The rapid decline of clinician-scientists in all facets of medicine, including gastroenterology, has been well documented. Many groups have also been severely challenged by the inability of their fee-for-service billings to enable them to meet their rapidly expanding educational commitments in addition to sustaining their research programs. Together, these trends have threatened the core academic mission at many Canadian institutions. In the late 1980s, the concept of a provincial government global funding envelope in place of fee-for-service billings was introduced in response to these challenges, and in 1990 the first Alternative Funding Plan (AFP) appeared in the Department of Paediatrics at the Hospital for Sick Children in Toronto, Ontario. We now have four additional AFPs or Alternative Relationship Plans (ARPs) in place, one each at Dalhousie University (Halifax, Nova Scotia), Queen’s University (Kingston, Ontario), the University of Calgary (Calgary, Alberta) and the University of Alberta (Edmonton, Alberta). Moreover, AFPs are currently being negotiated at all the remaining academic centres in Ontario and are being considered elsewhere in Canada. The existing programs are at various stages of maturity and a number have been renegotiated one or more times with their respective provincial governments and medical associations. In this interview, I have communicated with three heads of gastroenterology (GI) divisions: Dr Ron Bridges (University of Calgary); Dr Des Leddin (Dalhousie University); and Dr William Paterson (Queen’s University). I have also communicated with a previous Chair of Paediatrics, Dr Hugh O’Brodovich (the Hospital for Sick Children), as well as a department head, Dr Jon Meddings (University of Alberta), to gain their insights into whether they believe these funding plans will be the ultimate saviours of academic medicine and what experience and advice they have to offer to those who are considering joining similar programs.

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Vanner: How many years have you been in an AFP? How many members did you have at inception and how many do you have in 2007?
Paterson: The Queen’s AFP began in 1995. We had six members in our GI Division at inception, and we now have eight members, although one of the eight is funded purely by fee-for-service billings rather than by the AFP.
O’Brodovich: The Hospital for Sick Children’s AFP began in 1990. In 1996, there were 110 full-time equivalents (FTEs) in the department. In 2006, there were 163 FTEs.
Bridges: The University of Calgary’s Department of Medicine ARP began in the summer of 2004. The initial membership number was 12 (two more joined within three months). The current membership number is 24 (four more have committed to join in 2007).
Meddings: The Department of Medicine at the University of Alberta has had an ARP for the past six years. Over this period of time we have recruited approximately 62 FTE members, and as of March 31, 2007, we will have 145.25 FTE ARP members. We have experienced a 75% growth in ARP membership since inception.
Leddin: The Dalhousie University AFP began in 1999. As of January 1, 1999, there were 97.63 FTEs with seven people, with 4.65 of their 7.00 FTEs devoted to research. By January 1, 2007, there were 138 FTEs with 11 people, with 7.31 of their 11.00 FTEs devoted to research. Also note that Geriatrics and Palliative Medicine were not divisions of the Department of Medicine as of January 1, 1999, so part of the growth over the seven-year period is attributed to the addition of these two divisions (8.50 FTEs for Geriatrics and 5.00 FTEs for Palliative Medicine).
Vanner: Do you believe that the AFP has benefited the overall academic mission of your group?
Paterson: Yes. In the early 1990s, our department went from an approximate $1.2 million surplus to a $500,000 projected deficit over a few years. Other departments had comparable financial difficulties. This coincided with OHIP rates being frozen while operating expenses continued to rise. In addition, to maintain accreditation, it was necessary to expand faculty to meet specific Royal College training requirements. We were therefore looking at a collapse of the academic mission of the Department if fundamental changes to the funding mechanisms were not instituted.
The AFP clearly averted this, and was a major accomplishment for Duncan Sinclair, who was Dean at the time.
O’Brodovich: Yes, as reported in our publications (1-3).

