SASKATCHEWAN PHYSICIAN ENGAGEMENT AND LEADERSHIP ACTION RESEARCH PROJECT

Report by: G. Dickson, PhD & J. Van Aerde, MD, PhD

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Introduction

The purpose of the Saskatchewan Physician Engagement and Leadership (SPEL) longitudinal action research project, conducted between 2019 and 2021 is three-fold:

1. To investigate, explain, and document dynamics within the Saskatchewan health system that either enhance or mitigate the goal of achieving optimum levels of physician engagement and leadership in the stewardship of the province's future healthcare system.
2. To document the progress toward that goal over the period of the project.
3. To offer suggestions for further improvement where such suggestions might be warranted.

The goal of this report, written after three rounds of interviews, is to summarize final results, and to suggest some actions to move the province towards its' strategic goal of optimizing levels of physician engagement and leadership in the stewardship of the healthcare system. It is recognized that the strategic goal is a long-term goal, not to be achieved during the timeframe of this study, but more likely over a ten-year period.

Timing

This report was written in full acknowledgement that the COVID-19 pandemic is having a profound influence on all aspects of healthcare services. It recognizes the pandemic created contextual conditions for operationalization of physician engagement and leadership that were completely unanticipated when this project was launched. However, real life is the context for achievement or lack of it. The report recognizes the fluidity and ambiguity prevalent in today's health care systems, recognizes those challenges, and provides some suggestions to keep the momentum going toward the ultimate goal of optimizing physician engagement and leadership within the Saskatchewan health system.

Structure

The report is structured as follows:

1. Overview of methodology
2. Background
3. Key findings: A longitudinal analysis (Round 1—3)
4. Results and discussion
5. Suggested next steps
6. Summary and conclusion

Overview of Methodology

This study used a Participatory Action Research (PAR) methodology employing naturalistic inquiry methods and using a single case approach (i.e., Saskatchewan health system). The method involves three stages of investigation and documentation, resulting in a provincial case report describing lessons learned relative to optimizing physician engagement and leadership in Saskatchewan.

The overarching question was: *What factors within a local, regional, and/or provincial context enhance or constrain achievement of optimal physician engagement and leadership aimed at generating a more people-oriented Saskatchewan health system as defined by government*?

To help answer this question, data was gathered through individual semi-structured phone interviews. Interviews were conducted in three rounds during a three-year period. The first round was conducted at the beginning of this research project; November 2019. The phone interview was recorded, and a transcription made. Round 2 was conducted nine-ten months later by Zoom interviews; each zoom call was recorded, and a transcription made. A third round of interviews were conducted via Zoom in June-July 2021 and were recorded and transcribed.

An initial pool of fourteen physicians were interviewed in each of the first two phases of the project; in the third round, 13 interviews were conducted.

Analysis of the recorded data compiled from each round of interviews was separately imported into and analyzed utilizing NVivo 12 Pro for Windows software in a password-protected file. Once imported, data was read while broad-level codes were generated as they appeared in the data. Larger thematic areas were broken down into sub-themes if they were multi-faceted, with each sub-theme carrying enough weight to warrant its own node. It should be noted that high frequency themes/nodes do not necessarily correspond to a more prominent or important theme. The result was the creation of three reports, one for each round. These reports were then analyzed by the two researchers to identify (1) findings unique to each report phase; and (2) themes/issues/perspectives identified longitudinally across all three rounds.

After the second round of interviews an Interim Report of key findings was written to summarize key themes and results. This report is attached as Appendix A. This final report builds on the Interim Report by comparing findings and results in Round 3 with those from Rounds 1 and 2.

Findings are presented in the form of a longitudinal table showing areas of similarity and difference pertaining to each round. This is found in the section titled, *Findings: A longitudinal analysis of Round 1-3 reports.* The contents of the table and the data lying beneath it in the three reports were then analysed by the researchers to identify themes emerging from the longitudinal analysis. To help interpret those themes in the context of the practical world of Saskatchewan's health system, documentation from the SHA, MOH, COM relative to the strategic goal that was created during the timeframe of the study was reviewed; also informed by the literature. The resulting themes and a discussion of them is presented in the section titled, *Results and Discussion*. A fourth section of the report then outlines suggestions for 'next steps' in terms of moving the goal of optimizing physician engagement and leadership forward.

