Opening remarks and call to order

00:00:07
Michael T. Cohen: Thank you. Before we start I'd just like to remind people to please silence your phones for this. I would also like to let people know that when we get to the voting aspect of it I've been told there's a 15 second delay from the time people online receive the information you receive here. So if the delay seems longer when we're voting or there seems to be a bigger lag, 15 seconds can seem like an eternity at times, just judge accordingly. Thank you.

00:00:39
So we'll start as people enter the room, we should be online now, welcome everybody, I am Dr. Michael Cohen, President of the Canadian Medical Protective Association. Welcome to our 118th Annual Meeting. Bienvenue à notre 118ème assemblée annuelle.

00:00:56
Our meeting this year is being delivered online and in person, we are pleased to have over 120 members from across Canada with us today. We also have representatives from a number of health care organizations. Thank you for all taking the time to join us. I'll now hand the microphone over to my colleague, Dr. Lisa Calder, to call the meeting to order.

00:01:23
Lisa Calder: Thanks, Mike, and welcome everyone. Bienvenue à toute et à tous, I am Dr. Lisa Calder. I am the CEO of the CMPA. Je suis la dre. Lisa Calder, directrice générale de la CPM. There being a quorum present I hereby declare this meeting duly constituted and call it to order. Puisque nous disposons du quorum nécessaire, je déclare l'assemblée dument constituée et ouverte.

00:01:51

As you can see we are joining you from beautiful Vancouver, British Columbia and to honour and recognize the lands on which we meet today I am pleased to introduce elder and knowledge carrier Syexwáliya / Ann Whonnock from Squamish nation and to welcome her as she begins our meeting with an opening prayer.

00:02:11
Syexwáliya is a knowledge keeper and elder advisor with the First Nations Health Authority. She is widely respected and acknowledged for her work, energy and commitment to her community. And she has worked with organizations throughout BC sharing her wisdom, knowledge and advice to guide organizations through their ongoing journey towards cultural safety.

00:02:33
I was privileged to meet Syexwáliya at the recent Pacific Region Indigenous Doctors Congress meeting where through her words, song and actions it was clear to me the deep respect that she garners from her community and the integral role that she has played in guiding and grounding many physicians in their work. Syexwáliya, it is an honour to have you with us today. On behalf of CMPA I am pleased to offer you the tobacco here for sharing your knowledge and wisdom with us today. I turn the floor over to you.

00:03:15
Syexwáliya / Ann Whonnock: (Indigenous language). I'm grateful and thankful to you, Lisa, for the introduction. (Indigenous language). I'm really glad to welcome each and every one of you here today, all of you my friends. (Indigenous language). My name is Syexwáliya, also known as Ann Whonnock and I'm from the Squamish nation and it's an honour to be here and welcome you to our ancestral traditional territories of the (Indigenous language) Squamish Nation, my nation and our family at Tsleil Waututh and Musqueam.

00:04:05
And today, I'd like to be able to say that we come together in (Indigenous language) with one heart and one mind for all the good work that you've been doing for so long. I was really impressed to hear that it's 118 years that you've been an organization and was told actually 1901 is when you began. Really impressed me because you know Vancouver was just being a young city and you were already organized in the east.

00:04:44
And I, you know, just ask you to (Indigenous language), to continue to work together. (Indigenous language) is a phrase my grandfather taught me that means to stand and work together to hold each other up and support one another and that's what you need to continue to do.

00:05:08
My grandfather also taught me that we all have an inner energy and a force within us and he said that that energy we receive from Creator through the top of our head into our energy and

that we – if we believe in that energy it helps us through times when we need to draw on it and Creator and helps us emotionally, mentally, physically and spiritually.

00:05:41
And when we come together (Indigenous language) in unity and I do a song and prayer for you, we can't have our arms crossed like this and we can't have our hands like this. And the reason I'm going to share with you my grandfather shared about the energy and I had a hard time getting people not to do this. And then I thought the best way is get you relaxed. And when my children were young I went to see the second Star Wars was coming out and they brought the

first one out and I took my young children, they're adults now, and when I saw Obi Wan sharing with Luke about the force I went, that's what Papa said about our inner energy. And so I became a Star Wars fan.
00:06:35
So I have my baby (Indigenous language) and my Mandalorian earrings and I made my grandchildren like Star Wars, at first they didn't want to watch it, they want to watch Jurassic Park, my grandsons but now they're Star Wars fans too. And I say that because then you relax.

00:06:59
So now I'm going to ask you to stand, we're going to do some Tai Chi and yoga exercise now. We'll start with the downward dog, maybe standing tree, and I found that our elders believe laughter is medicine and that I need to make it not be like this. Not like this or this but that's why I say stand and make you laugh and we are going to do some breathing to ground you.

00:07:38
So just breathe in and out and then have your hands open, feel the energy flowing amongst all of you and from Creator and ancestors. We're going to sing Syexwáliya song, greeting of the day and then I'm going to do a prayer and then turn you back over to our hosts here.

00:08:05
(Prayer and song)

00:09:32
(Indigenous language), keep your hands open. (Indigenous language), asking you Creator to watch over and protect each and every one of your children gathered here today as well as all their families, their friends, the villages where they're from and the villages where they now live, work and play.

00:10:08
Put a shield of safety and protection around each and every one of them, help them all with their (Indigenous language) which means feelings in your heart and mind and your emotional, mental, physical and spiritual health and wellness. Asking you, Creator, to let today be a (Indigenous language), an excellent work today with everyone coming together in (Indigenous language) and unity, transferring knowledge, information and sharing their (Indigenous

language), their words with respect and listening with respect and creating positive solutions for the present and future.

00:10:49
Hear our prayers, Creator, for all our family and friends and communities, for all those who have serious illnesses and injuries and waiting for surgery and those who have had surgery and

COVID or long haul or COVID and many other illnesses and treatments we can't start naming or we'd be here maybe all day.

00:11:12
Hear our prayers for their health, healing and recovery. Hear our prayers for all family, friends and those in our community who have traumas and battle alcohol and drugs whether prescription or toxic supply that takes many, and also hear our prayers for those who are homeless because of their traumas and battles.

00:11:33
Let our prayers put a shield of safety and protection around them and help them maybe find help them with their (Indigenous language) and maybe help them find that healing path to wellness and recovery. Hear our prayers for all our family and friends who have lost loved ones and have heavy feelings of sorrow in their heart that our prayers help hold them up as they say farewell to their loved ones going home to Creator, ancestors and those who have gone before us and help them in the healing days ahead.

00:12:06
And always remembering that as my old people taught me that our loved ones who leave us they worry about us and they become what I call our spirit guardian warriors and when we're low in (Indigenous language) they send us signs, dragonflies, butterflies, ladybugs, hummingbirds, eagle, raven, something you don't see or you're walking where there's no stones or feathers or a shiny coin on the ground, pick them up because it's a sign that a loved one is nearby and the stone fits in your hand like a worry stone.

00:12:44
Every once in a while wash it underwater or in a creek and I say all the water in the cities come from our rivers. So wash it under there and make it fresh and then it'll be good energy for you.

00:12:58
And again, Creator, let our gathering today be at (Indigenous language). Let our gathering today be an excellent gathering. (Indigenous language), those are my words. (Indigenous language). I thank all of you and I'm grateful that you let me share a part of your day today.

00:13:44
Michael T. Cohen: Thank you, Syexwáliya, for sharing your knowledge and wisdom with us today. It is an honour to have you with us and we thank you for opening our meeting.

00:13:55
As we gather here today in Vancouver I'd like to acknowledge the land on which we sit.

Vancouver is situated on the unceded traditional territories of the Musqueam, Squamish and Tsleil Waututh nations. As an organization we recognize all first peoples who were here before us, those who have lived with us now and the seven generations to come.

00:14:18
I would also like to acknowledge that the CMPA offices located in Ottawa are on the unceded, unsurrendered territory of the Anishinaabeg Algonquin nation whose presence here reaches back to time immemorial. We honour and pay our respects to these lands and to all First Nations, Inuit and Metis peoples throughout Turtle Island. Lisa.
00:14:49
Lisa Calder: Thanks, Mike. I just want to say a quick word about our COVID protocols that we have in place for the in person meeting. I can assure you that all of the onstage participants are fully vaccinated and we encourage all of you to maintain physical distancing as much as possible. We also encourage you to wear a mask when you're not eating and drinking and please use a hand sanitizer that's made available to you.

00:15:11
Michael T. Cohen: Thanks, Lisa. Now let me introduce my colleagues some of whom will be presenting today. There's me, Dr. Michael Cohen, the current president, Dr. Jean-Hugh Brossard, our incoming president, Dr. Lisa Calder who you just met, Chief Executive Officer, Dr. Todd Watkins, our associate CEO, Corey Garbolinsky, our Chief Financial Officer, Dr. Pamela Eisener-Parsche, our Executive Director Member Experience, Dr. Armand Aalamian, Executive Director Learning, Chantz Strong, our Executive Director Research and Analytics, Christine Holstead, Executive Director Strategy and Operations, Leah Keith, our Executive Director People and Culture.

00:15:50
Also Dr. Darcy Johnson who is a council member and Chair of our audit committee who is not on stage but will be joining us, and Dominic Corolla(ph), general counsel for the CMPA.

00:16:02
We also have three former presidents of the CMPA with us today, doctors Debra Boyce, John Joseph Conde(ph) and Bill Tucker along with all of our CMPA counsel, and Dr. John Gray, a former CEO of the CMPA is in attendance as well. Thank you for all – all for joining us.

00:16:21
Over the next few minutes Lisa and I will look back on the year and share how the CMPA has continued to support our members and to bring value to the Canadian healthcare system. Before we do that there are two scrutineers who have been identified in advance of today's meeting, Doctors Heather Ross and Catherine Smart. If you have any objection to these two

members being named as scrutineers please let us know now by using the Ask A Question button or use the mics in the room. We will pause briefly to allow objections to be noted.

00:17:01
And remember I told you of the 15 second delay with the online so there's, there will be a lag with this hybrid meeting. And for those of you who came in a little late I'd ask you make sure you silence all your phones, please. As there are no objections Doctors Ross and Smart are appointed scrutineers of the voting.

00:17:25
I would now like to seek your approval of the minutes from the 2021 annual meeting which were posted in advance of today's meeting on the CMPA website. Please use the buttons to move and second the motion now. Additionally if you have any amendments to the minutes please submit them via the Ask A Question button now or by using the mics set up in the room. The motion has been moved and seconded, there are no changes to the 2021 Annual meeting minutes as they have been received.

00:17:59
I would now ask members to vote to approve the minutes. We will now pause for the voting. thank you to all who voted, the minutes of the 2021 annual meeting are approved. Le procès pour valider l'assemblée annuelle 2021 est approuvé.

A year in review

00:00:03
Lisa Calder: Thanks, Mike and thank you for your patience, we are learning as we are doing hybrid meetings. So the year end review, this year has been incredibly difficult for you, our members, and it's also been difficult for your patients and all health care providers. When we reflect on the past year and what you have experienced, scarce resources, delays in care, changing scopes of practice, wellness issues and threats to personal safety, it's a lot.

00:00:38
And through it all you have continued to strive to deliver safe and effective health care for Canadians. Thank you. Thank you for your perseverance, your courage, your skill. What you do every day makes a difference in the lives of countless Canadian patients. Le travail que vos faites chaque jour, a une incidence concrète sur la vie d'un très grand nombre de patients et patientes canadiens.

00:01:06
As you support your patients, our role at the CMPA is to support you, protecting your professional integrity and helping you provide safe medical care. Throughout the challenges

this year we have continued to be your partner in practice, we have focused on being there for you, modernizing the CMPA and doing so in a collaborative way.

00:01:29
Let me tell you a little bit about how we have delivered on these commitments to bring value to you and the Canadian healthcare system. If there's one message I would like you to take away today is that the CMPA is here for our members in Canada. Si vous devez retenir un seul message de la séance d'aujourd'hui, j'aimerais que ce soit le souvent: La CPM est là pour ces membres ici au Canada.

00:01:56

In 2021 alone our physician advisors responded to over 24,000 advice calls, helping members manage patient safety challenges and provide safe medical care. We also supported members with over 8,000 medical legal concerns ranging from college complaints to hospital matters and civil legal actions.

00:02:19
Over the past year when it came to emerging COVID-19 issues we advocated on topics like critical care triage protocols and the resumption of non urgent care. We also provided high quality medical legal advice on issues ranging from medical assistance and dying to effective patient communication.

00:02:41
We shared resources and information through many of our channels as you can see here. Our online COVID-19 hub was accessed by over 77% of our more than 105,000 members. We were and we continue to be a trusted source of compassionate support and empathetic advice.

00:03:02
We hear directly from you, our members. In fact we heard it this morning at our education session about the impacts of medical legal events on your health and wellness. We know the health and wellness of physicians directly affects the safety of medical care and the risk of medical legal events and that is why we are taking tangible steps to support the well being of our members who experienced medical legal issues.

00:03:29
In 2021 we created a new Physician Support and Wellness Department to enhance our ongoing wellness efforts. These include the actions you see here on this slide. And one of the key roles of the CMPA is our mandate to compensate patients on behalf of our members when it has been proven that a patient has been harmed by negligent medical care or known as fault in Quebec.

00:03:55
Over the past five years we have paid a cumulative total of $1.2 billion in patient compensation and a total of $276 million in 2021 which is $70 million more than in 2020.

00:04:12
Our focus is on preventing patient harm through member education and support. But when it is proven that harm has occurred due to negligent care we will compensate patients appropriately and as quickly as possible. We also invest prudently to ensure that we have adequate funding to compensate patients and support physicians now and into the future.

