QMA

Doctors
IN ACTION

QUEBEC MEDICAL ASSOCIATION

The Role of the Medical Profession in Governance of the Québec Health Care System

TABLE OF CONTENTS

QMA Doctors IN ACTION   QUEBEC MEDICAL ASSOCIATION

INTRODUCTION

Healthcare systems in Québec and the rest of the western world are undergoing major transformations that are aimed at enabling society to meet the increasingly complex challenges related to the accessibility, quality, appropriateness and cost of healthcare. Over the past 30 years, Quebec's healthcare system has experienced—and is still experiencing—many changes. We need to recognize that there is no quick and easy solution to the problems we are facing. The four variables of accessibility, quality, appropriateness and cost are interdependent. We need to find a balance between them, which will require choices and compromises to be made. It is therefore difficult to make decisions on the subject, since those decisions affect the medical community and the health of the general population. In this context of transformation, the Quebec Medical Association (QMA) has undertaken a reflection on the medical profession's future and relationship with Quebec society.

The QMA's recent annual meeting, held in April 2015, focused on the idea of the social contract. Discussions from this conference revealed points of contention between the medical profession and Quebec society, the latter of which was represented either by the population (survey results) or the government (bills and regulations). If we are unable to relieve or at least decrease the friction between the two groups, the medical community is at great risk of losing a significant part of its credibility as a party in the social contract with society. Given this fact, the QMA must act.

The main source of tension is the conflict between increasing amounts of regulation by the State and the prevalence of leadership among physicians, both individually as a whole. Both groups are aiming to improve accessibility.

Therefore, physicians' roles, responsibilities and accountability (both as a professional body and as individuals) are at the heart of the debate on the social contract between the medical profession and Quebec society.

The QMA holds a unique strategic position in Quebec. It is the only organization that combines practicing physicians (both general practitioners and specialists), residents, medical students and retired doctors.

In the past few years, the QMA has held positions on three major topics:

■ Overdiagnosis and optimisation of clinical practice (Choosing Wisely campaign);
■ Dying with dignity;
■ Time for a new social contract.

EVOLVING HEALTHCARE SYSTEMS

The contexts of medical practice have changed considerably over the last 30 years and will certainly continue to change over the next 30. The vast majority of these changes occur beyond direct control of the medical profession. They are demographic, epidemiological, scientific, technological, social, economic, political or cultural. They have an impact on the entire healthcare system, the medical profession and the health of the population as a whole.

A. GROWTH AND CHANGE IN DEMAND

| Demographics

Québec's population is growing. In 2011, Quebec had eight million inhabitants. In 2026, that number will have risen to nine million. The demographic makeup of the population is changing as well. Historically, Quebec has had relatively few seniors aged 65 or older. Over the past 40 years, however, the demographics have shifted and Quebec now has a higher proportion of seniors than Ontario, Canada or the United States. If anything, this will become even more the case in the future. In 2034, 24.9% of Quebec residents are likely to be aged 65 or older, compared to 24.1% in Ontario, 23.6% in Canada and 20.6% in the United States.

| Epidemiology

From an epidemiological perspective, better living conditions and medical progress have considerably improved life expectancy. However, aging is not the only variable influencing the increase in demand. The development of chronic illnesses and the increased prevalence of multimorbidities have a much stronger impact.

Chronic illnesses «require complex interventions over extended periods of time.»[1] Additionally, they require «coordinated assistance from a wide variety of healthcare professionals, as well as access to essential medications and follow-up systems. All of these need to be optimally integrated into a system that favours patient autonomy.»[2]

In Quebec, 52.6% of people aged 12 years or older have at least one chronic illness. This is at least in part due to youth adopting poor life habits. For example, obesity rates are continuing to rise. Between 1987 and 2010, the percentage of overweight and obese Canadians rose from 34% to more than 50%. Furthermore, seniors are experiencing more chronic illnesses. In Quebec, 74% of people aged 65 or older report at least one chronic condition. Among people 75 or older, that rate climbs to 80%.

The increased prevalence of chronic illnesses impacts the use of healthcare services. People with chronic illnesses use more healthcare services— and do so more often—than the rest of the population. «For example, 33% of Canadians who have at least one chronic illness are responsible for 51% of consultations with family doctors, 55% of consultations with specialists, 66% of consultations with nurses and 72% of hospital stays.»[3]

Multimorbidities are also increasing. According to the Association québécoise d'établissements de santé et de services sociaux (AQESSS),[4] 45% (2.7 million) of Quebec residents aged 20 or older have two or more chronic illnesses. Of that 45%, 20% have two chronic illnesses, 11% have three, 6% have four and 8% have five. As with chronic illnesses, multimorbidities increase over time and with age. Additionally, patients with multimorbidities use more family doctor, specialist, emergency and hospital services.

Essentially, more and more people are living longer, but they are doing so while needing medical treatments. Chronic illnesses and multimorbidities associated with an aging population are and will continue to have a major impact on the demand and use of healthcare services.

Epidemiology is also contributing to increased demand thanks to the emergence and resurgence of infectious diseases. Canada has witnessed the emergence of new infectious diseases, such as AIDS and SARS, that have impacted demand for and use of healthcare services. The outbreak of C. difficile in Quebec has demonstrated how antibiotic resistance is increasing in Canada. We are even seeing drug-resistant strains of tuber-culosis, which we thought had been eradicated.

| Patients' Increasing Influence

Another factor increasing the demand for care is the growing power of patients. Patients are becoming more and more aware of their rights. They are forming patient associations that are turning into lobbyists that attempt to defend patient rights and reclaim full access to the latest diagnostic and therapeutic innovations. The internet is granting them access to increa-sing amounts of information, both relevant and irrelevant. While many patients are responsible about their well-being, others are acting like «consumers» using a «product.» This gives rise to situations where patients are saying things like «Doctor, I need antibiotics for my flu,» or «Give me a scan for my back pain.»

Patients and patient groups are using traditional and social media as a means to exert pressure. This practice is more prevalent in Quebec than in other provinces. Traditional and social media have formed a sort of «commercial entity.» They aim to influence decision-makers and succeed in making their opinions known.

To sum up: Rising demand and the greater com-plexity of that demand will have a more and more of an impact on the use of care and services in terms of both quantity and quality. Demand will continue to evolve in a changing demographic, epidemiological, socio-economic and political context. It will require a major shift in clinical prac-tices and in the organization of care and services.

> **To sum up: Rising demand and the greater complexity of that demand will have a more and more of an impact on the use of care and services in terms of both quantity and quality. Demand will continue to evolve in a changing demographic, epidemiological, so-cio-economic and political context. It will require a major shift in clinical practices and in the organization of care and services.**

B. GROWTH AND CHANGE IN SUPPLY

| Sciences and Technologies

The development of new scientific knowledge and new technologies is the main variable in growth of the provision of care. This deve-lopment is the result of an increasing conver-gence between life sciences, physics, chemistry and engineering sciences, including materials science. The intersection of these sciences of-ten result in technological innovations in the healthcare sector.

Medicine is increasingly dependent on techno-logies. They are used for prevention as well as diagnosis, treatment, rehabilitation and home care. Healthcare technologies include all medi-cations, equipment, medical devices, implants and the support systems needed to provide care such as sterilization processes, information systems and telecommunications systems. Over the past decades, technology has not only in-creased the volume of services provided, it has changed the very nature of that provision.

The use of prescription drugs has skyrocketed.[5] Between 2009 and 2014, the number of prescriptions ordered through the Public Prescription Drug Insurance Plan (PPDIP) increased to 187 million from 140 million - an increase of approximately 10 million (or an average of 7%) per year. Between 1997 and 2013, the number of prescriptions for seniors aged 65 and older who were covered by the Régie de l'assurance maladie du Québec (RAMQ) grew by 367%, even though the number of insured persons in that age group only increased by 52%. Furthermore, since 2004 Quebec has had one of the highest numbers of new listed medications out of all the provinces.

Biomedical engineering is growing at an impressive rate. It has contributed to the development and use of numerous types of instruments, medications, implants and more. For example:

- Medical imaging devices (such as CT scans, MRIs, PET and PET-CT scans) have developed and are increasingly being used as tools to guide therapeutic inventions;
- Thanks to more flexible and precise instruments, developments in robotics and new medical imaging tools, minimally invasive surgery has also developed and is becoming more common;
- The use of prosthetics and implants (like in orthopedics and cardiology) has become more widespread;
- Digitalized patient records and telemedicine are playing an increasing role in medicine.

Furthermore, new disciplines/technologies are emerging, especially in the «bio-» (biomaterials, bioinformatics, bionanotechnologies, bionics, biophotonics, etc.) and «-omics» (genomics, proteomics, transcriptomics, metabolomics, pharmacogenomics, epigenomics, etc.) fields.

We are moving towards a more «personalized,» «predictive» or «precision» style of medicine. This style allows us to better understand the complexity of the systems and biological processes at the root of illnesses. Furthermore, it allows for individualized care that not only addresses genetic and biological specifics, but takes into account the patient's environment and lifestyle.

This approach will revolutionize the development of medications. The popularity of «blockbuster» medications is fading. New molecules are becoming more and more targeted. They are associated with biomarkers, which are «companion» diagnostic tests that allow physicians to identify markers that predict the effects of a treatment, thereby optimizing therapeutic management of patients for whom the treatment is intended. Given that the target market is more limited, the cost of these new molecules is currently very high.

«Regenerative» medicine is evolving. Stem cells and nanotechnologies may eventually allow damaged cells, tissues or even organs to be replaced. The most advanced research is currently in skin and epidermal reconstruction, for treating severe burns and ulcers; blood vessels, for treating cardiovascular disease; and cartilage, for correcting osteoarthritis. Clinical applications are already being implemented in some university hospitals in Quebec. Stem cell research has high therapeutic potential in the medium term.

Science and technology have changed and expanded the provision of care. Given the current progress of biomedical research, this will likely be the case in the coming decades as well.

| Increasing and Specialising Human

Another variable that affects the supply of care and services is the increase in human resources and their specialisation. According to ICIS,[6] the number of doctors in Quebec has increased from 16,782 to 18,496—an increase of 10.2% in four years. During those same four years, Quebec's population only grew by 3.8%. To compare, between 2006–2007 and 2010–2011, the number of nurses practicing in Quebec grew from 65,892 to 67,764, an increase of 2.8% over four years.[7]

In 2013, Quebec had 237 doctors per 100,000 residents, compared to 209 in Ontario and 220 in Canada as a whole.[8]

In medicine and nursing alike, specialization and subspecialisation are becoming more common. Most medical specialties have developed subspecialties. Even general medicine and family medicine have developed specific niche areas of practice. Nursing has evolved to include clinical nurse specialists and specialist nurse practitioners. Technical personnel have also had to adapt to using sophisticated technologies.