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Bridges: Without question. The ARP has enhanced our ability to recruit clinician-scientists and clinician-educators and provide them with protected time to complete academic activities. The AFP has also provided individuals with protected time to develop innovative programs such as the colon cancer screening centre.
Meddings: The ARP has not only benefited the overall academic mission but has been the single overriding influence on the entire academic mission of our department. Since the inception of the ARP, academic productivity has increased exponentially with time.
Leddin: On balance, yes but it has not, by any means, meant a major shift from clinical to academic work.
Vanner: Do you think the AFP has better enabled you to recruit clinician-scientists who hold (or will be competitive for) peer-reviewed funding and/or enhanced the competitiveness of your existing members?
Paterson: Yes, there is no doubt that the opportunity to come to a centre where income is not dependent on professional billings is attractive for clinician-scientists who plan to devote a major part of their career to research, particularly those doing bench research.
O’Brodovich: Yes.
Bridges: Yes, the ARP provides more competitive remuneration for clinician-scientists at all levels.
Meddings: Having an ARP has allowed us to protect time for academic pursuits rather than tell an individual that they have protected time and simply have to refrain from seeing patients, with a consequent reduction in income. Peer-reviewed funding per capita has increased since the inception of the ARP, and the number of people applying for peer-reviewed funding has increased with the ARP. This is due to both an increase per capita and a greater number of clinical scientists.
Leddin: It has had some effect but it has not been dramatic. It has allowed selected members to have more protected time without the concern of generating billings. The numbers are included above.
Vanner: Do you believe the AFP has provided a greater stimulus for trainees to pursue more in-depth postdoctoral training?
Paterson: No.
O’Brodovich: Yes. Some of the AFP has been allocated for fellowship training positions (all have a research component and some are research dominant-exclusive). It also provides role models because we have faculty who are clinician-scientists with significant research time allocation.
**Bridges:** I do not think more trainees are interested in research because of the ARP. However, those interested in research are relieved to learn that they will receive financial credit for training when they join the faculty and the ARP. The training program provides a half-day academic program and up to three months for a research elective. Provision is made for additional research time for those who have completed a PhD or are clearly on a PhD track.

**Meddings:** Whether the ARP provides a greater stimulus for trainees to pursue a clinician-scientist career path is, at present, unclear to me. My bias and deep suspicion is that the clinician-scientist’s lifestyle has been unappealing to many of our trainees for decades because of the inadequacies of university-based funding for clinician-scientists. In theory, ARPs should solve this perceived problem but it will take a while for deeply felt biases and perceptions to change. I am still waiting to see an increased number of people willing to undertake the rigorous training that the lifestyle of a clinician-scientist requires.

**Leddin:** At our institution, this has not been the case. Very few trainees have chosen to go the route of advanced postdoctoral training.

**Vanner:** How has the AFP impacted on the clinical mission of your group? The educational mission?

**Paterson:** I do not think it has altered our clinical or educational mission significantly. In the fee-for-service days, we were still a very research- and education-intensive division. Before the implementation of shadow billing last year, it encouraged more efficient use of clinical time (eg, more likely to deal with patients’ problems by phone).

**O’Brodovich:** Yes. The ability to create job profiles and career pathways.

**Bridges:** ARP has had a very positive impact. Protected time with remuneration for those involved in clinical care, research, education, quality assurance, innovation and fundraising for academic chairs. Several programs would not have been developed without the support of the ARP.

**Meddings:** We have had our ARP externally reviewed, and by using pre-established outcome measures this program has been a tremendous success. Numbers of patients seen per clinical FTE has increased, and numbers of teaching hours and student evaluations of teachers have increased in proportion to time within the ARP.

Most importantly, the ARP has had a tremendously positive impact on the ability of our members to develop and implement clinical innovation. Since inception of the ARP, the model of clinical service delivery has changed from a physician-led model to increased utilization of multidisciplinary teams, multispecialty teams, enhanced use of telehealth and associated forms of technology such as mobile clinics and outreach programs directed at rural Albertans.

**Leddin:** This has been one of the most profound effects, although the effect of the AFP cannot easily be separated from the results of merging the university hospitals into one large health district-containing nonacademic hospital. The expectation of the government has been that there will be a clinical return for money spent, and in some circumstances the system-wide problems in health care access have been laid at the door of the AFP.

**Vanner:** Do you think the AFP has enhanced the overall job satisfaction and productivity of your members?

**Paterson:** The AFP may have enhanced productivity before shadow billing was implemented last year. This enhanced productivity has been lost now that time and resources are being wasted with shadow billing. Job satisfaction may be decreased overall. A big part of this relates to deterioration in the hospital working environment. However, the faculty’s failure to implement an accountability system has also contributed.

**O’Brodovich:** Yes, as reported in our publications (1-3).

**Bridges:** The ARP helps define expectations by way of the individual service agreement. Quality of life has been enhanced for many individuals as a result of the ARP. We are now looking into productivity – this is a very difficult area to fully evaluate.

**Meddings:** The ARP has enhanced overall job satisfaction and productivity. Internal and independent surveys performed throughout the course of the ARP have been uniform in suggesting that without the ARP, individuals would not be working with us, and that they are satisfied with their job profiles.

**Leddin:** In general, yes, but complaints are still prevalent. However, there is no doubt that the chorus of concerns would
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be even louder if the AFP was not available to support activities, which are not viable under fee-for-service.

Vanner: How do clinician-scientists compare financially with clinical teachers? How do AFP members compare with private practice GIs in your province (per cent of the 75th percentile for the province)?

