

## Aramark Profile

By Cynthia Martin

Dr. Noni MacDonald graduated from Queen's University in 1970 with a BSc and from the University of Ottawa in 1971 with an MSc in microbiology/immunology. She received her MD from the UofO in 1975, graduating magna cum laude and winning the university medal for highest standing. She completed her residency in paediatrics in Ottawa, receiving fellowship certification from the Royal College of Physicians and Surgeons of Canada (RCPSC) in 1978. With subspecialty training in paediatric infectious diseases at McGill University and the University of Rochester, she became a Fellow, RCPSC, for Infectious Diseases in 1983. She was the first paediatrician in Canada to be certified in paediatric infectious diseases.

Dr. MacDonald joined the faculty of the University of Ottawa in March 1981, and over an 18-year span she served as Assistant Professor, Associate Professor and Professor in the departments of Paediatrics and Microbiology and Immunology. In addition to research and academic work, Dr. MacDonald was an active clinician at the Children's Hospital of Eastern Ontario (CHEO) and the Ottawa General Hospital, filling a variety of roles. In 1981 she founded the Division of Infectious Diseases at the UofO and led the Paediatric Infectious Diseases Service at CHEO, serving as Chief of the Division of Infectious Diseases from 1991 to 1999.

Dr. MacDonald was named Dean, Faculty of Medicine, Dalhousie University, in July 1999, the first woman to become a dean of medicine in Canada. She concurrently holds university appointments as Professor in Paediatrics, and Microbiology and Immunology, and is cross-appointed at IWK Health Centre as Professor of Paediatrics and Microbiology. Even with her heavy academic administrative responsibilities, she continues her paediatric infectious disease clinical service.

Dr. MacDonald has long been recognized nationally as an advocate for children and a leader in paediatric infectious disease, with major research interests in the microbiology of cystic fibrosis, stress management in medical faculty, sexually transmitted diseases in adolescents and vaccine development for infectious diseases in children. She has published more than 170 papers, been on the editorial board of several major publications and is founding editor of *Paediatrics & Child Health*, a journal of the Canadian Paediatric Society. Dr. MacDonald has been an active participant in many national and international societies and organizations as well as federal government committees. She has received numerous awards and



**DR. NONI MACDONALD**

honours, including the Canadian Infectious Disease Society Distinguished Service Award, the University of Ottawa Award of Excellence and a visiting scholarship to the University of Oxford Institute of Molecular Medicine.

### **What's with all the health reports now? Besides funding pressures, why is there such a drive – competition almost – to alter health systems?**

I think health has finally made it onto the national agenda in a big way, pushed from the U.S. with the Clinton initiative and an organized media campaign. Here, as times got tight, provincial governments looked into budgets, and health was their major cost. People are also fed up at the bickering among federal and provincial politicians. Romanow's commission was put into place because the issues required a comprehensive review, and it's all part of the feeding frenzy in pushing the issue forward. When medicare came in, it was very paternalistic and hierarchical. What's changing is recognition that healthcare has to be based on partnerships. Good health requires families, communities, governments, healthcare and businesses all to work together. That's a different thought process from

that in the '60s. The Dalhousie Research Foundation conducted our own health forum last June, in advance of all the reports, and brought together an eclectic mix of people. It's heartening to see that much of what's coming out now is in our report ([www.dmr.org](http://www.dmr.org) – click 2001 Fall River Forum).

### **The humanities ground us in recognizing there's more going on in the world ...**

#### **What do you think of fee-for-service and alternative payment mechanisms?**

Fee-for-service grew out of the hierarchical paternalistic system and is a huge problem as it was based on procedures, not on disease prevention or management. Alternative fee payment (AFP) systems represent recognition that fee-for-service doesn't fit all healthcare delivery anymore, with one reason being that if you're an expert, you don't get paid for a telephone consultation with another physician – you only get paid for seeing patients. Some high-paid procedures that in the 1960s were very high risk, you can now do in 15 minutes, but the fee didn't go down. There is a problem with balance here.

#### **Sure, cataracts in Ontario average \$800 for a consultation, surgery or a follow-up, and six out of 10 physicians in Ontario who billed more than \$1 million in 1999/2000 were ophthalmologists. Isn't something wrong?**

Yes, that's the example I was thinking of. There's work within the system to realign, but it's difficult to take away something from someone that they've always had. With Alberta's recent statement to the effect that 50% of physicians would be in AFPs, I think change is quite realistic. We have to look at the deliverables and outcomes that physicians are being paid for, and physicians with the AFPs have to be accountable, whether it's for teaching medical students, doing research, delivering clinical services or developing policy.