As a result, the complexity of patient needs and the specialization of medical staff require more and more interdisciplinarity.

> New knowledge, continuing technology developments and increasing specialization among health care professionals will continue to have a major impact on the supply of care, in particular the volume and complexity of clinical activities available for patients.

C. PRESSURE TO MANAGE INCREASING HEALTHCARE EXPENSES

| Increased Growth Rate

The steady rise in the supply and demand of care and services translates into a greater use of resources, and consequently, an increase in spending.

The question of healthcare funding in relation to the growth in spending is a critical issue throughout the Western world. Whether the payers are public, such as governments, or private, such as insurance companies, they face the same challenge: finding a balance between access, quality and cost.

The situation in Quebec is concerning. In 2015-2016, healthcare and social services spending will reach $32.9 billion, or 49.4% of government programs spending. That percentage, which is already high, has been growing year by year.

Between 2000–2001 and 2013–2014, Quebec's spending on the Healthcare and Social Services program grew from $16.1 billion to $31.2 billion, representing an average yearly growth of 7.2%. During that same period, spending on healthcare and social services facilities grew from $9.8 billion to $16.8 billion, representing an average yearly growth rate of 5.58%. In comparison, RAMQ spending on medical services[9] grew from $2.5 billion to $6.1 billion (an average yearly growth rate of 11.2%), and spending on medication and pharmaceutical services[10] grew from $1.2 billion to $2.4 billion, with an average yearly growth of 7.9%.[11]

The growth rates for medical services and medication and pharmaceutical services has been much higher than that of healthcare and social services facilities over the past 13 years.

In its 2015–2016 budget, the Quebec government announced that growth rates for healthcare and social services spending will only be 1.4% of that in 2014–2015 and only 1.9% in 2016–2017. Given the facts, that is a major constraint compared to past years. A large part of the growth of medical services and medication and pharmaceutical services spending comes from the supply-demand relationship between doctors and patients. It is therefore very difficult to reduce that growth given the current state of our healthcare system.

We must assume that 1.4% and 1.9% growth rates for healthcare and social services spending will have a considerable impact on establishments. Note that the AQESSS' 2014-2015 pre-budget representations stated that a 4.4% growth rate was needed to balance the budget in 2014-2015. The AQESSS stated that «this sum is essential, especially to cover payroll indexing and the increased costs of specific systems (medications, medical supplies).»[12]

Furthermore, in 2013 alarming projections were made by a team of economists from Laval University, in association with the Center for Interuniversity Research and Analysis of Organizations (CIRANO). By estimating the effects of population growth, aging, immigration and the structural costs of the healthcare system, the authors predicted that public healthcare spending could reach 68.9% of Quebec's total revenue in 2030. Structural costs will account for the majority of the increase. According to the authors, «in this scenario we would need to increase all provincial taxes and dues by 60%, assuming that the tax base was not affected.»[13] Although some hypotheses from the study are open to interpretation, the overall message is clear: if nothing changes, the pressure from increasing expenses will compromise our healthcare system.

| Increasing Pressure to Manage Growth

Over many decades, public and private payers have attempted many strategies to halt increasing costs. They have more or less met with success.

For governments, parametric budget cuts for healthcare establishments are the simplest, the easiest to explain to taxpayers and the most efficient, at least in the short term. The Government of Québec has been using this strategy for many years: the Ministry of Health and Social Services (MHSS) simply cuts an establishment's budget by a certain amount or percentage of the annual budget. The establishment is then forced to balance their own budget by any means necessary. Payers are interested in savings, so Quebec's Treasury Board and the MHSS still use this strategy today.

The second strategy involves grouping/merging institutions with the aim of improving the coordination and integration of services, and reducing administrative tasks and bureaucracy in order to achieve economies of scale. In Quebec and Canada, this strategy has become popular over the past 15 years but has not produced the expected results when it comes to improving services and managing increasing expenses. However, the government is still using this strategy; Bill 10 and the creation of integrated health and social services centres (CISSS) and integrated university health and social services centres (CIUSSS) reduced the number of healthcare facilities from 182 to 34.

Because parametric budget cuts and structural reform have provided few positive results, researchers and analysts are focusing on analyzing the effectiveness and efficiency of clinical and management activities.

The third strategy is called «Lean Management» and involves optimizing processes. It was inspired by Toyota, Six Sigma and Motorola, and was introduced to the American healthcare sector in the late 1990s. Lean Management improves efficiency by eliminating waste (anything that doesn't add value) in an organization and its processes. In Quebec, the Lean system gained momentum when the Liberal party came into office and started promoting it. However, the system was not standardized or monitored. Some companies applied it to certain processes and others completely ignored it. When the Parti Québéois came into office, the strategy was not prioritized.

The fourth strategy complements the third. We need to optimize processes, eliminate non-valuable activities and redesign workflow. Essentially, we need to do things well. But are we sure we are doing the right thing? This fourth strategy emphasizes the appropriateness of clinical and management activities. It stems from research by the Dartmouth Institute for Health Policy and Clinical Practice.[14] For more than 30 years, researchers from the Institute have been analyzing unjustified variations in clinical practices in the United States. These researchers have influenced the development of research on the relative effectiveness of clinical practices. They inspired the Choosing Wisely movement and were among the main experts consulted when developing Obamacare in 2010.

In December 2012, the journal Health Affairs published a Health Policy Brief on the enormous amount of waste in American healthcare.[15] Many sources can attest to the scale of waste in the healthcare system. According to the Dartmouth Institute, 30% of Medicare services could have been avoided without causing undue harm to patient health. Doing so would have saved around $700 billion. A study by the Centers for Medicare and Medicaid Services stated that five categories of waste accounted for 18–37% of all healthcare expenses in the United States. Similarly, the Institute of Medicine reported that, not accounting for fraud, the American healthcare system wasted $690 billion annually. The five main categories of waste are:

- Failures of care delivery
- Failures of care coordination
- «Overtreatment»
- Administrative complexity
- Pricing failures.

The QMA cited this article in its publication from April 8, 2013 entitled Optimizing Clinical Practice: Improving Choices. The few Canadian studies on the subject suggest that waste percentages are likely somewhat lower, but still significant. A relevant analysis of variations in clinical practice would require valid and trusted integrated databases, which are not currently available in Quebec.

A final strategy, called Value-Based Health Care Delivery, has been put forward by Professor Michael E. Porter from Harvard University.[16] This strategy is still emerging in Europe and the United States. For Porter and his colleagues,

quality should be measured in terms of «patient value,» or the relationship between 1) clinical results, defined by the patient and 2) the costs of results. Both are measured in terms of the patient's status throughout the episode of care.

An approach like this would require a major paradigm shift. Here are the main tenets of this approach:

- Creating «Integrated Practice Units» that unite patients who have similar or closely related conditions. These units would be codirected by a doctor-team leader and a care manager and involve an interdisciplinary care team that would be responsible for the entire care incidence and therefore accountable for all results and costs;
- Measuring the results of the episode of care on the patient's health (degree of recovery, complications, impact on quality of life, etc.);
- Measuring the costs for each patient—the actual costs incurred throughout the entire episode of care;
- Clinical integration of care and services, defined by patient needs; the network of integrated care and services from home to the hospital;
- Integration into primary, secondary and tertiary care;
- The integration of prevention, care and community organizations;
- Clinical integration that adds «value» for patients, clinicians and the healthcare system;
- Reimbursement in the form of a «bundled payment» for the entire episode of care (ambulance services, hospitalization, rehabilitation, follow-up), which will reward units that offer the best results at the best prices;
- Use of information technologies that support the transformation of the provision of care and allow for patient health and real cost results to be measured for each patient's episode of care.

Many areas of Sweden, Germany and the United States are taking this approach.

The third, fourth and fifth strategies were part of the framework for Barack Obama's reforms. The Patient Protection and Affordable Care Act, more commonly known as Obamacare, was enacted in March 2010. It is best known for its mandate to extend medical insurance coverage to more than 30 million Americans over the following decade. However, it also had a lesser-known and much more ambitious goal: to transform American medicine's «business model.» The law includes 45

measures that will change the way doctors provide care to their patients. These measures, which are currently being implemented, will shift the American healthcare system away from volume-based incentives and towards quality-based incentives. President Obama intends to reward providers who offer cheaper, more effective services.

The American healthcare industry is receiving a strong message from the single biggest payer, the American government, which is adopting this strategy through its Medicare program for seniors. From now on, the Medicare program will favour «Accountable Care Organizations» (ACOs) created by Obamacare. ACOs are voluntary groups of doctors, hospitals, other care providers and insurers who work together in order to provide coordinated, high-quality care to a given population at the best price possible. As an incentive, Medicare has committed to sharing the savings earned with ACOs. Members of an ACO agree to be collectively responsible for the costs and quality of care.[18] Insurance companies and Health Maintenance Organizations (HMOs) have received the message and are preparing to move forward.

The United States' change of course is calling into question traditional budgeting strategies for healthcare establishments and physician compensation.

As for Europe, most countries have used these strategies to make reforms over the past decades. Most scientific literature focuses on the United Kingdom, Sweden and Denmark.

> More and more, American hospitals will be paid per complete care incidence. The «fee for service» model is already becoming less common as a means of physician compensation. In March 2013, the primary recommendation from the United States' National Commission on Physician Payment Reform was the following: «Over time, payers should largely eliminate standalone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives.»[19]
>
> It is still too early to understand the effects of these last few strategies, but there is clearly a movement underway.

In the United Kingdom, the NHS has experienced a series of reforms over the years. The most recent reform is the riskiest.[20] It came in the wake of scandals in NHS hospitals, during a time of budgetary austerity. It triggered a major reorganization and centralization of the NHS and its governing bodies. In other words, it was a centralizing approach enforced by the government. The NHS has had an annual budget reduction of more than 1% over three years. The increase in productivity has mainly been the result of reduced salaries, reduced fees for employees and healthcare professionals, and merged facilities by closing hospitals. In terms of medical services organization, the former Primary Care Trusts were replaced by Clinical Commissioning Groups (CCG). The CCGs are directed by groups of general practitioners, who act as gatekeepers, manage budgets and buy hospital and primary care services for specific populations. Overall, results have been mixed. Certain CCGs had problems managing the budget because they didn't have the necessary management skills. There have been accusations of conflicts of interest between general practitioners and specialists. CCGs had a lot of trouble changing the NHS' rules, even though they were mandated to do so. They met with a lot of resistance. Finally, after three years, it seems that CCGs are moving towards a form of outcome-based contracting with healthcare providers. In order to sufficiently evaluate the results, better clinical and administrative data, as well as improved information systems, will be necessary.