Findings: A Longitudinal Analysis of Round 1-3 Reports

Each Round produced a summary report of key ideas and themes. Table 1 chronicles, longitudinally, a distillation of high-level findings from each of the three rounds of interviews. The table shows the progression (or lack of) with respect to the following topics: *Context and Role Clarity; Progress; Physician Engagement and Leadership; and Impacts of Provincial Regionalization and COVID-19*.

Results and Discussion

There are seven key themes that emerge from the longitudinal analysis of the data generated from the interviews. They are arranged under two main headings: Context (two themes), and Organizational/Personal Factors (five themes). The discussion around each theme is informed by existing documentation available from the SHA, MOH, CoM, or SMA, by reference to the original research protocol document, and relevant literature (see Reference section).

Context

1. *The impact of COVID-19*

The most recent MOH 2020--21Annual Report says it all: with respect to the objectives of integrating more physicians into the culture of SHA, the Prince Albert Demonstration project, improving service delivery through physician-led Practice Profile Reports, involving physicians in in designing an approach for virtual collaboration within health Networks, and establishing Health Networks to integrate physicians into daily team meetings, developing a measurement system to gauge progress—**were delayed due to COVID**.

All interviewees were conscious that most of the deliberate plans to facilitate improvements into physician engagement and leadership—whether they knew of them or not—had been either abandoned or put on hold due to the need to respond to the COVID-19 crisis. They also believed that the organizational response to the COVID-19 pandemic, in the form of instinctive collaboration to solve an emergent problem, rapid decision making which involved physicians, engagement of physicians in the Emergency Operations Centre, involvement of physicians within some of the acute care networks, and the plethora of physicians who stepped up at the local level to assist with the pandemic response all demonstrated the value of physician engagement. What they appeared uncertain about was (1) whether there would be a return to the previous engagement strategy and related tactics once the pandemic was resolved, because of the resultant stress on resources, new priorities, and surgical backlogs, etc. across the province; and (2) whether the 'newfound' engagement of physicians would be channelled back into a returned emphasis on policy and procedure rather than emergent innovation and contribution.

It appears—as relative to the interviewee's experience of progress—that ongoing efforts to reassure and reinvigorate commitment to the goal of optimizing physician engagement and leadership have waned or are no longer apparent. Reinvigorating this commitment and outlining

Table 1: A longitudinal analysis of three rounds of physician interviews from the SELP

Interviews	Round 1: November 2019	Round 2: Sept/Oct 2020	Round 3: June/July 2021
Context and Role Continuity			
Time after provincialization	23 months	34 months	43 months
Time frame re: COVID	Pre (4 months before)	Second wave (7 months into)	Between wave 3 & 4 (16 months into)
Participants #	14	14	13
Role changes	-	* 4 changed; 1 resigned (still interviewed) * Circumstances changed for 9 (due to COVID); new roles created for physician leaders	* 5 changed; 1 more resigned (still interviewed) * COVID-related role changes
Role clarity & accountability	* Fluid and changing * Who makes what decisions?	* No clear expectations and results * No clear accountability (due to COVID?)	* What results/accomplishments are expected from physician leaders? (fuzzy due to COVID?)
Progress			
Progress rating (mean; median; range)	(2016) 3.5 (3; 1-8) (2019) 5.5 (5.5; 2.5-8)	Not measured	6.1 (6.2; 3.5-8)
	Variability of ratings and increase or decrease within same individual between sampling times indicate that the ratings are not validated against measurable indicators of responsibility/accountability; all round 3 interviewees gave higher rates than in 2016		
General comments	* Optimism (mix + & - comments) * Long transition process anticipated * Unsure of reporting relationships and responsibilities * Success for upper levels to PDH; not much for grassroots docs & roles	* Progress slowed; whatever progress was made due to pandemic, not removal of structural, cultural, political barriers * Less optimism, particularly sustainability	* Progress due to COVID rather than planned changes? * COVID workload → burnout risk! For some resulted in reduced engagement * Catch-up of postponed procedures will be huge * Physician engagement was part of initial strategic plan; SHA recently removed it * Turnover increasing
Differences in progress	* Urban more progress than rural * Saskatoon more progress than Regina	* Progress variable in rural areas * Difference Saskatoon / Regina persists	* Saskatoon better culture of engagement and collaboration than Regina, but improving in Regina * Saskatoon has more resources and staff * CoM focuses more on city of Saskatoon

