. None of this funding is provided within the current C/AFP contracts' block-funding model, nor is it available to FFS academic physicians. Instead, academic departments must reallocate monies from physicians' own revenues to support the broader innovation agenda. This is challenging in an environment where most academic physicians are among the lowest paid in the country.

The situation is intensified as academic physicians' clinical work is being subjected to increased scrutiny from MSI billing assessments and audits, the purpose and tone of which seems more punitive than educational. The increased oversight, and the tone and manner in which it is conducted, has unintended impacts. Academic physicians have lost flexibility to design better service-delivery models, making it more difficult to collaborate as a multi-specialty team to solve health-system problems. Several academic physicians indicated they are reporting lower-value billing codes to mitigate the risk and perceived harassment of MSI pre-assessments and post audits.

> **All physicians in Nova Scotia, no matter their specialty, location or payment model, are facing issues** with insufficient resources, burnout, insufficient engagement and challenging decision-making processes.

Using shadow billings to measure clinical activities has always been problematic for many of the C/AFP departments, because billing codes for much of the work of academic physicians have been non-existent. The problems are worsening as academic physicians now opt for lower-value billing codes to mitigate audit risk, and contemporary records will no longer align with historical productivity benchmarks. This makes it more difficult to monitor and understand the work of academic physicians as an input to system planning and analysis. The issue is all the more problematic because the Department of Health and Wellness (DHW) has, to date, focused on shadow-billing as its sole performance metric for academic physicians. Ironically, the majority of the C/AFP specialties indicate that shadow billing represents just a fraction of their clinical/academic work, and as such, is an incomplete indicator of their workload and productivity.

Increasing workloads are another issue. Academic physicians report added pressures as their academic mandate evolves. For example, recent curriculum changes (such as Competence by Design) and increased oversight required by residents necessitate more academic resources. Other mandatory changes impacting physician resource requirements include meeting the evolving Accreditation Canada standards. For example, evolving rules around oversight and supervision of oncology diagnosis and treatment necessitates physician peer review of cases. Finally, using new technology that results in better information is often more time consuming.

There is an increasing need for integrated care, which translates into developing and delivering more innovative, multi-disciplinary service models to provide patient care. While patients benefit from this innovative approach to patient care, fee codes do not exist for these models. The need for more human resources and the lack of appropriate remuneration makes these models a double-edged sword.

Another key challenge identified as a barrier to academic physicians' ability to work within an innovative practice environment is the lack of access to appropriate technology and IT infrastructure – including electronic medical records (EMRs) in hospitals. Academic physicians also reported difficulties in gaining access to timely IT support.

3 Decision-making and engagement

Physicians across Nova Scotia report feeling that their professional knowledge and advice are not valued by system stakeholders. The lost opportunity to influence key health-system decisions is an issue common to academic physicians, family physicians and rural/regional specialists.

The merger of nine district health authorities into a single provincial health authority was a substantial shift and growing pains were to be expected, but three years later, problems persist. The resulting governance and administrative structure of the Nova Scotia Health Authority (NSHA) is complex, continually changing and difficult to navigate.

Academic physicians have reported that when they encounter an issue, they often don't know who at the NSHA to contact for help. Physicians need greater clarity regarding roles, responsibilities and the process for resolving issues within their work environment. Decision-making processes and approvals also need to be streamlined. In what is perhaps an extreme example, one academic physician indicated that he had to secure 21 signatures to have a piece of equipment approved for purchase.

Academic physicians reported feeling disconnected from decision-makers; they are unclear on who makes decisions, and how and why decisions are made. Many physicians who reach out to the NSHA report being greeted with delayed responses or, worse, no response at all. Some physicians feel they are no longer in a position to contribute to key decisions affecting their patients and the delivery of health-care services. The perception is that physician input was once valued, but it is no longer actively sought.

Some academic physicians shared an opinion that the government has taken on an unnecessary role at the operational level, rather than the strategic level, of health care. These physicians perceived too much focus on budget-minded, short-term decisions, which is detracting from an emphasis on patient-care-centric, long-term planning. This short-term focus is frustrating for academic physicians, whose mandate is to pursue innovative health-care solutions to improve the health of Nova Scotians, which can take a long time to come to fruition.