00:04:38
Speaking of investments, you will hear more about this at the – later on today but I did want to share with you that 2023 member fees will be reduced across all regions through fee credits.

00:04:51
To support members one of our goals is to maintain relative fee stability and refrain from significantly increasing member fees. Due in large part to recent investment performance we closed 2021 in a strong financial position. This has provided us with the opportunity to reduce member fees via fee credits. Cette situation financière favorable nous a permis de réduire la cotisation de nos membres en appliquant les crédits de cotisation.

00:05:22
Moving forward we will continue to ensure the Association has sufficient funds to compensate patients on behalf of members over the long term and weather any changes in medical legal trends that may come. Over to you, Mike.

00:05:42
Michael T. Cohen: Thank you, Lisa, for the overview of how we continue to support members. I'd now like to walk through how we are modernizing the Association. Across the organization we continue to look for new ways to modernize and improve the way we support members and contribute to safe medical care.

00:05:59
A key component of this is to prioritize equity, diversity and inclusion, or EDI. EDI is vital to who we are, how we operate and deliver services and the environment in which our members practice. We know members and patients experience racism and inequities across the system and we recognize that this significantly affects physicians, threatens patient safety and creates medical legal risk.

00:06:27

We have a responsibility to address this risk and we are committed to help mitigate bias and inequity in the services we provide to members and build a workplace culture which supports EDI.

00:06:41
In the last 12 months we have taken significant steps to do just that. We engage with members and listen to and learn from stakeholder groups and EDI leaders to help us better understand and respond to challenges facing our members. We provided CMPA leaders and counsellors with comprehensive EDI and bias training. We worked with expert consultant, the Canadian Centre for Diversity and Inclusion to assess our own diversity and explore ways to make our work culture more inclusive and equitable and we continued to enhance capacity among our staff to understand and support member EDI concerns.

00:07:23
We also began the development of our long term EDI strategy which we'll share today. Lisa will tell you more about this later but I'd like to say how proud I am of this strategy. Its development has been a collaborative effort between counsel, management and employees and it truly reflects the CMPA's commitment to action across all levels of the organization.
00:07:46.
As an organization we are always looking for ways to modernize and improve the way we support members. This work includes our efforts to support EDI, but we are also taking steps to modernize our governance. In the past year and a half we have engaged independent external governance experts to provide learning and resources to counsellors and senior leaders around best governance practices.

00:08:12
As part of these conversations we have begun discussing council size, composition, representation, scope and structure. We've also been exploring opportunities to ensure our governance model and procedures are aligned with contemporary practices and that our governance framework supports the needs of both the Association and its members.

00:08:37
Contributing to safe medical care is a cornerstone of CMPAs mission. We actively provide continuous learning to help our members reduce patient harm and lower their medical legal risk. In 2021 we delivered our virtual residents and podium to 17 faculties of medicine. We continued to enhance our good governance practice guidance and we've provided accredited evidence based eLearning activities. Our subsidiary, Saegis, also expanded its online programming and enhanced its capacity for facilitator led group and individual learning.

00:09:14
Part of the CMPAs role is to advocate for system enhancements. In 2021 we created the strategic engagement advocacy department. Since then we've made 59 submissions to

regulatory authorities and we've engaged with governments, colleges and stakeholders providing insight on multiple topics as you can see on this slide. We also signed the Canadian Health Workforce call to action on the healthcare human resources crisis and we also recently reached out to the federal, provincial and territorial governments asking them how to work together to protect members from US medical legal issues when providing abortion services to non Canadian residents.

00:09:59
Speaking of this issue we know that the recent decision to overturn Roe vs. Wade has been incredibly distressing for many members. We also know you have questions about your medical legal risks and CMPAs assistance with abortion services to US patients. We will be hosting a virtual one hour session on September 6th open to all members to answer your questions. This session will include a panel of experts in the field and will be simultaneously interpreted. You will receive an invite to the session soon, so keep your eyes on your email please.

00:10:37
Advocacy is not the only way in which we support patient safety. The CMPA has the largest collection of physical physician medical legal data in the world. We use these data to identify gaps that affect patient safety and pinpoint opportunities for quality improvement.
00:10:55
Our data insights inform our safe medical care learning resources. In 2021 we modernized our research focus to provide timely insights into sepsis, never events and rural health. We also publish manuscripts in peer reviewed journals and fulfill research, project and data requests as you can see on this slide. Ultimately our research supports patient safety and helps prevent patient harm from happening in the first place.

00:11:26
Collaboration both within CMPA and across Canadian health care is key to many of the updates Lisa and I have just shared. In these challenging times it's more important than ever that we work together to support the changing needs of our members, their patients and the healthcare system.

00:11:46
We work with the Health Care Insurance Reciprocal of Canada to create learning aimed at reducing risk in obstetrical care. We provided advice to the Ontario Medical Association, Alberta Health Services, Health Canada and the Public Health Agency of Canada on vaccine hesitancy. We participated in a town hall in British Columbia to discuss physician bullying and harassment and we were part of the CMPAs virtual care taskforce helping to develop strategies for the use of virtual care.

00:12:20

I trust that this provides you with a clearer view of how the CMPA brings value to our members, patients and the healthcare system. J'espère ces renseignements vous en donnent une idée plus précise de l'avantage qui confère le CPM à ces membres, patients et au système de santé.

00:12:38
Now let's take a look at our financial information. We'll start with a message from Dr. Darcy Johnson, chair of the audit committee who I will invite to join us on stage.

2021 Report of the Audit Committee

00:00:01
Darcy Johnson: Good afternoon, everyone. Thank you, Mike. And the CMPA audit committee is comprised of five members of council plus two external financial experts all of whom are independent of management. The committee meets quarterly to ensure that it's duties are discharged in an appropriate manner with good governance and sound operational procedures.

00:00:20
As Chair of the audit committee I'm pleased to report on our activities with respect to 2021 financial statements which have been prepared by management and audited by the firm of KPMG.
00:00:30
The audit committee has reviewed these statements with management and with the auditors. KPMG has attested that the CMPAs statements properly represent the results of operations in 2021 and the financial position of the Association as at December 31st, 2021.

00:00:47
We'll now hear from our Chief Financial Officer, Corey Garbolinsky with respect to the 2021 financial report. Thank you.

2021 Financial report

00:00:24
Cory Garbolinsky: CMPAs financial model has several interconnected components: membership fees, medical legal costs, the money needed to pay for future claims and our investment portfolio. We must have sufficient funds to assist our 105,000 members and compensate Canadian patients on their behalf if the care provided is found to be negligent.

00:00:55
These are the key principles that drive our financial model. First, occurrence-based protection means that physicians are eligible for assistance anytime in the future even if they are no longer active CMPA members as long as they remember when the care was delivered. The financial

horizon or window to pay out all potential cases from a given year is long. In fact we must hold funds to pay out potential cases up to 30 to 40 years from the time the care was delivered.

00:01:32
Second, our financial goal is to hold at least $1 of assets for every dollar of liability to appropriately compensate patients and their families. We do not seek to generate a profit.

00:01:47
Third, members pay the full cost of their protection through their fees. This means that in 2021 we collected the fees needed to protect our members for all occurrences taking place in 2021 even though they may not become apparent for up to four decades.

00:02:08
Finally, the CMPAs financial model is self-correcting. Sometimes our actual results differ from our estimated results. This can create a temporary excess or a temporary deficit. As a not-for-profit, we are not allowed to pay dividends to our members, but if we have a temporary excess, we may lower membership fees.

00:02:34

Let me explain how the various parts of our financial model are connected. Our funded position is the difference between our assets and liabilities and is a key factor in determining the membership fees in any given year. Membership fees are used to pay the medical legal costs of protecting and assisting our 105,000 members. The changing trends in medical-legal costs shape the size of the provision needed for outstanding claims. This provision is the amount of money needed to appropriately compensate injured patients and manage future legal and administrative expenses.

00:03:23
We also have a solid investment portfolio which earns income to ensure we can appropriately compensate patients and fund future medical legal expenses. Finally, the change in the funded position is the sum of all of the financial items mentioned.

0:03:47
Now let's look at our 2021 finances. The membership fees collected in 2021 will pay the medical legal costs resulting from care provided in 2021. There is a relationship between the estimated yearly protection costs as calculated by our actuarial team and the membership fees collected.

00:04:13
The difference between the two lines shows the fee adjustments to reflect our financial position across our four fee regions over the past five years. When we find ourselves in a

positive funded position, which is our current situation, we may lower membership fees where appropriate through the application of a fee credit.

00:04:37
The CMPA's actuaries calculated the estimated cost of protection for 2021 to be $603 million. Due to favourable financial positions in all fee regions, the Association was able to reduce fees by approximately $99 and a half million dollars in total. Therefore, the total membership fees collected was $504 million and in line with our estimate.

00:05:07
Now we move on to medical legal costs. We collect membership fees to pay medical legal costs. These costs include compensation to injured patients due to negligent care, legal and expert fees, safe medical care education programs and the cost to run the Association.

00:05:31
Compensation to patients is our single largest expense. Here we see the annual compensation payments and the annual legal costs over the past five years. In 2021, the Association paid $276 million to patients injured as a result of negligent medical care. While the total compensation amount varies from year to year, the CMPA has paid over $1.2 billion in compensation over the last five years. The legal costs over this same period where $939 million.

00:06:18

An important point is that the trends and expenditure levels are not equal across our four fee regions. Ontario represents 40% of our members, but this region has the highest legal fees and compensation amounts awarded to patients, so they represent more than 50% of our annual costs. These regional cost differences mean members pay different fees as each region is independent and there is no subsidization between regions.

00:06:51
The provision for outstanding claims is the sum of all the expected future medical legal costs resulting from the care delivered by members up to the end of 2021. For care delivered in 2021, we must look ahead and make sure we have funds available to cover any expense related to that care for the next 30 to 40 years.

00:07:18
Compensation to patients accounts for approximately two thirds of the $4 billion provision. We review the provision each year and we increased the provision by $133 million in 2021 based on updated cost trends.

00:07:39

In order to provide some additional oversight, we engage an actuarial peer reviewer, Ernst and Young, to perform an independent calculation of the provision. The provision is then audited by KPMG as part of their external audit of the CMPA's financial statements.

00:07:57
The investments part of our financial model is closely linked to the provision for outstanding claims. The provision includes an estimated payment pattern which we use to model the investment portfolio. We target our investment portfolio to reach a 5% investment return over the long term.

00:08:21
We are looking at the hypothetical return on our investments using our targets over the past 10 years and the actual return. As you can see, we have outperformed the target by approximately $1.25 billion over the last 10 years due to the favourable performance of the financial markets exceeding our expectations.

00:08:46
These excess returns have fuelled the growth in the CMPA's net asset position which may allow us to lower the cost of membership in future years. 2021's investment return was 12.8% which is more than our target of 5% and positively contributed to the funded position.

00:09:09
Finally, let's look at the funded position which all of the other items in the financial model feed into. The funded position is the difference between the total assets of the Association which is primarily the investment portfolio and the total liabilities of the CMPA which is primarily the provision for outstanding claims. Given our long-term approach to the management of our

finances that involves estimates, we take a measured approach to either a temporary shortage or a temporary excess of net assets.
00:09:50
You can see this in our funded position over the last 10 years. At the end of 2021, our total assets were 135% of the total estimated liabilities or a positive position of $1.66 billion. This is a marked improvement from 2014 when there was a $360 million shortfall. This improvement can be attributed to better than forecast investment performance.

00:10:28
This strong financial position will help us to weather the unpredictable investment markets, fluctuations in medical legal case volumes as a result of the pandemic and the current high inflation environment. We recognize this funded position is higher than desired and may allow us to reduce membership fees in the future. We will return to this theme when Lisa discusses the 2023 membership fees.

00:10:58
As I conclude my financial update, I'd like to summarize the key takeaways. The various parts of our financial model are interconnected and self-correcting. Due to our occurrence-based protection, the CMPA operates within a long time horizon of up to four decades, allowing us to protect members long after they retire.

00:11:27
Our current strong funded position is primarily a result of strong investment returns over the past 10 years. Fee increases or decreases are the primary tool used by the CMPA to manage our funded position.

00:11:48
And finally, our positive funded position in 2021 should provide confidence to members and their patients that we are there for them when needed. Thank you.

2023 Aggregate fees by region

00:00:03
Lisa Calder: We strive to ensure the fees we collect from members are used efficiently and appropriately. We are committed to containing growth and medical liability protection costs and we aim to optimize the stability and predictability of fees over time.

00:00:27
As appropriate, we reduce membership fees when we are in a strong financial position and prudently increase them if we are in deficit. As you just heard in Cory's 2021 financial report, the CMPA's current financial position is strong and as a result we are reducing 2023 fees again this year across all four fee regions.

00:01:01
The CMPA has four unique fee regions in response to the regional cost differences across the country, allowing for an equitable allocation of costs. The four regions are British Columbia and Alberta, Ontario, Quebec and Saskatchewan, Manitoba, Atlantic provinces and the territories. Each region is independent and there is no subsidization between regions. For example, if one region is in a positive or negative funding position, this does not impact the other regions.

00:01:41
The aggregate cost per region is the total amount to be collected in each region. The aggregate fee per member is an illustrative number that is the aggregate cost per region divided by the number of members in that region. It is only an average and not an actual membership fee. When determining membership fees, we first calculate the aggregate costs for the region and use this as the foundation to determine regional fees based on the type of work.

00:02:20
I will now share with you the 2023 aggregate amounts per fee region starting with British Columbia and Alberta.

