

In Conversation with Bill Barrable

Ken Tremblay

Bill Barrable is the recipient of the University of Toronto Department of Health Policy, Management and Evaluation Society of Graduates Leadership Award for 2010. For 15 years, Bill was chief executive officer (CEO) of British Columbia Transplant where he implemented several innovative approaches to transplant services including activity-based alternative payment plans for physicians and the world's first online digital signature organ registry. In other roles, he was founding chair of the Michael Smith Foundation for Health Research, former entrepreneur-in-residence at Simon Fraser University, recipient of Canada's Top 40 under 40 and co-founder of a venture capital fund for British Columbia's biotechnology sector. Bill recently became CEO of the Rick Hansen Institute, a Vancouver-based organization committed to minimizing disability and maximizing quality of life for those with spinal cord injuries. *HQ's* Ken Tremblay recently had a chance to chat with Bill about challenges and opportunities, both in work and in life.

HQ: You were selected by your University of Toronto alumni as their 2010 leadership recipient. How did you react to the news?

BB: I felt very humbled. To be recognized in this way is a huge honour.

HQ: How have your approaches to leadership changed over time – for example, from your formative roles in Ontario to those in British Columbia?

BB: From a leadership perspective, vision is critical in terms of affecting change, but you can't be so focused on the plan that you don't execute. Vision is critical because it identifies where you want to go. It gives people an understanding of what you're working toward as a team. Sometimes we get distracted by the operational urgencies in front of us; we forget about the long term. A clearly articulated vision reminds us of what we're there for.



I am an optimist by nature and believe in possibilities.

Over the years, I've become more aware of how important it is to seek out good advice. That means gathering people around you who are smart and really know what they're talking about. The quality of people is key.

We're better off if we seek fundamental change rather than the incremental change. You cannot do that without knowing where you are going, and you cannot do that without describing a vision. These are the things I value more than I did 25 years ago.

HQ: What accomplishment has made you most proud, and what was your darkest day?

BB: From an outcome perspective, we had three successive years with the national organ and tissue donation/transplantation website where we had record numbers of transplantations for the province. We did that in spite of a precipitous drop in the number of deaths that can lead to organ donation, that is, there were fewer deaths because of safer roads, a reduced incidence of drinking and driving, an aging population and better trauma care – all good things. The potential for organ donations diminished.

Yet we were able to do more transplantations largely because our teams developed other strategies, such as living donations, while trying to maximize on the potential for deceased donations. This was a source of real pride because people received transplants who otherwise wouldn't have – it made a real difference in the lives of people.

One of the darker days was a failure to launch a national organ donor registry. Technology is now available for a digital signature, a technology we adopted in British Columbia. It could be national, web based, complete with legal consent, inexpensive (under half a million dollars) and achieved quickly. There is no reason why we do not have a national organ donor registry that would allow Canadians to participate more actively in organ donation. It would have all sorts of benefits. I was unsuccessful in convincing enough people that this is a worthwhile endeavour.

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HQ: How did a leadership role in transplantation affect your personal views on death and dying?

BB: Profoundly, no question about it. When I came into transplantation, the prevailing imagery of “transplant” focused on the donor. We tried to shift [the conversation] to the life-giving impact on the people survive as a result of the gift of organs.

There are two ends to this continuum: the family of the donor and the impact on their lives of losing their loved one, typically in a sudden fashion that comes out of the blue; and the recipient, who has mixed feelings knowing that someone died for him or her to live. The recipient's family has a profound and sincere appreciation for this incredible gift that has given their loved one back to them. It really underlies the fragility of life and how things can change in an instant.

People I have met who received transplants are just incredible people. They are so grateful and so appreciative. They have learned to live in the moment, have stopped worrying about everything in the future and appreciate what they have [today]. It's great to be around them because they provide a great example for all of us.

HQ: What advice would you give to those considering a career in health services management?

BB: [Healthcare is] hugely rewarding and demanding. In my experience, it becomes personal because of the involvement with incredible people, meeting talented care providers and remarkable patients.

[Initial] idealism is great, but it is like capital. You start with a certain amount and choose how you spend it. You need to be realistic: not all of your ideals will necessarily be fulfilled. I

think the best [in healthcare] is yet to come in terms of delivery [models], new technologies and the remarkable opportunities that will surface – it's going to be very exciting. I would love to be transported into the future to see what materializes.