Paterson: In our division, remuneration is the same for clinician-scientists and clinical teachers. This is not true in other departments and divisions, where clinician-scientists are sometimes disadvantaged. We remain far behind private practice gastroenterologists in terms of income (approximately $100,000 below the 50th percentile), despite a very heavy workload.

O’Brodovich: All job profiles are equally rewarded for equally challenging, albeit different, expectations (see our publications [1-3]).

Bridges: At all points in the financial grid, clinician-scientists and clinician-educators receive the same remuneration. I do not know the exact numbers for comparison to remuneration for private practice GI, but suspect that a senior person in the ARP would make approximately 75% of what an individual in private practice would make. A more junior person in the ARP would make approximately 50% of what an individual in private practice would make.

Meddings: Within our ARP, there is no difference in funding between clinician-scientists and clinician-teachers. All members are paid the same regardless of job description.

Leddin: Clinician-scientists are remunerated at the same rate as clinical teachers, and in many ways, given their contracts with industry, do much better. AFP members do not compare very well with private practice – numbers are difficult to calculate with accuracy but are likely, at best, approximately 75% of community-based colleagues.

Vanner: Since the inception of your AFP, what changes in the terms of the AFP have occurred with subsequent negotiations and how have they impacted on your mission?

Paterson: The major change has been the necessity to now shadow bill, which has been a bit of a disincentive to provide efficient patient care. The fact that personal income increases are tied purely to this shadow billing will disadvantage divisions like ours with heavy academic commitments.

O’Brodovich: Many, too many to mention (see our publications [1-3]).

Bridges: No changes thus far. The initial contract ended in June 2007. Negotiations with the next contract are under way.

Meddings: Most of the key terms of the ARP have remained constant throughout the length of the ARP’s lifetime. What has been noticeable to us is the incredible amount of work and preparation required on an administrative basis to justify ARPs. It is somewhat concerning to me that ARPs are held to a double standard. It is very simple for us to recruit individuals into a fee-for-service system with limited justification as to whether or not outcomes are better with these individuals in the system than without. However, to bring people into an ARP, the documentation and justification required is phenomenal. We have one brilliant manager who works full-time to justify our ARP to government, regions and the Alberta Medical Association.

In addition to this, we have appeared on several public relations programs simply to demonstrate to people the success of ARPs and what they mean to different health regions, rural patients, training programs and to medicine as a whole. The benefits of ARPs are generally underappreciated in the community and there appears to be a bias against an alternative form of payment. I do not believe that ARPs represent the only form of payment that should be available, but then neither should fee-for-service.

Leddin: We have moved away from a classical AFP model to a blended model of fee-for-service-based remuneration combined with an academic supplement. We bill approximately two-thirds of our income and the academic supplement makes up the difference.

Vanner: What is the major challenge facing the success of your group working within your AFP in the future?

Paterson: Ensuring that in future AFP negotiations, appropriate funded time is provided for teaching and research.

O’Brodovich: Getting the government to return to the negotiating table despite explicit timelines being within the contract (ie, they just ‘extend’ old contracts).

Bridges: Maintaining a cohesive division, including ARP physicians and private practice physicians. Ongoing communication with government to emphasize the importance of remunerated protected time for research, education, innovation and administration.

Meddings: Our major challenge is the ongoing threat that ARPs will be withdrawn and that the tremendous infrastructure and support that we have developed for what is an outstanding program would be for naught. Perhaps the greatest threat to the medical school at the University of Alberta would be the potential and catastrophic loss of funding to ARPs that support the majority of undergraduate and clinical teaching in this institution.

Leddin: Keeping pace with ARPs in other provinces, remaining competitive with the private sector and providing clinical service, the shortcomings of which are blamed on the AFP but are, in reality, due to system constraints.

Vanner: Based on your experience with the AFP, what is a key issue or issues for those currently negotiating an AFP?

Paterson: Ensuring that there is an effective accountability system in place with activity-based compensation tied to external...
marketplace benchmarks is crucial. It is also important that the
government clearly understands the time required to meet the
teaching and academic responsibilities of a university-based
medical centre.

**O’Brodovich:** Getting the government to return to the nego-
tiating table despite explicit timelines being within the con-
tact (ie, they just ‘extend’ old contracts).

**Bridges:** First, remuneration for all aspects of clinical and aca-
demic medicine at the same level. Second, a transparent sys-
tem of advancement, with opportunity for merit increments.

**Meddings:** Key issues are legion. But perhaps most important is
preparation – it is important not to underestimate the amount
of work that governments require to establish ARPs.

**Leddin:** Securing adequate remuneration, negotiating a suit-
able mix of clinical and academic deliverables, maintaining
clinical credibility as system-wide issues drive wait times and
restrict access.

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