00:02:36

The forecast aggregate fee in BC and Alberta in 2023 is, on a per member basis, $4,839. However due to our strong financial position we are able to reduce these fees by $3,138 per member, resulting in an aggregate fee of $1,701. The overall aggregate cost for BC Alberta is $48.8 million which is down 56% from 2022 or a reduction of $60.3 million dollars. All members in BC and Alberta will see a reduction in their membership fees.

00:03:29
In Ontario, the cost of providing medical liability protection is greater than any other region and this is reflected in the membership fees. The cost of providing medical liability protection in Ontario in 2023 is forecast to be, on a per member basis, $6,646. However, since Ontario is also in a positive funded position the aggregate fee per member is being reduced by $3,448 to $3,198. This is a 45% decrease from last year. Across the entire fee region, the reduction is $107.8 million.

00:04:28
As has been previously reported the projected costs of liability protection in Quebec have risen at a slower rate than in other parts of the country. In general, we have also not seen the same level of variance in compensation to patients year over year as in the other three regions. As a result, membership fees are generally stable in this region and the lowest of all four regions

00:05:03
Given Quebec's positive funded position we continue to be able to reduce the membership fees in this region. This results in a per member aggregate fee of $227, which is 56% lower than in 2022.

00:05:26
I will now turn to Saskatchewan, Manitoba, the Atlantic provinces and the territories. For 2023 given the region's positive net asset position, the aggregate fee per member is $345, a reduction of 90% from last year. For the entire region the reduction is $41.6 million.

00:06:04
As you can see there are significant regional differences in protection costs with Ontario being far and away the most expensive region. The CMPA is committed to charging members only those fees required to provide effective medical liability protection through a sustainable model, and this gives our members confidence that assistance will be available to you in the

event of a medical legal difficulty. We will continue to modernize and enhance our member services to maximize the value we deliver to you, our members

00:06:45
Having shared the aggregate fees, here's an example of the actual membership fees for family physicians practicing in type of work code 35 in 2023 versus 2022 across the four fee regions.

00:07:10

The full listing of 2023 membership fees are now available on our website. You will be notified by email in the fall when the annual invoices are available on our website via the secure CMPA member portal. Moving forward we will continue to explore opportunities to leverage our knowledge to enhance patient safety and reduce fees while ensuring we remain financially sustainable and able to compensate patients and support physicians today, tomorrow and well into the future. Thank you.

2022 Council election results

00:00:03
Lisa Calder: Each year approximately 1/3 of our council positions are scheduled for nomination and election. This year 11 council positions were up for nomination and election in seven areas. Voting occurred in Alberta and Ontario. Candidates in the remaining areas were elected by acclamation.

00:00:23
It is my sincere pleasure to present to you the 2022 council election results. We welcome Doctors Oyelese, Sockanathan and Chafe, Doctors Mela, Halparin, Tang and Ross, Doctors Bouchard, Saoud, Gillis-Doyle and Dr. Cohen. We welcome the diversity of the candidates who submitted their names for election and thank them all.

00:00:51
In a time when maintaining strong leadership at the CMPA is critical, these individuals deserve our collective gratitude for their willingness to serve the CMPA.

00:01:08
(Translation starts) In a time when maintaining strong leadership at the CMPA is critical, these individuals deserve our collective gratitude for their willingness to serve the CMPA. (Translation ends)

00:01:13
I would also like to thank our two departing council members, Doctors Paul Farnan and Christopher Wallace. It has been a true pleasure working with each of you and I thank you for

your commitment to the Association and to its members during your CMPA tenure as councillors over to you, Mike.

Member motion

00:00:02
Michael T. Cohen: Thanks, Lisa. On July 15th all members received an email from the CMPA letting you know that we have received a member motion focussing on a review of the CMPA governance model. You can find the motion on the slide in front of you.

00:00:20
Now let me walk you through the motion process. First off, only active members may vote on the motion and ask questions. In the interest of time I would ask if all speakers including the mover restrict your comments to two minutes, this should allow us to hear from as many members as possible.

00:00:40
The discussion of the motion will be restricted to 25 minutes total. The process of the member motion will be as follows; Dr. Cooper will move the motion, I will then call for a motion – the motion to be seconded. Once the motion has been seconded Dr. Cooper will first speak to the motion and we will then open the floor to questions. I will monitor the discussion and address any issues accordingly. I have asked Doctors Watkins and Eisener-Parsche to assist me in managing the questions from the floor and from our online participants.

00:01:13
Prior to moving the motion and opening the floor to discussion I would like to provide a brief overview of aspects of CMPAs governance structure that are relevant to this motion. The CMPA is governed by an election – elected council of 31 practicing physicians from across Canada who work with management to foster the long term success of the Association.

00:01:38
We were incorporated over 100 years ago by an act of Parliament. The act and our bylaw lay out the rules that guide the conduct of our affairs. The bylaw outlines the requirements and composition of council including its size. The terms of reference for council and councillors set

out the way in which council organizes and conducts itself to fulfill its responsibilities and described the responsibilities of councillors.
00:02:06
As today's motion focusses on amending our bylaw I want to clarify that changing the CMPA bylaw is not an internal only process.

00:02:22

(Translation starts) As today’s motion focusses on amending our bylaw I wanted to clarify that changing the CMPA bylaw is not an internal only process. (End of translation)

00:02:35
Amending the CMPA bylaw is an extensive process which takes significant time and consultation. Our governing documents also require membership and ultimately government approval for the amendment to pass. This process can take up to two years. We have certainly changed our bylaw in the past and in fact as I shared previously we are in the process of reviewing our governance practices and model so this discussion is very timely.

00:03:03.
I would like to thank all members who have made the time to attend this annual meeting to discuss the important issue and help us contribute to good governance. Now, let me invite Dr. Cooper to come to the mic and move the motion.

00:03:24
Dr. Cooper: Thank you, Mike. I move the following; Be it resolved that the CMPA commits to undertaking a comprehensive review of its governance model with a view to potential bylaw amendments including but not limited to council composition including size, representation including geography, specialty and diversity and skills. The CMPA will bring forward an update to the 2023 Annual General Meeting and the final report on the governance review including any proposed bylaw changes to the 2024 Annual General Meeting for consideration and approval.

00:04:02
Michael T. Cohen: Please second the motion online or using your mobile device. Motion has been moved and seconded. I invite Dr. Cooper to speak to the motion for two minutes and then we'll open the floor to discussion. Dr. Cooper.

00:04:23
Dr. Cooper: Thank you again, Mike. The CMPA is a fantastic organization run by physicians for physicians. The staff are incredible, they're motivated to help physicians and they care. I thank them and congratulate them for their exceptional dedication.

00:04:38

As we've heard today, Dr. Calder, Dr. Watkins and their team have done a remarkable job and are committed to modernizing the CMPA. The last archaic vestige of the 20th century is an expensive, oversized, inefficient board. This motion is for the CMPA to investigate and apply governance best practices so that the CMPA is sustainable and here to protect physicians and our patients for the foreseeable future.

00:05:06
My name is Rob Cooper. I'm a family physician from Ontario and I do primarily addiction work. I had the honour of serving on the CMPA council for 18 years and was on almost every committee including the executive committee.

00:05:20
A full governance review is long overdue at the CMPA. It is nice to hear that council is supporting this motion today but if the CMPA council had wanted to do this, they would have done it already. They could have done it any time in the last five years when they heard the CMA CCFP, OMA and Medical Council of Canada went through this exact same process and made their board substantially smaller.

00:05:44
I love the CMPA mission and vision but I was told that if I wanted to ensure that this governance review was to take place I had to bring a motion here today. So I'm here today to make sure the CMPA becomes even better. I'm here alongside two other former CMPA councillors who also care about the future the CMPA and signed and supported the motion, Dr. David Naismith(ph) and Dr. Carol Williams(ph). Thank you both for caring and for being here.

00:06:13
What is an ideal board size? It is clearly not the 31 people the CMPA currently has. The Wall Street Journal says that for many organizations the ideal board size is between five and seven members. Up to 15 board members are acceptable on the high end in unusual circumstances.

00:06:31
This motion provides for the CMPA to conduct a comprehensive review of its council, assessing important factors including but not limited to size, diversity, geography, specialty and the skills that someone can bring to the board. On behalf of the 105,000 CMPA members I want to thank the CMPA staff for caring, for dedication to our members and for the exceptional job they do every day helping Canada’s physicians.

00:07:01
Let's send a clear mandate to the CMPA that we expect a modern, efficient, cost effective council. Our members and our patients deserve it. I ask everyone here to vote in favour of the motion. Thank you so much for your time.

Q&A for members

00:00:03
Michael T. Cohen: I'll now open the floor for questions. Please restrict your comments and questions to the motion on the screen and limit your time to two minutes each. Please use the

Ask A Question button to submit your questions or use the mics set up in the room. Remember, only active members may participate in the discussion.

00:00:23
Comment/Question: (inaudible, technical) Dr. David Naismith.

00:00:25
Michael T. Cohen: It is indeed.

00:00:27
Comment/Question: My name is David Naismith, I'm a surgeon, I practice in Victoria, BC. I'm standing in support of this motion. I've been a member, as have many of you for a long, long time, mine starting in 1983 and I have served on council as Dr. Cooper has for the last 18 years with my reign of care ending in August of 2021.

00:00:50
When I arrived in council in 2003 I was immediately impressed with the commitment of council management and staff to the membership and our needs as members. My admiration has only grown over the 18 years that I served council. This association works, and I mean that in every sense.

00:01:06
A little over two years ago, Dr. Calder took over as the CEO of the Association, one of her main goals has been to modernize the CMPA. Dr. Cooper's motion to minimize the size of council is critical to modernizing the Association. Look at every association you're a part of, CMA, provincial medical associations. As Dr. Cooper had suggested many, many including businesses general, there is a move to decrease the size of boards, it is time for the CMPA to catch up with the rest of the business world.

00:01:37
Council has considered this in the past and in the past it was decided that we were different and that no change was made. I can assure you we are not that different. If you look at the annual report you will see a section on core values. There are six, one of them is responsible stewardship. And here we are talking about stewardship of funding of the association by way of fees.

00:02:02
If you look at the financial statements for the last normal year before COVID the governance costs were $11,905,000, almost $12 million spent on governance, this must change. If it was just about money it might be enough reason to change, however it is about much more than that, it is about efficiency and adopting a governance model that is appropriate for the times.
00:02:28

Decreasing council size will require a change in the bylaws of the Association and this carries some risk. However there are other issues requiring opening of the bylaws and so now is a very appropriate time to be considering this. There is no time to be wasted. As Dr. Cohen mentioned it's 31 members now, although it's not part of the motion I can tell you that my opinion would be that we could drop this to 10 to 12 without compromising the fiduciary responsibilities of council to membership. Thank you for listening and I encourage you to support this motion.

00:03:04
Michael T. Cohen: Thank you, Dr. Naismith. Do we have any questions online?

00:03:09
Moderator: Thank you, Mike, and we do have our first question. Good afternoon everyone, from Dr. Ajit Noonan(ph) from London, Ontario. Dr. Noonan asks, is there a specific measure of outcome in conducting a review of governance that would support a change in the size of the board? How is this review to be guided?

00:03:29
Michael T. Cohen: Dr. Brossard, would you like to (inaudible, technical)?

00:03:35
Jean-Hugues Brossard: Well that motion that is brought today beyond – before us is for me a friendly motion because we have already begun the work and our intention has been to review that governance, to make that governance review over the next few years.

00:03:56
So well it's complete alignment, so it's not a problem there. So what is the best governance? What is the best governance model for an organization? Well there's – it's not a one size fit all

and it's clearly something that needs to be assessed and you want to be sure that you make change that will bring value and that will help the organization in – to attain sustainability over time.

00:04:25
So well we'll think about that, we'll work on that and we'll bring you results that I hope will answer all those questions, be more sustainable, be more nimble, be more able to tackle the future. Thank you.

00:04:40
Michael T. Cohen: Thank you, Jean-Hugues.

00:04:44

Moderator: We have a second question from Dr. Douglas Wilson from here in Vancouver. He asked, equity, diversity and inclusion flies in the face of a smaller board. How will this impact the process?

00:04:56
Michael T. Cohen: Lisa.

00:05:00
Lisa Calder: Thank you for that question, Dr. Wilson. I mean this is the reason why we wanted to incorporate modernizing governance into our EDI strategy is we are committed to enhancing the diversity on council. And so when you really think about what that looks like and what that means and also how we can modernize the organization.

00:05:19
So while it seems that you are competing, I believe you can achieve both goals, it requires just careful thought and consideration of what that looks like and what you're trying to achieve. So we are committed to advancing diversity, we are committed to modernizing. So we will be working with counsel and with a consultant to help us move through this work to ensure that we are looking to advance on both those goals.

00:05:43
Michael T. Cohen: Thank you, Dr. Williams.

00:05:46
Comment/Question: Thank you, my name is Carol Williams, I'm a small town GP on a small island who is struggling through this COVID thing and trying to keep my head above water. As the seconder of this motion I strongly speak in support of this action by the council. It's time that the board became a little more nimble, a little more focussed I think on not just equity and diversity but skills.

00:06:15

It distresses me somewhat that most of the positions this year were obtained by acclamation. I think there's some message to get out to the public and to physicians for this particular organization. I served on this group for over 12 years. This is a wonderful committee, this is a wonderful organization, I can't say enough about it. Some of my best friends have come from this place. My lawyer is still sitting up there. I can't say enough good about the staff and the organization, it just needs some tweaking and I see it as a friendly motion.

00:06:52
Michael T. Cohen: Thank you Dr. Williams. Dr. Buckner, do we have any more questions.

