



2024-25 EXTERNAL REVIEW OF REGINA HOSPITAL PHYSICIAN CULTURE

Prepared for the Honourable Jeremy Cockrill,
Minister of Health

Reviewers: Dr. Nancy Merrow and Dr. Douglas Sinclair

2024-25 External Review of Regina Hospital Physician Culture

REVIEW TEAM

Dr. Nancy Merrow is a certified Executive Coach with a career in senior medical leadership roles since 2004, having served as Chief of Department, Chief of Staff and VP Medical, Regional Medical Director and Program Director with experience at small, medium and large sized community hospitals as well as regional and provincial initiatives. She is a family physician by training, with a focus in palliative medicine from 2004-2013. Dr. Merrow is recognized as a mentor and a role model among her peers and trainees. Her current career focus is on physician success and the advancement of medical practitioners in leadership roles.

Dr. Douglas Sinclair is currently the Vice-President, Medicine, Quality and Safety for the IWK Health Centre in Halifax, Nova Scotia. He has over 30 years of experience working in academic health sciences centres as a clinician, teacher, and leader. Previously, he was chief of emergency medicine at the IWK as well as chief of emergency medicine at the Queen Elizabeth II Health Sciences Centre. Most recently, Dr. Sinclair held the role of Executive VP and Chief Medical Officer at St. Michaels Hospital in Toronto.

Message from the Reviewers

We would like to express our sincere appreciation for all the people who took the time to offer their comments and insights to inform this review. Without exception, the people we met are keen to create forward momentum in a positive direction for the future of the SHA and the system to benefit patients.

A special shout out to Marilyn Day for her superb organizational skills in coordinating all the interviews and site visits.

We encourage readers to explore the entire content, resources, links and appendices to achieve a full understanding of the issues, root causes and recommendations. We have done our best to represent all perspectives accurately without attributing comments or content to any individual or group. We hope the Regina Area physicians and all the teams and administrators that support their programs will find the report helpful and actionable, and in keeping with the stated values of the SHA, the SMA, the College of Medicine and the CPSS.

Nancy and Doug

2024-25 External Review of Regina Hospital Physician Culture

Table of Contents

Review Team	1
Table of Contents	2
Executive Summary	3
Introduction and Background	4
Methodology Summary	5
Out of Scope	6
Key Findings	6
Benchmarking and Best Practices	10
Recommendations	11
Appendix 1 Glossary of Terms	13
Appendix 2 Culture in Healthcare	14
Appendix 3 Culture in Medicine	15
Appendix 4 The Social Contract	17
Appendix 5 Factors Impacting Physician Engagement and Impact of Physician Disengagement	20
Appendix 6 Physician Self Governance in Canada	23
Appendix 7 Laws governing the practice of medicine in Canada	25
Appendix 8 Basic checklist for a well functioning medical division or department	28
Appendix 9 List of participants and interviewees	29

Resources and Links:

[Ontario Hospital Association Guide for Developing an Effective Hospital Physician Relationship](#)

Canadian Medical Association [“Managing Disruptive Behaviour in the Healthcare Workplace”](#)

Canadian Medical Protective Association [“Just Culture”](#)

[The Canadian Quality and Patient Safety Framework](#)

SMA -CPSS joint [survey on Racism in Medicine, October 2024](#)

[CMPA Essentials of Medical Professionalism](#)

Canadian Journal of Physician Leadership – [Disengagement in Healthcare-Today’s New Culture](#)

Resource: CMAJ- [Self-regulation in healthcare professions comes under scrutiny](#)

2024-25 External Review of Regina Hospital Physician Culture

Executive Summary

The Saskatchewan Minister of Health commissioned an external review of the culture in the medical serving patients in the Regina hospitals and surrounding areas. The request was in response to a recurring theme of challenges being raised from physicians within the Regina medical community as well as patients/media citing lack of access to certain specialized services.

Limitations of the Review

The review is narrative based. We did not request or receive data sets on service volumes, outcomes or any other quantitative measures of how well the system is functioning. The review is about culture, and the experience of those working within it.

Out of Scope: Community Primary Care, Prior reviews and investigations.

Key Findings affecting the Culture of Medicine in Regina

1. Strengths and points of pride
2. Spirit of independence
3. Relationships
4. High volume community hospital service in Regina vs academic mission of the College of Medicine in Saskatoon – competition for resources and perceived inequities
5. Under-developed information management systems
6. Historic tolerance of aberrant practices and disruptive behaviour
7. Lack of an overall quality agenda for departments and divisions
8. Modern trends in compensation for physicians
9. Contract management
10. Need for coordinated collaborative medical human resource planning
11. Medical leadership crisis

Recommendations

1. Finalize and implement Bylaws and Rules.
2. Manage issues of physician practice, performance and quality promptly and decisively.
3. Enhance understanding of perceived and actual conflict of interest for medical leaders and physicians relative to commitments and endeavours outside the hospital.
4. Build on the SHA Culture of Belonging.
5. Create a Medical Human Resource plan based on data.
6. Adopt or enhance three key areas of data management: Electronic Health Record (currently hybrid in hospitals), a Physician Information Database and an Electronic application and re-appointment system such as CMaRS.
7. Continue and enhance the involvement of patient and family advisors in the reform process.
8. Select physicians and medical leaders using existing recruitment processes in a standardized and transparent way.
9. Use periodic physician engagement surveys more effectively to inform action plans to improve engagement.
10. Implement a comprehensive suite of supports for medical leaders to include training, mentorship, feedback, administrative support and benchmarked compensation models.
11. Review the entire SHA Medical Leadership structure for efficacy, role clarity and accountability.
12. Apply various models of physician compensation to optimize access to care, performance and outcomes. Review the pros and cons of the Fee for Service model of physician compensation, and

2024-25 External Review of Regina Hospital Physician Culture

where it remains, enact mitigations such as Practice Plans to reduce inequities and the risk of sacrificing quality for quantity of services provided.

13. Ensure that all Contracts, Alternative Funding Plans, Academic Payment Plans, etc. are reviewed, updated and renewed annually and when material changes are required to support patient care.
14. Use medical trainee and post graduate resident feedback to learn more about the impact of the culture on learners.

...End of Executive Summary

INTRODUCTION AND BACKGROUND

The Saskatchewan Minister of Health commissioned an external review of the culture in the medical community serving patients in the Regina hospitals and surrounding areas. The request was in response to a recurring theme of challenges being raised from physicians within the Regina medical community as well as patients/media citing lack of access to certain specialized services.

Historical and recent concerns exist about circumstances that impact patient access to care by impeding recruitment and retention of physicians. When the Minister of Health was presented with questions about fair treatment of physicians, gaps in on call coverage and loss of potential recruits to Regina due to various developments, he requested that a review be conducted by external experienced medical leaders to determine root causes and make recommendations. Previous focused reviews have had limited lasting impact on improving things. The goal of the review is to provide a thorough and extensive understanding of the Regina hospital workplace settings. The reviewers were tasked with assessing the current landscape and challenges within the Regina medical community to bring forward recommendations to the Ministry.

The review aims to provide recommendations that will enhance patient access to care by:

1. Supporting practicing physicians and medical leaders in the system.
2. Attracting physicians to the province and integrating them successfully.
3. Ensuring an excellent experience for medical trainees at the Regina site.

Definition of culture

Culture in healthcare can be defined as the collective values, beliefs, behaviors, and practices that shape how physicians and staff interact with each other, patients, and the larger community. It encompasses the attitudes and norms around patient care, teamwork, safety, accountability, respect, and empathy that guide everyday actions influencing decision-making, communication styles, and the overall workplace environment.

See Appendix 2 and 3 for details on culture in health care and medicine.

The Social Contract

In the training and practice of medicine, the culture is shaped by a combination of social, ethical, professional, and institutional influences that collectively impact how medical care is learned, delivered, received, and understood. Over time, one of the most enduring and powerful elements of medical professional culture is the implicit social contract that grants physicians the trust to act in the best interest of their patients, and the right to self governance. We heard examples of divisions and departments where it appears pursuit of financial compensation has overtaken the priority for high quality accessible care for patients, in words to the effect of “some physicians have lost the plot of why

2024-25 External Review of Regina Hospital Physician Culture

we are here”. We invoke the Social Contract to remind everyone of where the profession is grounded. We encourage that this be read in detail.

See Appendix 4 for details on the social contract.