HQ: What ethical considerations have been the most challenging for you?

BB: In transplantation, because of the scarcity of organs for transplant and the length of the waiting lists, the dilemma becomes who gets the organs, who is going to live and the criteria around that decision. [Such decisions are] very, very challenging for the whole team.

As well, we are faced with patients who leave the country to get a transplant, knowing that some of the organs may have come from conditions or circumstances that would not be accepted in Canada. This is especially important for their follow-up care. The dilemma is how to treat the individuals without judgment who made that decision while recognizing that they will require ongoing treatment here. Our job is to provide care to all people who need it.

HQ: As the healthcare system weathers pressures for performance, accountability and transparency, how will these drivers affect transplant programs or the work you are going to do at the Rick Hansen Institute?

BB: There will have to be more transparency within the public sector. There is certainly more accountability for outcomes. Over time, this will impact individual care providers. This is [already] impacting institutions in terms of reporting requirements. As healthcare funding takes up a greater proportion of provincial budgets, there will be more pressure to demonstrate efficiency and effectiveness. This [pressure] will filter into the professions in ways not yet experienced. That may manifest in different payment models, various care transfer processes between professions and more competition between and among providers. We are going to see more competition on the basis of cost and quality; it's inevitable. That doesn't mean that the system needs to be privatized, but it does mean that public providers are probably going to be competing in a way they haven't in the past.

Ultimately, we are going to see some fundamental changes. [Some] are beginning to recognize that demography, per se, is not the main driver of [health system] costs. It's actually the growth and the cost of the system. [Those pressures] will show that the system itself is going to need to change, and change fundamentally.

HQ: How have your perspectives on quality and safety evolved over the years, let's say with the data that help drive best practices?

BB: I've seen a huge change. Early in my career, quality assur-

ance committees in hospitals were just starting via accreditation standards. Now, quality has gained far more prominence, with a plethora of clinical guidelines and best practices, largely developed from excellent data, new information and research. The challenge is that these may not always get implemented.

The biggest challenge is creating incentives that ensure that knowledge and data are used in practice [in order to] benefit the system. We're not there yet. While there has been structural reform, we now need functional reform; incentives in the system must change. It's the old saying, form follows function. Changing structures is not healthcare reform – changing incentives is.

Quality and safety are cheaper. It is always cheaper to do it right the first time than to do it over again. One excellent example is pressure ulcers that plague persons with spinal chord injuries. If not treated promptly, pressure ulcers can be life threatening. Sources indicate that pressure ulcers are the most expensive medical error, costing billions, and they are almost entirely preventable through implementing inexpensive best practices.

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HQ: Tell us more about your new role at the Rick Hansen Institute. Given your success with transplantation, describe your mandate with spinal cord injuries over the next three years.

BB: There are some similarities between transplantation and spinal cord injury, in the sense that lives are changed in an instant as a consequence of an accident, an unexpected medical event resulting in a very serious [life-altering] injury. The impact of that is felt by the individual, the family and the personal network.

Transplantation results essentially in a chronic disease. We trade an acute, life-threatening disease (organ failure) for a chronic disease (transplantation) that is managed with drugs over a lifetime. With spinal cord injuries, after the event is treated, secondary complications follow that need to be managed for a lifetime. There are similarities [in terms of approaches to care].

HQ: Rick Hansen has become synonymous with achieving “the impossible.” How will that help you in your new role?

BB: Rick is an inspiration to people all over the world. He has

accomplished a lot in the past 25 years. My challenge is to tap into that energy and vision, and align it with our mandate at the Rick Hansen Institute and bring people along.

Our role is to lead collaboration: bringing people together with an interest in developing cures for spinal cord injury and accelerating the adoption of those cures nationally and internationally. Rick would say, “If you believe in a dream and you have the courage to try, great things can be accomplished; anything is possible.”

I am an optimist by nature and believe in possibilities. Where some people see risk, I see opportunity. Our opportunity is to do what Rick does best: bring like-minded individuals together [in order to] accelerate cures in spinal cord injury by using the best possible information, supporting world-class research and supporting adoption through implementation. **HQ**



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