THIS REPORT IS A FOLLOW-UP to *Healing Nova Scotia: Recommendations for a thriving physician workforce,* published in September 2017. That report represented the experiences of family physicians and rural/regional specialists from across the province. This report represents the experiences of academic physicians who are primarily practising in Halifax (as well as Dartmouth and Cape Breton, in some cases).

Physician Information Line
In response to physician feedback, the NSHA instituted a physician information hotline. Call 1-833-876-1724 for assistance during regular business hours.

4 Relationships and professional satisfaction

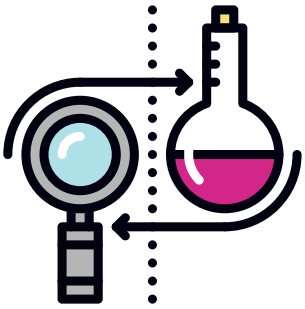
Academic physicians play a critical role in directing, coordinating, advocating for and delivering advanced, specialized health care. Organizations that work with clinical/academic physicians in their areas of expertise can benefit from health-care breakthroughs, not only for the institutions where the physicians work, but also for the medical students and residents they teach and the patients they serve.

In recent times, academic physicians feel they are seen as cost-drivers, rather than patient advocates – part of the problem, rather than a potential source of solutions. Several academic physicians reported they had experienced an adversarial approach and negative tone in their interactions with the government and the NSHA.

Also MSI's ongoing billing audits have contributed to strained relationships. Physicians report being repeatedly targeted for pre-payment assessments and post-payment audits and receiving "threatening" letters. As a result, some C/AFP physicians have decided to shadow-bill lower-value health service codes in an effort to deflect billing audits.

Ongoing scrutiny from MSI, a lack of physician engagement and cumbersome decision-making processes are contributing to low morale among academic physicians. Low morale contributes to challenging work environments and compounds physician retention challenges. High staff turnover means that both academic and clinical environments are constantly training new employees. This results in inefficiency as new people come and go, adversely affects morale and job satisfaction, and is making it increasingly difficult to recruit academic physicians to Nova Scotia, particularly those at or beyond the middle of their careers. Without constructive interventions to improve relationships and stabilize resource issues, academic departments are caught in a cycle of recruitment and retention issues, and the quality of Nova Scotian health care is at risk of decline.

> Some academic physicians reported they had **experienced an adversarial approach and negative tone** in their interactions with the government and the NSHA



5 Resources and work environment

The ongoing scarcity of resources means academic physicians are burning out and at increased risk of being unable to meet patient needs. Human resourcing and infrastructure issues are affecting service delivery processes, increasing wait times, delaying access to care and decreasing physicians' professional satisfaction.

Financial constraints are a significant issue for academic physicians. Many of Nova Scotia's academic physicians are among the lowest paid in Canada. This is exacerbated by the inflexibility inherent in the C/AFP block-funding model, and by the 10% holdback imposed on departments by the 2015 C/AFP contract. Additionally, the academic departments' operational budgets received no additional funding as part of the 2015 C/AFP contract. This means that essential equipment purchases and administrative and office support for new physician FTEs are being funded from practice plan revenues.

The combination of a fixed, block funding model and an insufficiently funded New MD process is a serious concern in an environment with ever-increasing patient needs and volumes. Workloads continue to increase while physician FTE resources do not. The academic departments report consistent increases in academic and clinical work – some of them to the tune of three to five percent increases in demand annually. This problem is compounded by the critical shortage of primary care physicians, as academic physicians are providing out-of-scope clinical care to patients without family doctors. Academic physicians repeatedly reported working unpaid overtime just to keep up. One frustrated academic physician said, "I'm tired of feeling tired all the time."

The academic physicians also noted how disheartening it is that even with their extra effort, patients continue to face long wait times. Many departments have unsuccessfully sought increased physician resources through the New MD process despite significant and confirmed volume increases. *Note: Concerns regarding the New MD process and insufficient*

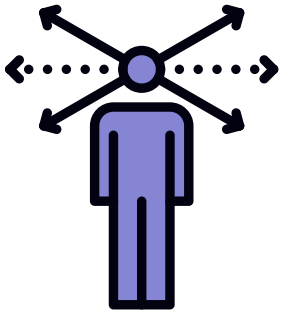
physician resourcing have also been raised consistently by physicians outside of the academic departments.