Physician Self Governance

Physician self-governance is not without challenges. Some of these include the increasing complexity of healthcare delivery, changing patient expectations, evolving standards of care, and the integration of new technologies. Additionally, issues such as physician burnout, healthcare inequities, and access to care require ongoing attention and reform. The medical profession must adapt to these challenges while preserving the core principles of autonomy, accountability, and professionalism that underpin self-governance. They also must take responsibility for how they treat each other and sustain the culture whether positively or negatively.

See Appendix 6 and 7 for details on Physician Self Governance and Laws Governing the Practice of Medicine in Canada.

Physician Engagement

In our review of the medical professional culture in Regina, in addition to the incredible dedication and efforts of everyone we met and interviewed, we heard a theme of progressive disengagement of physicians. Physician disengagement is a serious issue that can have profound effects on individual physicians, their patients, healthcare teams, and the broader healthcare system. It is often driven by factors such as burnout, excessive workload, lack of support, and frustration with systemic inefficiencies. Medical leaders are equally susceptible to the impact of these pressures which impair their ability to enact change and manage performance. Ineffective actions to address contributing factors can cause passive disengagement to progress to active disengagement, which is destructive to the interprofessional work environment, the healthcare system and ultimately puts patient care at risk.

See Appendix 5 for details about physician engagement and the impact of disengagement.

The ability to modify the factors that affect physician engagement, and to reduce the risks of further disengagement rests equally with the Ministry, the SHA, the SMA, the CPSS, the COM, the medical leaders at every level of healthcare, and the physicians themselves who live the culture on a day-to-day basis.

METHODOLOGY SUMMARY:

The review team was selected based on relevant experience in medical leadership and clinical settings, and prior successful work done for the SHA. They were provided with documentation about the leadership structure of the organizations, Interim Bylaws, Clinical Department Draft Rules, Policies, Procedures, Processes, SCORE Surveys on engagement, Complaints and other information such as Job Descriptions and Organizational Charts. Some complaints were reviewed in more detail with the Area Department Leads due to the seriousness or repetitiveness of incidents. These provided examples about the effectiveness of existing processes and what changes might be of benefit.

The reviewers used virtual and in person meetings to interview local Saskatchewan Health Authority medical and administrative leaders, Saskatchewan Medical Association leaders, College of Medicine leadership, and key members of the medical community to understand perspectives, experiences and challenges. Interview questions were semi-scripted, and discussions flowed depending on the position and experience of the interviewees. Interviewees signed confidentiality agreements, and the report has been structured such that findings and recommendations are not attributable to individuals. Site visits

2024-25 External Review of Regina Hospital Physician Culture

were conducted at the Regina General Hospital and the Pasqua Hospital, and a general attendance meeting of the Regina Medical Staff Association was held to reach as many front-line physicians as possible. We thank the RMSA Executive for planning and facilitating this session at which over 40 physicians attended.

Limitations of the Review

The review is narrative based. We did not request or receive data sets on service volumes, outcomes or any other quantitative measures of how well the system is functioning. Data about the success or failure of recruitment processes is manual and not easily extracted so information was anecdotal. The review is about culture, and the experience of those working within it.

OUT OF SCOPE:

Community Primary Care

The reviewers would like to acknowledge that the current nation-wide crisis in access to primary care is a real and fundamental contributor to many pressures in the system. The family physicians who agreed to participate in this review are very much seen and appreciated. However, we are not able to make recommendations specifically on their behalf for reform in community settings within the scope of this project. There seems to be some optimism for the recently established networks.

Prior reviews and investigations

We were not tasked to comment on the process or outcome of prior reviews and investigations including any legal proceedings and filings with the Human Rights Commission. This project is a current, qualitative, future focused, practical report with actionable recommendations. That said, it was a frequent comment to us that prior reviews and investigations were not shared or communicated in ways that allowed closure and the ability to move on. Some feel that allegations of wrongdoing, made public, were not publicly refuted despite exoneration of individuals. People have been hurt and reputations tarnished. To the extent possible, those involved and affected may have to come together, if necessary, with professional mediation, to close issues, reset expectations and put the past in the past.

KEY FINDINGS:

The medical culture in Regina is strong, longstanding and will be challenging to shift. However, several aspects of the existing culture are no longer serving physicians' work life satisfaction, access to patient care, recruitment and retention efforts. The ability to sustainably staff patient care areas is directly affected by gaps in on call coverage and wait times for scheduled services. In extensive interviews with all levels of medical and administrative leadership, the following themes emerged as key influences on the culture.

1. Strengths and points of pride

The Chief Medical Officer is well regarded and has a clear vision and goals for the organization. Without exception, people who were asked to participate in our review showed up and gave us their candid and meaningful input about how the Regina area can move forward in a positive direction aligned with the Minister's goals to enhance access to patient care by supporting physicians and trainees. There were moments of high emotion expressed because caring about this community runs deep in its physicians. We met several emerging leaders in the SHA and the SMA who are determined to make a difference for their patients and their colleagues. They are looking to the SHA and SMA to support them through

2024-25 External Review of Regina Hospital Physician Culture

challenging issues and foster their development as leaders. Some departments have had long term success in recruitment, retention and engagement (Emerg, OB/GYN, Paediatrics). They have created their own informal rules, constitutions and team norms to cement the collegial bonds that make high risk specialties safer and more attractive to trainees and new recruits. Others, like Surgery, are working across the province to set practice norms and quality targets. Those that have embraced the academic mission and provide an excellent experience for trainees are benefitting from a pipeline of potential recruits. **See Appendix 8: Basic checklist for a well functioning medical division or department**

2. Spirit of independence

Physicians in Regina have largely held themselves apart from the mission, vision and values adopted by the SHA since its formation in 2017. Citing the sudden change to a single governance model and perceived inequities between Regina and Saskatoon, physicians convey a sense of distrust of administration and leadership. Passive and active disengagement is impairing progress on patient care initiatives. Physician autonomy is clashing with the broader social contract to ensure quality and safety for patients. **See Appendix 4 and 5 about The Social Contract and the Impact of Physician Disengagement**

3. Relationships

Relationships between individual physicians and groups are suffering due to all the factors discussed above affecting engagement. Civility and professional courtesy have eroded. However, physicians are in control of what they say and do, so must take responsibility for the way they treat each other including effective communication and support between referring physicians and consultant specialists. Appropriate consultant response times on call and timely assessment of patients are basic elements of professionalism. Deliberate breaches are unacceptable. If necessary, the development of Division and Department specific rules can specify how physicians will conduct themselves on service. This is a key element of the privilege of physician self governance.

Relationships between the Ministry of Health, the Saskatchewan Health Authority and the Saskatchewan Medical Association are vital to the provision of care in the province. There needs to be a high expectation of constructive collaboration on all sides. We heard several comments about how difficult it is to move things forward that require multiple levels of approval, such as the Bylaws, which remain interim since the inception of SHA in 2017. The SMA is embedded in hospital operations, which is not common in other provinces and adds complexity to working relationships between physicians and administration. The roles and responsibilities at each level of leadership and administration are not clear to those inside or outside the SHA. The difference between the SMA as physician advocates and the SHA medical system leaders is not clear for front line physicians and some leaders, who should declare a conflict of interest during contract negotiations.

The Ministry of Health was, by necessity, directly involved in operations during the three years of pandemic response. It has allowed avenues of communication to develop that bypass SHA processes. It is time to pull back and not be seen as interfering or working around SHA leadership. The SHA was in its early stages of development when the pandemic disrupted all normal operations and strategic planning. It needs to mature and progress as intended with MOH oversight and support.

Resource: [Ontario Hospital Association Guide for Developing an Effective Hospital Physician Relationship](#)

4. High volume community hospital service in Regina vs academic mission of the College of Medicine in Saskatoon – competition for resources and perceived inequities

2024-25 External Review of Regina Hospital Physician Culture

The physicians in Regina provide a high volume of service, and various groups have historically been willing to endure frequent and demanding duty and on call obligations. Some have retained powerful influence and control on the planning and delivery of service such that physician interests and population care needs are becoming mismatched. It is also difficult to develop a focus on teaching at this pace. As the medical culture more broadly has begun to address workload, compensation and wellness priorities, some Regina physician groups have maintained their autonomy to a degree that is now impairing their ability to staff their services. Physician recruits to the province are preferentially drawn to opportunities in Saskatoon where compensation models and service delivery have developed to support the academic mission, research and trainee experience. Over the years, the difference between the work environments has become starker. That said, the rising importance of the Regina site in training medical students and residents requires that physician preceptors be supported and that the teaching mission be adopted across all sites.