#### **Do you think tenure is still appropriate for publicly funded universities?**

I think the issue comes back to accountability in public institutions. The same thing is happening in healthcare, and I don't think universities are immune. Tenure came in when freedom of speech was a big issue and we didn't have a lot of accountability from outside, but the public is growing increasingly concerned that publicly funded institutions provide good value, whether that's hospitals, elementary schools or universities. There are concerns about quality of education. Similarly, the public is holding medical licensing bodies accountable, in that if a physician is providing poor care, there's sexual impropriety, or

communications issues, his or her licence may be pulled. The public expects this now and the medical profession cannot turn a blind eye to misbehaviour anymore. I think university teachers and researchers need to be allowed freedom of speech and research in non-politically correct areas, but tenure should have public accountability for quality and quantity of academic output.

#### **A great strength here is the inclusion of the humanities, such as the art in medicine show and Dalhousie Medical School Chorale, unique among universities. How do the humanities help students be better doctors?**

It helps with stress, with perspective and allows them to be more than a pair of hands and a brain. The art show came from the students themselves and the past three years focused on transplantation, Alzheimer's and Attention Deficit. It's recognition from early on in medical education and encouragement by the faculty that future physicians will be recognized and valued as whole people. It's entirely possible to become so sucked into medicine that you lose perspective on what it's like in the "real world." The humanities ground us in recognizing there's more going on in the world. This is linked to healthcare in a partnership model, because if you understand what to do to improve health, you need to ensure that your personal health is also being dealt with; your spiritual, social and emotional health. Students also see faculty participating and feel positive community response to what they're doing.

### **You need to ensure that your personal health is also being dealt with...**

#### **Is there a particular management theory you find valuable?**

Disruptive innovation, out of Harvard University. I feel I've been a disruptive innovator my whole life and I never knew that's what I was doing! Essentially, you look at a segment of the market that's at a very low level, that nobody's paying attention to, and you provide just what that market segment needs and do it better than anyone else. An example where disruptive innovation might work in healthcare is caregivers for street people. We currently have no one trained to deal with all the problems. We should train one worker who has "street" expertise – some each of social work, foot care, mental health, addictions and just how to fill out forms. The system is so complex we're trying to pay attention to everything, but because of hierarchy, we have professional relations and silos, which make it difficult to address patient group needs. Instead of asking what the system needs, let's ask what a patient group needs; what are the geography and resource issues. Not the other way round, which is to build the system. Let's find a little hole where a patient can come in.

**You've spoken with Roy Romanow. What are some issues you hope the commission addresses?**

We need public education that helps people understand what the health system buys and what it doesn't, and what are the implications. Gut-wrenching stories about an individual sway the public, while other health stories are not so newsworthy; for example, vaccines are not sexy. We need balance in anecdotal reports, as almost always we have to justify that vaccines will save money. We don't have these conversations in other areas, for example, P24Ag testing on blood still distresses me. This test for HIV decreases the window period, but by only a few days. In the United States, every case of HIV from infected blood transfusions prevented through P24 antigen testing is estimated to cost \$880,000US. Since P24Ag testing on blood in Canada started during the Krever Commission, we've not prevented or picked up one case by this intervention. When I tell any audience this, 90% of people are appalled that millions have been spent on this with little or no benefit, but 10% say it's right to make the blood system as safe as possible. P24Ag testing is not the problem; it's what we are not doing to pay for this and how healthcare spending items are prioritized.

Another issue is the age difference in medicine. For medical students, residents, and those in practice largely under the age of 45, the vast majority will talk to you about quality of life in practice, staying current and how difficult that is with the ongoing avalanche of technology and information, and of the need to work in teams and groups, because they want peer support to deliver 24/7 care. In physicians over 50, they speak very much about autonomy and don't want any controls; they say, "Just pay us more and we'll do it." James Clarke, president of the Canadian Association of Interns and Residents, who's at Dalhousie training in radiology, said a very important thing. This generation is the new face of medicine – they're physicians of the future. So some of what other older physicians are saying may not jive, because they're of another generation. New physicians need to be part of any discussions on reshaping the system.