Physician Engagement and Leadership			
What favors engagement	* Increased networking/collaboration * Better communication * Increased learning opportunities * Perception docs have more input in new system * Increased opportunities for engagement among physicians	* Crisis helped acute engagement (COVID) * Increased communication due to COVID * Positive role modeling * PMI courses * Leadership huddles * Wellness initiative	* Improved engagement mainly among acute care physicians (due to COVID) * Improved partnerships * Virtual meetings better attended than f2f * Town hall meetings & huddles
Barriers	* High time investment * No work/life balance * Insufficient compensation and/or FTE * Lack of clarity for personal responsibilities * Lack of interest from docs * Lack of being valued * Culture shock of admin work	* Time/FTE allocation – workload too high * Silos/mental models impair collaboration * Regional differences & 'competition' * Inappropriate remuneration * Lack of role clarity, process, accountability * Reversal to all pattern due to previous bureaucracy? * Lack of onboarding & training * Disconnect between upper/lower levels of physician leadership * Undervalued and not involved in decisions * Risk losing clinical skills	* Remuneration * Burnout * Uncertainty over roles with organizational structure * Unable to influence meaningful change * Top-down decisions * Reversal to old practices stifles enthusiasm * Unrealistic expectations
Suggestions	* Promote learning and mentorship opportunities * Focus on co-leadership development	* Create clear career pathway	* Offer formal leadership training and mentorship * Mitigate burnout
Role clarity & accountability	* Lack of role clarity * Fluid and changing * Lack of planning * Who makes what decisions?	* No clear expectations and results * No clear accountability (due to COVID?)	* Progress in role clarity and understanding of organizational structure * What results/accomplishments are expected from physician leaders? (unclear due to COVID?)
Impacts of Provincial Regionalization and COVID-19			
Positive	* Increased networking/collaboration * Increased opportunities for engagement among physicians * Better communication * Increased learning opportunities * Hiring quality personnel	* Accelerated hiring, decision-making and common goal due to COVID crisis * Increased communication due to COVID * Increased scope of engagement due to COVID * Use of technology – virtual meetings	* Provincialization helped deal with COVID which in itself gave a common purpose * Quicker adaptation due to COVID (not due to provincialization) * Crisis engaged some docs in leadership positions faster; crystalized need for

	* Increased shared infrastructure & support * Perception that docs have more input in new system	* Town hall meetings * Integrated community response to COVID * Importance of co-leadership	physician leadership * Accelerated decision-making & willingness to try new methods during COVID * Virtual meetings allow more efficiency and less travel * Crisis communication faster and efficient * Improved collaboration * Rapid access to data and good communication with SHA
Negative	* Difficulties recruitment; lack of capacity or personnel * Lack of awareness of regionalization & opportunities by family medicine docs * Transition increased confusion * Exec structures don't yet align well with physician leadership structures	* Lack of role-modeling and mentorship * MoH taking back decision-making from docs; political interference * No evidence-based planning * Covid highlighted issues of an unprepared structure	*No formalized plans to engage physicians *No more prompt hiring *Lack of engagement of community *Lack of engagement of family docs *Lack of engagement of non-hospital docs *Planned physician leadership & engagement put on hold due to COVID *Discrepancy between recommendations of physician leaders & actions by government *Lack of support staff * Lots of bureaucratic red tape
Suggestions	* Support for mentorship * Well-rounded learning opportunities * Rotation medical leadership * Recognize importance of academicians and administrators * Structure, role clarification, streamline concern handling * Invest in technology to facilitate collaboration among groups	* Importance to have patient advisor at table	* Accelerate physician engagement across entire organization * Some stepped into leadership positions because of crisis; don't lose them * SMA not involved * SHA changing priorities * Don't go back to inefficient meetings and unnecessary travel time to meet *Hire high quality leaders with right skills * Improve collaborative culture * Succession plan * Continue physician town halls * Offer incentives * Organize by topic, not geography

support for the goal and contextualizing it in the new normal would assuage such concerns. As part of those commitments, it would be helpful for the original coalition of partners—the SHA, the MOH, the SMA and the CoM—to see themselves as a guiding coalition to re-invigorate the initiative. While most interviewees initially, in 2019, were aware that all four organizations 'championed' the initiative, their ongoing role and commitment was questioned in subsequent interviews, not because of anything the organizations did, but more because their public and clear commitment to the goal, and how they would contribute, were unclear.