5. Under-developed information management systems

The preponderance of paper charting was very evident in the hospitals we visited. A modern EHR is part of an attractive work environment especially for trainees who come from centres where this is in place. Efforts must be made to complete the transition to effective EHR implementation. The lack of tools to do effective planning such as a Physician Information Database is deterring progress in key areas such as effective wait list management and workforce planning. Streamlining repetitive processes such as applications and re-applications for professional staff privileges would free up resources in Practitioner Staff Affairs to manage more intricate matters such as concerns and contracts.

6. Historic tolerance of aberrant practices and disruptive behaviour

Addressing aberrant practices and unprofessional behaviour with respect to physicians is challenging and time consuming. It requires a diplomatic and deliberate approach rooted in respect for the individual balanced with an ethical and moral imperative to protect the patient experience and the wellbeing of the team surrounding the physician. The physician's rights do not trump the responsibility to keep patients safe and the team intact. Whether rooted in illness, aging or personality factors, disruptive patterns of behaviour have often been in place for many years and not addressed in a decisive fashion. In our experience taking the time to follow due process to deal with physician outliers in professional behaviour has huge dividends, both to recruitment and retention of physicians and health care staff, but also in the wellbeing of the team providing patient care. Dealing effectively with a few outlying cases sets a positive tone that improves expectations for all and encourages and supports a Just Culture. There is an existing policy called RHA Disruptive Behaviour Policy for Practitioner Staff Ref #703 which is dated 2009 and could be updated and adapted.

Leaders who have identified problematic behaviours and acted appropriately to protect patients and teams should not be vilified or suffer retribution. Training and education for new and existing leaders in how to intervene effectively is essential.

Resource: Canadian Medical Association [“Managing Disruptive Behaviour in the Healthcare Workplace”](#)

Resource: Canadian Medical Protective Association [“Just Culture”](#)

7. Lack of an overall quality agenda for departments and divisions

Very few physicians were able to describe how they monitor and improve quality in their services. This is an area where working with Patient and Family Advisors with lived experience can inspire and

2024-25 External Review of Regina Hospital Physician Culture

energize physicians in their work. Where physician groups have been fractious, measuring and focusing on the quality of care they deliver can be a unifying activity.

Resource : [The Canadian Quality and Patient Safety Framework](#)

8. Modern trends in compensation for physicians

The Fee for Service (FFS) model of physician compensation has always had pros and cons. In recent years, many physicians have adopted alternative funding plans of various kinds (academic, blended, other). Where pure FFS is still in place, the challenges with it have become more obvious in contrast. Protectionism in small powerful groups leads to lack of effective planning for changes in medical human resource needs and modern team-based care. And in some cases, efforts to recruit have been thwarted by physicians to preserve their service volumes despite wait times. Wait times are not overseen provincially and are only visible in physician offices. We heard from more than a few interviewees that the FFS model carries a high risk of aberrant billing practices and perverse incentives for how care is provided, and how work is divided. This needs to be mitigated with Rules, practice plans, quality measures, wait time management and other ways to ensure that patient care needs are met.

9. Contract management

Due to the amalgamation of 12 health regions into the SHA there are legacy contracts, deals and arrangements that create inequity and inconsistency in negotiating with physicians and groups. When patient service needs change, outdated contracts are sometimes in the way of being able to adapt. Some contracts have expired, and others are not up to date in meeting emerging patient care needs and physician work life expectations. Many contracts lack clear deliverables to protect all parties and access to patient care. SHA, PSA, ADLs, and ACOS know where focused attention is required.

10. Need for coordinated collaborative medical human resource planning

The aging demographic of physicians and the lifestyle expectations of newer recruits have collided to cause fractures in the ability of groups to maintain 24 x 7 x 365 coverage of services. However, there is a lack of succession planning for the current and future needs of many services. Rather than groups taking primary responsibility for the number of members needed to staff at sustainable levels, it has occurred that departures or unilateral decisions by a few to change coverage become the emergent problem of the SHA to fill gaps in schedules and to find recruits. This an example of the loss of a social contract. When recruits learn that in some groups resources are not equitably distributed to members, they have been known to withdraw applications and move to other jurisdictions.

11. Medical Leadership Crisis

There is a medical leadership crisis in the Regina area. Leaders who met with us are almost universally discouraged about their ability to make positive changes where needed. There is a legacy culture of lack of decisive intervention for issues of concern with physician practice, behaviour, performance and quality. It was repeatedly stated by interviewees that “everyone is in charge, so no one is in charge”. Physician Executives with SHA are distanced from these issues. Provincial Department Heads are mostly based in Saskatoon and focused on the academic mission. A general sentiment was expressed that “Regina does their own thing and will call us if there is a problem”. However, in Regina it feels like neglect. Issues of performance, behaviour and quality are mostly left for the Area Department Leads and Area Chief of Staff to manage and some excellent work has been done on some challenging cases. However, from their perspective, seeking help up the chain does not result in real support. Unfortunately, the volume and seriousness of complaints and concerns has effectively buried the local

2024-25 External Review of Regina Hospital Physician Culture

leaders in crisis management, preventing them from turning their attention to strategic initiatives, reforms and modernization of processes to improve care. In some cases, medical leaders have been bullied, threatened, harassed and intimidated into either leaving their roles or retreating to ineffectual levels of interaction. Numerous examples were described to us of unprofessional conduct at formal and informal meetings, resulting in inability of groups to reach consensus and create positive forward momentum on important issues. The suffering among this group is extremely regrettable as it is perpetrated by physicians upon physicians. The appointment of an Advisor to the ACOS and Interim Area Department Lead has been controversial among physicians but very effective in setting expectations. This is a creative use of local leadership expertise when dysfunctional divisions are unable to lead themselves. There also could be a much stronger role for the Physician Executives and the Deputy CMOs in how challenging behaviours and practices are managed. The Provincial Department Heads must also set expectations and assist in resolving such issues that can affect the learner experience and quality of care provided on these services.

An important point was made to us that although the SMA has been very successful in negotiating clinical compensation increases over the years, the compensation for medical leaders has been stalled at 2016 levels. The increasing disparity between clinical and administrative compensation is a disincentive to be involved in leadership.

BENCHMARKING AND BEST PRACTICES

Since the establishment of the Saskatchewan Health Authority 2017 and the development of the College of Medicine Regina Campus, the Regina region is developing into an academic health sciences centre which will benefit both patient care and the recruitment of the best physicians and health care providers.

The governance model for such a complex corporate structure needs to be clear, transparent and accountable. Most large academic health sciences systems both in Canada and the US have developed a clinical program model with a co-leadership oversight for each clinical program. Close affiliation with the appropriate University and faculty of medicine [in this case the provincial College of Medicine] is important to advance the clinical and academic mission and is governed by an affiliation agreement. In general, responsibilities for academic activities – teaching and research are accountable to the university, and clinical care to the health science centre. In a well functioning system, there is lots of overlap and shared accountabilities. Recruitment and retention of the best physicians is a shared goal of the Health Authority and the College of Medicine.

Annual performance review, feedback and goal setting is an important tool that all Department and Division Chiefs should utilize to ensure alignment and support for excellent patient care. There are a number of tools available to help Chiefs coach their physicians, especially in the area of teamwork, communication and interprofessional relationships. Two tools in use include the Medical Council of Canada 360 tool and the PULSE tool, which was developed in the US, but utilized in a number of settings in Canada.

For the selection of physician leaders at the local level, best practice is an open transparent search process with a fixed leadership term of five years and one renewal for five years, following a successful review. Physician leaders need both coaching/mentorship and administrative support to achieve their goals, which should be set by both the SHA and the College of Medicine. Physician leaders – especially those close to the front line, need appropriate paid administrative time than minimizes clinical income loss and gives them the time they need to work with their administrative co-leads to achieve the strategic goals of both the SHA and College of Medicine. The same principles should be applied by the

2024-25 External Review of Regina Hospital Physician Culture

SMA to ensure that physicians in positions of power in the province are appropriately trained and supported.