00:06:56
Moderator: Thank you, Mike. Next question comes from Dr. Susan Hayden. Hello, Susan. Susan's from Saskatoon and a past councillor of the CMPA. She asks, Dr. Cooper gives examples of suggestions for board size when discussing the idea of revisiting board size at the CMPA. The CMPA a is unique organization providing support for a complicated and critical profession working in Canada. Do these examples of board size really apply comparatively to other organizations such as a the CMPA?

00:07:27
Michael T. Cohen: Dr. Brossard.

00:07:30
Jean-Hugues Brossard: Again me, oh, okay. So well those organizations have some similarity with CMPA but they are not CMPA. We are a unique organization and we'll find a unique solution to our governance review. We'll find a way to have enough representation, we're a member based organization, we need some representation from membership.

00:07:54.
We need skills on council. So we need a variety of skills, we'll find a way to get that skills. We want diversity, so we need to consider that and we want to have some diversity. We also have work to do and committee that need to work so it needs time, it needs people, it needs a workforce to do that. We need to – so multiple things that need to be considered that need to be balanced to find the right governance model and we'll find it and we'll present it to you in two years.

00:08:28
Michael T. Cohen: As soon as I mentioned we have engaged in governance consultant to help us along this path to ensure we get it right because if we're doing this we want to make sure we do it right because that will benefit you, the members. Dr. Oyelese, please.

00:08:43
Comment/Question: Thank you. Actually someone had already alluded to the point I was going to bring up about EDI and I do want to thank both my colleagues for the amount of time they put into the CMPA, 18 years, I'm new to this. But I just want us to reflect on the fact that with a

smaller council size it would have been impossible for you to contribute 18 years and get all that experience on the different competencies you've been on.

00:09:15
I would agree with the people who would identify the fact that CMPA is a unique organization and it's going to be very difficult to treat it you know like a typical business organization, realizing the fact that representation and especially representation of minority groups becomes

increasingly difficult as you reduce your council size. So I am not opposed to the motion but I do find it difficult to support it at this time.

00:09:48
Michael T. Cohen: Thank you. Do we have another question, Dr. Watkins?

00:09:53
Moderator: We do, Mike, thank you. The question is from Dr. Rob Robson from Dundas, Ontario. Rob says, do any considerations of bylaw changes allow for the possibility of non physician members? If only in an advisory capacity it would be truly unique from a modernization perspective if we were to find mechanisms to include voices of patients who are the recipients of the care that was provided by CMPA members.

0:10:18.2
Michael T. Cohen: Dom.

00:10:19
Dom: Thank you, Dr. Robson for the question. So if we are changing the bylaw there is the ability to include non members, not likely as you suggest by your question in a entirely decision making capacity but you could conceivably involved in an advisory role. So if we are going to be changing the bylaw and the governance reviews requires considering changing the bylaw then that could be one of the issues that's addressed.

00:10:51
Michael T. Cohen: Thank you.

00:10:52
Moderator: Please come to the mic.

00:10:55
Comment/Question: Hi, my name is Diane Francoeur, I'm an OB GYN from Montreal. I'd like to make some recommendations because I used to be the president of all specialists of Quebec, I just terminated two years ago. We revised our board and I think it's a very good motion that I'm in favour to but I would make some recommendation because board of physician are not easy to handle and I would recommend that you have a strong curriculum in getting all the skills that everyone wish to have because you have to know about reputational risk, you have to know about legal issue, you have to know about finances also.

00:11:35
So the board not need not to be too small but not too big but also the terms not need to be long enough that people know because having four to six board a year it's hard to get to know what's going on.

00:11:51
CMPA has a long history, we celebrate today your membership fee, we've never seen them so low. Quebec has been taking the lead into that and we are always happy to see that the other provinces are following us.

00:12:06
But I think that decreasing the board member is a good issue but we have to be careful in the terms of references and making sure that not only diversity will be the skill set but we make sure that everyone has the opportunity to learn them as well.

00:12:25
Michael T. Cohen: Thank you, and I can assure you that will all be part of the discussion that has taken place and will be ongoing. Dr. Watkins again.

00:12:33
Moderator: Mike, I don't have any further questions. You might want to invite additional questions.

00:12:38
Michael T. Cohen: Are there are any additional questions from the room or online?

00:12:51
Comment/Question: I'm Dr. Voyne(ph) from Calgary. This is my first CMPA meeting official welcome. I think CMPA is a bit different but to ask my question and probably give my comment. So my question is, what is the current criteria or strategy for allocating board members to various regions? Why do we have 31? That's one. Two, I think keeping the number small as the case may be may be great but it may actually not allow us to fulfill the reason for having board members, you know, or get more people to be involved in CMPA.

00:13:37
So my question is, how did this number 31 come? What constitutes this 31 and how does it come about? How – so we can start from there. But I think we should probably do that before we consider reducing because CMPA comprises of family docs, specialists, different people from different areas of practice and all that. That's why things are a little bit different otherwise we end up not really getting that unique perspective in – about that diversity.

00:14:08
Michael T. Cohen: Thank you. Dom, would you like to respond please?

00:14:11
Dom: Sure. Thank you for the question. So the current model, Doctor, is based on specialty geography and of course number of members approximately. There's no formula but those

factors form part of the model that's been adopted. So that's one of the issues that will be explored during the governance review, how do you balance or rebalance those issues along with the the points made by Dr. Brossard and Dr. Calder and Dr. Cohen. We need to come up with several different models and through the consultation process I'm sure we'll be able to propose something that will make sense.

00:14:56
Michael T. Cohen: Thank you, and we hope to see you at more meetings. Todd, no more questions? If not...
00:15:03
Moderator: We have no further questions.

00:15:04
Michael T. Cohen: No further questions? No further people at the microphone? I will call the question please and request a vote. Please vote online now and remember there will be a 15 second delay. Thank you everybody, the motion has been approved.

00:15:38
I would like to say that we just received a question from a French member after I called the question so we will respond to that member privately. As that concludes consideration of the member motion I will briefly speak to next steps.

00:15:55
As previously stated the Association appreciates members guidance on this issue. Moving forward council will continue a period of study and consultation on this matter and others identified for review. The Association will provide an update at the 2023 annual meeting.

00:16:15
I would now like to open the floor to questions on other business. We will be alternating between taking questions coming in online and through the app and questions from the floor. I have asked Doctors Watkins and Doctors Eisener-Parsche to continue to assist me in managing questions from the floor and online. Have we already received some questions?

00:16:41
Moderator: Thanks, Mike. Our first question is from Rob Rob, is from Dr. Rob Robson in Dundas, Ontario. Rob asks, during the 2021 annual meeting there was a discussion about the efforts of the Association to undertake to collaborate with First Nations here in BC with respect to two feasibility projects related to analyze and evaluate the introduction of restorative justice approaches within healthcare. Can you please provide an update to the Association's efforts in

this area? Will the Association actually encourages members to participate in projects such as this?

00:17:18
Michael T. Cohen: Thank you, Pam, would you please like to respond?

00:17:21
Pam: Thanks, Mike, I'd be happy to answer that question. Thank you, Rob, for an excellent question and one that as you know I'm quite excited about. We've had a number of meetings with various organizations with respect to restorative approaches to addressing conflict in health care or harm that's resulted from health care, some with the – those who are conducting the feasibility studies that Rob is referring to where we have been discussing with them what they're collecting, how they're collecting and what the research looks like and providing some thoughts and advice on that.

00:17:52
In addition to that we've had a couple of members of our senior team participating in workshops about better understanding restorative approaches to justice to ensure that we have the deep understanding that we need in order to advise our members appropriately.

00:18:05
We've also had meetings with the First Nations Health Authority leadership around these issues and have a follow up meeting with them in the next few weeks. Actually our last meeting with them was as recent as July and this is truly a priority for the work that we're doing.

00:18:19
Finally there are other organizations who are looking at restorative approaches to health care. In general the first few messages, first few meetings I was referring to are primarily around indigenous approaches to addressing healthcare harm. But other organizations are also looking at mechanisms for doing this and we've been meeting with them as well so that we can better understand what's being proposed and ensure that we're providing the appropriate guidance and being supportive of ways that restore relationships and restore the sense of healing after there has been events in which patients have felt harmed. So much work more to come but we are quite dedicated to this and are greatly committed to that work. Thanks for a great question.

00:19:04
Michael T. Cohen: Thank you, Pam. Do we have any more questions, Todd?

00:19:09
Moderator: Questions from the floor? Please approach the mic. Thank you.

00:19:14
Comment/Question: Hello, I'm Dr. Doug Wilson, I'm president of the SOGC for this next ‘22/’23 period and I certainly want to thank the CMPA for their acknowledgement about the concerns

that we have at the SOGC in regards to the recent Supreme Court overturning of Roe v. Wade and its potential impact on Canadian providers of abortion services.

00:19:44
I want to thank also the CMPA for the organizing the September 6th opportunity when it comes forward and also for a letter that was sent to some of the federal politicians.

00:19:59
My question though about the letter was that you left off the Minister of Justice. This – the two primary recipients of the letter were from Health and from Family and Child and Social Development which obviously would be impacted by this but Justice is clearly the area that we need support in.

00:20:27
At SOGC we certainly understand the CMPAs position about what they can support for physician activities and understand that this would be new and unique to be dealing with criminal charges from American states. But I want to emphasize that these US states are serious about this.

00:20:53
Just last week there was a Nebraska mother of a 17 year old who she helped have an abortion, she has been charged with assisting in this abortion by the state of Nebraska. This just shows the significance and potential risk, we have no idea whether they are – Americans are going to just you know charge Americans or whether they will move it across the border.

00:21:22
But I don't think that we can wait until these charges were implemented on Canadian providers, we need to do some proactive work ahead of potential outcomes. We support the CMPA and all the great work they've done but SOGC needs groups like CMPA to assist us with a really robust and and national federal government approach because this is where it's going to have to happen, we're going to have to have Canada stand up and say we support a woman's right for choice, first of all, and if you do support that choice, if by chance these services are – need to be required by Canadian providers either as an emergency which obviously may well fall under CMPA, but majority of these would be scheduled, they potentially would come across.

00:22:22
We don't know but we do need some agreements and some discussions with the federal ministers to understand this and support Canadian providers of abortion services which are both specialists in obstetrics and gynecology and family medicine. So this is not just for one group but if you look across the country at the different centres that each province has that it provides these services they're generally a mixture of OB GYN and family medicine. So I thank

you and look forward to going forward but we do need Justice, the Minister of Justice at this discussion.

00:23:08
Michael T. Cohen: Thank you. Lisa, would you like to say something?

00:23:12
Lisa Calder: Thank you, Dr. Wilson, and thank you for recognizing the efforts. I just wanted to recap for the audience what the CMPA has done in this area. So the CMPA we believe in and support equitable and timely access to abortion service. We are the Canadian Medical Protective Association which means we have a national mission and mandate which means that we are here to support our members who are providing abortions when there are any actions or complaints arising within Canada.
00:23:43
You are right that the States are very serious about what they're introducing and the nature of the legislation we are seeing across 50 states is unprecedented and not anything we've seen before.

00:23:54
You referenced a letter that I sent to Minister of Health Yves Duclos as well as the Ministry of Health, Child and Social Development. I'm happy to report back to you that we've had a response from the federal government to that letter, the Assistant Deputy Minister for Strategic Policy of Health Canada reached out to me and asked to meet with me and at that meeting which included Dr. Pamela Eisener-Parsche and Domenic Crolla from our general counsel there was also a representative from the Department of Justice, in addition to the executive director of the Canadian Health Act.

00:24:29
In the course of our conversation we made it very clear to the federal government that this is the role of the CMPA to support our members for any issues arising within Canada but the nature of this legislation, some of what's being called long arm legislation means that some abortion providers can be charged in American states for providing abortions to American citizens, that includes criminal charges and that that is something that we would need the federal government to think carefully about their response.

00:25:03
So what I said to the members of that call was I said what we are asking for is an awareness of the scope and mandate of the CMPA and our role that we can provide. But secondly, to ask the federal government to consider what does this mean for extradition agreements between the US and Canada. What does this also mean with respect to how anyone with criminal charges would be represented on databases that borders and security, the US Customs will be receiving.

00:25:27
They are aware of our level of concern, they are aware that that something needs to be done beyond what the CMPA can do. So I am encouraged, Dr. Wilson, that is an active conversation at the federal government level. We have also reached out to the ministers of health across the

provinces and territories and that was a key message that I emphasized in our conversation is this will require coordination and cooperation between the provinces, territories and the federal government to generate a response.

00:25:55
One of the biggest challenges that – I will be honest with you that they – the federal government recognizes as do we is that this is a dynamic and rapidly changing situation. It's not even clear to understand what the implications of these legislations are within State, interstate never mind internationally. It will take some time for this to unfold but we are committed to have – engage in these conversations to highlight the challenges, the concerns, the risks for our membership with the governments. Thank you.

00:26:27
Michael T. Cohen: Todd, do we have any more questions?

00:26:30
Moderator: We do not, Dr. Cohen.

00:26:32
Michael T. Cohen: Thank you. That concludes the question and answer period. But before we

adjourn Lisa's going to share a few thoughts on how the CMPA is looking to the future. **Looking**

to the future

00:00:01
Lisa Calder: Thanks, Mike. I would like to start with a reflection. I believe that right now health care delivery in Canada is being transformed before our eyes. In this country many Canadians are used to being able to access a family doctor, an emergency department, a specialist. This is changing and it's due to many factors including the human health resource crisis and the impact of virtual care. We will be discussing this in the information session this afternoon and I'm really looking forward to hearing from our panel of experts as well as the members who were participating in that discussion.