The healthcare systems in Sweden and Denmark have historically been decentralized on a regional or county level. Over the past decade or so, both countries have been trying to find a balance between centralization and decentralization. In contrast with the United Kingdom, Sweden and Denmark have taken a «top-down» approach and consistently engaged local powers in their reforms. They have also integrated doctors. On one hand, both countries had a greater centralization of highly specialized hospital care that reinforced the critical masses of expertise. On the other, they kept a decentralized and flexible approach to organizing frontline healthcare services. Other activities were centralized to allow for the development of clinical standards, as well as administrative and clinical information systems. Much of the focus was on a comparative analysis of the effectiveness and efficiency of clinical activities and management, both in frontline care and in specialties and subspecialties.

Doctors in these two countries also take a leadership role and collaborate with decision-makers. Throughout their internships and residencies, doctors are made aware of their role as partners in the management of the healthcare system. In Denmark, the Danish Medical Association demonstrated its leadership by favourably positioning itself as an essential partner for the government in managing the healthcare system. However, it is important to note that physician compensation in Sweden and Denmark facilitates engagement with management functions. Furthermore, these two countries have the most efficient and best-integrated clinical information systems out of all Western countries. The systems are used by all doctors.

The above strategies only cover the «supply» part of the equation. Few recent strategies offer ways to deal with demand. Some healthcare systems are trying to control an increase in demand by rationing access to services, either through high co-pays or the creation of bottlenecks, such as waiting lists. Studies have shown that these strategies do not produce the desired economic results. They also tend to create issues with the quality of service and may even pose ethical problems.

Taking a population-based approach, such as preventative action on determinants of health, has generally proven successful. This is evidenced by the results of anti-smoking campaigns that were based on the health of the population. More and more healthcare systems, such as Kaiser Permanente, Mayo Clinic and Geisinger Health System, are integrating prevention and health promotion activities. They are also conducting epidemiological surveys of their patient bases. In Canada, public health departments are generally the ones responsible for prevention and health promotion programs. From an economic perspective, this strategy has been shown to have a potential for savings in the medium and long term.

Another demand-based strategy involves empowering patients to proactively manage their health. In Quebec, initiatives focusing on patients as partners are following this model. In Canada and the United States, the strategy is often used in preventing and managing chronic illnesses, where patients are encouraged to co- or self-manage their illnesses. For example, Kaiser Permanente developed a program

that proved effective in reducing the number of emergency room visits and hospitalizations for patients with cardiovascular diseases, among other conditions. This program aims to share information with patients, actively engage them in diagnostic and therapeutic decisions, help them evaluate risks and benefits and give them tools to better manage their health. In doing so, the program works directly with families and communities through a user-friendly information and telecommunications system.

Whatever the choices in Québec, if nothing changes, the continued increases in health spending risk compromising the viability of our public health care system. Parametric cost cutting only amplifies the risk, and structural reforms alone give few results. In addition, there is growing recognition that the Québécois and Canadian healthcare systems have enough money. «More is not necessarily better.» The real manoeuvring room in the short and medium tern lies in changing clinical practices and clinical management practices. This transformation will require interdisciplinary teamwork. It will also require introducing budgeting and compensation methods that favour the outcomes in the state of health, the appropriateness and quality of clinical activities, and the effectiveness of the processes. Finally, it will require an assessment process for the services and a greater demand for accountability in terms of the results achieved and the use of services. In the longer term, increasing patients' responsibility for their illness and state of health, as well as individual and populational contributions to health determinants, will offer significant potential for transforming health care systems. In the longer term, increasing patients' responsibility for their illness and state of health, as well as individual and populational contributions to health determinants, will offer significant potential for transforming health care systems.

THE MEDICAL PROFESSION IN A SYSTEM UNDER PRESSURE

| Four Competing Regulatory Logics

Throughout the Western world, increasingly greater attempts are being made to regulate health care systems and the medical profession. This regulation is «permanently the result of tension between four aspects of regulatory logic: market logic, professional logic, technocratic logic and political logic[21].»

These four regulatory logics correspond to the rationale of four agents, all of which have differing interests:

- Market logic: the population;
- Professional logic: the professionals and the organizations they work for;
- Technocratic logic: paying agencies and the government;
- Political logic: the State.

Before the arrival of health and hospital insurance, healthcare involved the application of market logic in the doctor-patient relationship. Hospitals and other healthcare facilities were owned by religious communities or charities that served doctors or other professionals.

The idea of «right to health» emerged during the postwar period, at the same time as scientific progress in medicine and complex diagnostic and therapeutic technologies. After experiencing pressure from their citizens, Western governments introduced health insurance and social security programs. In Canada, the federal government introduced hospital insurance in 1957 and health insurance in 1966. Quebec was the last province to apply these changes; hospital insurance was introduced in 1961 and health insurance followed in 1971. The Canadian and Québécois health insurance program intends to offer a full range of medical and hos-

pital services, regardless of residency, social class, ability to pay, etc. From the beginning, the State's role has been to provide resources so that science-based medicine can care for and improve the population's health. Paying bodies like RAMQ exist mainly to pay for the services provided. There is little room for technocratic regulation. Professional logic dominates.

However, the State is quickly becoming concerned about increasing healthcare expenses and the effects that the increases might have on its other programs. Technocratic regulatory logic is coming into play, as is Quebec's Treasury Board's increased role in allocating public finances to the healthcare system. «Offering the most services possible is no longer a priority. Instead, the focus is on finding an acceptable balance between quantity, quality and cost of services. Cost control, rationalisation and efficiency are becoming the buzzwords in discussions about the healthcare system.»[22] Technocratic and political logic are taking precedence over professional logic.

At the same time, new information is causing us to question how important science-based medicine and curative services are to maintaining the population's health. In Canada, the Lalonde report[23] is providing a new perspective on health. It states that personal and populational health can be determined by four factors: individual biological predispositions, the population's habits and lifestyles, the environment and health services. Note that the latter two are not the most important factors. This new paradigm recognizes the importance of prevention and health promotion, as well as the contribution of departments other than health (e.g. education, employment, environment) to public health. It reveals that the healthcare system is far from the only major determinant of a population's health. The State of Quebec does not only need to try to control increasing costs in the healthcare system. It also needs to ensure equal distribution of public funds between MHSS and other departments that may influence public health.

This evolution has created a complex environment where the professional, technocratic and political logics are in conflict and cancel each other out, and where no group of players can claim to have a monopoly on regulation of the health systems. This confrontation places

healthcare systems in an increasingly awkward position at the center of tensions between various interest groups and lobbyists. As for the population's dissatisfaction, market logic tends to take precedence and put forward its methods of regulation.

Tensions in Quebec are also amplified by the fact that the major players (the State, the government and professionals) have had little to offer in terms of suggestions for leaving the status quo behind. As mentioned above, the State and the government have focused their regulatory efforts on structural reform and parametric budget cuts. Professionals, on the other hand, have resorted to union confrontation strategies to defend their interests and enforce their professional regulatory logic. This is certainly the case in major employee unions and the two physician unions, the Fédération des médecins omnipracticiens du Québec (FMOQ) and the Fédération des médecins spécialistes du Québec (FMSQ). Given the current context of power struggles and centralized negotiations, there is little room for innovation. We are actively maintaining the status quo, so the impasse continues.

| Bills 10 and 20

Certain government bills are further reinforcing the power struggles. The introduction of Bill 10 reduced 182 facilities to only 34: 13 CISSS and 9 CIUSS. CEOs, VPs and members of administrative councils are named by the Ministry. The AQESSS[24] and the Association of Executive Directors of Quebec Health and Social Services (AEDQHSS)[25] were both disbanded. The State and its representative, the Ministry of Health and Social Services, are centralizing power. The State has taken direct control of the governing and management of service organizations. Political logic has become the primary regulatory logic, overshadowing technocratic logic.

Through Bill 20, the State and its ministry are trying to change negotiations between the government and medical associations. The conflict between political and professional logic is becoming more widespread, especially since political logic had trumped professional logic until the election of the current government. Negotiations with the FMOQ have resulted in an agreement, but the Ministry refuses to withdraw Bill 20. If FMOQ members do not deliver the expected results between 2015 and 2017, the Ministry reserves the right to intervene de jure.

As a result, the power struggles between the medical profession, the Ministry and the government are further reinforced, to the benefit of the latter. Furthermore, the FMOQ and FMSQ's monopoly have left very little room for the medical community to express concerns other than that of compensation or control of physician productivity with regards to the number of patients or acts.

| Effect on the General Public

During the 2007 negotiations, which were said to be a means to catch up to the Canadian average, medical federations received a pay increase far superior to inflation and the average salary growth in Quebec. This pay increase, which was legally negotiated, attracted negative comments from the population, but no more than that. Between 2010 and 2014, researchers and journalists alike published many articles on the decrease in medical productivity. After having studied the RAMQ's annual reports, they reported that the increase in average pay was accompanied by a decrease in the number of acts. To the general public, that translated to «We are paying more for fewer services, and we no longer have access to the services we did before.» In March 2015, the government confirmed what everyone else had been saying: two official studies stated that the number of services offered by general practitioners and specialists alike had decreased. Traditional and social media largely echo the Minister's statement.

In this context, the medical profession's main concern is keeping the public's trust, a trust that forms the foundation of the implicit social contract between the medical profession and Québec society. That said, how can we avoid reaching a breaking point if the medical profession is no longer able to regulate itself and meet the population's expectations?

Media reactions, in addition to the Léger survey ordered by the QMA in April 2015, indicate that even if Quebec society largely still trusts the medical profession, they are dissatisfied with the following:

- The results of the latest negotiations, which largely focused on physician compensation catching up to the national average (in other words, money);
- Follow-up for problems with access to care, even after a substantial fee increase was negotiated;
- The perception that physician privileges are far greater than their obligations;
- Patients' desire to be more involved in decisions about their health;
- The perception that doctors are not open to eventual changes to their practice or their position in the healthcare system;
- The perception that doctors are not willing to work with other healthcare professionals (such as nurses or pharmacists) to improve access to care;
- The perception (by one-third of the population) that the medical profession is not disciplining itself properly - in other words, physicians' work is not being controlled or evaluated enough to guarantee the quality of the services offered.