RECOMMENDATIONS:

- 1. Finalize and implement Bylaws and Rules.** Specifically, remove the Alternative Dispute Resolution process from Bylaws and develop an appropriate policy to support a staged response to physician professional behaviour that becomes part of the physician's credentialing file. Recent work done on this for the SHA by an external coach is almost complete and suggestions have been made to strengthen it. **ACTION: SHA Bylaws Committee, ADLs, ACOS**
- 2. Manage issues of physician practice, performance and quality promptly and decisively.** Use Bylaws, Rules and Policies to clearly delineate expectations and consequences for breaches. Adopt a Just Culture approach and include progressive discipline with defined timelines to keep processes moving toward resolution. **Action: PSA, ACOS, Deputy CMO, Physician Executive, PDHs.**
- 3. Enhance understanding of perceived and actual conflict of interest for medical leaders and physicians relative to commitments and endeavours outside the hospital.**
When physicians have outside endeavours and interests that may affect their relationships or responsibilities as members of the medical staff or as leaders, they need clear guidelines to recognize and mitigate when a perceived or real conflict of interest is present. A clear policy on this for the SHA needs to be in place, and if it is, it needs to be communicated and reinforced. **Action: SHA**
- 4. Build on the SHA Culture of Belonging.** Consider the extensive diversity of the physicians who have come from all over the world to live and work in Regina. How are their cultures respected? How are those who trained in other jurisdictions oriented to the culture of Canadian medicine and health care? What conflicts have arisen due to underdeveloped understanding of differences? Significant work has been done to address racism in the healthcare system, exemplified by the SMA -CPSS joint [survey on Racism in Medicine, October 2024](#). The CoM has a curriculum for trainees on this. Use what has been learned to strike a diverse joint SHA-SMA-CoM working group to address and implement relevant strategies. **ACTION: SHA, SMA, COM**
- 5. Create a Medical Human Resource plan based on data** such as demographics of current physician groups, wait lists, population, community need and impact analyses to identify resources needed to support new positions. Use a front-line, in person, outreach approach to ensure that physicians have direct input on how the needs will be assessed and met. Identify protectionism where it exists and challenge with population-based planning, wait time targets, fairness in remuneration and appropriate resource allocation. **ACTION: PSA, MOH**
- 6. Adopt or enhance three key areas of data management: the Electronic Health Record (currently hybrid in hospitals), a Physician Information Database and an Electronic Application and Re-appointment system such as CMaRS.** **Action: MOH, SHA**
- 7. Continue and enhance the involvement of patient and family advisors in the reform process.**
When patients and families are consulted in complex issues of how to deliver services, their perspective cannot be overstated, and they can help keep the focus on the patient experience. **ACTION: SHA**

2024-25 External Review of Regina Hospital Physician Culture

- 8. Select physicians and medical leaders using existing recruitment processes in a standardized and transparent way** (posted job descriptions, qualifications, resource allocation). When this process has been skirted in the past, integrating new physicians and leaders has been problematic and resulted in dysfunction and departures. **ACTION: PSA**
- 9. Use periodic physician engagement surveys more effectively to inform action plans to improve engagement.** The SCORE Survey has had low response rates and members of the RMSA did not seem to be aware of them. **ACTION: PSA**
- 10. Review the entire SHA Medical Leadership structure for efficacy, role clarity and accountability.** Many interviewees commented that except for the CMO, they do not know who is in charge and it feels like no one is in charge. It is difficult to escalate issues to the Physician Executive, the Deputy CMO and PDH level. The CMO is involved more often than should be necessary. Most Provincial Department Heads are in Saskatoon and focused on the academic mission, leaving Regina to manage itself on most matters. This contributes to an Us vs Them sentiment between Regina and Saskatoon, which is longstanding. The current structure is top heavy at the VP level and front-line leaders are not feeling supported in managing challenging behaviours and quality issues. Develop an outreach strategy that requires regular Deputy CMO, PDH and Physician Executive presence in both major centres. **ACTION: SHA CEO, CMO and COM.**
- 11. Implement a comprehensive suite of supports for medical leaders to include training, mentorship, feedback, administrative support and benchmarked compensation models.** The ACOS office is understaffed and overwhelmed, resulting in delays and accumulation of issues awaiting action and results. Support from Legal and Practitioner Staff Affairs is stretched beyond the limits of effectiveness due to a backlog and accumulation of matters requiring analysis and action, such as concerns, physician re-appointments and contracts. Excellent software systems for the re-appointment process exist and should be sourced, purchased and implemented. **ACTION: SHA CMO**
- 12. Apply various models of physician compensation to optimize access to care, performance and outcomes.** Work with the SMA to identify best practices in Alternative Funding Plans across the province and the country. See Key Findings, Section 8, above. Review the pros and cons of the Fee for Service model of physician compensation, and where it remains, enact mitigations such as Practice Plans to reduce inequities and the risk of sacrificing quality for quantity of services provided. FFS is not the preferred arrangement for current recruits, and it is causing issues in multiple divisions and departments with wait list management, protectionism and conflict. (ADLs and ACOS know where focused attention is required). **ACTION: MOH, SHA, SMA, PSA**
- 13. Ensure that all Contracts, Alternative Funding Plans, Academic Payment Plans, etc. are reviewed, updated and renewed annually and when material changes are required to support patient care.** It is evident that this is not being achieved with existing resources in PSA and SHA Legal. It has resulted in work to rule actions in at least two divisions whose contracts have expired. A one-year appointment of a contract expert to catch up, review, update and renegotiate physician contracts should be employed. Other contracts, while current, have not been designed to ensure that patient services are protected. (SHA and MOH know which areas need focused attention). These should be re-opened and have deliverables negotiated that close the gap in service provision such as turnaround times for reports and on-site interventional radiology procedures. **ACTION: PSA**

2024-25 External Review of Regina Hospital Physician Culture

14. Use medical trainee and post graduate resident feedback to learn more about the impact of the culture on learners. ACTION: COM and SHA

Appendix 1: GLOSSARY OF TERMS

ACOS -	AREA CHIEF OF STAFF
ADL -	AREA DEPARTMENT LEAD
CMA -	CANADIAN MEDICAL ASSOCIATION
CMO -	CHIEF MEDICAL OFFICER
COM -	COLLEGE OF MEDICINE – SASKATCHEWAN MEDICAL SCHOOL
CMPA –	CANADIAN MEDICAL PROTECTIVE ASSOCIATION
CPSS -	COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN
DEPUTY CMO -	DEPUTY CHIEF MEDICAL OFFICER
MOH –	MINISTRY OF HEALTH
PDH –	PROVINCIAL DEPARTMENT HEAD
PSA –	PRACTIONER STAFF AFFAIRS
PHYSICIAN EXECUTIVE –	DYAD PARTNER FOR SHA VPs OF PATIENT SERVICES
RMSA –	REGINA MEDICAL STAFF ASSOCIATION
SCORE-	Safety, Communication, Operational Reliability, and Engagement Survey
SHA –	SASKATCHEWAN HEALTH AUTHORITY
SMA -	SASKATCHEWAN MEDICAL ASSOCIATION

2024-25 External Review of Regina Hospital Physician Culture

Appendix 2: CULTURE IN HEALTHCARE

In a healthcare organization, “culture” refers to the collective values, beliefs, behaviors, and practices that shape how physicians and staff interact with each other, patients, and the larger community. It encompasses the attitudes and norms around patient care, teamwork, safety, accountability, respect, and empathy that guide everyday actions influencing decision-making, communication styles, and overall workplace environment.

A positive culture in healthcare emphasizes patient-centered care, collaboration, ethical standards, continuous learning, and inclusivity, aiming to create a safe, supportive environment for both patients and staff. The culture also influences how effectively the organization adapts to change, handles crises, and strives for improvements in health outcomes and quality of care. A strong, positive culture in healthcare can lead to improved employee satisfaction, enhanced patient care, and better overall organizational performance.