**Is that different from U.S. medical students? An article in *Academic Medicine* recently stated that medical schools teach students the doctor/patient relationship is a business that undermines teaching and care.**

The American system is a business in many HMOs. When I was visiting professor for the Paediatric Infectious Disease Society at the University of Michigan Medical School for five days in the mid-1990s, each doctor asked me specifically about the Canadian system. I'm no healthcare economist and I wanted to talk about infectious disease! But Americans are fascinated with our system, especially as theirs is under increasing stress. It's a big issue for me that

medical students are not taught enough about how health systems work. We're working on correcting this at Dalhousie, but many MDs in practice still see themselves as individual entrepreneurs outside "the system."

**One role is to obtain funding for research and clinical programs – is this difficult?**

Very. Dalhousie and three other medical schools in Canada have small populations with relatively large geography, so problems in funding infrastructure, recruitment and retention are naturally more difficult. It's hard to sustain quality research without significant external funding. For example, at Dalhousie we've had no new space built for medical research in more than 30 years. This is very important to healthcare in the region, since there's a major intertwining of health research and clinical care. Think of a tricycle with education and research as back wheels and clinical care at the front, driving towards improved health. If a back wheel falls off, it's pretty hard to drive. Research is also a big-ticket item in the local economy – here we bring in more than \$35 million a year. I could be saying the same thing if I was at Memorial, Saskatchewan or Manitoba, because in all of these have-not economic regions, the medical faculties have difficulty in sustaining access to quality clinical care and maintaining a vibrant research and educational community. If the medical schools were not in place, much tertiary care would leave these regions. So, going back to Romanow, sustaining faculties of medicine and academic health science centres in regions with dispersed geography and economic problems must be considered federally if we're going to have equity of access in Canada.

**What are your assets?**

Many have told me that I'm energetic and quick. I think I'm a very good connector and think out of the box. I'm an optimist – tell me what the problem is and I'll work towards solutions. I'm also passionate about the work I do, but with people who are concrete, narrow, and sequential thinkers, I need to be more patient. One thing that's a difference – maybe this is a woman thing – I've never been a power person. Some men I've worked with have been far more interested in power; to get honoured or get credit than in finding solutions to problems. I couldn't care less – I want the solution. I think I frustrate some people, as they don't understand the currency I trade in and how I measure success – it's different achieving the goal, hopefully by consensus, and following through is what counts.

**You're the first female dean of medicine in Canada; surely you faced difficulties.**

When I was on the short list here, I specifically asked if I was the token woman. If so, I didn't want the job – I don't do token woman. While there are still a few dinosaurs, in

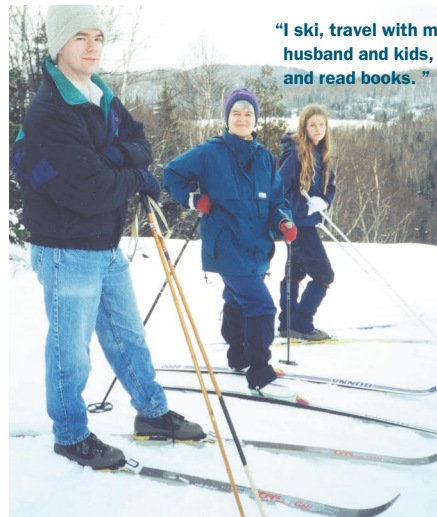
## Profile

the generation that's coming up things are changing. I grew up when women in senior academic medicine were not the norm, and I learned to survive. I was extremely fortunate to work with a couple of forward-thinking department heads who were ahead of their time to be so enlightened. When I initially started on faculty in Ottawa, at far reduced wages than males doing the same job, my department head set about fixing it. That was in 1982. Within three years, my salary doubled because I'd been started out for less than my counterpart males; I was naive and I didn't know what men were paid. Fortunately, times are changing, and many more women are in academic medicine and some are moving up.

### What do you do for fun?

I ski, travel with my husband and kids, and read books. In Ottawa, I took pottery classes, but I haven't here, as I've been so busy. I enjoy pottery because I get to use a piece of me that isn't valued in my other world, and this goes back to the importance of the humanities in medical education. Working with clay is restorative, whereas with bad diseases, some patients died despite the best care we knew how to give. While one can really make a difference in making

death as gentle and as caring as possible, it takes a lot out of you. In contrast, in pottery, no one dies. If one of my pieces doesn't work out, who cares? We all need a place in our lives where decision-making isn't so critical and success is measured on a more personal, different scale.



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