CONCERNS FOR THE QUEBEC MEDICAL PROFESSION

In the current social context, the medical profession's main challenge involves keeping the public's trust, a trust that forms the foundation of the implicit social contract between the medical profession and Québec society. That said, how can we avoid reaching a breaking point if the medical profession is no longer able to regulate itself and meet the population's expectations?

Related concerns have arisen:

- How do we reconcile legitimate societal goals surrounding access to and quality of care with the need to manage healthcare expenses?
- In social and political debates on the topic, how can members of the medical profession have a strong, legitimate and credible professional voice while differentiating themselves from medical federations? What should be the new foundations of a professional regulatory logic?
- What should be the underlying values of this new professional logic? And what should be the main tenets?
- Is the medical community still able to self-regulate given the current context of political centralization, where medical productivity is being questioned?
- How can doctors individually and collectively contribute to the transformation of medical professionalism and clinical governance in Quebec?

MEDICAL PROFESSIONALISM AND CLINICAL GOVERNANCE ELSEWHERE IN THE WORLD

The evolution and influence of the medical profession in society and healthcare systems reflects that of medical professionalism and clinical governance.

| Evolution of Medical Professionalism

In preparation for its 17th annual meeting last April, the QMA published a position statement entitled «Time for a New Social Contract — Discussion paper.»[26] Relying heavily on work by Dr. Richard L. Cruess and Dr. Sylvia L. Cruess, the discussion paper describes the evolution of medical professionalism in the wake of major changes in society and the healthcare systems environment. The document also identifies questions raised by those changes.

Similarly, on May 12 «The Journal of the American Medical Association» (JAMA) published a special edition that focused on professionalism and governance.[27] The special edition contained 22 articles on the subject of medical professionalism and clinical governance in various contexts, including that of Barack Obama's healthcare reforms in the United States (Obamacare).

Historically, medical professionalism was viewed as a function of a doctor's role as healer. As outlined in the AMQ discussion paper's summary, «The changes to the medical environment have changed modern professional dynamics. More specifically, the terms of the social contract have changed. This contract, which tends to be implicit, assumes an agreement between the medical community and society. As with official agreements, the contract confers rights and responsibilities on all parties. Although the idea of a social contract can be applied to society as a whole, it can also be understood on an individual scale. The terms of this moral engagement apply both on the macro (medical community-society) and micro (doctor-patient) level. The same obligations and privileges guide the provision of care and services on any scale.»[28]

We have had to rethink medical professionalism in order to account for the changes to our social contract with society. As the AMQ discussion paper states, «Practicing medicine relies on the fact that doctors are professionals as well as healers. These are distinct but complementary roles. Doctors must find a balance between the two, even though they are sometimes in opposition.»

According to Cruess and Cruess' conception of the implicit social contract, medical professionals are granted major privileges that meet their expectations. Meanwhile, society has expectations of the medical community— expectations that it wants to see met. Annex 1 describes the expectations in detail.

■ The medical profession's expectations:
o *Clinical autonomy;*
o *Trust;*
o *Monopoly;*
o *Social status and compensation;*
o *Self-regulation;*
o *Functioning of the healthcare system.*

Society's expectations:
o *Healer's availability;*
o *Advanced clinical competence;*
o *Altruism;*
o *Morality and integrity;*
o *Promotion of the public good;*
o *Transparency;*
o *Accountability.*

In Canada, the Canadian Medical Association (CMA) launched a strategic initiative at its general meeting in Halifax last August. The initiative aimed to engage CMA members in an important conversation on medical professionalism. One of the triggers was His Excellency the Right Honourable David Johnston's address at the Royal College of Physicians and Surgeon's 2012 convocation. He stated:

«What happens if you fail to meet the obligations under the social contract? Canadians will change that contract and redefine professionalism for you. Regulations and changes will be forced upon you—quite possibly in forms that diminish or remove your self-regulatory privilege.
One of the best ways for you and for men and women in any profession to avoid having change forced upon you is to relentlessly embrace new ideas, tenaciously set and reach higher standards and, most importantly, passionately strive to ensure your profession serves the public good.»[29]

Previously, the Royal College had dedicated a chapter to training and evaluating medical professionalism in its book «Competency by Design: Reshaping Canadian Medical Training,»[30] published in March 2014.

In the US, the discussion about the evolving social contract and medical professionalism was the spearhead of the American Board of Internal Medicine (ABIM) and its foundation, the ABIM Foundation, created in 1989. The ABIM Foundation's mission is «to advance the core values of medical professionalism to promote excellence in health care.» The ABIM Foundation website also outlines the evolution of medical professionalism:

«Today's definition of medical professionalism is evolving – from autonomy to accountability, from expert opinion to evidence-based medicine, from self-interest to teamwork and shared responsibility.» This is a major paradigm shift.

In 2002, the ABIM Foundation, in collaboration with the American College of Physicians (ACP) Foundation and the European Federation of Internal Medicine, published «Medical Professionalism in the New Millennium: A Physician Charter.» This charter has three fundamental principles:

■ Principle of primacy of patient welfare;
■ Principle of patient autonomy;
■ Principle of social justice.

The charter also lists 10 professional responsibilities:
■ Commitment to professional competence;
■ Commitment to honesty with patients;
■ Commitment to patient confidentiality;
■ Commitment to maintaining appropriate relations with patients;
■ Commitment to improving quality of care;
■ Commitment to improving access to care;
■ Commitment to a just distribution of finite resources;
■ Commitment to scientific knowledge;
■ Commitment to maintaining trust by managing conflicts of interest;
■ Commitment to professional responsibilities.

Annex 2 contains the complete Physician Charter. It perfectly illustrates the paradigm shift described by the ABIM Foundation.

Over the past decade, the ABIM Foundation has worked to promote its idea of medical professionalism. It is the founder of the Choosing Wisely campaign, which launched in 2011.

In the UK, a series of scandals involving physicians relaunched the debate on medical professionalism. Dixon-Woods, Yeung and Bosk (2011)[31] identified eight cases, occurring in the late 1990s and early 2000s, where doctors were implicated in medical malpractice, falsification of records, removal of human tissues and organs without permission, sexual assault of patients and even accusations of murder. All of these events were made public. The media covered them, the population was outraged, politicians demanded justice, inquiries were made, and reports were published. Many reports severely criticized the General Medical Council (GMC—equivalent to the Collège des médecins du Québec) for laxity in its duty to protect the public. Pressure from the public and the media forced legislators to act and caused a rupture in the implicit social contract between the medical profession and society in the UK, a contract that had existed for over 150 years.

The Council for Healthcare Regulatory Excellence was created in 2003. It reports to the British Parliament and supervises the GMC and other professional orders in healthcare as they regulate the profession. The Council is now known as the Professional Standards Authority for Health and Social Care.

In 2009, the GMC's peer-based, self-regulatory model was brought to an end. Previously, the GMC was made up of doctors elected by doctors. Today, the 12 members of the GMC are named by an independent nomination committee and the GMC has become a joint committee, made up of 6 physicians and 6 non-physicians.

In the United Kingdom, the State (the National Health Service, or NHS) and civil society are now much more involved with controlling the medical profession and its members. In France, however, the idea of medical professionalism has not yet taken hold. In the foreword of the QMA's discussion paper on medical professionalism, the authors indicate that the report «looks at the evolution of the medical profession from an Anglo-Saxon point of view. While the French perspective defines professions as any job or occupation that requires specific training, the Anglo-Saxon perspective states that a profession is a group that organizes itself into professional associations. It also maintains that professions have standardized and scientific training, strong morals and regulated professional, ethical and legal responsibilities.»

In France, a corporate view of the medical profession prevails. The website of the Ordre des médecins (the French equivalent to the Collège des médecins du Québec) describes the organization as follows: «The Ordre des médecins is committed to serving physicians to ensure patients' best interests. It is a private organization designed to serve the public. The Ordre defends the medical profession's honour and independence and represents the profession in French society (public powers, citizens...). It is the only French body that unites and federates all physicians, no matter their status, age, specialty or practice...»[32] The Conseil national de l'Ordre des médecins supported the doctors, interns and students who protested Minister Marisol Touraine's Health Act[33] on March 15, 2015.

The French medical profession is highly unionized, but also highly fragmented and experiencing many different tensions. There are tensions between specialists and general practitioners, between private ("liberal")or city doctors and hospital doctors, between doctors in general hospitals and university hospitals, and between rural and urban doctors.

Private medicine is still prevalent in France. Its primary characteristic is that since the 1920s it has opposed State control over the medical profession. For private physicians, the free choice of physicians and their patients, the freedom of establishment, the freedom to charge higher fees, and the refusal of third-party payers are key elements of «the liberal identity of French medicine as defined in the late 1920s, combined with a closed corporate vision of the medical profession»[34] according to political scientist Patrick Hassenteufel. Several French medical unions are opposed to the generalization of the third-party payer imposed by the Health Act, which was adopted on April 14 of last year. There are currently calls for strikes and civil disobedience. It will be interesting to follow the progression of this issue and examine its effect on French society and the medical profession.

In contrast, physicians in Scandinavian countries like Sweden and Denmark have collaborated with decision-making managers for a much longer time. Both countries have a history of collaboration between social groups and the State. Physicians hold management positions in local, regional and national organizations. They have integrated their roles as managers into their definition of medical professionalism. In Denmark, the medical profession has taken leadership in this area since the mid-1980s. Inspired by the Royal College of Physicians and Surgeons of Canada's CanMEDS framework, the role of «manager/administrator/organizer» is now recognized as one of Danish physicians' seven roles. As with the six other roles, Danish physicians have identified skills to develop on individual, organizational and societal level[35] for this role. We will return to the Danish system in the following section on medical governance.

In sum, the terms of the implicit social contract between the medical profession and society are being called into question by the evolving environment and expectations of the two parties in the contract. The signs of this challenge vary depending on the country, but the issue remains the same: the bond of trust between society and the medical profession. In order to maintain this trust, medical professionalism must evolve to account for not only the doctor-patient relationship (doctors as healers), but also the relationship between the medical profession and healthcare, State and societal organizations (doctors as professionals).

| Evolution of Clinical Governance

The changes in the health care systems and the environment surrounding the practice of medicine have created a high level of organizational complexity and interdependence between the players. Health care organizations and physicians can no longer work independently without collaborating. The system no longer works and frustrations are high on both sides. The search for excellent care and efficient resource use requires doctors, other medical professionals and organizations to work together to improve clinical processes. For example, a senior citizen with several chronic illnesses will likely need care and services provided by different professionals who probably work in different organizations. It becomes a matter of interdisciplinarity, networking and intersectionality. This complex, interdependent work requires collaboration and synergy between individual professionals, as well as between professionals and organizations.