2. *The impact of regionalization*

Overall regionalization was perceived by most interviewees as a positive contributor to perceived successes of the physician engagement and leadership strategy. It did so in two ways: first, it created a provincial context that everyone—including physicians—had to adapt to and adjust their current worldview and daily behaviour; and second, it created opportunities, within the restructuring to create new positions to reflect this priority. The fact that the initiative was "part of the strategic plan" of the new authority gave it substance and heft. Integrating physician recruitment into the provincial structure showed a commitment to attracting the best physicians to Saskatchewan. The ability to respond to COVID with a single voice and to have a central communications centre was seen as a positive result of regionalization; in particular, the elevation of a number of physicians to take on major leadership roles during the pandemic to "improve policy development" was noted.

Regionalization and COVID together also illuminated many of the impediments that still must be overcome. Many of the interviewees were concerned that the amount of time given to physicians in formal leader roles was not adequate to deal with the workload. The job itself was evolving and accountabilities unclear. Confusion sometimes existed as to what should be standardized at a provincial level versus left for local discretion. Regarding the latter, some worried, for example, that after COVID "bureaucracy would reassert itself" and physicians would lose some of the autonomy and decision-making power they were granted during the COVID pandemic. For some, the stubbornness of prior cultural belief systems (i.e., I can only see my local role) detracted from the ability to see challenges such as physician engagement and leadership from an overall provincial perspective. Some physicians find it difficult to embrace the changes needed to create a provincial approach.

One element that did not surface during the interviews on in accompanying documentation was clear references to an overall change process. Regionalization "evolved" and is being "co-created" in the minds of many, but the process to facilitate change was not mentioned. Subsequently the inevitable confusion and angst associated with emergent change has affected different physicians in several ways. Some worry about their ability to do the job. Some feel they have been left on their own. Some welcome the fluidity and ambiguity of evolution as an opportunity to create a role that is meaningful. It would be valuable to reflect on: whether the psychological support many need to go through major change is in fact in place; and whether a change support process, built into the overall initiative, would alleviate some of the more destructive stressors associated with change. In fact, during the third round of interviews, the 'burn-out' factor was identified as crucial

to address in to move forward. What is the safety net to support these physicians who choose to move into the uncharted territory of leadership?

Personal and Organizational Factors

When the longitudinal data in Table 1 is looked at in the context of efforts made by the MOH, SHA, CoM, and SMA (as revealed in their strategic plans and annual reports during this time period), the following themes emerged and needed to be explored in order to help shape a deeper understanding the interviewee experience, and to identify potential actions that can be taken to move this project forward—beyond COVID.

1. *The confluence of personal and organizational factors for success: what more is needed?*

For physician engagement and leadership to grow, efforts must be made on two fronts: engagement and leadership opportunities for physicians need to be made available by the organization(s); and doctors themselves must have the capabilities to take advantage of those opportunities (the same applies for dyads).

From the perspective of organizational opportunity, the SHA and MOH annual reports and business plans describe such initiatives. The Demonstration project[1], the creation of networks, developing dyads, and inviting physicians at all levels to step up and become part of the response to COVID—created multiple opportunities for physicians to engage and lead. In listening to the interviewees, while they seemed to have appreciated the opportunities that they knew about, nobody actually mentioned the Demonstration project. Some interviewees also pointed out that factors contributing to facilitating engagement were positive role modeling from their colleagues; when non-physicians or physician colleagues reached out and welcomed them to become part of the organization. Many commented that positive relationships have been built across traditional boundaries during the pandemic.

However, interviewees also commented on the lack of a concomitant changes in facilitative practices. For formal leaders, these were: time allocated to leadership roles (FTE allotments), on some occasions a 'bureaucratic, control mindset on behalf of their supervisor or partner, remuneration (i.e., taking a major pay cut to take on a leadership role), and for many, a lack of job clarity (i.e., no clear expectations or feedback on results) and greater than expected workload. For informal leaders and frontline physicians who wished to be engaged, cultural issues such as these roles being undervalued compared to clinical work, the risk of losing their clinical skills and profile, and disinterest on behalf of colleagues, are cited as problematic.