Key aspects of healthcare culture include:

1. **Values and Beliefs:** The core principles that guide the organization’s approach to patient care, staff interactions, and ethical considerations.
2. **Communication:** The methods and openness of communication within the organization, affecting teamwork and the sharing of information.
3. **Leadership Style:** How leaders interact with staff, set expectations, and foster an environment of trust and collaboration.
4. **Physician and Staff Engagement:** The extent to which employees feel valued, motivated, and connected to their work and the organization’s mission.
5. **Patient-Centeredness:** The emphasis placed on patient care, including how staff prioritize patient needs and experiences.
6. **Diversity and Inclusion:** The commitment to fostering an environment that respects and values diverse perspectives and backgrounds among staff and patients.
7. **Being a Learning Organization:** There is a continuous focus on improvement based on lessons learned across all aspects of the organization

2024-25 External Review of Regina Hospital Physician Culture

Appendix 3: CULTURE IN MEDICINE

Resource: [CMPA Essentials of Medical Professionalism](#)

Key aspects of medical professional culture include:

1. Professionalism

- Medicine has a strong code of ethics, emphasizing compassion, competence, and integrity. The concept of professionalism guides doctors and healthcare practitioners in their interactions with patients, colleagues, and the community.
- The doctor-patient relationship is central, with a focus on trust, communication, and respect for patient autonomy.

2. Medical Education and Training

- Medical culture is heavily influenced by the rigorous training process, including medical school, residency, and continuing professional development. This process often emphasizes a hierarchical system, where experienced practitioners guide novices.
- The culture of mentorship and apprenticeship is key in shaping the identity of healthcare professionals.

3. Ethical and Moral Considerations

- Medical culture is deeply influenced by the ethical principles that govern the profession, such as beneficence (doing good), non-maleficence (doing no harm), autonomy (respecting patient choices), and justice (fairness in care).
- Physicians often face moral dilemmas, especially when dealing with life-and-death decisions, issues of consent, or resource allocation.

4. Interdisciplinary Collaboration

- Medicine involves a collaborative culture where different healthcare providers (doctors, nurses, allied health professionals) work together to ensure holistic care for patients. The value placed on teamwork can vary by specialty, institution, and region.
- The culture of collaboration and respect for different expertise is critical for patient outcomes.

5. Technology and Innovation

- Medical culture is increasingly influenced by advances in technology, such as electronic health records (EHRs), telemedicine, and medical research. The integration of these innovations into practice can impact both the clinical environment and patient care.
- The pace of technological change can challenge traditional practices, but it also offers new opportunities for improving patient outcomes.

6. Patient-Centered Care

- Modern medical culture often emphasizes a patient-centered approach, which focuses on treating individuals holistically, considering their emotional, social, and cultural needs alongside their physical health.

2024-25 External Review of Regina Hospital Physician Culture

- This involves shared decision-making, where patients are encouraged to participate actively in their treatment choices, with respect to their values and preferences.

7. Cultural Sensitivity and Diversity

- Healthcare practitioners are increasingly aware of the cultural, linguistic, and socioeconomic diversity of their patient populations. A culturally sensitive approach ensures that patients from diverse backgrounds receive equitable and effective care.
- Physicians and medical teams are trained to be aware of and address health disparities, ensuring that care is inclusive and considerate of different cultural beliefs and practices.

8. Workplace Environment and Well-being

- The culture within healthcare institutions, including hospitals and clinics, can impact both the well-being of healthcare workers and the quality-of-care patients receive. Factors like job satisfaction, work-life balance, and a supportive work environment influence the morale of medical staff.
- Burnout is a significant concern in the medical profession, with a growing emphasis on mental health and self-care for healthcare providers.

9. Global Medicine and Public Health

- The global nature of health issues, such as pandemics, infectious diseases, and environmental health concerns, increasingly shapes medical culture. Healthcare providers must navigate these challenges while adapting to the needs of both local and global populations.
- Public health initiatives often promote preventive care and health education, impacting cultural attitudes toward wellness and disease prevention.

10. Legal and Regulatory Framework

- Medicine is heavily regulated, and legal aspects, such as malpractice laws, patient confidentiality and consent, shape the practice of medicine.
- Ethical concerns and legal requirements often intersect, influencing how healthcare providers approach treatment, documentation, and patient interaction.

Conclusion

The culture in the practice of medicine is multifaceted and constantly evolving, with a strong focus on professionalism, ethical practice, patient-centered care, and collaboration. However, it is also influenced by broader societal trends, technological advancements, and the challenges faced by both patients and healthcare providers.

2024-25 External Review of Regina Hospital Physician Culture

Appendix 4: THE SOCIAL CONTRACT

Resource: [CMPA Essentials of Medical Professionalism](#)

The social contract is an agreement between the profession as a whole and the public it serves in return for professional autonomy, the profession commits to upholding the values and duties of medical professionalism and to promoting the public good within its domain. This contract is dynamic and adapts to cultural, ethical, and technological changes, but its core elements have remained relatively constant over time.

1. Trust and Autonomy

- **Trust from society:** Society grants physicians the privilege of making critical decisions about health and life, based on their expertise and training. This trust is fundamental to the doctor-patient relationship and the functioning of the healthcare system.
- **Respect for patient autonomy:** Physicians are expected to respect the autonomy of patients, which includes providing clear information about medical conditions and treatment options, allowing patients to make informed decisions about their care.

2. Commitment to Beneficence

- Physicians are bound by the ethical principle of **beneficence**, which dictates that they act in the best interest of their patients. This means prioritizing patient health and well-being over other interests, whether personal, financial, or institutional.
- They are expected to offer care that maximizes health outcomes, prevent harm, and advocate for patients, sometimes in the face of adversity or resistance.

3. Accountability and Transparency

- The social contract requires physicians to be **accountable** to the public, their patients, and their professional bodies. This accountability involves acting ethically, maintaining professional competence, and being transparent in their medical practices and decisions.
- Physicians are expected to admit mistakes, learn from them, and work toward improving the quality of care they provide.

4. Equity and Justice

- Society expects physicians to deliver care equitably, meaning that all individuals, regardless of their background, economic status, or social identity, have access to quality healthcare.
- The principle of **justice** extends to advocating for policies that promote the health and well-being of all people, particularly vulnerable or underserved populations. Physicians are expected to contribute to addressing health disparities and work toward making healthcare more inclusive.

5. Maintaining Competence

- Physicians must continually **update their knowledge and skills** to ensure they are practicing the most current and effective methods of care. This includes lifelong learning, adapting to advances in medicine, and participating in professional development.
- Society expects physicians to maintain their competence, and through licensing and certification, there is an inherent agreement that physicians will meet these ongoing educational standards.

2024-25 External Review of Regina Hospital Physician Culture

6. Ethical Practice and Integrity

- Physicians are expected to practice medicine with the highest ethical standards, free from conflicts of interest, undue influence, or personal gain. This includes maintaining patient confidentiality, delivering care based on clinical evidence, and avoiding practices that could harm patients or erode public trust.
- The social contract obliges physicians to place patient welfare above financial incentives or any pressures that might compromise medical integrity.

7. Service to the Public Good

- The social contract implies that physicians have a **responsibility to society** as a whole, not just to individual patients. They must engage in practices that benefit public health, such as participating in vaccination efforts, responding to public health crises, and advocating for health policies that improve access and care.
- This also includes the broader role of physicians in the community—whether it's engaging in public health initiatives or contributing to the betterment of healthcare systems.

8. Professional and Personal Integrity

- Physicians are expected to hold themselves to high standards of personal and professional integrity. This involves adhering to ethical norms, showing respect for patients and colleagues, and upholding the values of the medical profession.
- Society entrusts physicians with the authority to make life-altering decisions, so the integrity of the individual physician is critical to the effectiveness and trustworthiness of the healthcare system.

9. Advocacy and Health Promotion

- Physicians are expected to advocate not only for individual patients but also for broader public health goals. This includes supporting efforts to improve health education, prevent disease, and address social determinants of health.
- The social contract emphasizes the physician's role in **promoting wellness** and providing leadership in addressing health crises, health inequities, and policy reforms.

10. Transparency in Resource Allocation

- In times of resource constraints (e.g., during pandemics or in underfunded healthcare systems), physicians are expected to act ethically in allocating care. This means making difficult decisions with fairness, transparency, and in line with societal needs and values.
- The social contract obligates physicians to uphold their commitment to fairness even when resources are scarce, ensuring that decisions are made based on clinical need and equity.

11. Respect for Cultural and Social Diversity

- Physicians are expected to be aware of and sensitive to the cultural, social, and personal factors that influence patients' health beliefs, practices, and decisions. The social contract demands that physicians provide culturally competent care and respect the diversity of the populations they serve.