In Quebec and Canada, medical leadership has been practiced in healthcare establishments since the 1970s through the Association of Councils of Physicians, Dentists and Pharmacists of Québec (ACPDPQ) and its committees, as well as department and service heads and the Director of Professional Services (DPS). Medical leadership and facility managers have never shared responsibilities or even a vision regarding costs and quality of services, especially since physicians have not prioritized or received compensation for these tasks. In the 1990s and 2000s, attempts were made to implement clinical governance models that had administrators and physicians co-managing service and client programs. However, little effort was made to develop an integrated vision, compensate physicians for these duties or train them for leadership and management.

The idea of «clinical governance» emerged in the United Kingdom following the Bristol Royal Infirmary scandal (involving the hospital's abnormally high mortality rates for pediatric cardiac surgery) in the late 1990s. Under political and media pressure, the British government and the NHS introduced legislation for clinical governance, which they defined as «a framework through which NHS organisations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish.»[36] Six elements were associated with clinical governance, which was seen as a movement to continually improve quality:

- Scientific research and development (evidence-based medicine);
- Clinical audit;
- Clinical effectiveness—using clinical practice guides and care protocols;
- Training and professional development;
- Risk management;
- Transparency.

However, according to a literature review by Brault, Roy and Denis[37], «clinical governance has been difficult to implement in practice for many reasons. Discourse on the subject hasn't specified priorities or steps for implementation. The concept is vague and its limits are difficult to define. This perspective remains largely normative; strategies for implementation are often misunderstood and inaccessible to practitioners. Furthermore, little attention has been paid to the organizational levers needed to facilitate implementation.» Many doctors and other medical professionals saw the government and the NHS' «top-down» approach as an attempt to control medical practice in order to reduce costs. Even today, results are mixed. While medical organizations like the General Medical Council and the Royal College of Physicians are actively working to improve clinical governance, the initiative has been unequally applied since it was announced 15 years ago.

According to Brault, Roy and Denis, clinical governance requires strong clinical leadership, a factor that has been largely neglected in Britain. «Work by the British has focused little on the dynamism that needs to be developed within an organization to increase the quality of care and services. Furthermore, little attention has been paid to the organizational levers needed to facilitate the implementation of clinical governance and potentiate the role of professionals.»

The authors propose a renewed definition of clinical governance. This definition would take into account Henry Mintzberg's «professional bureaucracy,» which is based on professionals' experience and expertise in executing their tasks. Brault, Roy and Denis' renewed clinical governance «aims to coordinate the work of independent professionals when they are placed in interdependent situations

while fulfilling their professional responsibilities. It includes coordinating and integrating the necessary care to help a person who is suffering. Clinical practices are built on high-level professionalism that is characterized by responsible, independent judgement, as well as the critical and skilful use of scientific knowledge to provide high-quality, individualized care to patients as needed. Clinical practices encompass all practices related to caring for a sick person, while recognizing that every person is unique and there is always going to be a certain level of uncertainty that requires professional judgement."

Further on, the authors add: «As for clinical governance, it is the space between the management system and the clinical system. This new space allows for the mobilization of knowledge and relationships. It also leaves room for new clinical and managerial initiatives that favour quality care and services, clinical excellence and performativity within the system. It aims to bring together clinical and management systems in the pursuit of excellence. All agents retain governing authority, which encourages their involvement in implanting high-quality initiatives and gives them a measure of accountability and responsibility for those initiatives.

In our opinion, the following organizations provide the best examples of clinical governance and medical leadership in North America:
- **Kaiser Permanente;**
- **Mayo Clinic;**
- **Cleveland Clinic;**
- **Geisinger Health System;**
- **Virginia Mason Medical Center;**
- **Intermountain Healthcare.**

The above organizations are different, but they do share certain qualities that encourage doctors to participate and engage with clinical leadership and the implementation of effective clinical governance:

- An organized group of doctors who are able to choose leaders, who have management skills, who accept collective responsibility and who understand that their collective performance is being measured and evaluated;
- Shared leadership between administrators and doctors, based on an understanding that they are interdependent;

- A clear, coherent vision of the organization's mission and strategies that is shared and participated in by doctors and managers alike;
- A strong culture and shared values based on quality of care and ensuring efficiency to achieve quality, while still taking the patient experience into account;
- Medical leaders who continue clinical activities;
- Integrated levels of care, interdisciplinary collaboration and teamwork, and a coordinated care trajectory;
- Doctors and administrators who share responsibility and accountability for quality of service and optimal resource use;
- Compensation and incentives that support the mission and its objectives;
- A contractual agreement (either formal implicit) between doctors that identifies goals, including steps to take if those goals are not met;
- Systems to measure clinical results, efficiency and patient experience, as well as peer evaluation;
- Information systems that integrate clinical, operational and financial data:
- Leadership training, mentorship and support for doctors;
- A systematic succession plan for medical leaders;
- Stable governance and management, as well as a long-term investment strategy.

These organizations have been pioneers in clinical governance and medical leadership. They have a decades-long record of excellence.

They are not the only ones. Since the mid-1980s, medical professionals and others have implemented strong medical governance (without calling it such) in Denmark.[38] In 1984, the Danish government released a report on productivity in its hospitals. In the report, the government recommended moving away from the management model hospitals were using, which placed doctors and administrators in separate but parallel hierarchies. Instead, the report suggested a management «troïka» (trifecta) composed of a general director, a doctor and a nurse. Instead of protesting or resisting, the Danish Medical Association decided to take the opportunity to occupy the field of hospital management and influence its development. By the end of the 1980s, experienced doctors were participating in hospital management, taking positions as CEOs, seeing to logistics and organizational development and managing budgets, human re-

sources and service quality assessment. The Danish Medical Association's proactive leadership reform allowed medical professionals to become leaders of their troïka in most cases. Moreover, in the following years doctors have become decision-makers not only in hospitals, but in the development of health policies and the organization of the Danish healthcare system as well. Since 2007, management has largely been recognized as a part of medical work; hospital and healthcare management is now seen as «natural territory» for medicine. In 1999, 41% of medical leaders had received between one and four weeks of management training and 34% had received more than four weeks of training.

In the United States, Obamacare has become a powerful incentive for doctors and administrators to collaborate and integrate, forming a real partnership. After two years of collaboration, the American Medical Association (AMA) and the American Hospital Association (AHA) released a position paper entitled «Integrated Leadership for Hospitals and Health Systems: Principles for Success»[39] on June 3 of last year. The six principles for success proposed by the AMA and the AHA are:

1. Physician and hospital leaders with:

   - similar values and expectations;
   - aligned financial and non-financial incentives;
   - goals aligned across the board with appropriate metrics;
   - shared responsibility for financial, cost, and quality targets;
   - service line teams with accountability;
   - shared strategic planning and management;
   - shared focus on engaging patients as partners in their care.

2. An interdisciplinary structure that supports collaboration between physicians and hospital executives. It is important that physicians preserve the clinical autonomy (defined as putting the needs of the patient first) needed for quality patient care while working with others to deliver effective, efficient and appropriate care.

3. Integrated clinical physician and hospital leadership, including nursing and other clinicians, present at all levels of the integrated health system and participation in all key management decisions:

   - Teams of clinicians and hospital or practice management administrators (leading together at every level of the integrated health system);
   - Teams accountable to and for each other and who can speak and commit for each other.

4. A collaborative, participatory partnership built on mutual trust. This sense of interdependence and working towards mutual achievement of the Triple Aim[40], better care and improved health at a lower per capita cost, is crucial to alignment and engagement. It is important for physicians and hospital leadership to trust in each other's good faith and abilities.

5. Open and transparent sharing of clinical and management information, throughout the care continuum and by all stakeholders, is essential in order to improve care.

6. A clinical information systems infrastructure is crucial to be able to compile and measure key performance indicators for clinical quality and efficiency.

This shared position of the AMA and AHA shows the strong need for a paradigm shift in the relationships between doctors and managers in healthcare organizations.

In Canada, interesting initiatives have been introduced, mostly in other provinces. However, these initiatives are isolated and don't translate well into more generalized applications. Former Minister of Health and Welfare Monique Bégin said in 2009 that «Canada is a country of perpetual pilot projects.»

One such pilot project is the Taber Integrated Primary Healthcare Project (TIPHP) in rural Alberta. The project was initiated in the 1990s through an agreement between a group of eight doctors and a regional health authority. The goal was to improve and better integrate primary care for a rural population of 15,000. From the beginning, it was a difficult undertaking: organizations were

working in isolation, there was no shared vision or coherence between objectives and incentives, low-incentive compensation for doctors and little real engagement from managers or doctors. The project only started to take shape when some leaders (doctors and managers) agreed on a shared vision and gradually started to mobilize main internal and external agents. Researchers who evaluated the TIPHP[41, 42] found the following:

- Improved quality of care;
- More efficient use of physician, laboratory and hospital services;
- Better life habits and decreased use of services in the population;
- Increased patient satisfaction throughout the project.

Researchers also identified the following success factors:

- Success for doctors:
  o No authoritarian imposition: the project was a joint initiative between medical and management leaders;
  o Emphasis on improving care and services;
  o Delegation of powers and tasks to non-physicians with the approval of physicians.

- Global success:
  o Evaluation of the community's needs and shared planning (solutions adapted to the area);
  o Evidence-based interdisciplinary care and services that were adapted to the target audience;
  o Integrated digital information systems and shared clinical information;
  o Investments in structures and processes that favoured change:
    - An Alternative Payment Plan for doctors that was adapted to their situation: mixed payment with a per-capita component that was based on patient age and the complexity of the case. This allowed some activities to be delegated to team members so that doctors could spend more time with more complex cases;
    - Organizational changes to encourage interdisciplinary teamwork;
    - Decentralization of power on the ground.

The Canadian Institutes of Health Research (CIHR) and the Canadian Foundation for Healthcare Improvement (CFHI) funded a research project on physician engagement and medical leadership for improving the Canadian health system. The report was published in April 2013.[43] Here are the key messages:

- «Physician leadership and physician engagement are essential elements of high-performing healthcare systems, contributing to higher scores on many quality indicators. Likewise, physician participation in hospital governance can improve quality and safety.