An interesting question is this: are the 'negative facilitative factors' due to the organization's lack of attention to those interviewed, or are they due to the individual capacity of some interviewees to adapt and adjust to the demands their leadership roles create? For example, as one stated, is it the "culture shock of the administrative work" that creates factors like not enough time, etc., or is that shock the consequence of not yet possessing the skills that the work demands? Going forward

[1] The Ministry of Health (MoH), the Saskatchewan Medical Association (SMA), and the SHA engaged with local physician groups in Prince Albert and Shellbrook to develop strategies for a new unified model of primary health care delivery.

this begs the question: With burnout growing within the larger physician community of Saskatchewan due to COVID, is it realistic to expect its 2700 doctors to embrace the engagement and leadership challenge post-COVID? Is a breather required? Will support be built into the system?

Individual capacity to engage or lead is particularly important as the interviewees also point out that the developmental processes needed to grow into the new roles are not as available as they would like them to be (see section 7). One gets the impression that for some the transitions required to become engaged or to take on leadership roles is a little like "being thrown to the wolves" and beyond their existing skill set, while others naturally adapt and adjust to the new demands. For example, it is clear from interviewee responses that the capability to be an effective strategic leader, to see decisions on a provincial system basis, and to lead in a context of constant ambiguity is for many hard to come by without a developmental support system.

Another explanation for some of the interviewees' statements like "there is a lack of engagement of family doctors", and there are "no formalized plans to engagement physicians," may simply be a communication divide: i.e., they aren't aware of how all the pieces identified earlier collectively contribute to physician engagement. In addition, they might not be getting the information needed to 'see' what those efforts are accomplishing. And of course, a further explanation is that some non-physician SHA managers/leaders themselves may not 'tuned in' to the initiative. This might explain the comment that COVID has "revealed strong leaders and weak leaders".

2. *Job churn.*

Churn is defined as to "agitate or turn; move or cause to move about vigorously". There are two dimensions to the concept of churn as experienced by our interview cadre. The first is that Job profiles and descriptions are evolving along with regionalization and emergent challenges due to the need for a provincial response to COVID. For example, in the third round of interviews, three individuals indicated they had a significant job change (role expanded to include work on COVID vaccination campaign; role went from .4 to 1.0 FTE; role expanded to include DOVID immunization strategy). The second is that two of the fourteen individuals interviewed have left their role (one for perceived discrimination reasons and the other micro-management) and returned to their clinical roles. Both factors can contribute to a sense of uncertainty, or confusion, as per job expectations on the one hand and to organizational disruption in continuity on strategic imperatives that require ongoing stewardship. Clearly, issues related to potential discriminative practices should be concerning.

In terms of the goal of the strategic initiative being researched—progress toward optimizing physician engagement and leadership—the churn, of both kinds, has affected progress and contributed to stress. Obviously, some degree of churn, caused by the massive change of provincialization within the catastrophic COVID pandemic, is to be expected.[2] Certainly when it gets to the point of burn-out for many individuals, some additional measures to address such problems become much more important. COVID itself has encouraged a massive exodus of

[2] We are also aware that at the time of writing, the CEO of the SHA has resigned, and the COO has retired. This is another element of churn that might have an impact of the future of this initiative.

clinicians in health care in many jurisdictions, and that problem—if manifested in Saskatchewan—will negatively influence progress of this initiative. It is for the readers/leaders of this project to determine whether the level of churn and the level of progress are acceptable or not as it relates to maintaining focus on this initiative, and the pace at which it should proceed.

3. Interviewee experience of progress

One of the most interesting findings is the varied, and in many ways, contradictory experience of the interviewees as it relates to their perception of progress toward the goal of optimizing physician engagement and leadership within the Saskatchewan health system. Six interviewees rated the progress on a scale of 1-10 as having improved, from 2016 until the final interview in June 2021, by four or more points. Two showed a negative drop over the time frame (indeed, one not giving a score in the last round of interviews: and one was not interviewed because that physician left the system; both these interviewees rated progress much lower in the second round of interviews than in the first one); and the remainder—six—showing small incremental improvement of between 0.5 to 2.0. That picture looks somewhat different when comparing the results between the progress scores of round 2 and round 3 for the 12 interviewees who provided a score for both rounds: six scored the progress as higher (between 0.5 and 4), and six scored it as lower (between -0.5 and -2.5).

While the above data shows a modest belief in progress, it appeared to be less a function of deliberate planning and tactical effort than a reflection of the individual physician's personal experience of what has happened in the province over the four-year duration of the initiative. For example, many found that the workload was higher than anticipated, and increased more during COVID; cultural and mindset differences seemed to perpetuate (e.g., the cultural divide between Regina and Saskatoon, "town and gown"; some described the leadership provided by their direct supervisor as inadequate; and specific issues such as contractual/remuneration issues were not addressed.