00:00:42
Another important significant development is that we as physicians have a responsibility to bring forward steps when it comes to advancing equity, diversity and inclusion in healthcare and that is why I'm proud to share one of CMPAs biggest tangible steps in our EDI journey and

announce our long term equity, diversity and inclusion strategy. You can find this strategy on our website and members are encouraged to check their email because you'll be receiving an email from us today with a link to the strategy.

00:01:15
We recognize that we have a lot of work to do. We are actively seeking to change our workplace culture to bring about more learning and to embrace a growth mindset. Our EDI vision is that we are an organization where members and employees can be their authentic selves and are valued for their diverse experiences and perspectives and where we provide members with fair and equitable support, helping you provide safe medical care.

00:01:49
We know that we will make missteps and when this happens we are committed to acknowledging them, apologizing and striving to do better.
00:02:04
(Translation started) We know that we will make mistakes and when this happens we are committed to acknowledging them, apologizing and striving to do better. (End of translation)

00:02:13
Our strategy addresses five essential elements; members, governance, employees, learning and advocacy. We are focussing first on the members, governance and employees aspects of our strategy. Guided with this strategy we are committed to taking action to better understand our members EDI experiences and challenges and enhance our service delivery model to support you.

00:02:40
The member pillar of our strategy has three goals that we will work towards over the next three years. Goal one is to provide members with safe and inclusive services. This includes providing more culturally sensitive services focused on fair and equitable support.

00:02:57
Goal two is to explore opportunities to assist members in resolving medical legal concerns using alternative approaches, this includes less adversarial dispute resolution approaches and to sit in situations of discrimination. And goal three is to enhance representation in our service delivery model.

00:03:18
To achieve our member EDI goals we will strive to continue to listen, learn and engage with our members and stakeholders to explore how we can better support underrepresented and marginalized groups. We will continue to forge partnerships with EDI organizations to understand how we can include anti black racism and anti racist approaches in our service

delivery model and we will continue to actively look for ways to foster truth, healing and reconciliation for indigenous members and stakeholders.

00:03:52
As Mike mentioned earlier, EDI is essential to supporting good governance. Our council approved strategy lays out three governance goals to help us continue to build a governance environment that is equitable and inclusive. These goals are evolving our council nomination procedures to better support diversity and representation, this includes working with EDI leaders to make sure that our governance opportunities are more visible and accessible to candidates.

00:04:21
We will strengthen governance structures to support EDI initiatives. This includes committing to an ongoing review of council size and composition. And thirdly, we will grow inclusive governance practices through organizational learning and training. I encourage you to take a look at our EDI strategy which provides more information on our goals.
00:04:43
We are focused on being action oriented in our EDI strategy and I look forward to providing you with regular updates. I also commit to continuing to engage and consult with you to better understand how we can build a more inclusive CMPA.

00:05:05
(Translation started). I also commit to continuing to engage (inaudible, crosstalk) to understand how we can build a more inclusive CMPA. (End of translation)

00:05:11
As we look ahead there is no question that the future is uncertain and rapidly changing, especially as we continue to deal with the pandemic. But as I look around this room and I welcome our online attendees I think of all of the inspiring conversations I have had over the past few months with members and I continue to have hope.

00:05:34
This is an opportunity for the CMPA to look how we can better support you, our members, and this is an opportunity to find out ways to meet your needs in different ways to advocate for system change while continuing to deliver our core services. We are currently developing our next strategic plan to do just that. This will be a focused, practical vision to ensure that we continue to be there for you, modernize the organization and do so collaboratively. I look forward to presenting you with a new plan at the end of the year so stay tuned.

00:06:16
(Translation started). I look forward to presenting you with a new plan at the end of the year so stay tuned. (Translation ended)

00:06:20
And now, as many of you know this is Dr. Michael Cohen's last annual meeting as president of the CMPA and I would like to take this opportunity to thank Mike for his guidance and leadership. Mike, over the past two years which has been quite (inaudible, technical) years, hasn't it, you have been instrumental in helping the CMPA continue to be there for our members and our employees and you have helped us to continue to understand members evolving needs whether they're related to COVID or medical assistance in dying or the human health resource crisis.

00:06:53
You also supported the new organizational structure which leaves us better positioned to be able to support physician wellness, leverage our data and develop learning to foster patient safety.

00:07:05
Under your guidance we have developed an EDI vision and we have begun to take steps to enhance our workplace culture and strengthen the delivery of fair and equitable member services. Following your leadership we have also made significant strides towards modernizing our governance.

00:07:20
So thank you, it has truly been a pleasure to work with you and thank you for continuing to strengthen the CMPA's role as an essential component of the healthcare system. And thank you for helping us become a more modern and responsive organization. Over to you.

00:07:41
Michael T. Cohen: Thank you. Thank you, Lisa. It's been a privilege to work with you, your dedicated, knowledgeable professional management team. It's also been an honour to chair CMPA council and collaborate with my council colleagues to guide the association.

00:08:07
While this moment is bittersweet I'm delighted to be passing the baton to my trusted colleague, Dr. Jean-Hugues Brossard who is a talented physician and quite knowledgeable leader. For those of you who don't know him, Jean-Hugues is a bilingual endocrinologist from Quebec with significant experience in education and association governance.

00:08:28
A current managing partner of the Clinique d'Endocrinologie de Montréal Jean-Hugues was taught and practice endocrinology as an Associate Professor of Clinical Medicine at the Centre Hospitalier de l'Université de Montréal since 1994. He has also served as your Chief of Endocrinology until 2015.

00:08:47
Jean-Hugues is the past president of the Fédération des médecins residents du Québec and the Association des médecins endocrinologues du Québec. He possesses a deep and broad knowledge of the CMPA and I have every confidence that his strong leadership, governance and healthcare system experience will position the CMPA for success for years to come. Please join me in welcoming Jean-Hugues.

Remarks from incoming President

00:00:01
Jean-Hugues Brossard: Thanks, Mike, for those very kind words, well maybe a bit too much but very kind. First I want to echo Lisa's gratitude for your guidance and leadership during the past two years. Having been beside you during those two years, you in Newfoundland and me in Montreal, I know leading the Association during the pandemic was not an easy task. Nevertheless you met every challenge with your usual grace and continued to provide both council and management with thoughtful direction, encouragement and support. Thank you for all you did, for your commitment throughout your time on council. Thank you, Mike.
00:00:51
Looking back on the last few years it's been very clear that health care is changing quicker than ever before.

00:01:02
(Translation started). As Mike and Lisa mentioned, the speed of change in our society and healthcare system doesn't seem like it’s going to be slowing down and as I take on this mandate, my first steps in this mandate I can see that the shortage of human resources in health care, the shift towards virtual care, various stressors because of the pandemic will lead to profound changes around us, and we’re faced with a big challenge.

00:01:36
We have to understand all of the challenges that our members face (inaudible, crosstalk) and understand future challenges and being nimble, to evolve and adapt to change without losing sight of our core values and priorities. I’m convinced that the CMPA is in an excellent position to solve the challenges. For over 120 years CMPA has been there for its members and we’ve managed this by being true to our values, to our core values, ethics and the excellent services to name a few.

00:02:21

As I begin my mandate I would like to reaffirm that this commitment will be there for members and respect the values (inaudible, crosstalk). (End of translation)

00:02:29

As president my main objective is to continue to modernize the organization and to modernize the governance of the association. If you've seen it's a large part of our EDI strategy and of our next strategic plan. I fully support that governance review.

00:02:48
I will achieve this while holding fast to our values, supporting the evolving needs of our members and maintaining the sustainability of our organization. It is truly an honour to lead such an exceptional team and I look forward to working with council, with my colleagues and with the talented CMPA staff to continue to protect the professional integrity of our over 100,500 – all those members, helping them provide the safest medical care. Thank you. Thank you for the confidence you put in me. Thank you.

Closing remarks

00:00:01
Michael T. Cohen: Jean-Hugues, I know the CMPA is in excellent hands and I look forward to continue to work with you on council to further the Association's mission. It's been a real pleasure and a privilege to serve the Canadian physician community in my capacity for the last two years.
00:00:16
I'd also like to thank physician members for the care that you give every day through these extraordinary times. For your time and for your attention and your thoughtful questions today I would also say thank you. We are here for you. Nous sommes là pour vous.

00:00:36
If there is no other business this concludes the business part of the meeting. I will take a short pause to see if there's anything comes in online. Is there any other - nothing's coming in online? Okay.

00:00:51
I will now declare this meeting adjourned. Please, I hope you will join us for the information session that will start at 2:45, I think it's next door, bound to be interesting. We're going to discuss medical legal realities emerging from the pandemic, opportunities and challenges of virtual care. Thank you, merci. Oh, in this room, sorry, not in the next room. The meeting is here. Thank you.

Information Session

00:00:09
Todd Watkins: Welcome back everyone to those that were here before and welcome to our new guests online and in person. My name is Dr. Todd Watkins, I'm the associate CEO of the Canadian Medical Protective Association and it's my pleasure to provide a few words of

introduction. The topic today of course is our information session on medical legal realities emerging from the pandemic, opportunities and challenges of virtual care.

00:00:33
Before we begin I'd like to take a few minutes to offer my land acknowledgement for this session. As we gather here today in Vancouver I'd like to acknowledge the land on which we sit. Vancouver is situated on the unceded traditional territories of the Musqueam, Squamish and Tsleil-Waututh nations. I want to thank Syexwáliya for her opening prayer at our AGM just earlier today.

00:00:59
As an organization, we recognize all first peoples who were here before us, those who live with us now and the seven generations to come. I would also like to acknowledge that the CMPA

offices located in Ottawa are on the unceded, unsurrendered territory of the Anishinabe Algonquin nation whose presence reaches back to time in memoriam. We honour and pay our respect to these lands and to all First Nations, Metis and Inuit peoples throughout Turtle Island. Thank you.

00:01:30
So virtual care. Virtual care continues to evolve rapidly, the pandemic to say the least has lit a fire under the profession and the health care system in adopting virtual care in order to manage the realities of the pandemic and it has done so superbly in many ways.

00:01:50
The reason that we as an organization chose this topic today is we really wanted to take the opportunity to look at where we go from here in relation to virtual care. How do we responsibly and proactively continue to evolve virtual care in a way that's going to meet the needs of patients and the needs of providers and the needs of the system. And this is a perfect opportunity to bring together this extremely illustrious panel who will be able to provide some comments and Kendall is going to lead us through that.

00:02:22
You'll also note online on your app that we've developed a white paper and I would turn your attention to having a read of that white paper.

00:02:31
The learning objectives are on the screen, I won't repeat those for the interest of time. Today's session will be moderated by Kendall. It's a fully accredited session by the College of Family Physicians and the Royal College of Physicians and Surgeons of Canada.

00:02:47

Now Kendall and I met my 25 years ago, Kendall, when I was working at the CMA back then and it's been some time since we've seen each other. Kendall has a very distinguished career in this space. He's Health Canada's scientific adviser, he's on the Health Canada's Scientific Advisory Committee on Digital Health, the CMA Virtual Taskforce, the National Research Council Medical Devices Research Centre Advisory Board and chair of the Canadian Association of Physicians Digital Emergency Medicine Committee. Many research interests in virtual care, digital health, big data and artificial intelligence. So with that I will turn it over to Kendall and thank you to our panellists in advance.

00:03:26
Kendall Ho: Great, thanks, Todd. Can everybody hear me okay right at the back? Great, thank you so much. Todd, thank you so much for inviting me. To be able to moderate this session, I think I'm really honoured to have an illustrious panel of members here who have great expertise to share about virtual care. I'm very, very curious also about you and your thoughts about virtual care. So what I'd like to do is like to facilitate this conversation together, I really want to draw out what you think and also bring some of the thoughts from our experts, what

they think and then really get to a sense about where virtual care is today. What's the opportunities for us as health professionals? What are some of the challenges that we currently face? And where do we want to go in the future together?

00:04:14
And so I'm, as Todd introduced I'm an emergency physician in Vancouver, also a professor at UBC Faculty of Medicine and really interested in this theory of virtual care. Maybe let me ask you a question first perhaps, may not be completely related. How many of you deposit your cheques by taking a picture of your cheque? Nice, all right, fantastic. I got to say it took me a few years to get used to it. When my bank first came out I said, no, I got to go to the bank and get that deposited and only in recent last two or three months I started to get comfortable with it.

00:04:52
Now of course very fortunately I've been more comfortable with online banking, etcetera, but it took me a while especially with new things that comes out like such as eBanking and taking a photo of the cheque. And so I think many of us are comfortable with hybrid banking, you know we know when we need to go into the bank and do stuff and when do we use our computer, use our mobile phones to do banking.

00:05:21
In some ways when we think about virtual care, in fact virtual care is not new obviously. In Canada the first time it was introduced not as a research project but as a service was in the 1970s in Newfoundland, Dr. Maxwell really introduced that to Canada as a recognized person who lead us.

00:05:40
So over the last you know 30, 40 years we've been evolving in terms of virtual care. But really it has been a bit of a niche type of care if you will. The pandemic really kind of switched – flipped the switch. Now suddenly many of us are doing that, many of our patients would like to do that, governments encourage us to do that. And in fact I imagine many of us are comfortable in certain aspects of virtual care, for example using telephones. I think many of us may be already using it fairly actively.

00:06:11
But we start thinking about you know oh, video conferencing, text messaging, communicating with apps, sensors and wearables, electronic health records or in the future virtual reality, prescribing digital therapies. All these are ways of evolution of virtual care.

00:06:29
How should we look at it? How should we as health professions look at the different ways that digital health is being used in virtual care, and in fact the governments, the patients, the industries, caregivers they would like to see this happen. But I think they all would look to us as our health medical profession, health profession to redefine what is best practices.