- Although much of the literature on healthcare reforms suggests the importance of physician engagement and leadership, this literature is less explicit about the processes by which health systems and organizations can convert physicians' autonomy, knowledge and power into resources for health system performance and improvement.

  - Physician leadership is important at the apex of the organization, but leadership occurs at all levels of the system. Increasing attention is being paid to high-performing clinical microsystems as well as new leadership modalities (e.g. dyads of physician and manager leaders and other forms of distributed leadership) and processes (e.g. physician 'compacts') that are fostering what some refer to as 'organized professionalism.'

- Physician engagement does not happen on its own. Organizations must use diverse strategies and initiatives to strengthen physician engagement and leadership, including (but not limited to):
  o physician compacts as mechanisms that help clarify roles, expectations and accountabilities between physicians and other system leaders;
  o leadership that is linked to broader improvement strategies to create a receptive context for physician engagement in improving clinical outcomes;
  o leadership development—especially for collective and distributive leadership—to support physician engagement;
  o teams and team leadership—especially inclusive leadership—as a favourable context for physician engagement and leadership and performance improvement.

■ A key variable for success in these approaches to physician involvement is trust between physicians and organizations, which can develop around these elements: open communication, willingness to share relevant data, creating a shared vision and accumulating evidence of successful collaboration. True physician engagement and leadership begins with understanding and addressing the underlying characteristics and values of the engaged physicians.

■ Organizationally, physician engagement depends on a mosaic of factors and can therefore be difficult to achieve. Physician leaders may experience obstacles in assuming leadership roles in organizations and systems. Such obstacles may be partly attenuated with purposeful changes to shape the organizational culture (called 'cultural work').

■ Successful strategies to engage physicians need to go beyond, but not ignore, appeals to their economic motives. In the same vein, formalized strategic leadership positions are important but are insufficient to effect high performance. Because of the major 'cultural problems' posed by management–professional tensions, economic and symbolic solutions do not necessarily translate into greater physician engagement. The main challenge is to bridge and integrate cultures, and not be limited to buying commitment.

■ Developing physicians' skills and competencies to support improvements in health systems means targeting a full range of physicians rather than only individual physicians. Key core competencies for engaging and fostering physician leadership include leadership, strategic planning, «systems thinking,» change management, project management, persuasive communication and team building.»

Finally, a very recent report identified (among other things) obstacles for healthcare innovation in Canada. In June 2014, Canadian Minister of Health Rona Ambrose launched the Advisory Panel on Healthcare Innovation, which was led by Dr. David Naylor. The group was mandated to identify the five most promising areas of innovation in Canada and internationally that have the potential to sustainably reduce growth in health spending while leading to improvements in the quality and accessibility of care. The Naylor report[44] identified the following five sectors as having high potential for innovation:

■ Patient engagement and empowerment;
■ Health systems integration with workforce modernization;
■ Technological transformation via digital health and precision medicine;
■ Better value from procurement, reimbursement and regulation;
■ Industry as an economic driver and innovation catalyst.

That said, the Naylor report was also highly critical of our healthcare system and identified major obstacles to innovation.

«First, consistent with polls showing that Canadians are concerned about the state of their healthcare systems, the Panel heard from many stakeholders who see the need for fundamental changes in how healthcare is organized, financed, and delivered.

The Panel's review suggested that these concerns were well-founded. While Canada's healthcare systems remain a source of national pride and provide important services to millions of Canadians every week, the scope of public coverage is narrow, and their overall performance by international standards is middling, while spending is high relative to many OECD countries. Canada also appears to be losing ground in performance measures relative to peers.

Second, pockets of extraordinary creativity and innovation dot the Canadian healthcare landscape. Local, regional and even provin-

cial programs worthy of emulation have simply not been scaled up across the nation.

Many barriers to effective scaling-up were identified by stakeholders. One key challenge was the lack of any dedicated funding or mechanism to drive systemic innovation. Additionally, the fragmented nature of the system – with separate budgets and accountabilities for different provider groups and sectors – emerged as the most important structural barrier to both new reform initiatives and effective scaling-up of well-tested ideas and programs. This shortcoming appeared to be operating in a vicious cycle with slow deployment and incomplete utilization of modern information technology.

The Panel observed further that Canada's healthcare systems appeared to be ill-prepared to respond to various shifts in their context. Patients are demanding more participation in their own care and engagement with the design of healthcare programs. As the population ages, there will be a greater premium on seamless delivery of multi-disciplinary care across diverse settings, not least the patient's place of residence. The digital revolution continues to disrupt many enterprises, and sooner or later will transform healthcare. Moreover, accelerating advances in biotechnology are now ushering in an exciting but challenging new era of precision medicine. Canada has pockets of research leadership in this field, but only one small province has taken steps towards implementation of the required learning systems to make precision medicine a clinical reality. Meanwhile, polling data show that the majority of Canadians no longer believe that an increase in operating funds is the primary solution to the perceived shortcomings of their healthcare systems.»

In our opinion, the 1984 Canada Health Act does not create an environment that fosters innovation. The five keystone principles of the law were fundamental, but only in the context of the 1970s and 1980s:

- Universality: all residents have access to public health care insurance and insured services on uniform terms and conditions;
- Public administration: each provincial or territorial health care insurance plan must be administered on a non-profit basis by a public authority;
- Accessibility: financial or other barriers must not impede insured persons from satisfactory access to required services form a doctor or hospital;
- Portability: coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country;
- Comprehensiveness: all medically necessary services provided by hospitals and doctors must be insured.

It is important to understand that the wording of these principles was only focused on medically necessary services provided by hospitals and doctors. Our situation has changed. Even if provincial governments have gradually adapted their services to suit the changing environment, it remains that the law, as written, does not encourage innovation. It is even used as a «sacred cow» that favours the status quo. At the very least, it needs a serious update.

In essence, major changes in society and the health services environment have caused the role of physicians to be challenged, both as care providers and as professionals. The concept of medical professionalism has expanded to include responsibilities for the relationship with society. We refer to a new social contract, not just between physicians and their patients, but also between physicians and society. We have seen that this contract is fragile and based on trust. In addition, just as medical professionalism has expanded, the relationship between physicians and the managers of healthcare organizations is shifting. Historically, these two key players have been able to operate in parallel, without having to work closely together. Today, they must recognize their interdependence when it comes to the mission of providing better care at a lower cost. These two key players are developing new ways to collaborate. We now talk about clinical governance, medical leadership and integrated leadership. Québec, even more so than the rest of Canada, is just beginning to recognize these issues and take on the challenges associated with them.

THE QMA'S POSITION

Outside of the QMA, the medical profession in Quebec lacks a legitimate credible voice to promote renewed medical professionalism and collaborative medical leadership for the governance and management of our healthcare system and its organizations.

The QMA has positioned itself as the only Québécois medical association that can bring the vision of this new form of medical professionalism and collaborative leadership, both in governance and in management.

As its mission states, the QMA brings together members of the Québec medical community in a context that promotes reflection and action in the best interests of the health of Quebecers. The QMA is:

- The association that gives a voice to the medical profession in all its diversity;
- A forum for reflection focused on the main issues affecting the profession and the health of the population;
- A dynamic interface with the medical profession in Canada and abroad;
- An organization committed to addressing the personal, professional and organizational concerns of its members;
- An organization that makes medical leadership a priority.

This mission, combined with the quality and diversity of the Association's members, give the QMA legitimacy and credibility.

The QMA releases position statements on issues that concern the healthcare system and the future of the medical profession. These statements reveal the organization's openness to innovation, social responsibility, collaborative leadership and dedication to ensuring the healthcare system's sustainability, quality and equality.

Finally, the QMA has a network of national and international contacts, giving it access to the best practices in medical professionalism, medical leadership and clinical governance.

In Quebec, there is currently a window of opportunity to improve the quality of healthcare services, the health of our population and the optimal use of our limited resources.

This report shows that the key to opening this window lies in renewed medical professionalism and integrated, collaborative leadership between doctors and managers in our healthcare organizations.

The QMA is the only Quebec medical organization that can find this key and put it to good use. The QMA draws inspiration from the Danish Medical Association, which in 1980 positioned itself to occupy the fields of management and healthcare institution governance, and in doing so discovered that improving the population's health was the «natural territory» of the medical profession.

The Quebec Medical Association confirms the following principles for the role of physicians in clinical governance:

A. PRINCIPLES RELATED TO THE RESPONSIBILITIES OF PHYSICIANS

These principles mainly, though not exclusively, concern doctors. Certainly, they would not produce concrete results without the committed, active participation of the medical profession.

| Population-based Responsibility

Medical professionalism includes not only the personal commitment of physicians to the well-being of their patients, but also the collective efforts aimed at improving the health care system for the well-being of society.

In this sense, individually and collectively, physicians have a population-based responsibility that they are prepared to assume.

Therefore, doctors are asked to participate in a collective paradigm shift. They must keep in mind the very legitimate need to properly meet the individual needs of their patients. However, this concern must be accompanied by collective responsibility, which manifests in two ways.

Doctors must work together and in concert with other professionals in order to appropriately respond to their patients' needs. Doctors are also responsible for maintaining optimal overall health in a specific region or sub-region.

| The Medical Profession's Engagement

The medical profession's active engagement in governing and managing the health care system and its institutions is essential to ensuring the best balance between accessibility, appropriateness, quality of care and optimal use of limited resources.

This engagement can take different shapes; it doesn't exclusively involve occupying medico-administrative roles. Doctors can exercise strong clinical leadership, or show strong interest in facing the challenge of balancing clinical excellence with the practice of medicine while taking into account limited resources.

| Contractual Agreements with Physician Groups

Contractual agreements should be introduced to specify the roles, responsibilities and accountability of physicians.

These agreements should provide for the achievement of outcomes, which would shift the incentive for compensation from "volume" to "value". They would also provide an opportunity to end the conflict between incentives that encourage inflation among doctors and the rationing measures of managers who need to balance the budget.

B. PRINCIPLES RELATED TO THE RESPONSIBILITIES OF PHYSICIANS AND THEIR PARTNERS

Doctors cannot be the only ones responsible for the success of clinical governance. The time has passed for the government and society to see the medical profession as solely responsible for the flaws in our healthcare system. All parties need to commit to respecting the two following principles.

| Joint Accountability and Responsibility between Physicians and Managers

It is essential to introduce mechanisms that will ensure that physicians and managers share accountability and responsibility.