While not getting into the contract and remuneration issues, it should be remarked that these issues were identified as fundamental to success as early as the session whereby representatives from the MOH, Regional Health Authorities, CoM, and SMA met in 2016 to craft the original vision and commitment to optimizing physician engagement and leadership. Indeed, in recognition of the importance of these two issues (amongst others) the Demonstration project was established in Prince Albert and environs to take on the challenge of working out—at a local level—these and related impediments to the achievement of meaningful physician engagement. This initiative has been highly profiled in the 2018-10, 2019—20 MOH annual reports to government; and the SHA's report to the legislature in 2018-19. For example, the MOH report of 2018-19 states that the Demonstration project "developed working groups that focus on governance of the UMG (unified Medical Group)[3]…, data and accountability required to have the group function optimally,

[3] A Unified Medical Group (UMG) as part of the Demonstration site in Prince Albert was established. It is a project whereby physicians are collectively responsible for high-quality patient care, provider well-being, and improved accountability for the health system and patient outcomes.

leadership development within the UMG, and funding and compensation models that enhance operations and improve health outcomes." It is interesting to note, however, that virtually no reference to this project was found in the interview transcripts; and the most recent MOH 2020-21 annual report indicates that it is 'delayed due to COVID'.

The above narrative points out two areas of potential improvement going forward. First, in the minds of the interviewees, there is "no formalized plan to engage physicians"; "Still need better linkages between executive leadership and grassroots leadership."

This condition is not because there is an insufficient number of initiatives aimed at realizing this goal. Indeed, there are many (e.g., provincial networks building in physician participation; a leadership and governance structure that has generated dyads at a senior level (albeit only for the most senior leaders); the creation of the Provincial Department Head role (as the glue to hold the work of CoM and SHA in positive tension); huddles and town halls; and dyad creations in many program areas. These were all mentioned as 'facilitators' of improved physician engagement by the interviewees, and as part of the plan for Saskatchewan's future health system as articulated by the SHA and MOH.

The challenge is that no-one can point to an overall plan, strategy formulation, etc. that brings all of these under one umbrella as an expression of the provincial commitment and that are systematically employed over the long term to improve engagement and leadership as well as solve emergent clinical issues or problems. In other words, many doctors do not see these as deliberate efforts to improve physician engagement, they see them as individual efforts as opposed to a broader provincial strategic plan. Almost all interviewees suggest that any deliberate planned effort either didn't exist (i.e., to drive leadership and governance processes down to the regional and/or local level with respect to family physicians), or that if it did, they were unaware of it. Such plans did exist at the governance level: however, it is unclear if they were ever operationalized lower in the organization.

4. *Murky accountability.*

The interviews provide insights from the physicians—in various roles—as to their attitudes, perceptions, and beliefs relative to the progress of physician engagement or leadership. However, no-one refers to any form of measurement or method by which progress toward the ultimate goal of optimizing physician engagement and leadership is to be measured. Indeed, some said that "there is not common understanding of what engagement and leadership mean".

Their own assessments of progress (we asked them to rate progress on a scale of 1-10 in 2016, 2019, and 2020) are qualitative comments on what they have experienced and seen in the context of their own work. They point on occasion to a strategic goal of the MOH or the SHA that legitimizes the priority related to this goal; but none refer to any overarching strategic plan or stewardship work aimed at achieving the goal. While several interviewees in very senior roles have made a disciplined and deliberate effort to build dyads at their own level of responsibility, there is a lack of clarity in some other roles, and particularly at the grassroots level as to what structures

are best to be developed to create effective engagement and leadership, and what supports are there to facilitate their development.

Compounding the above issue is the lack of measurement of progress province-wide. It is difficult to assess progress unless that goal is expressed in measurable terms; and unless it is also clear as to who is to be accountable for that progress. One can look to the provincial jurisdiction of British Columbia and Alberta to find a measurement system for physician engagement that is well-established and is measured yearly.

It is acknowledged that in the MOH's 2019—20 Annual report, a measurement system was to be put into place but COVID delayed its implementation. Without such a system it is difficult to determine what progress has been made, where the responsibility lies to champion it, and to what degree the interviewees themselves see a responsibility to create the conditions to facilitate such progress.