00:06:55
And so in this evolutionary time how do we think about these issues and how do we discuss this amongst ourselves to get comfortable? We all have different comfort level. And so I really want to thank CMPA today for bringing this opportunity for us to explore this topic. I really want to thank our panel members here who can help us guide in some of those thinking. And I'd also love to hear you as audience to guide us in that.

00:07:19
So the format today is that will be first I'll be introducing you to the panel members and ask kind of three general questions to ask, that's pretty much the learning objectives. Number one, what are some of the opportunities that we see? Number two, what are some of the challenges that we face? And three is if we were to project a little bit in the future, in tomorrow what would hybrid medicine look like? What would virtual care combined with in person care look like? And then we'll be opening up for dialogues with audience members both in the room and also online. So really welcome active question discussion on that. And I hope to be able to keep track of the time and get us going.

00:07:19
Well let me first introduce the exciting panel that we have, and when Todd invited me and I looked at the names I go geez, I – boy, I want to be here. First I'd like to introduce Dr. Heather Ross. By the way, all their CVs are on the app so you can get the full information about that. But Dr. Heather Ross, head of division of cardiology, Piedmont Cardiology Centre, University Health Network, lots of things you're doing very, very exciting.

00:08:31
So and then we have Dr. Katherine Smart, our president and Canadian Medical Association, great to have you here. This is wonderful. And Dr. Ewen Affleck, a senior medical adviser health informatics and College of Physicians and Surgeons of Alberta, also leading a lot of wonderful national international efforts in that area. And also Dr. Nancy Whitmore, she's a registrar and chief executive officer for the College of Physicians and Surgeons of Ontario. Thanks for being here.

00:09:00
We also have Dr. Pamela Eisener-Parsche, she's executive director of the Member Experience in CMPA looking at doctors, doctors relationship and issues related to that area. And finally very glad to have Domenic Crolla. Domenic is the senior partner on Growling WLG and also really a legal counsel expertise in this area. So wonderful that all you are here. So on behalf of our audience thank you very much for being here.

00:09:32
Before we start maybe the next slide is just to show some conflict of interest. Just want to declare, for me, I'm the only one who has conflict of interest so please bear with me. You can see that there's – because of my work on virtual care in British Columbia I do receive grant

funding from the Ministry of Health and also I do research grants and some of my work I do partner with private industry in virtual care, so you need to be aware of this conflict when I discuss issues. But primarily hopefully this is contributory to the experience that we have.
00:10:11
I have no IP, no commercialization company to declare and I also understand that for the panel members there's no meat, no conflict of interest to be declared, is that correct? Excellent.

00:10:26
Okay, why don't we jump right in. First question, opportunities, and I ask the audience members, whenever you have questions just type right into the app, okay. Opportunities. I also want to ask you the same question as I asked my panel about the potential opportunities for us to get there. Maybe Heather, I'll start with you first if you don't mind. You have long standing practical experience with telemedicine, virtual care in your specialty, collaboration with different groups. Could you describe some of your current experience of using virtual care and what are some of the opportunities you see and that you feel is advantageous.

00:11:03
Heather Ross: So I think as everyone has said, COVID pushed those 10 years in two weeks, right? I mean that's said by smarter people than me and I think it's actually quite true. If you go and look at Ontario in 2018 a report came out and only 1% of Ontarians who had heart failure were actually receiving remote patient monitoring despite data that supports the use of RPM in the setting of heart failure. So it was available, but it wasn't really being used.

00:11:34
And so with COVID there was this absolute push for us to be able to provide patient centred care, improve the patient experience in an environment where we couldn't bring the patient in because it was considered to be significant risk. So how do we meet the patient where they're at and how do we provide that care for them. And the technology, the digital, the virtual, all of that is just an enabler because the key piece is that we continue to provide the best care. And if you think about it that way, that's sort of how we approached things during COVID.

00:12:09
So we started to leverage a lot of different technologies that our Health Canada approved. So patients who had a certain type of pacemaker we would turn on what's called a heart logic algorithm which would allow us to follow and see if they were worsening and actually do that in the home environment. We were implanting pulmonary artery monitors, called CardioMEMS to again allow us to manage the human dynamics of heart failure patients while they were at home. We use something called Medley(ph) which is a remote patient management tool that looks at simple information from the patient and allows us to push instructions around diuretics to reduce hospitalization. And during COVID we also used it to titrate guideline directed medical care or foundational care.

00:12:58

We leveraged an increased use of the Apple Watch for Afib and cardia in order to get ECGs to our clinic, we actually sent all these things out virtually to patients and had 500 patients that never touched the clinic from start to the end of COVID where the visit, they were triaged virtually, we looked at what technology was going to be best for that patient to keep them in the home environment.

00:13:23
And obviously there are patients that still need to come in and we know that virtual care is not for all and we're going to talk about that. But I do think that COVID made us move at a pace that we probably already should have been moving at but for patient safety it really pushed us hard to do that.

00:13:42
But it is just technology, the key is best practice and the key is providing the best standard of care and I think that's what we have to keep in front of us whenever we're thinking about expanding virtual care, or digital health.

00:13:58
Kendall Ho: Love it, best practice. Also bringing the care where the patient is.

00:14:02

Heather Ross: Where the patient is at, where the patient is at.

00:14:04
Kendall Ho: Yeah, amazing. Thank you very much. Maybe, Katharine and Ewan, maybe let me address this question to both of you and you know we'd love to hear your thoughts, with your different experience often looking at using virtual care in a kind of more rural remote setting or non urban setting what are your experiences there and how do you see it as opportunities and benefits? Katharine do you want to start and then Ewan.

00:14:28
Katharine Smart: Okay, thank you, Kendall. So my clinical work is as a pediatrician in the Yukon. So you know it's very unique in terms of of course the remoteness and the complexity of allowing our patients to access sometimes sub specialized care in pediatrics. So we have you know both the issue of getting our general pediatrics care out to our communities and we have the issue of bringing sub specialized pediatric care into the Yukon for our patients that have more complex medical needs and in conjunction with our referral centres.

00:14:59
So as you can imagine for people when you're living in that area of the country just the travel burden can be substantial and the cost of that a big barrier. And often I find you know not – this is – you know I've been fortunate because I've also worked at tertiary hospitals delivering pediatric care and what I've noticed is I think sometimes when you're in a big busy hospital

there's not enough attention to where people come from and enough thinking about the burden of what you're asking them to do for the value it adds to their care.
00:15:27
So I've seen things you know as ridiculous as we want this child to come to Vancouver to get a CBC done. Clearly very doable in Whitehorse directly. But and, you know, you know it's not poorly intentioned it's just people haven't thought about where does this patient live and does this make sense?

00:15:44
So what I found has been really powerful in our experience with virtual care is it's allowed us to really shift how we do things in many ways. So in terms of our basic general pediatrics care we do provide outreach to all the communities, but using virtual care allows us to support those families in between those visits, it allows us to titrate interventions much more quickly because we can follow up with people over the phone or a virtual meeting you know every few weeks until the patient's stabilized.

00:16:11
It's allowed us to bring in the community into the care of children much more effectively so we can have you know meetings of the community and the various people involved with the child's

life and our medical team all at the same time and really solve for some of the social complexity of some of the children that we care for. And I think it allows people to feel much more supported in between visits, and again limits people, because even in our context you know a family might be driving five hours to see me in Whitehorse in the winter, is that an unnecessary thing or is there a way that we can work in this sort of hybrid model.

00:16:42
What I've also loved about it is the ability to bring sub specialists right into our examining room with the patient. So we've had several children that have had kind of rare complex things and one child comes to mind that had this really odd rash and we were really struggling to figure out what it was and we actually brought the pediatric dermatologist in to our meetings with the family. So the appointment was myself, the family, the child and the pediatric dermatologist and we were all consulting together. And that was so powerful because we were able to get that expertise, the family was able to hear all of us talking together about the plan and we were able to figure out what was going on and get that child sorted out over a very short period of time and with no travel to Vancouver which was meaningful for that family who had another young child and really didn't want to have to leave the territory unless it was necessary.

00:17:30
And I've had other things like that as well where children, we have a lot of quite medically complex and some technologically dependent children where we've been able to bring their subspecialist into the room. And the other piece of that that I think we often don't think enough about is the value for me as the practitioner because I'm also learning then from that interaction with my sub specialist colleagues. So it's increasing my skill, it's making me more

aware of how they're thinking things I need to be thinking about that patient and as we all know, communication is so important in care and I think for especially families who have children with medical complexity one of the real challenges is just so many cooks in the kitchen and I think you know that benefit of hearing everyone collaborating with them around the plan for their child as one unified team is actually really powerful as well and makes people feel better cared for and it's much less confusing and you can problem solve together around what to do. So I think it just provides a much more seamless care.

00:18:24
And the other piece I think is you know sometimes I'm sure many of us in this room are generalists but sometimes we undersell what we have to add. So you know we also do a collaborative clinic with the pediatric endocrinologist for our type one diabetes patients and the other beautiful thing about that was you know if they were focused on the diabetes, I might notice that there was other concerns the child had. And then as the general pediatrician I was able to say actually it sounds like there's mental health pieces here that need to be addressed, let's make sure we don't ignore that. Or oh, you know what, I think a Jordan's Principal application could solve that problem for you. So I was able to bring that expertise into that

subspecialty experience for the family without them then having to go have another appointment or another referral to get that care.

00:19:03
So again I think it's just really allows us to meet people where they are, provide much more comprehensive care, to share the expertise of both a sub specialist and more of a generalist specialist around a family and really be thinking about multiple things and problem solving together while as the rural practitioner feeling really supported.

00:19:22
Because I think one of the challenges of rural and remote medicine is you have to be able to do all the things and it really helps when you feel like you're on that team with the people that support you and it really helps when they get to know you as well, because then they know your skills and often they get more comfortable with you doing more in the community which means less travel for families, you're able to provide better care, more comprehensive care and do a lot for people in their own homes and in their own communities which is what most people want. So I think it's a really powerful tool in many ways and it just allows us I think to reimagine our collaborations and how we work together even amongst ourselves as physicians.

00:20:01
Kendall Ho: Wow, excellent, thank you. So again I hear this patient centred care and bring the care where the patients are and also that kind of partnership that you have with them, and also enriching yourself in terms of bringing colleagues in. Amazing, thank you. Ewan, your context and your thoughts about rural remote and your general sense. I'm sorry, I just want to check your – are we hearing microphone or? Can you say it again? It could be me. Can you hear? Nope, okay. Not yet. Great, thank you. Oh, nice. There we go.

00:20:43
Ewan Affleck: Now you can hear me.
00:20:45
Kendall Ho: Yes, thank you.

00:20:47
Ewan Affleck: So I'll put a little context on what Katharine – I'll build on what Katharine has said. And so what – first of all I just want to acknowledge that it's sort of cool to have two individuals who report – who represent two of the territories on a panel of six people in Canada. So usually people don't notice us so it's very nice.

00:21:05
So you know I do my clinical work in the Northwest Territories and I work now as a hospitalist but I had a family practice and visited remote communities for many, many years until recently. And what's unique about the Northwest Territories is that we have one single patient centric

chart and many of you may know this, maybe you don't. So it took 17 years to build it but every single physician, specialist, GPs, nurses, rehab, the rehabilitation services, OT PT, so forth we all use the same chart through 33 communities other than one community because of connectivity issues, (inaudible, technical).

00:21:47
So wherever the patient goes through the entire Northwest Territories it's the same chart and their information follows them, it's sort of like a dream. So this was my project, it took, I started it in 2001 and it took 17 years to build. So virtualization is implicit in everything we do because you're seeing the information. So now when I have an admission, an acute admission on the hospital from Gameti or Wekweeti or some remote community I can look and see exactly what's happened leading up to their admission and the nursing notes and the medevac notes and everything and then I can communicate through the chart with them.

00:22:28
So it just becomes a way of being and we talk a lot in Canada about person or patient centricity, it's actually something we built. I will say when this project was started in 2001 virtually everyone resisted it including with physicians, including the government, including every professional group, just about everyone thought it was a terrible idea. And it took – the reason it took 17 years was to convince people that actually building health information around the patient is an intelligent thing to do, it actually helps all of us because we have the information we need. Even if we didn't care about patients which fortunately we do, it would still be beneficial as a provider and a patient centric information architecture.

00:23:14
So just looking at COVID I will just give you an example, another example of the value of this. When COVID started you know borders shut down, so forth and so on. We had immediate issues with sustainability of some services because we could not get some – you know there were shortfalls all over the place, people were being told they can't go on a locum, we need you locally in the emerg because people for all the reasons that we all know and clearly these human resource issues are continuing.

00:23:45
We virtualized a whole variety of services, some GP services, some psychiatric services, some other specialty services were virtualized from different places in Canada, we set up a rapid licensure process but many of them were already licenced because these were consultants that were – or specialists that were coming up already.

00:24:04
But because there was a chart they could see all the patient information, they had remote access to it so they would just see the patient either on phone or by video and could chart in

our chart and so the continuity of information was not interrupted whatsoever, it was quite beautiful.

00:24:22
So I can give you manifold other examples but that's a an acute example in the face of COVID of the value of person centric architecture of data and something that we sort of pay lip service to in Canada but largely we have custodian centric information architecture which is really quite destructive to coherent information flow. So I'll stop there and hand it back to you.

00:24:51
Kendall Ho: Thank you. Very important point about data flow that accompanies the virtual care to support it. Very, very important. Maybe let me ask the audience, certainly start to welcome you using the app, if there are question fields, if you have any questions, but also welcome your thoughts about how virtual care may help you as an opportunity for your delivery of services because love to hear your thoughts, and then during the interaction we'll certainly bring that up.