This joint accountability and responsibility will impact the quality of services in terms of results for patient and populational health. They will also influence the appropriate attribution and use of resources in an integrated manner.

| Interdisciplinarity

Interdisciplinarity and teamwork are key elements for ensuring optimal clinical governance.

New knowledge, continuing technology developments, increasing specialization among health care professionals and the complexity of patient needs will require more and more interdisciplinary work.

Great strides have been made in the field of interdisciplinary work over the past few years. This progress has been made possible due to collaboration and consultation between the professional orders involved. However, it has not translated to progress «on the ground,» in clinical settings, where ideas have been met with resistance from unions and businesses alike. We need to find ways of fighting that resistance. The era of individual work has come to an end.

C. "STRUCTURING" OR SYSTEMIC PRINCIPLES

These principles, because of their «structuring» nature, require strong intervention from the government and other stakeholders. They require long-term investments (in money, but also in time and energy) and a strong will to push forward and navigate professional and bureaucratic obstacles.

| Sharing Clinical Information

Open and transparent sharing of clinical and management information, throughout the care continuum and by all stakeholders, is essential in order to improve care.

Doctors should not give up in the face of the administrative blunders surrounding the development and deployment of information technologies like the QHR.

Particular attention needs to be paid to patients' increasing role in the monitoring of their health status and development of their treatment plans.

| Measuring Key Performance Indicators

A clinical information system infrastructure is crucial to be able to compile and measure key performance indicators for clinical quality and efficiency.

This issue is particularly important because of the government's clear intent to start financing facilities on a per-activity basis. The QMA believes that this change to the method of allocating budgets is more than a simple administrative adjustment. It will likely have a significant impact on clinical practice, especially on the professional choices faced by doctors in their daily practice. It is important to clearly recognize doctors' indispensable contributions to collecting and managing clinical information. To do so, we will need a strong infrastructure for clinical information systems.

| Incentives Linked to Compensation Methods

The balance between the different physician compensation methods must be reviewed. The importance given to a fee-for-service system must be decisively reduced and more value placed on a mixed compensation method involving capitation and salaries. It is a prerequisite to ensure doctors' accountability and responsibility.

| Management and Leadership Training

Physicians must have access to management and leadership training to help them carry out their roles and responsibilities better.

They are at the heart of the changes to the healthcare network, since they are socially responsible for their peers; they are also responsible for the healthcare network through their medical leadership and their direct contributions to the organization of services. They participate in decisions that can directly influence the balance between the patient's best interests and those of the community as a whole. Physicians' continued participation in these processes can also have benefits for organizations. More specifically, organizations see an improvement in the quality and coordination of care, as well as increased efficiency and appropriateness in the provision of services. There are also benefits in the form of improved strategic and governance planning, improved communication, better communication and networking between parties, and a better grasp on the financial situations involved.

However, doctors are not always ready to serve as leaders. Their path to leadership and management is unusual compared to that of other management professionals. As a result, they may end up feeling ill-prepared and isolated. It is therefore necessary to provide support in the form of skill development for physician-leaders, as well as services that meet their needs.

| Sources of inspiration

The principles explained above were inspired by an analysis of the environmental factors behind the success of medical leadership and clinical governance at several healthcare organizations and systems: Kaiser Permanente, Mayo Clinic, Cleveland Clinic, Geisinger Health System, Virginia Mason Medical Center, Intermountain Healthcare, Taber Integrated Primary Healthcare Project and healthcare systems such as those in Denmark and Sweden.

The QMA was also inspired by the proactive, attentive strategy of the Danish Medical Association, which has favourably positioned itself as an essential partner for the government in managing the healthcare system. The QMA is defined as a legitimate, credible, non-confrontational medical organization that is concerned about the future of our health care system, and that fervently wishes to contribute to making it more effective, efficient and equitable for the good of our population and our society.

The QMA also considered many academic and professional opinions that argue for integrated leadership between physicians and administrators in order to face the future challenges of the health care systems.

One of the most influential opinions is undoubtedly that of the American Medical Association and the American Hospital Association, which worked together to propose six principles to facilitate integrated leadership.

Finally, and this may be the heart of our reflection, the QMA wants to leverage the intelligence of the Québec public, which is no doubt ready to hear proposals from the medical profession on topics other than compensation and the volume of services.

THE TERMS OF THE SOCIAL CONTRACT

THE MEDICAL PROFESSION'S EXPECTATIONS:

Clinical Autonomy

Clinical autonomy is necessary because of the complexity and diversity of the situations doctors encounter. Clinical judgement must be free from obligations or constraints that could threaten the doctor-patient relationship.

Trust

Trust is the basis of the professional relationship. Traditional systems such as codes of ethics, graduation, continuing education and moral commitments are intended to ensure the quality of medical services and allow patients to keep a high level of trust in doctors.

Monopoly

Exclusivity is a central tenet of the medical profession. The practice of medicine is strictly regulated because it is seen as a legal right. Doctors must maintain exclusivity in order to guarantee the quality of medical practice.

Social status and compensation

The medical community believes that commitment and devotion to patients also merit fair and equal pay.

Self-regulation

Self-regulation is one of the foundations of the medical community's excellence. Many authors state that in order to ensure the well-being of patients, doctors must remain independent but beholden to the influence of the State, as well as the institutions and organizations in which they evolve.

Functioning of the healthcare system

There are many different professional groups in the healthcare system. This network of relationships requires strong links between all partners in order to guarantee integrated care and services to patients. More than ever, doctors are asked to meet this major challenge. This assumes that the medical community is invited to share its skills and points of view in order to create organizational management strategies that prioritize the patient's experience.

SOCIETY'S EXPECTATIONS

Caregiver's availability

One of society's primary expectations of medical practitioners is the professional's availability. Because doctors have such a critical role (as healers and professionals), availability is seen as sacred. The population wants appropriate, respectful, confidential, dignified care to be provided within a reasonable time frame.

Advanced clinical competence

Doctors are professionals who provide expertise, clinical judgment and skills in order to work together with their patients. Patients are important agents who want to fully participate in the doctor-patient relationship. However, they still expect their doctors to be qualified, trained and ethically responsible enough to guide them in their decisions.

Altruism

The practice of medicine is focused on one essential virtue: the best interests of the patient. Medical professionals must prove themselves worthy of the privileges and status given to them by going outside of their own best interests. Altruism must always supersede personal interests.

Morality and integrity

The public's trust is a key element of the social contract. Doctors who erode that trust pose a threat to the medical profession.

Promotion of the public good

Society expects the medical community to invest in and defend the best interests of their patients. Medical professionals must focus on something other than simply practicing medicine as it has always been practiced.

Transparency

Society no longer allows professions to isolate themselves from social life. More than ever, the medical community must be completely open in order to cooperate with society and build the foundations of medical practice. The recent public debate surrounding doctor-assisted death is an example of this paradigm shift.

Accountability

As members of society, doctors must reconcile their interests with their professional needs, taking into account the resources available and the patient's best interests. The growing tension resulting from this situation cannot be ignored. Doctors' practices must be transparent due to the public nature of the healthcare system in which they operate.

THE PHYSICIAN CHARTER ON PROFESSIONALISM

PREAMBLE

Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession.

At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and universal principles and values of medical professionalism, which remain ideals to be pursued by all physicians, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of the healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways. Despite these differences, common themes emerge and form the basis of this charter in the form of three fundamental principles and as a set of definitive professional responsibilities.

FUNDAMENTAL PRINCIPLES

Principle of primacy of patient welfare.
The principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.

Principle of patient autonomy.
Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.

Principle of social justice.
The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

PROFESSIONAL RESPONSIBILITIES

Commitment to professional competence.
Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. More broadly, the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available to accomplish this goal.

Commitment to honesty with patients.
Physicians must ensure that patients are completely and honestly informed before the patient has consented to treatment and after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on the course of therapy. Physicians should also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide the basis for appropriate prevention and improvement strategies and for appropriate compensation to injured parties.

Commitment to patient confidentiality.
Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to disclosure of patient information. This commitment extends to discussions with persons acting on a patient's behalf when obtaining the patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever before, given the widespread use of electronic information systems for compiling patient data and an increasing availability of genetic information. Physicians recognize, however, that their commitment to patient confidentiality must occasionally yield to overriding considerations in the public interest (for example, when patients endanger others).

Commitment to maintaining appropriate relations with patients.
Given the inherent vulnerability and dependency of patients, certain relationships between physicians and patients must be avoided. In particular, physicians should never exploit patients for any sexual advantage, personal financial gain, or other private purpose.

Commitment to improving quality of care.
Physicians must be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care. Physicians must actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Physicians, both individually and through their professional associations, must take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.

Commitment to improving access to care.
Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession.

Commitment to a just distribution of finite resources.
While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. They should be committed to working with other physicians, hospitals, and payers to develop guidelines for cost-effective care. The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one's patients to avoidable harm and expense but also diminishes the resources available for others.

Commitment to scientific knowledge.
Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience.

Commitment to maintaining trust by managing conflicts of interest.
Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organizational interactions with for-profit industries, including medical equipment manufacturers, insurance companies, and pharmaceutical firms. Physicians have an obligation to recognize, disclose to the general public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determine the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.

Commitment to Professional Responsibilities.
As members of a profession, doctors are supposed to collaborate to optimize patient care, respect each other, and self-regulate, particularly through the use of appeals and disciplinary measures for members who have not respected professional norms. The profession must also define and structure processes for teaching and establishing norms, for the benefit of current and future members. Doctors have individual and collective obligations to participate in these practices. This includes engaging in internal assessment and accepting external assessment of all aspects of their job performance.

SUMMARY

The practice of medicine in the modern era is beset with unprecedented challenges in virtually all cultures and societies. These challenges center on increasing disparities among the legitimate needs of patients, the available resources to meet those needs, the increasing dependence on market forces to transform health care systems, and the temptation for physicians to forsake their traditional commitment to the primacy of patients' interests. To maintain the fidelity of medicine's social contract during this turbulent time, we believe that physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society. This Charter on Medical Professionalism is intended to encourage such dedication and to promote an action agenda for the profession of medicine that is universal in scope and purpose.

N.B. This Charter was developed by the American Board of Internal Medicine, in collaboration with the American College of Physicians Foundation and the European Federation of Internal Medicine. The Charter's French version was translated in 2004 by Daniel Sereni, MD, Vice-President of the European Federation of Internal Medicine's Executive Committee.