5. *Leadership development support system*

Almost all interviewees indicated that they would benefit from a more coherent and organized leadership development process. The adjustment experienced during the transition from a clinical role to a leadership role was challenging for many: "hard to see the results of my work"; "little quality onboarding and training", and there is "a lack of leadership training; all physicians need it".

It is noted that the SHA's organizational development department has identified a career path for physicians as they move into more senior roles and has recognized the need for them—along with their non-physician administrator co-leaders—to receive leadership development commensurate with the challenges of the role (see SHA Leadership Transitions document). Within Saskatchewan interviewees referred to the following resources: the Clinical Quality Improvement Program (CQuIP); the Saskatchewan Leadership Development program offered by the SHA and available to physician leaders (if they are aware of its existence: some do, some do not); graduate programs offered by the local university. Others referred to the CMA's Physician Leadership Institute (PLI) courses—usually sponsored by the SMA—as valuable for physicians to grow their leadership skills. None of the interviewees referenced the CoM's list of programs and resources available to physicians for leadership development purposes.

Many seemed to be aware that the LEADS framework was the articulation of leadership expectations within the SHA. The focal points of development, i.e., self-reflection, communication, initiative; system thinking and the ability to lead with uncertainty—identified in the round 3 interviews--fit nicely within the LEADS framework. However, none could point to a clear organized set of developmental options readily available to them and directly related to the leadership roles they are moving into. A multitude of options appear to exist; but clarity as to what fits best with what role and how it would contribute to an individual's growth at a particular stage of their career does not exist.

The SHA's efforts in this regard (i.e., the Organizational Development department's Leadership Development and Pipeline schemas)—and in particular, the Provincial Department Head

Initiative—should be accelerated and made a priority to provide supports for physicians moving into leadership roles. Physician leadership development needs clear career pathways, associated learning opportunities for those pathways, and a cost-effective method of making them available to ALL physicians: (1) to support regionalization; and (2) to support standardization of provincial expectations.

Suggestions/Next Steps

The following are next steps suggested by the research team based on their interpretation of the data and findings of this study.

1. *Reflect, Refresh, and Regroup due to the Impacts of Regionalization and COVID-19.*

   A multitude of issues arising from the impact of regionalization and COVID-19 on the pace of change, workload demands, position churn, backlog of surgeries and other medical treatments, budget pressures, and in particular the psychological health and welfare of clinicians, suggests it is time to take a 'breather' and refocus the initiative. As part of that refocus, it is important to recognize that further progress is very much dependent on how the overall looming crisis of the clinical workforce crisis across Canada will manifest itself in Saskatchewan, and what impact it will have on moving forward in the spirit of this initiative.

   In that context it is suggested that subsequent suggestions outlined in this report be considered as part of a collective organizational 'regroup'—i.e., stepping back at this point of the initiative—and reframing it in an appropriate timeframe moving forward.

2. *Integrate Communication and Marketing.*

   We would, from a communication/marketing catch phrase, suggest that the phrase, *The Saskatchewan Way to Optimize Physician Engagement* be used to describe this ongoing initiative, and be highlighted, and constantly re-iterated.

   Commensurate with that messaging are four primary points:

   - It is time to reflect, refresh and regroup to respond to the 'new normal'.
   - A clear, long-term strategic timeframe to achieve success for *The Saskatchewan Way to Optimize Physician Engagement* needs to be emphasized in all reports and communications.
   - *The Saskatchewan Way to Optimize Physician Engagement* has been, and needs to continue to be, an ongoing process that has been driven and defined by leaders themselves across all facets in health care in Saskatchewan.
   - The many components of an overall plan to achieve *The Saskatchewan Way to Optimize Physician Engagement* that already exist in many different aspects of the SHA/MOH/CoM/SMA work should continue and be recognized under the umbrella of this initiative.

3. *Form a guiding coalition between MOH, SHA, CoM and SMA to support further progress toward The Saskatchewan Way to Optimize Physician Engagement.*

   All four parties are necessary to solve ongoing, deep-seated issues that mitigate success. These include: determining the appropriate time as FTE needed for physician leader roles; addressing inequities of remuneration; job clarity with respect to expectations and accountabilities of individual physician leaders' role in the SHA; a comprehensive and well understood suite of programs and services for leadership developmental of physicians; and culture change in organizations and within the physician community. All of these issues require the four organizations to "champion and orchestrate" the change together to achieve this goal. There is also great power in the symbolism of this approach.