2024-25 External Review of Regina Hospital Physician Culture

Conclusion

The social contract between physicians and society is a mutual agreement based on trust, ethical responsibility, and a shared commitment to health and well-being. Physicians promise to act in the best interests of individuals and communities, continuously strive for professional excellence, and uphold the values of justice, equity, and integrity. In return, society entrusts physicians with the authority and autonomy to make life-changing medical decisions, supported by the collective belief that they will use this power responsibly for the good of all.

Appendix 5: FACTORS IMPACTING PHYSICIAN ENGAGEMENT AND IMPACT OF PHYSICIAN DISENGAGEMENT

Resource: Canadian Journal of Physician Leadership – [Disengagement in Healthcare-Today's New Culture](#)

1. Burnout and Emotional Exhaustion in the Canadian Healthcare Context

- **Prevalence of Burnout:** Burnout is a major factor contributing to physician disengagement in Canada. Studies show that a significant proportion of Canadian physicians experience burnout due to high levels of stress, emotional exhaustion, and feelings of depersonalization. This is especially evident in high-pressure environments like emergency rooms or rural and underserved areas where physicians are expected to manage heavy caseloads.
- **Workload and Time Pressure:** Long working hours, inadequate staffing, and a constant need to juggle multiple responsibilities (clinical care, administrative duties, teaching, research) contribute to physician burnout. In Canada, especially in rural or remote areas, physicians often face overwhelming patient demand, which can leave them feeling overburdened and disengaged from the profession.

2. Administrative and Documentation Burdens

- **Electronic Health Records (EHR) and Paperwork:** The shift to digital health systems and the widespread use of electronic health records (EHRs) have been associated with a significant increase in administrative work for physicians. In Canada, many physicians spend a substantial portion of their time on documentation, which detracts from their ability to engage fully with patients. The documentation burden is especially heavy in primary care settings, where family physicians are often responsible for maintaining comprehensive patient records in addition to their clinical duties.
- **Time Spent on Non-Clinical Tasks:** Physicians in Canada are increasingly frustrated by the time spent on non-clinical tasks, such as billing, insurance paperwork, and meeting various regulatory requirements. These activities take time away from patient care, which can lead to disengagement, frustration, and a diminished sense of professional fulfillment.

3. Impact of Healthcare System Strain

- **Healthcare System Pressures:** Canada's healthcare system, though publicly funded, is under significant strain due to factors such as increasing healthcare costs, aging populations, and a shortage of healthcare workers, particularly in rural and underserved areas. These system-wide pressures contribute to physician stress, burnout, and disengagement. Physicians may feel powerless or frustrated by their inability to address these systemic issues directly, which can lead to a sense of detachment from the larger healthcare system.
- **Physician Shortages:** Canada has been experiencing a shortage of physicians in many areas, particularly in rural and remote communities. This shortage exacerbates the workload of existing physicians, leading to burnout, job dissatisfaction, and ultimately, disengagement. Physicians in these areas may feel that their personal and professional needs are not being met, leading to high levels of turnover and a reluctance to remain in practice.

4. Impact of Passive Physician Disengagement on Patient Care

2024-25 External Review of Regina Hospital Physician Culture

- **Decreased Quality of Care:** Disengaged physicians may provide lower-quality care, as they may not be as attentive to patient needs or may not take the time to engage in shared decision-making with patients. This can lead to lower levels of patient satisfaction and can even result in medical errors or missed diagnoses.
- **Reduced Communication with Patients:** In Canada, patient-centered care is emphasized as a core principle, but disengaged physicians are less likely to engage in meaningful communication with patients. This lack of communication can erode trust between physicians and patients, making it harder for patients to follow treatment plans or express concerns about their health.
- **Long Wait Times and Delays in Care:** As disengaged physicians may be less motivated to engage fully in patient care or organizational improvements, the overall efficiency of healthcare delivery can be impacted. In Canada, where long wait times for certain medical procedures and specialist consultations are already a challenge, disengagement among physicians may contribute to further delays in care.

5. Impact of Active Physician Disengagement

Active disengagement refers to a state in which an individual not only disengages from a particular activity, organization, or responsibility but actively withdraws from involvement or works against the goals or values of that entity. Unlike passive disengagement, where a person may simply become indifferent or less involved, active disengagement involves deliberate actions, such as neglecting responsibilities, undermining efforts, or contributing to negative outcomes.

An actively disengaged physician or group may display the following:

- **Resistance to Change or Innovation:** In healthcare, active disengagement by physicians could manifest in resistance to adopting new technologies, treatment protocols, or healthcare models. For example, they might openly oppose the implementation of electronic health records (EHRs) or new patient care approaches.
- **Disrupting Patient Care:** Disengaged healthcare professionals might actively neglect or undermine patient care by not following evidence-based practices, failing to communicate effectively with patients or colleagues, or ignoring guidelines and protocols that ensure quality care.
- **Withdrawal from Leadership Roles:** Physicians or other healthcare providers who are actively disengaged may actively withdraw from leadership or administrative roles, refusing to participate in hospital committees, quality improvement initiatives, or system-level reforms.
- **Skepticism or Opposition:** Active disengagement might also involve promoting negative viewpoints, challenging the legitimacy of social reforms, or advocating for inaction, thus hindering progress.

Consequences of Active Disengagement:

- **Disruption:** Active disengagement can disrupt workflows, affect relationships, and harm organizational or societal goals.
- **Reduced Morale and Productivity:** In workplaces and organizations, active disengagement can lead to a toxic environment, reducing morale, productivity, and collaboration among team members.

2024-25 External Review of Regina Hospital Physician Culture

- **Negative Outcomes for Personal or Group Objectives:** In any context, when an individual or group becomes actively disengaged, they can negatively affect the long-term success and well-being of the system, whether it's an organization, community, or project.

Conclusion:

Active disengagement is a more pronounced and deliberate form of disengagement where individuals actively withdraw, resist, or undermine efforts. It is often driven by dissatisfaction, frustration, or a fundamental lack of alignment with the goals, values, or interests of the group or system they are a part of. Recognizing and addressing active disengagement is crucial to maintaining a positive, productive, and cohesive environment in any setting, from workplaces to educational institutions and healthcare systems.

BARRIERS TO PHYSICIAN ENGAGEMENT IN CANADA

- **Lack of Support from Health Authorities:** Physicians in Canada often report feeling unsupported by health authorities or hospital administrations, particularly in times of crisis such as during the COVID-19 pandemic. Without adequate administrative support, resources, or opportunities for professional development, physicians may withdraw from leadership or collaborative roles.
- **Lack of Recognition and Respect:** Physicians in Canada, like elsewhere, may feel underappreciated, particularly when they face systemic challenges like overcrowded hospitals or inadequate compensation for the work they do. This lack of recognition can contribute to a sense of disengagement, where physicians may feel that their efforts are not valued by the healthcare system or the public.
- **Work-Life Balance Issues:** Many physicians in Canada struggle to maintain a work-life balance, particularly those in busy practices or underserved areas. The demands of being on-call, managing patient loads, and fulfilling administrative responsibilities often leave little time for personal life or self-care, which can lead to burnout and disengagement. Achieving work-life balance is often difficult for physicians, especially when they feel a sense of duty to care for their patients despite personal sacrifices.
- **Promoting Work-Life Balance:** Institutions can encourage better work-life balance by offering flexible scheduling, reducing on-call hours, and fostering a culture of respect for personal time. This would help prevent burnout and allow physicians to maintain engagement in their work for longer periods.
- **Leadership and Career Development:** Providing physicians with leadership opportunities and professional development programs can increase engagement by giving them a sense of purpose and ownership over healthcare initiatives and reforms. Physicians who feel they can influence healthcare policy or practice are more likely to remain engaged in the system.

Conclusion

Physician disengagement in the Canadian healthcare system is a multifaceted issue influenced by systemic challenges, work pressures, and emotional exhaustion. It can have serious consequences for both the healthcare workforce and patient care. Addressing disengagement requires systemic changes that support physician well-being, reduce administrative burdens, and promote work-life balance. By fostering a supportive and collaborative work environment, the healthcare system can help ensure that physicians remain engaged, motivated, and committed to providing high-quality care to their patients.

Appendix 6: PHYSICIAN SELF GOVERNANCE IN CANADA

Resource: CMAJ- [Self-regulation in healthcare professions comes under scrutiny](#)

1. Regulatory Bodies, Ethical Standards and Professionalism

In Canada, **self-governance** is primarily exercised through provincial and territorial medical regulatory bodies such as the **College of Physicians and Surgeons of Saskatchewan (CPSS)** responsible for licensing, disciplining, and regulating physicians within its jurisdiction.