Payment relativity issues between specialties are an increasing concern, not only from a recruitment and retention perspective, but also due to the potential for interdepartmental discord. These disparities are difficult to remedy, though, in an environment where most physicians, regardless of specialty, are among the lowest paid in the country.

Ongoing issues with fee codes and billing processes have worsened since the implementation of the 2015 C/AFP contract. The lack of fee codes that accurately reflect the work done by radiation oncologists, psychiatrists, pathologists, geriatricians, medical oncologists, gynecologic oncologists and multiple other specialties is a key issue. Physicians in specialties that do have fee codes in place find the codes often significantly underrepresent the work involved in doing complex surgical procedures, providing geriatric care, performing autopsies, and so on. New codes, such as the non-face-to-face-care fee codes, are underutilized because the billing rules are perceived as too cumbersome.

Finally, the lack of an integrated, centralized EMR and the inability to use EMRs in hospitals not only pose an increased risk of system errors and patient safety concerns, but also create potential issues for continuity of patient care.

> **I'm tired of feeling tired** all the time." – *C/AFP physician*



6 Recruitment and retention

Academic physicians have invested heavily in their role as leaders, innovators, teachers, researchers and clinicians, committing significant amounts of time and resources to their subspecialty training. Ensuring these specialists stay in Nova Scotia will require an equally intensive investment on the part of health-system stakeholders.

Nova Scotia's academic physicians have a number of financial concerns, some unique to the 2015 C/AFP contract. These include the impact of the 10 percent funding holdback; significant funding disparities with academic physician peers working at other AHSCs; and recent changes to the federal taxation rules for private corporations. Taken together, these factors are having a significant negative impact on academic physicians' income potential in Nova Scotia. These circumstances are especially daunting for academic physicians just entering practice, who are typically carrying significant student loan debt.

Many academic physicians indicated that financial issues are driving them to investigate practice opportunities elsewhere in Canada, particularly in places where physicians have significantly higher incomes. Some academic specialties are highly mobile, and some of these specialists are highly sought-after. Physician remuneration will continue to pose a problem for recruitment and retention of academic physicians in Nova Scotia until the province compares more favourably with the rest of the country. Academic departments report losing mid-career physicians and facing challenges in finding replacements; funding constraints make it difficult to entice academic physicians much beyond entry level.

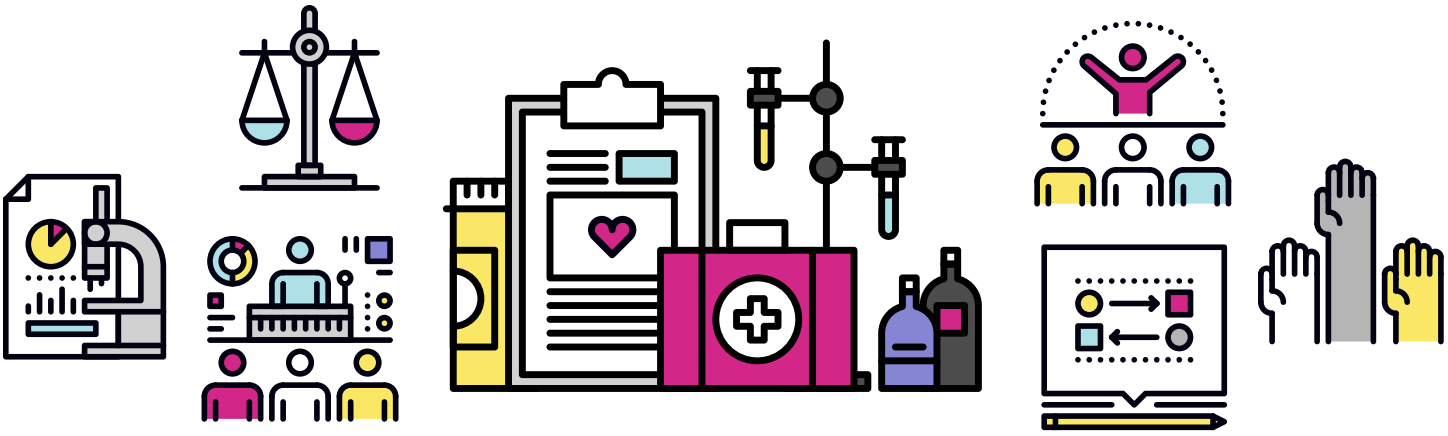
The factors contributing to recruitment and retention challenges are not just financial. As previously described, academic physicians' increasing workloads, coupled with little to no ability to secure additional physician resources in response to demand, are significant. This contributes to low morale, which undermines the province's ability to retain and to recruit academic physicians.