00:25:22
Maybe Nancy, love to hear your thoughts from the regulatory community, I'm going to ask you to wear that hat for now. What do you see? What do you hear about the adoption of this rapid growth of virtual care? And what do you see are the opportunity seen from the regulatory view from your view? Ah, good thing we have the mobile mic.

00:25:49
Nancy Whitmore: All right, switching over. So I think to follow up with what Heather has started with I mean we saw certainly in Ontario phenomenal adoption of virtual care out of necessity. And I think as challenging as the pandemic has been, it's been an incredible opportunity for innovation. And it really just you know moved people lightyears along in in delivery of care, much of which we know from information from both physicians, but also from patients how incredible that has been for them.
00:26:16
So I think we have to remember you know what it has brought and I think it is an evolving space. It started with you know about one, two percent of care in Ontario, I think we're up to about two thirds during sort of the peak of the pandemic and I'm not sure where those numbers sit now in terms of percentage of care delivered.

00:26:35
And certainly from a regulatory standpoint in the Ontario space we were quite flexible in our expectations of what that care might look like knowing that when you didn't have much opportunity to do in person care some virtual care was better than the alternative which was no care and so we were quite flexible around that.

00:26:53
I think as we get into a more stable space you know the expectation is that one has to meet the standard of care and as a regulator in Ontario our sense is that that really is up to the physician's professional judgement, they are there in the room trying to decide in that particular environment what is the best that they can do, and I think that's an always changing space.

00:27:14
And so we really are in that you know talking to physicians to say you're in the position to make the best decision. There's some care that really can I think be delivered virtually very, very well. There's some that really has to be in person, you can – it's hard to immunize a child virtually. And then there's that care that really is, you know you might start on a virtual visit and realize you have to transition across. And so I think it's keeping that flexibility and this will continue to evolve. So I think it's fantastic and lots of opportunity.

00:27:44
Kendall Ho: Excellent. Thank you, Nancy. The evolution of it, it's very important.

00:27:47
Nancy Whitmore: Yeah, big evolution and quick evolution.

00:27:50
Kendall Ho: Absolutely, yes indeed. Maybe, Katherine, let me also draw you out from a different perspective. You have been president for CMA, you start to see across the systems, health system and some of the challenges we have now like helping resource crisis, you know the ER closure, close to my heart, but I also know the primary care challenges, wait time, addiction, mental health. What do you see you know when you go across the country and you know understanding about these challenges, what are some of the opportunities you hear from physicians or patients about virtual care that may be helpful at least?

00:28:28
Nancy Whitmore: Yeah, I think you know we're all very aware of the human health resource crisis that's getting worse by the day. Yeah, I think it seems and I think you know for a long time we've been talking in the health system about that very valuable human health resource and how those resources are best leveraged to meet the needs of patients and I think that's you know not a new discussion.

00:28:49
But I think more and more we're realizing that we need to really start moving the dial on what team based care looks like, we really can no longer I think be stuck in this very transactional way we do medicine where it doesn't always necessarily need to be the physician doing the transaction and there's the opportunity to work with other healthcare professionals in our

teams to really make sure people are at top of scope and we're better able to provide more medical homes to more patients so that people can have that consistency of care.

00:29:20
And I think virtual care can be one of the tools there. And I think also there's the opportunity to really be looking differently about how we resource the country as a whole. And one of the things we've been talking about or looking at at the CMA is some of the regulatory challenges to workforce mobility and also how that impacts virtual care.

00:29:40
Because you know right now of course that it is challenging with the fact that you have to be licenced in each individual province or territory to deliver care and that does limit some of the ability to leverage our health resources across borders to the benefit of some of the areas of the country that suffer more in terms of access and you know certainly in the territories our ability to access specialists in other provinces which is essentially almost a guarantee if you need a specialist they're not going to be where you are. I mean we have some basic specialty care but not all the depth. You know places like the Maritimes that are really struggling with people.

00:30:16
So you know is there more opportunity for us to be thinking differently about workforce mobility, thinking differently about regulation, opportunities for licensure to allow more cross border care of patients and really allowing us to look at the human health resources differently so that we – you know if Heather's group of 62 cardiologists is available and the one cardiologist that serves the Yukon has a three year waitlist does that make sense for the patient? Right? I don't know your wait list.

00:30:43
But you know so but the reality is we know there's areas that are very well resourced and areas that aren't and I think there's some potential for virtual care to bridge that. And again I think there's also opportunities to be providing virtual supports in places that don't necessarily have a physician so at least there's some care.
00:31:03
It's never – you know obviously the ideal would be everyone has access to a doctor and the option of in person, but I think we know that that's not really the reality and right now, unfortunately, we've got many Canadians who aren't even accessing basic health care, you know things as simple as they can't even get their prescription refilled because they've literally exhausted their ability to find someone to help with that.

00:31:27
So how could virtual care, how could team based care how could be changing the way we think about the way we work? Our scopes allow us to meet the needs of more people and I think we

need to be thinking about that. I think it's a huge challenge and you know there's, of course as we all know there's many reasons for what those challenges are and a lot of them are working in a very antiquated system. And physicians often, especially I think in primary care not being well supported around the infrastructure of care and not a lot of that administrative burden and just even the cost of providing community based care being downloaded onto physicians in a model that just economically is not that viable anymore.

00:32:05
But I think when you look at the amount of time people spend doing work that they don't, doesn't need their level of expertise we're not using the resources we have probably optimally. And again I think when you look at how virtual care, remote patient monitoring, chronic disease management could really be optimized with teams with virtual care I think there's an opportunity to have much better outcomes, much better value. And again for us to feel like we're more on teams and more supported.

00:32:33
Because I think so much of the burnout, which is the other huge challenge we're facing right now in our system, is people feeling like these systems limitations are being downloaded onto them as individual providers and they don't always have the tools to do what needs to be done and I think it's a huge burden to carry to feel like you can't do the right thing for your patients.

00:32:52
And I think for especially people in family medicine that are really in it because they're committed to their communities to see so many people in their communities suffering without access to care is a big burden to carry.
00:33:02
So I think we have to be getting more creative and innovative about how we use tools both for our own longevity in this work and to feel supported and to feel like we're not alone but also to be able to create a robust healthcare system where the right people are doing the right things and people are getting their chronic and complex needs met by a team of experts across health professions who can meet them where they are and make sure they're getting that care.

00:33:26
Kendall Ho: Thank you, thank you very much, really a great – some of the important aspirations for us to how can we leverage technology as opportunities with team based care, decreasing burnout, increasing equity of access of care, I think that's very important.

00:33:40
I'm going to invite the audience again, please use the question function to put in your thoughts online. Please go ahead. Also please do it either in French or English, we will be coming to you very soon.

00:33:56
But maybe this is a good time maybe you know to seek the expertise of CMPA. Maybe Pam, let me ask you this question. You know as you see virtual care advancing are you seeing any issues about the role of virtual care in medical legal areas, either praise or complaints or any issues that you're seeing? Pam, what's your perception on this so far?

00:34:17
Pamela Eisener-Parsche: So it's a fantastic question and it's time for me to take the mic. Thanks, Nancy. It's a fantastic question and one that we're still looking to answer. So as you'll know there is a lag time between provision of care and medical legal events and that lag time has so far not resulted in a significant surge of cases that we can see are tied to virtual care.

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I think part of it is also how we collect data and how we review that data. So we need to be aware that that care was provided virtually to be able to say that virtual care was part of that. So that requires some deeper dives into our data and we are committed to doing that and Chantz Strong, our executive director of Research and Analytics and I have been discussing just exactly how are we capturing that information so that we can get that in a form that we can then use to better educate our members and to better provide support to the system in terms of what needs to be done to reduce any risks.

00:35:10
I think many of us intuitively think there are risks. We haven't seen the hard data to confirm that at this point in time. I've also had a number of conversations with providers of medical liability protection elsewhere in the world asking these questions of them as well and I'm getting very similar answers, that they're very wary, they're watching, they're looking for the data but they don't just just have it yet but they have that same sort of angst about the potential risk that that we feel.

00:35:37
So it is something that is top of mind for us. It's something also that we know is top of mind for members, it was one of the most common COVID related calls that we had in the last two years, questions about how do you do it safely? What kind of platform should I use? What sort of privacy do I need to put in place? What does end to end encryption even mean? So all of those kinds of technical questions were a lot of what that was about. And you know our advice and guidance to them resulted in a number of publications that are on our website so that we could try and help provide them with that information up front.

00:36:07
One of those key messages is what I just heard you say, Nancy, which is you know the standard of care is the same. If your patient needs an abdominal exam your patient needs an abdominal exam and so you need to be upfront with the patient at the beginning of that conversation that

we're going to start this in a virtual way but we may not end this interaction in a virtual way, we may need to arrange for an in person visit in whatever capacity is required.

00:36:32
So we don't yet know the answer to your question and we are actively collecting the information to try and see and I'm going to continue to connect with our international partners to hear what their experiences are as well.

00:36:45
Kendall Ho: Thank you, Pam. And for audience members, if you have any kind of thoughts about medical legal issues or related issues, again please put it into the questions and comments for us. Pam, maybe a little bit of follow up questions, beyond medical legal do you see any other things that CMPA is observing about the rapid introduction of virtual care that we should pay attention to or think about beyond just the medical legal realm of things?

00:37:10
So on the positive side the sort of rapid uptake of virtual care brought a number of issues to light and had members calling us as I've said to ask for guidance and ask before things started to happen. So we were able to more proactively provide guidance to a number of members who called which you know we might not have been able to if this had been that slow, incremental growth, they might not have recognized, holy cow, this is a huge shift in how I practice and I need to make sure that I'm addressing some of the risks associated with that. So I think that was actually of benefit to most members, and to us at the CMPA to be able to provide them with some guidance.

00:37:47
There have been a number of challenges as well, particularly as individuals became more comfortable with providing virtual care, we've ended up with some situations in which physicians for instance have relocated outside the country with no intention of coming back and are wanting to continue to provide care to their Canadian patients from abroad which of course creates all sorts of risks. I mean there's jurisdictional issues, there's issues with where is that physician licenced and what is the patient's jurisdiction going to think about where that physician is licenced?

00:38:18
So for instance is the regulatory authority in the location of the physician going to think that that physician who's out of Canada is practicing in their jurisdiction or not? What does that mean from them if the patient is outside the country, does the jurisdiction where the patient is think that this is a physician from outside the country who's practicing medicine in that country without a licence. So those jurisdictional issues are complex and very concerning, not to mention the potential for civil legal issues arising outside of Canada. And of course we don't assist with civil legal issues arising outside of Canada, that's beyond our scope.

00:38:51
So we really have had to do a deep look at our extensive assistance principles with respect to virtual care and what that means. And so essentially trying to balance what our principles have been for years which were if there is a physician who is leaving the country to go on a vacation or go to a conference for a couple of weeks and they're best placed because of their relationship with that patient and continuity of care to provide that guidance to the patient in a virtual way, that's the sort of reason why we had our extentive(ph) assistance principles that we will assist you with something that arises from that while you're temporarily out of the country.

00:39:22
But we've had to be very clear that it is a temporary absence from Canada and that a prolonged absence from Canada is – and provision of virtual care from a prolonged absence means that the care that you've provided and any issues arising from that will not be eligible for the assistance of the Association either in Canada or abroad. That has concerned a number of members certainly, but there are implications for us as an association, there are implications from the jurisdictional issues as I've talked about them and they need to understand those implications and consider that in their decision making.

00:39:22
Kendall Ho: That's a great, that's an important issue for us to pay attention to, Pam, thanks for raising that so much. Maybe, Nancy, I'll come back to you for the regulatories. Of course you've seen a lot of rise of virtual care. Are you seeing virtual care related complaints? And if so, what kind of areas are you seeing it? Or are you getting hints of it? What are your thoughts there, Nancy?

00:40:27
Nancy Whitmore: Yeah, so if we look at our complaints, and I think they're probably consistent across the country, I can only speak specifically around Ontario. So early in the pandemic complaints went way down I think as everything sort of settled down and everything's very, very quiet. And now we have subsequently have quite a significant rebound of a significant number of complaints.

00:40:48
But if we really look at what those complaints are about, many, many of those complaints are about health system issues, access to care, lots of issues that are truly outside of any individual physicians you know ability to control in many cases. And if we look specifically at virtual care not a lot of an issue, I would say if there is anything we sometimes see it would be around the quick adoption of, in Ontario at least and many other places virtual first. So we're in the pandemic this idea you know need to be seen virtually first and then potentially in person and trying to move from that to, as I mentioned or there's some types of care that simply can't be done virtually.

00:41:27
So we sometimes see some complaints that are around my physician won't see me in person, or the exact flip of that, my physician will not allow me to have a virtual visit. But I would say in general you know and I think time will tell, but we're not seeing a substantial number of complaints around virtual care. I mean the complaints we hear are from the public and you know the public really has embraced virtual care. And so I would say in general that's not yet been what we have seen and I – it will be hard to say but I don't think we're going to see a large issue with that.

00:42:03
Kendall Ho: Excellent, thank you, Nancy. Again I'd like to ask the audience members, are you hearing or sensing any issues or challenges that you have in delivering virtual care? I'm going to actually address that question to all three clinicians on the panel here in your practice. Are you seeing any challenges? Maybe you know what are your thoughts there? Maybe can I start with you?

00:42:24
Unidentified Speaker: Two of my favorite stories would be a patient that I did a virtual visit with and he took it on a secure platform but he took the visit on his phone and then held the phone to his ear and so I spent the entire virtual visit staring in his ear. And I tried to explain to him to move it from his ear but he couldn't hear and so he just kept the phone in his ear.