These regulatory bodies ensure that physicians meet the required standards of competence, ethics, and professionalism. They establish and enforce the rules that guide medical practice, conduct, and discipline.

Physician self-governance emphasizes adherence to ethical guidelines and high standards of **professionalism**. These guidelines often focus on principles such as **patient-centered care, confidentiality, informed consent, and respect for patient autonomy**.

The medical regulatory bodies enforce these ethical standards through various mechanisms, including codes of conduct, continuing medical education (CME), and peer review processes. These bodies also investigate complaints or concerns related to physician behavior or practice.

Regulatory bodies are responsible for investigating complaints against physicians and ensuring that any breaches of conduct, malpractice, or incompetence are addressed. The process typically involves an independent investigation, and disciplinary actions can range from warnings to suspension or revocation of a physician's license to practice.

These disciplinary processes are designed to protect the public and maintain the integrity of the medical profession, ensuring that physicians remain accountable for their actions and adhere to the highest standards of care.

In hospitals and other healthcare organizations, physicians use Bylaws, Rules, Policies, Procedures, Practice Agreements, Funding Contracts and various other processes to ensure that local departments, teams and groups can function effectively. Such documents are developed within and aligned with the broader framework and accountabilities outlined above.

2. Continuing Education and Professional Development

Self-governance also requires physicians to engage in **lifelong learning** to maintain their competence and stay up to date with advancements in medical knowledge, technology, and practices.

In addition to provincial or territorial licensing, physicians must also be **certified** by the **Royal College of Physicians and Surgeons of Canada (RCPSC)** for specialists or by the **College of Family Physicians of Canada (CFPC)** for family doctors. These organizations play a role in overseeing specialty and family medicine certifications and maintaining standards across the country by mandating continuing education and professional development as part of licensing and certification renewal processes. This helps ensure that physicians maintain the skills and knowledge needed to provide safe, effective, and current care.

3. Scope of Practice and Policy Advocacy

Physician self-governance allows physicians to define and regulate their **scope of practice** through professional standards and practice guidelines, which help ensure that the care provided is safe,

2024-25 External Review of Regina Hospital Physician Culture

evidence-based, and appropriate to the specific context of practice (e.g., rural versus urban settings). Many specialty associations exist such as the Society of Obstetricians and Gynecologists of Canada (SOGC), the Canadian Anaesthesiologists' Society (CAS), the Canadian Association of Emergency Physicians (CAEP), etc.

Physicians, through professional organizations like the **Canadian Medical Association (CMA)**, also have a voice in health policy advocacy. They help shape healthcare policy, work with governments, and provide input on public health initiatives, access to healthcare, and other key issues.

4. Autonomy and Ethical Decision-Making

Physician self-governance ensures that doctors have the **autonomy** to make clinical decisions based on their professional judgment and expertise. However, this autonomy is balanced by the ethical responsibility to act in the best interests of patients and adhere to legal and professional standards.

This balance is often challenged by evolving healthcare models, new technologies, and societal expectations. Physicians must constantly navigate these challenges to maintain the integrity of their self-governance.

5. Collaboration with Other Health Professions

While physicians in Canada are self-regulated, they also collaborate with other healthcare professionals (nurses, pharmacists, physiotherapists, etc.) to deliver patient-centered care. Physician self-governance includes understanding and respecting the roles of other healthcare providers in ensuring comprehensive care.

In recent years, there has been a shift toward **interprofessional collaboration**, where physicians work as part of a broader healthcare team. This model acknowledges the importance of working together, while maintaining individual accountability within each profession.

6. Public and Government Oversight

Despite the autonomy granted to physicians, self-governance does not mean complete independence from government oversight. Provincial and territorial governments set the legal and financial framework for healthcare delivery, and physicians are ultimately accountable to the public through their regulatory bodies.

Governments may intervene in cases of public concern, such as during healthcare crises or when there are concerns about the accessibility and quality of care. The medical profession, therefore, operates in a system of oversight that balances self-regulation with external accountability.

Conclusion

Physician self-governance in Canada is a vital element of the healthcare system, enabling physicians to maintain high standards of care, uphold ethical principles, and remain accountable to society. Through regulatory bodies, professional organizations, and licensing systems, physicians are empowered to govern their practice while balancing their autonomy with the obligation to serve the public's best interests. The ongoing evolution of healthcare, both in terms of policy and practice, requires physicians to remain flexible and responsive to societal needs, while preserving the integrity and trust placed in their profession.

2024-25 External Review of Regina Hospital Physician Culture

Appendix 7: LAWS GOVERNING THE PRACTICE OF MEDICINE IN CANADA

Resource: [CMPA Medical-legal handbook for physicians in Canada](#)

In Canada, the practice of medicine is governed by a combination of federal, provincial, and territorial laws, as well as regulatory bodies and professional standards. These laws ensure that medical practitioners meet the necessary qualifications, adhere to ethical guidelines, and provide safe, effective care to patients. Here's an overview of the key laws and regulations that govern the practice of medicine in Canada:

1. The Canada Health Act (1984)

The Canada Health Act is the cornerstone of Canada's publicly funded healthcare system. While it does not directly regulate the practice of medicine, it sets the conditions and criteria for provincial and territorial health insurance programs to receive federal funding. The act aims to ensure that all Canadians have access to medically necessary hospital and physician services without direct charges at the point of care.

2. Provincial and Territorial Medical Act

The **Medicine Act, 1991** of Saskatchewan provides the legal framework for the practice of medicine within the province. It regulates the licensing, conduct, scope of practice, and discipline of physicians, ensuring that medical care is provided in a safe, ethical, and competent manner. The Act works in conjunction with other provincial and federal regulations, ensuring that physicians in Saskatchewan deliver high-quality care while adhering to professional standards and protecting patient safety. The College of Physicians and Surgeons of Saskatchewan plays a key role in enforcing the provisions of the Act and ensuring that the medical profession maintains its integrity and public trust.

3. Medical Licensing and Regulation

Regulatory Bodies: College of Physicians and Surgeons responsible for licensing and regulating physicians. These bodies ensure that physicians meet the necessary standards of competence and professionalism and that they adhere to the ethical guidelines established by the medical profession.

Licensing Process: Physicians must graduate from an accredited medical school and complete a residency program to be eligible for licensure. The Medical Council of Canada (MCC) plays a role in the certification and examination process for physicians. The MCC Qualifying Examination is required for international medical graduates to practice in Canada.

4. The Criminal Code of Canada

The Criminal Code of Canada contains provisions that impact the practice of medicine, especially concerning issues such as assault, fraud, and negligence. For example, if a physician is found guilty of providing care that leads to harm or death through gross negligence or intentional harm, they can be charged with a criminal offense under the Criminal Code.

Consent: The Criminal Code also addresses consent for medical treatments and procedures. Informed consent is a legal requirement for any medical intervention, meaning that a physician must fully explain the procedure, its risks, and potential outcomes before proceeding.

5. The Health Information Protection and Privacy Laws

2024-25 External Review of Regina Hospital Physician Culture

Health Information Protection Act (HIPA) plays a crucial role in safeguarding the privacy of personal health information in Saskatchewan, ensuring that it is collected, stored, used, and disclosed appropriately. It establishes clear guidelines for consent, access, security, and accountability, and it provides mechanisms for addressing breaches of privacy. The Act ensures that individuals' health data is protected while facilitating the delivery of healthcare services.

Federal Protection: At the federal level, the Personal Information Protection and Electronic Documents Act (PIPEDA) applies to private-sector healthcare providers and ensures that personal health information is kept secure and confidential.

6. The Medical Professional Liability Laws

Medical Malpractice: Physicians in Canada are required to carry professional liability insurance to protect themselves against potential malpractice claims. Laws related to medical negligence and malpractice are defined by civil litigation, where physicians can be sued if they fail to meet the standard of care expected in their practice and cause harm to patients.

Statute of Limitations: Each province has laws that determine the time limit within which a patient can file a malpractice lawsuit, generally ranging from 1 to 3 years after the injury or discovery of the harm.

7. The Regulated Health Professions Acts

The Regulated Health Professions Act (RHPA) in Saskatchewan provides a structured and comprehensive framework for the regulation of health professions. By empowering regulatory bodies to establish professional standards, oversee licensing and registration, and investigate complaints, the RHPA ensures the public's safety and confidence in the healthcare system. It sets clear expectations for health professionals, maintains high standards of practice, and helps ensure that all health services provided are in line with ethical and professional guidelines.