The province's deficit of family physicians is also affecting physician recruitment. Some departments reported losing potential physician recruits to other provinces when their relocation offer did not include assurance of a family physician for the recruit and their family. Primary care recruitment issues are also compounding the retention situation for academic physicians by further exacerbating increased workloads, as academic specialist physicians step up to fill the primary care service delivery gap.

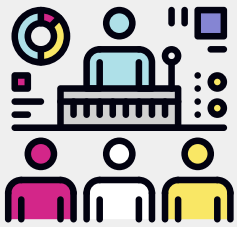
Another noteworthy concern expressed by the academic physicians is a lack of succession planning. Many academic departments have significant numbers of physicians contemplating retirement, but there is neither bridge funding nor a formal process in place to facilitate a transition that would enable a more senior physician to phase into retirement, ideally while mentoring a newer physician into practice.

The same factors also affect physician retention. While academic physicians work as independent contractors, they have limited control over where and for whom they work. It is unfortunate, but perhaps unsurprising, that low morale – the net effect of lower pay, higher workload and an unappealing practice environment – is resulting in retention challenges for many of academic departments.

Recommendations
for action

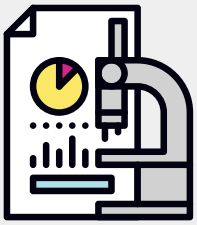


Doctors Nova Scotia and academic physicians have identified a number of ways to address the issues facing academic physicians. Improved collaboration among health-system stakeholders is a key. Doctors Nova Scotia is keen to work with academic physicians and health-system stakeholders to make the following recommendations a reality.



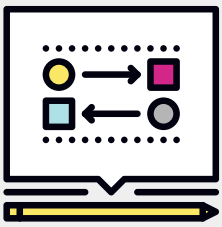
1. Improve access to primary care for patients and physicians.

This will help with physician recruitment and allow academic physicians to spend more time practising within their scope of specialty, thus helping to relieve wait times and improve access to specialist care. The provincial government's recent $39.6-million investment in primary care in Nova Scotia is a promising step in the right direction, but more is needed.



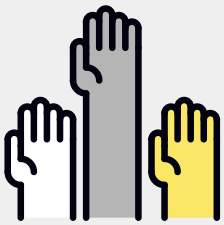
2. Provide greater support for the clinical/academic mandate.

Creating an environment conducive to innovation and ensuring that adequate funding is available to support both academic and clinical work is crucial. MSI pre-payment assessments and post-payment audits should be educational rather than punitive. Other, more effective accountability metrics should be established in place of (or at least in addition to) shadow billing.



3. Clarify and streamline decision-making processes.

Stakeholders need better coordination of roles, responsibilities and decision-making in their accountability frameworks. The NSHA operationalizes physician services to deliver patient care, the DHW is the funder/payer for the delivery of services, and Dalhousie provides functional support. This necessitates ongoing communications to ensure rational, informed and patient-centred decisions. Physicians should be meaningfully engaged in health-system decision-making.