4. *Create a five-year change and growth plan that consolidates, the overall effort to improve physician engagement and leadership, and titled, The Saskatchewan Way to Optimize Physician Engagement.*

   This consolidation plan should profile key initiatives and activities within the SHA designed to achieve engagement and leadership of physicians (i.e., clinical health networks; quality and safety improvements; Demonstration site at Prince Albert; committees formally engaging physicians in shaping progress on specific projects, huddles, town halls, etc.) and be integrated into one document. That document would address clarity of job profiles for formal physician leaders; standardized reporting structures and constitution of dyad relationships where appropriate and consistent across the province, with adaptation for local context; develop a system to measure progress toward the goal; outline leadership and engagement opportunities for physicians; (re)develop, advertise, and open up leadership developmental content and processes for physicians linked to the SHA. *NOTE: Although some of these initiatives already exist, they are not consolidated into a coherent plan toward the goal. The wholeness of approach and the multiplicity of existing efforts need to be communicated better within the organizations sponsoring this initiative—SMA, CoM, MOH--so physicians see who is contributing to its realization).*

5. *Develop specific project teams or task forces and charge them with a specific responsibility to change factors hindering progress toward* The Saskatchewan Way to Optimize Physician Engagement.

   These groups would make recommendations for change in two ways: first, by identifying existing 'facilitators' for physician engagement and leadership that need to be amplified; secondly, by identifying barriers that must be removed to improve physician engagement and leadership. One group each should tackle the following areas of focus.

   a. *Structural enhancements*: i.e., time allocations, payment for, and position profiles for formal physician leadership roles. To tackle the thorny challenges where necessary in the realm of bargaining/remuneration.
   b. *Legal/procedural issues*: i.e., By-law and/or legal regulations, policy, or procedural changes to existing provisions that will enhance physician engagement and leadership; and removal/alteration of those that are barriers.

c. *Culture change*: i.e., with a focus on attitudes, beliefs and unconscious operating practices that are inconsistent with the goal of optimizing physician engagement and leadership, such as the role being devalued within the physician community, and administrative belief systems re authority and accountability for decision making.
d. *Leadership Development support*: i.e., a more comprehensive plan, building on the existing work of the Organizational Development (OD) team within the SHA and utilizing the LEADS framework (as a common vocabulary for desired practices of leadership), is required to provide leadership development opportunities to physicians who need it. Use the current PDH project as a 'developmental site' for lessons for the SHA as a whole.
e. *Communications*: i.e., Under the banner of *The Saskatchewan Way to Optimize Physician Engagement*, develop communications tactics to contribute to greater awareness and understanding of the effort being made, and to bring clarity to the specifics of what is happening and what can be taken advantage of by physicians to become more engaged, or to move into leadership roles.
f. *Technological innovations*: i.e., explore how the new models of working (i.e., at home and at work), virtual care, E-learning, and innovations such as the Swift Current self-edit program, can be leveraged up to give physicians more time and more tools for engagement and leadership.

6. *Monitor progress systemically and clarify accountabilities toward the goals of The Saskatchewan Way to Optimize Physician Engagement.*

   It is suggested that the MOH's goal of measuring engagement of physicians as per the 2019—20 Annual report be revitalized, measurement used to target areas where no or little progress is being made.

Summary/Conclusion

The purpose of the Saskatchewan Physician Engagement and Leadership (SPEL) longitudinal action research project was: to investigate, explain, and document dynamics within the Saskatchewan health system that either enhance or mitigate the goal of achieving optimum levels of physician engagement and leadership in the stewardship of the province's future healthcare system; to document progress over a three year period; and to offer suggestions for improving progress where such suggestions might be warranted.

This report, written after three rounds of interviews, and exploring the patterns of responses over a three-year period, summarizes the final results in two forms: a table depicting the changes and/or stability in approach over time; and a section designed to interpret those results in the context of the organizations supporting the project. A final section suggests some actions to move the province towards it strategic goal of achieving optimum levels of physician engagement and leadership in the stewardship of the healthcare system. It is recognized that this project would benefit from a regrouped approach due to the impacts of regionalization and COVID-19, quite

appropriate because the strategic goal is a long-term goal, not to be achieved during the timeframe of this study but perhaps over one decade.

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