8. The Controlled Drugs and Substances Act

The Controlled Drugs and Substances Act (CDSA) is a federal law that governs the use, distribution, and prescription of controlled substances in Canada. Physicians must comply with these regulations when prescribing narcotics, controlled drugs, and other substances that are subject to government regulation. Violations of the CDSA can result in severe penalties, including criminal charges.

9. Employment Laws Impacting Physicians

Physicians who are employed in hospitals, clinics, or other healthcare institutions are also governed by employment laws in their respective provinces. These laws cover areas such as contractual obligations, workplace rights, unionization, and discrimination.

Workplace Safety and Health: Physicians are also subject to occupational health and safety laws, which regulate the safety of their workplace, particularly when dealing with infectious diseases, hazardous materials, and other workplace hazards.

10. The Canadian Medical Association (CMA) Code of Ethics

Although not a law, the CMA Code of Ethics and Professionalism provides guidelines for physicians to follow in terms of ethical practice. This document outlines the expected conduct and responsibilities of physicians, including patient confidentiality, informed consent, honesty, and maintaining a professional relationship with patients and colleagues.

11. Human Rights Legislation

Physicians are subject to human rights laws in their practice, which prohibit discrimination based on race, gender, religion, disability, and other protected grounds. In many provinces, this legislation extends to ensuring equal access to healthcare services, and physicians must ensure that they do not discriminate against patients in providing care.

Conclusion

The practice of medicine in Canada is governed by a comprehensive framework of laws, regulations, and professional standards. These laws ensure that physicians are properly trained, licensed, and held accountable for their professional conduct. They also guarantee that patients are protected from malpractice, that their personal health information is safeguarded, and that they receive quality, ethical, and non-discriminatory care. Physician practice is primarily regulated at the provincial and territorial level, but federal laws like the Canada Health Act and Criminal Code also play a significant role in shaping healthcare delivery in Canada.

2024-25 External Review of Regina Hospital Physician Culture

APPENDIX 8: BASIC CHECKLIST FOR A WELL FUNCTIONING MEDICAL DIVISION OR DEPARTMENT

Departments or divisions who can meet these criteria are more likely to attract and retain top talent, and to effectively manage quality, risk and performance in their programs and services:

- Rules, Code of Conduct, Team Norms, Policies and Procedures that govern the workings of the group with specific attention to meeting attendance, transparent, fair and consistent methods for assigning work, on call duties, back up coverage, teaching, vacation, leaves, and locum support.
- Regular meetings with set agendas plus time for open discussion, including time with administration for shared decision-making on policy development, and strategic planning, ensuring that operational decisions reflect the realities of patient care and physician needs.
- Knowledge of the resources available to support their programs and services, how they are shared, and how to advocate for expansion.
- Attention to data that represents key quality indicators, service volumes and wait times.
- Regular rounds and education on clinical advancements, challenging cases and unexpected outcomes.
- Communication avenues that are open and transparent among the group and between the group and other departments, interdisciplinary teams and administration.
- Minimum requirements for continuing professional development.
- Structured orientation and supervision of new members.
- Commitment to a high-quality experience for trainees.
- Opportunities for social engagement among physicians and across teams.
- Annual review of medical human resource needs, recruitment and succession planning.
- A structured onboarding program to ensure that new physicians integrate smoothly into the team, understand departmental processes, and quickly adapt to the organizational culture.
- Participation in organizational awards and recognition.
- Participation in performance evaluations and professional development.
- Effective processes to address outliers in quality, behaviour and performance.

2024-25 External Review of Regina Hospital Physician Culture

APPENDIX 9: PARTICIPANTS IN THE REVIEW

MINISTER OF HEALTH	The Honourable Jeremy Cockrill
ASSISTANT DEPUTY MINISTER OF HEALTH	Ingrid Kirby
ADMINISTRATIVE SUPPORT	Marilyn Day

TABLE OF INTERVIEWEES:

Role	Names
ADM	Ingrid Kirby
ED of MSB	Kim Statler
CEO SHA	Andrew Will
CMO SHA	Dr. Susan Shaw
ED of PSA	Steve Chard
	Tamara Ferraton - Director of PSA
Dean of Medicine	Dr. Sarah Forgie
Vice-Dean Regina	Dr. Gill White
Regina Area Chief of Staff	Dr. Dorothy Thomas
Physician Executive	Dr. Rashaad Hansia
VP Regina	- Sheila Anderson
Regina Acute Care Admin Leads	Tom Stewart (Kerri Hysuick cancelled due to personal emergency)
Saskatchewan Medical Association (virtual)	Marcel Nobert – ED Physician Services & Benefits
Regina Medical Staff Association Executive	Ankit Kapur & Matthew Butz
	Dr. Tom Lloyd - SHA External Coach
	Dr. Ingi El Sayed - Nephrologist and husband Dr. Yehia Kamel
	Dr. Mike Kelly (PDH Surgery)
	Dr. Terry Klassen (PDH Pediatrics)
	Dr. Fergall Magee (PDH Pathology & Laboratory Medicine)
Provincial Department Heads (all virtual)	Dr. Sheldon Wiebe (Radiology)
	Dr. Sam Haddad (PDH Medicine)
	Dr. Mateen Raazi (PDH Anesthesiology)
	Dr. Kathy Lawrence (PDH Family Medicine)
	Dr. Joanne Sivertson (PDH O&G)
	Dr. James Stempien (PDH Emergency Medicine)
	Dr. AG Ahmed (PDH Psychiatry)
	Dr. Gary Linassi (PDH PM&R)
Area Department Leads - Regina	Bonnie Richardson (Medicine)
Area Department Leads - Regina	Vijay Trivedi (Radiology) (term is up, currently recruiting for new)
Area Department Leads - Regina	John Tsang (Surgery)
Area Department Leads - Regina	Tim Rosser (Anesthesiology)
Area Department Leads - Regina	Donna Ledingham (Pathology)
Area Department Leads - Regina	Sam Haque (Psychiatry)
Area Department Leads - Regina	Chris Chukwujekwu (Psychiatry)
Area Department Leads - Regina	Lyndsay Sprigg (Critical Care)
Area Department Leads - Regina	Tiann O’Carroll (Emergency Medicine)
Area Department Leads - Regina	Christine Lett (O&G)

2024-25 External Review of Regina Hospital Physician Culture

Area Department Leads - Regina Jacquie Kraushaar (PM&R)
Area Department Leads - Regina Glenda Kaban (Emergency Medicine)
Area Department Leads - Regina Winston Lok and Nishen Bhagaloo (Family Medicine)
Dr. Andre Grobler - President, Saskatchewan Medical Association and Prince Albert Physician
MSA Group (Matthew Butz and Ankit Kapur host/chair meeting and send out invite)
Dr. Pam Arnold - Board of Directors Saskatchewan Medical Association
Dr. Shanchit Bhasin - Board of Directors Saskatchewan Medical Association
Dr. Mohamed Moolla - Board of Directors Saskatchewan Medical Association and Family Medicine
Dr. Lookman Abdul - Division of Nephrology
Dr. Amanda Ellwood - Division of Nephrology
Dr. Olumide Ogundare - Division of Nephrology
Dr. Mohamed Abdulhadi - Division of Nephrology
Dr. Arwa Gargoum - Division of Nephrology
D. Joy Dobson - Consultant to the Area Chief of Staff
Dr. Philip Fourie - Deputy Chief Medical Officer
Dr. Bhanu Prasad - Professor of Medicine, U of S, Consultant Nephrologist
Dr. Siva Karunakaran - Department of Medicine
Dr. Johnathan Grynspn - Physician - Imaging
Dr. Lenny Pillay - ENT Specialist - Regina
<u>Dr. Linas Kumeliauskas ADL of GIM</u>
Concerned Physicians Group of 10: 1.Dr. Babatunde Adewunmi 2.Dr. Moyosore Abimboye 3.Dr. Anita Lwanga 4.Dr. Steven Lwanga 5.Dr. Ghulam Moinuddin 6.Dr. Olu Ogundare 7.Dr. Abiodun Abdulazeez Olajide 8.Dr. Tom Perron 9.Dr. Habib ur Rehman 10.Dr. Rosemary Serwadda