REFERENCES AND NOTES

1. *Main source of data in this section: « Maladies chroniques : Agir là où ça compte ». AQESSS, 2nd quarter 2014. Available at http://www.aqesss. qc.ca/docs/public_html/document/Documents_deposes/Agir_Maladies_chroniques_2014-04-08_VF.pdf*

2. *NOLTE, Ellen, KNAI Cécile and MCKEE, Martin (2008). "Managing Chronic Conditions: Experience in Eight Countries", European Observatory on Health Systems and Policies, Observatory Studies Series n° 15, WORLD HEALTH ORGANIZATION, 181 p. Available at http://www.euro. who.int/ data/assets/pdf_file/0008/98414/E92058.pdf*

3. *LAMOTHE, Lise, SYLVAIN, Chantal and SIT, Vanessa (2015) «Multimorbidité et soins primaires : émergence de nouvelles formes d'organisation en réseau», Santé publique, Vol. 27, No 1, January-February SUPPLEMENT, pages S129 – S135. Available at http://www.medsp.umontreal.ca/IRS-PUM_DB/pdf/27641.pdf*

4. *See Note 1.*

5. *Commissaire à la santé et au bien-être (2015) «Les médicaments d'ordonnance : agir sur les coûts et l'usage au bénéfice du patient et de la pérennité du système». Available athttp://www.csbe.gouv.qc.ca/fileadmin/www/2015/Medicaments/CSBE_Medicaments_Recomm.pdf*

6. *Canadian Institute for Health Information (CIHI) (2012) «Nombre, répartition des médecins canadiens 2011». Available at http://publica- tions. gc.ca/collections/collection_2013/icis-cihi/H115-23-2011-fra.pdf*

7. *Ordre des infirmières et infirmiers du Québec (OIIQ) (2011). «Rapport statistique sur l'effectif infirmier 2010-2011». Available at https://www. oiiq. org/sites/default/files/292S-Rapport_statistique_2010-2011.pdf*

8. *CIHI (2014) «Les médecins au Canada 2013 : rapport sommaire». Available at https://secure.cihi.ca/free_products/Physicians_In_Canada_ Sum-mary_Report_2013_fr.pdf*

9. *Population growth, an increasing number of acts and raised fees are contributing to healthcare expenditures.*

10. *These amounts only relate to medication and pharmaceutical services for seniors and people using last-resort financial assistance.*

11. *The data in this paragraph comes from a table entitled «Montants des dépenses consacrées à la santé et aux services sociaux, selon les éléments de la structure budgétaire, au Québec, 2000-2001 à 2013-2014 du MSSS» available in French only at http://www.informa.msss.gouv. qc.ca/Details. aspx?Id=xwwbq/us7X8=*

12. *AQESSS (2014). «Représentations prébudgétaires 2014-2015». May 2014. Available at https://www.aqesss.qc.ca/docs/dossiers/budget/Repre-sentations_prebudgetaires_2014_2015_F_20140509.pdf*

13. *CLAVET, Nicholas-James, DUCLOS, Jean-Yves et al. (2013). «Les dépenses en santé du gouvernement du Québec 2013-2030 : projections et déterminants.» CIRANO, Décembre 2013. Available at http://www.cirano.qc.ca/pdf/publication/2013s-45.pdf*

14. *See http://tdi.dartmouth.edu*

15. *«Health Policy Brief: Reducing Waste in Health Care.» Health Affairs, December 13, 2012.*

16. *See the «Value-Based Health Care Delivery» website: http://www.isc.hbs.edu/health-care/vbhcd/Pages/default.aspx*

17. *KLIFF, Sarah (2012). «Health reform at 2: Why American health care will never be the same.» The Washington Post, March 24, 2012. See http:// www.washingtonpost.com/blogs/ezra-klein/post/health-reform-at-2-why-american-health-care-will-never-be-the-same/2012/03/22/ gIQA7s-sUVS_blog.html*

18. *To learn more about Accountable Care Organizations, visit https://www.healthcatalyst.com/what-is-an-ACO-defini- tive-guide-accoun-table-care-organizations*

19. *See http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician_payment_report.pdf*

20. *BLACK, Nicholas (2015). «Can England's NHS Survive?" The New England Journal of Medicine, July 4, 2013. See http://www.nejm. org/doi/ pdf/10.1056/NEJMp1305771*

21. *The description of the four regulatory logics is taken from the following article: CONTANDRIOPOULOS, André-Pierre (1994). «Réformer le système de santé : une utopie pour sortir d'un statu quo impossible.» Ruptures, revue interdisciplinaire en santé, Vol. 1, No 1, pages 8 – 26. Voir le site http://www.medsp.umontreal.ca/ruptures/pdf/articles/rup011_008.pdf*

22. *Ibid.*

23. *LALONDE, Marc (1974). «Nouvelle perspective de la santé des Canadiens». Ottawa. See http://www.phac-aspc.gc.ca/ph-sp/pdf/pers- pect-fra. pdf*

24. *AQESSS: Association québécoise d'établissements de santé et de services sociaux*

25. *AEDQHSS: Association of Executive Directors of Quebec Health and Social Services*

26. *Quebec Medical Association (2015). «Time for a New Social Contract – Discussion Paper», Montréal, February 2015. See https://www.amq.ca/ images/stories/documents/amq_document_reflexion_fr_FINAL.pdf*

27. *JAMA (2015). «Professionalism and Governance». The Journal of the American Medical Association, Vol. 313, No 18, May 12, 2015. See http:// jama.jamanetwork.com/Issue.aspx?journalid=67&issueID=933933&direction=P*

28. *Quebec Medical Association (2015). «The Medical Profession: Time for a New Social Contract - Online Summary and Discussion Guide», Mon-tréal, February 2015, page 2.*

29. *This quote available on the CMA website: https://www.cma.ca/fr/Pages/medical-professionalism.aspx*

30. *Royal College of Physicians and Surgeons of Canada (2014). «La compétence par conception : une nouvelle ère de la formation médicale au Canada», Ottawa, March 2014. Seehttp://www.royalcollege.ca/portal/page/portal/rc/common/documents/educational_initiatives/ rc_competency-by-design_ebook_f.pdf*

31. *DIXON-WOODS, Mary, YEUNG, Karen, BOSK, Charles L. (2011). «Why is UK medicine no longer a self-regulating profession? The role of scandals involving 'bad apple' doctors». Social Science & Medicine, Vol. 73, No 40, November 2011, pages 1452 – 1459. See https://www. kcl.ac.uk/ law/people/Bad-Apples-in-Medicine-Karen-Yeung.pdf*

32. *See the Conseil national de l'Ordre des médecins website: http://www.conseil-national.medecin.fr/qu-est-ce-que-l-ordre-1206*

33. *See http://www.conseil-national.medecin.fr/node/1575*

34. *HASSENTEUFEL, Patrick (2015). «La défense de la médecine libérale». La vie des idées, June 16 2015. See http://www.laviedesidees.fr/ IMG/ pdf/me_decinslibe_raux16062015.pdf*

35. *Danish Health and Medicines Authority (2014). «The Seven Roles of Physicians». April 2014. See https://sundhedsstyrelsen.dk/en/ news/2013/-/media/39D3E216BCBF4A9096B286EE44F03691.ashx*

36. *Department of Health (1998) «First Class Service: Quality in the new NHS». London. United Kingdom Department of Health. 1998. See http:// webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/ dh_4006902*

37. *BRAULT, Isabelle, ROY, Denis A., DENIS, Jean-Louis (2008). «Introduction à la gouvernance clinique : historique, composantes et conceptualisation renouvelée pour l'amélioration de la qualité et de la performance des organisations de santé.» Pratiques et Organisation des Soins, Vol. 39, No 3, July– September 2008. See https://papyrus.bib.umontreal.ca/xmlui/bitstream/handle/1866/9641/Introduction_a_la_gouvernance_ clinique.pdf;jsessionid=5808C27F223254DE0F35B47C4BD4D3D7?sequence=1*

38. *KIRKPATRICK, Ian, KRAGH JESPERSEN, Peter, DENT, Mike, NEOGY, Indareth (2009). «Medicine and Management in a Comparative Perspective: The Case of Denmark and England». Sociology of Health & Illness, Vol. 31, No 5, pages 642 – 658. See http://onlinelibrary.wiley.com/ doi/10.1111/j.1467-9566.2009.01157.x/epdf*

39. *American Hospital Association and American Medical Association (2015). «Integrated Leadership for Hospitals and Health Systems: Principles for Success». Washington D. C., June 3, 2015. See www.aha.org/content/15/ahaamaintegrleadership.pdf*

40. *«Triple Aim» is a reference framework developed in the United States by The Institute for Healthcare Improvement (IHI) to optimize the performance of healthcare systems. The «Triple Aim» describes three goals that should be pursued simultaneously: 1) Improving the patient experience of care (including quality and satisfaction), 2) Improving the health of populations, and 3) Reducing the per capita cost of healthcare. See http://www.ihi.org/engage/initiatives/tripleaim/Pages/default.aspx*

41. *HASSELBACK, Paul et al. (2003). «The Taber Integrated Primary Care Project – Turning Vision into Reality». Canadian Health Services Research Foundation, Ottawa, August 2003. Seehttp://www.cfhi-fcass.ca/Migrated/PDF/ResearchReports/OGC/hasselback_final.pdf*

42. *WEDEL, Robert, GRANT KALISCHUK, Ruth, BROWN, Sharon (2007). «Turning Vision into Reality: Successful Integration of Primary Healthcare in Taber, Canada». Healthcare Policy, Vol. 3, No 1, 2007. See https://www.longwoods.com/content/19175*

43. *DENIS, Jean-Louis, BAKER, G. Ross et al. (2013). «Exploring the Dynamics of Physician Engagement and Leadership for Health System Improvement – Prospects for Canadian Healthcare Systems». Canadian Foundation for Healthcare Improvement, Ottawa, April 4, 2013. See http:// www.cfhi-fcass.ca/sf-docs/default-source/reports/Exploring-Dynamics-Physician-Engagement-Denis-E.pdf?sfvrsn=0*

44. *Advisory Panel on Healthcare Innovation (2015). «Libre cours à l'innovation : soins de santé excellents pour le Canada». Health Canada, Ottawa, July 2015. See http://canadiensensante.gc.ca/publications/health-system-systeme-sante/report-healthcare-innova-tion-rapport-soins/ alt/report-healthcare-innovation-rapport-soins-fra.pdf*

PUBLICATION