

community where he practised, and, given that they all had full practices, it would likely mean an unacceptable increase in the number of patients without family physicians. The loss of those patients to the family health team (FHT) would result in a considerable decrease in the FHT's roster numbers. At the same time, both of the traditional approaches would mean a substantial change in income, both in overall amount and in predictability.

Coincidentally, Celeste, a colleague with the same FHT, wished to decrease her clinical load to gain more time for her family and other interests. Celeste was Chief of Staff at the local hospital, a position Bob had held for a number of years previously. They began a conversation that started with "Wouldn't it be nice ..." which eventually led them to an elegant solution.

Both doctors had large practices. They decided that they would each cut back their patient numbers to a level such that the total number of the combined practices was manageable by 1 physician. This was made much more attractive by the fact that a new physician was scheduled to open a practice in the community and agreed to take on all of the patients released by both Bob and Celeste. Bob and Celeste then agreed to cover each other's reduced practice on alternate months, resulting in half-time practices for both. Patients remaining in their practices were assured of coverage at all times through the year, with no holiday gaps. Those patients "released" from their practices were assured a new family physician if they so chose. More important, both physicians managed large inpatient loads at the local hospital and the care of these patients continued seamlessly. The hospital board agreed that Bob and Celeste could job share the chief of staff position.

We have now been practising in this way for 9 months. Most patients have accepted this solution happily, as we are both well-known physicians in the community. Sacks et al note from their literature review that "creating a successful job share requires trust, open communication, and shared beliefs."<sup>1</sup> To this list we would add a common work ethic and practice style. Each of us strives to ensure that at the end of our work month, all administrative work (eg, laboratory results, paperwork, insurance forms, messages) is complete. We share available office appointment slots equally between the 2 practices. We each take ownership of the various challenges of the chief of staff position, copying each other on important e-mail messages. As often as possible, only one of us attends meetings.

We have learned a lot over the past months, and would endorse the list of recommendations by Sacks and colleagues.<sup>1</sup> We have managed to work half time, and our income is settling in at roughly 50% of what we earned previously. Our patients, colleagues, and the hospital staff are pleased with our arrangement thus far. We recommend consideration of a similar solution to community family physicians who have need of greater time away from their practices for whatever reason.

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—Celeste Collins MD CCFP FCFP  
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**Competing interests**

None declared

**Reference**

1. Sacks J, Valin S, Casson RJ, Wilson CR. Are 2 heads better than 1? Perspectives on job sharing in academic family medicine. *Can Fam Physician* 2015;61:11-3 (Eng), e1-3 (Fr).

## Geography aside

A thank-you to Dr Vance for raising the important issue of the red tape around physician mobility in Canada in the February issue of *Canadian Family Physician*.<sup>1</sup> During my tenure as Chief of Staff at Moose Factory General Hospital (Ontario's most remote hospital), I was equally frustrated in our efforts to hire Canadian locums to cover staff physicians on leave. Most rural communities suffer because of the unnecessary obstacles to locum mobility in Canada. This is not just a supply issue. On the supply side, there are many young physicians like Dr Vance who are eager to explore Canada by working in rural and remote communities. On the demand side, we only need to look at the numerous classified ads in Canadian medical journals to comprehend the need. Dr Vance has some excellent suggestions; I would like to put out 1 more: a national medical licence. Given our geography, it will require provincial administration (as is the case with the College of Family Physicians of Canada). However, a Canadian national licence would greatly improve locum mobility and rural patients' access to health care, as well as give physicians a medical practice experience of a lifetime. It's time.

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**Competing interests**

None declared

**Reference**

1. Vance M. Provincial licensing process. Unnecessary barrier to locum coverage. *Can Fam Physician* 2015;61:169-70.

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