4. Continue to strengthen working relationships.

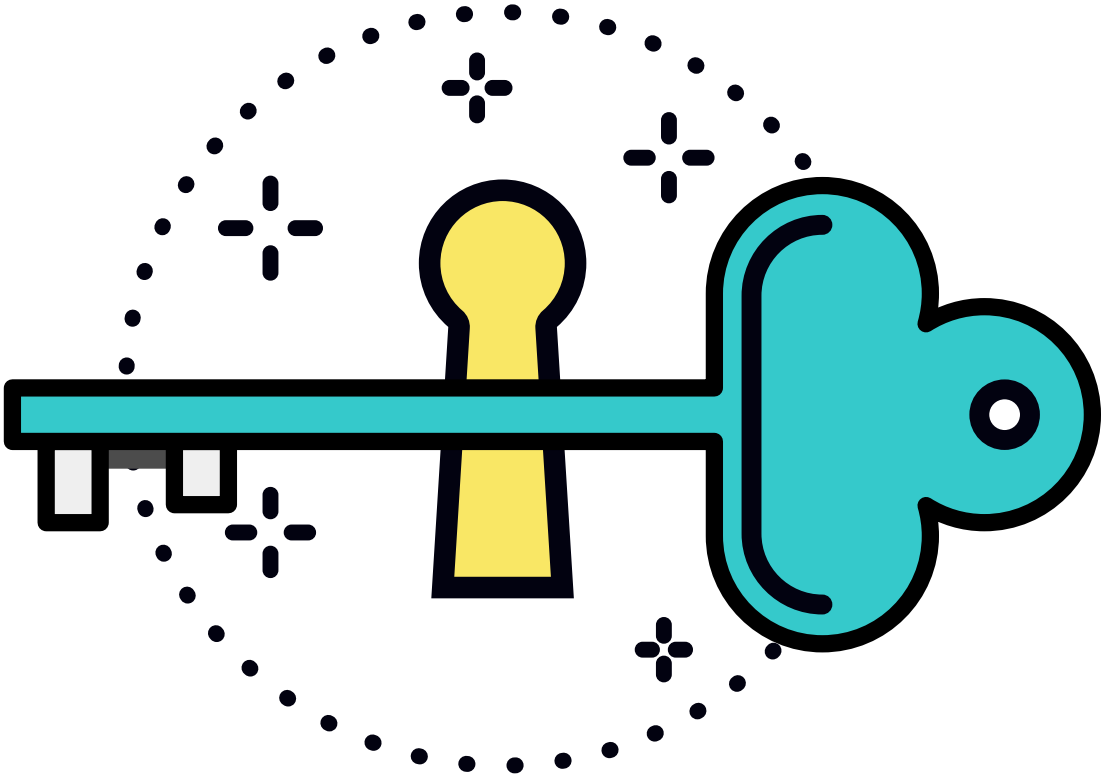
Strengthening collaborative working relationships with health-system stakeholders will help ensure physicians are both seen and treated as part of the solution, not part of the problem. Academic physicians have suggested that some health-system leaders and administrators need to get closer to the bedside. This will deepen their understanding and knowledge of health system issues and help to inform credible, evidence-based decisions. Physicians should be provided more opportunities to engage with health-system partners.

5. Provide sufficient resources to academic physicians.

In order to accomplish their clinical/academic mandate and to meet patient needs, academic physicians need greater resource support. This is an imperative to improving recruitment and retention of academic physicians in Nova Scotia. Retention and recruitment issues will not improve as long as Nova Scotia's physicians remain among the lowest paid in the country. It is vital to address issues like the 10% holdback, ensure adequate funding for new and replacement physicians, and work with physicians to use technology to alleviate redundancy and inefficiencies.

6. Improve the practice environment.

Working with health-system stakeholders to create an appealing clinical/academic workplace will improve the practice environment and help improve recruitment and retention. Stakeholders need to work collaboratively to find creative solutions to address and mitigate the risk of spiralling retention issues, with particular attention to professional satisfaction and adequate resourcing. Recruitment plans need flexibility and should be integrated with succession planning. This would ensure that new academic physicians and retiring academic physicians are provided with optimum opportunities to transition into, and out of, practice.



Conclusion

Academic physicians in Nova Scotia are acutely aware that the provincial health-care system is under significant strain and their colleagues in family practice and rural/regional specialties also face significant challenges. A constrained fiscal environment, escalating physician recruitment and retention issues, ongoing challenges within the current practice environment, a need for more streamlined, effective decision-making and a need for better use of technology – all of these factors are affecting physicians' ability to continue to provide high-quality health care in Nova Scotia.

Following the publication of *Healing Nova Scotia: Recommendations for a thriving physician workforce* in September 2017, DNS and health-system stakeholder partners renewed their commitment to working together to improve the state of primary and rural specialty care in the province. The formation of the Health System Physician Coordination Council is an important initiative. The provincial government's recent investment of $39.6 million in primary care is another significant step.

With that work underway, it is also time to address the issues affecting academic physicians in Nova Scotia. This is not an either/or situation; the issues facing primary and rural/regional specialists exacerbate the issues facing academic physicians, and vice versa. All parties need to continue to work together to rebuild a collaborative health-care system and an environment that enables physicians to thrive and to make a meaningful difference to the health of all Nova Scotians.

Fixing Nova Scotia's health-care system won't happen overnight. It will require the concerted, collaborative and collective effort of many health-system stakeholders. It's time to get to work.