00:42:49
And the second visit I was upside down for the patient on her, on her screen. And so it raises patients comfort levels with technology, let's get the patient voice going. So patients have got to be comfortable with the technology that you're using. They've got to be able to use the technology and in that area the big challenge I think that we still have to face is issues related to the digital divide. So you know with companies like Starlink and others putting in broadband into major areas, but right now it's a huge challenge for patients to have broadband coverage in large sections of the country. So that remains a major issue.

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And then from a social determinant of health perspective and of course many have considered broadband to be a social determinant of health access to broadband. But but the other is some patients don't want to do a virtual visit because they don't want you seeing what's in their home and what is behind them and they may not know how to put a screen or you know a picture behind them. Some patients are going to want to do the phone.

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As a practitioner I prefer the video visit because I actually like to see my patients but this is really important that we follow the patient's choice. So some of that will be dictated by what they have access to. But otherwise this is the patient experience and if we're thinking about

quintuple aim as a goal of virtual care which is lower cost, better outcomes, improved patient experience, improved provider experience and equity and equitable access to care we have to make sure that the patient voice is really well represented. And I think that's been one of the challenges around some of the technology, yeah.

00:44:34
Kendall Ho: Excellent point (inaudible). Katharine, do you have thoughts?

00:44:38
Katharine Whitmore: Yeah, I would say similar. You know in the Yukon many of my patients don't have internet access, the internet's extremely expensive and many patients don't even have necessarily minutes on a cell phone so it can be quite challenging sometimes, you know just that expectation that people can just hop online or even be reliably be available by phone can be quite difficult.

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So I agree, I think there's the real social determinants piece there that we have to be mindful of. And then even for people that do have internet in our remote communities, the quality of it's quite poor and it's generally not good enough to support a virtual visit.

00:45:14
I think you know and similarly I found that people largely prefer the phone, like it is tricky to get people on video. I think some of it is you know because you can see yourself too, like it's just awkward and people feel a bit uncomfortable. And I agree, I think some of it is also just you know do you want someone kind of staring in your house that can be hard?

00:45:34
I think ensuring privacy for vulnerable populations can be tricky, you know I deal with a lot of high risk youth and is that teenager in a safe space? Or who's listening? Or who's around? And even if you're asking, are they comfortable to answer? That can be challenging. Trying to talk to people about personal things or just what you would glean from being in the room with someone like hey, you look a lot slimmer than last time I saw you, like how's the eating? You know some of that people aren't always forthright with so I think we have to be mindful that there's things that we can miss that patients may not offer up and that's again the risk I think of only doing virtual care.

00:46:11
And then I think you know the other challenge I'm sure we've all experienced that is on the patient side is a little bit not maybe taking the visits always so seriously. So I think I've found that can be tricky. You know I've booked the time I've said I'm going to phone, they don't answer the phone. You know I phone back, they don't answer the phone. You can't – you know just sometimes people aren't maybe as invested in the appointment, virtual or phone call

appointment as they would be as an in person one and I've spent a lot of time you know tracking people down. So that can be a bit frustrating, I think.

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And then I think again sometimes people struggling to understand that you're not necessarily then available an hour later, right. Like so I think it's about expectations on both sides of negotiating those relationships which is part of medicine but I think the virtual pieces added some layers to that that that can be tricky. So I think there's things that we need to you know work around for sure and you know comfort with the technology is definitely a big one but I think these are all things that can be overcome.

00:47:05
And overall I still think the benefit of it much outweighs these, but there are those growing pains and I think it's not surprising. And again I just think it's like many things, we have to be having those conversations with our patients around what to expect and be mindful of the limitations and the risks and my own experiences I definitely think some hybrid is important.

00:47:26
Like I also like to be able to see my patients and obviously in pediatrics eyes on a youth or a child are very important in terms of just their growth and their development and some of those things you have to see someone really to know so I wouldn't want to be only providing phone based care. But I do find it can be a great augment for certain things. So I think it's just again you have to be using your professional common sense and we have to be negotiating those things with our patients.

00:47:50
Kendall Ho: Excellent point. Yeah, so (inaudible).

00:47:51
Unidentified Speaker: Is this working? Yes it is. Lots of these are virtual mics. This one is anyway. So I collect a whole bunch of mics around my head. So a few issues here that I'll raise to build on what my colleagues have said, Northwest Territories has 11 official languages so you begin to have to navigate that many people don't speak, to one is French, one is English and then there are many, there are nine other indigenous languages, so that becomes a real obstacle, let alone all the other issues.

00:48:27
I sort of approach this through social determinants of health and digital determinants of health and you can be a guy like me living in Yellowknife who you know is privileged and educated and so forth but I have bad internet. That's a digital determinant of health in my situation because I certainly don't – I'm not subject to the social determinants but because the internet is bad up there. So these issues need to be addressed certainly very coherently.

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And you know there's a report from Health Canada in June 2021 that I helped author that looks at this, that we really need a pan Canadian approach to virtual care equity. That being said we don't have a pan Canadian approach to health equity as it is so – and maybe we're putting the cart before the horse but if virtual care or our sudden fascination with it in March 2020 has done anything it's raised interest in these issues, because for an informaticians like me for many years, sort of like a Maytag repairman, no one seemed to care about these issues. And COVID came around and the virus happened, now everyone seems interested, so I'm happy.
00:49:36
And if we look back at the data around virtual care, Canadians were wanting this for a long time. It was the health sector that for some reason seemed to have trouble getting around to it. And so we – why were we able to transition so rapidly? Clearly, we were able to although mostly it's just phone care we provide, but why was it that we were unable to make that transition despite the fact that most Canadians wanted that option? It's very interesting.

00:50:09
The other thing – the other observation I will make is, and this is something that is happening to – in the north but not exclusively, we're all familiar with health services and the human resource shortfalls that Katharine was mentioning, you know there are emergency rooms closing in some communities all over the country, so forth and so on. There are communities in the north there where all health service has closed, in Nunavut in particular there is simply no health service, they could not get staff so the health centre is shut for the summer and people are saying, well we can provide virtual services.

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There is a trend in some places that virtual services are replacing in person services which is a really – so what's interesting is we're asking the question can virtualization you know help address equity issues which was part of my fascination with this starting 30 years ago. Well it can also actually drive inequities. So like most changes and most technology changes or most social changes they can be good and bad. We need to be very conscious of how we approach it in order to make sure that as a collective we design this appropriately because we can actually produce results that are actually deleterious to people.

00:51:28
Kendall Ho: Thank you for that. So again please share your experiences, some challenges you may face. We'll be opening up in about a couple of minutes. I'll be relying on Todd, also, Tim, thank you very much for tracking those questions. I really welcome your thoughts, want to hear about, audience, your reactions and thoughts on that. Before we go there though, Dom, you know you are a medical legal expert here, you know really understand the legal areas. Anything you'd like to add after you've heard about these issues? And what's your perspective? Welcome your thoughts.

00:52:02
Domenic A. Crolla: Thanks, Kendall, but are we getting? Yes, (inaudible, crosstalk) I have a real mic. So a couple of comments based on what my colleagues have said. So the rapid adoption of virtual care is actually a fairly unique thing in medical legal terms. We don't have a lot of events where we can see such a significant shift in a very short period of time so it's actually quite an important development.

00:52:37
But even within that period, the beginning of the pandemic is not the same as where we are today. So you know so the judgement that physicians need to bring to deciding how they implement virtual care in their practices is actually different today than it was in April or May of 2020 when you know many of us were in lockdown.

00:53:03
Secondly, as we've heard from everyone, the spectrum that is virtual care is actually very broad. It's quite different to do a quick video call where you're titrating treatment from an initial visit. And so the – again the importance of the judgement to be borne by the physician in how to utilize virtual care I can't overstate it.

00:53:32
Thirdly I would say the legal standard of care, so lawyers and judges in particular say they are the arbiter of the legal standard of care. So what physicians do is relevant, what regulators say is relevant but what is finally determined to be the legal standard of care in the context of a case is going to be determined by a judge or jury or some other body. That's very important in terms of what clinicians need to do today, so they do need to listen to what their regulator is saying.

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Some may not like that but they do need to listen to that because that is one part of what would make up the legal standard of care. And of course it has an implications for your licence but I'm talking about defining the legal standard of care is quite important.

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Secondly, context is really important. So whether you are in the Yukon or the Northwest Territories that can be very important to what constitutes the appropriate standard of care in that context versus being in downtown Vancouver where in person care is probably more readily available.

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And then lastly and I would emphasize this, although we're in Western Canada it's not the Wild West. You know virtual care for physicians at least has real ethical, legal and professional standards. And so you know you can work with digital health companies, you can facilitate

virtual care in your own practice but you still have to live up to those legal, ethical and professional standards and that's really quite important.
00:55:14
Kendall Ho: I like your three points. So the importance of what regulators are saying and hearing and looking at that area to practice context. And then third is maintaining ethical, legal and professional standards. Great points there, really appreciate that. Thank you.

00:55:33
Why don't we turn to our audience for now, do some interactions there. I welcome those in the room, please feel free to use the mics. What we'll do is we'll try to alternate between an electronic question and also in person. So please I'll keep track of who's going to where, and of course online. Really thank you for being with us. Of course always welcome your comments electronically.

00:55:57
I also know that Todd and Pam are both tracking. Pam is tracking the French questions and Todd is tracking all kinds of questions. So I'm going to maybe turn to Todd first and then Pam, and then thanks, Mike too, I'll come to you. Todd.

00:56:12
Todd: Thanks, Kendall. Sorry. The first question is a pretty – is one that I've heard many times actually, it comes from Dr. Wayne Rosen who's on our council, which is can someone define virtual care for us? It seems to – he goes on to say that it seems to be in most instances we're talking a simple phone conversation between a patient and a provider which we've been doing for years. But does speaking on the phone constitute virtual care, or how do we define virtual care? Maybe that's a question for you, Kendall?

00:56:44
Kendall Ho: Well as a moderator I can defer, you see I can deflect the question. I know you have done a lot of work there, maybe I'll get a definition from you. And maybe, Nancy, I wonder from a regulator's point of view whether you also have a definition to add to it. Ewan?

00:56:59
Ewan Affleck: It a topic, thank you, this – whoever – brilliant question, thank you. Thank you, you get – get the man a prize. We suffer in Canada, actually internationally but particularly in Canada with definitional and taxonomic chaos in this business. So we don't know the interrelationship between things and we don't know what they are.

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And what I'm seeing is there are lots of organizations and I was just working with one of them who decided to define – everyone's defining virtual care or digital health according to their own

needs and it's leading to chaos. So there needs to be a standard. If we all spoke a different version of English we wouldn't be able to communicate, that this is a problem, so thank you.

00:57:47
So the definition that was in the virtual care taskforce report, it's also in the Health Canada report and virtual care equity, it's also in the Alberta virtual care working group report and it tends to be becoming the standard as a definition from Women's College Hospital and it really defines it as three things.

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First of all it's remote communication, so whoever is communicating is in a different location then the person they're communicating with. It is between a provider and another provider or another member of the circle of care of the patient or the patient. So the patient can be communicating with the provider or maybe the provider is communicating with – you note I say provider, it's not about physicians, it's about the entire circle of care.

00:58:42
The third thing is it is using any communication technology and there are many of these definitions who get hung up on saying it's about phone, it's about video, it's about whatever, these things are continuously changing, so it is any communication technology.

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And the last and very importantly, it is used in the context of an effort to improve the quality of care or maintain wellness. We should not be engaging in something that makes people sick. Now unintentionally that may happen but this embeds in the definition our accountability, our fiduciary responsibility to quality of care and suggests that we should be evaluating like we were talking about before, evaluating what we're doing to ensure that and this speaks to what colleges say and so forth. So I can't read the actual – I could almost get it right but that's what the definition says and we can circulate that that later. I'm happy to circulate it to everyone.

00:59:38
Kendall Ho: Thank you. Nancy, anything to add to that?

00:59:39
Nancy Whitmore: I'm really glad you went first because that was a really good definition. That's pretty much what our – so our policy that we just recently put out is on virtual care, the previous policy it replaced was called telemedicine so that tells you the advance that occurred in that very narrow window of time. And we speak about exactly that relationship between either a patient and a provider and another provider or a provider and a patient, that communication platform, whether that is telephone or some sort of video platform and then the idea of it's synchronous or asynchronous.

01:00:12
So that then brings in the whole text messaging and email type conversations that are occurring where you're not at – you know having that conversation at the same time. So lots of different platforms. Yeah, so I think that's essentially and I think it will continue to evolve because I think the types of interactions are going to continue to expand and the usefulness of those interactions.
01:00:37
Kendall Ho: Thank you very much. And also I welcome, CMPA has a white paper online you can access. And again please give feedback in that area about the definition. Pam, maybe I'll come to you and I'll go to mic two and then mic three. Any questions there from you?

01:00:54
Pamela Eisener-Parsche: There is not yet a question in French so you can go to the floor.

01:00:58
Kendall Ho: Okay. Maybe I'll go to mic two, thank you very much. Could you let us know your name and your question please.

01:01:04
Question: Yes, thank you. It's Patrick Bergen(ph), I'm an internist from Charlottetown, PEI. So thank you for a fantastic – the panel demonstrating the opportunities of virtual care, enhancing patient centred care. You know and I think you're really the only one that has kind of started to touch on the dark side of virtual care, although others have and that's – you know watching the social divide which was referenced it's definitely enhancing access, it's enhancing convenience (inaudible) there are some amazing opportunities technologically.

01:01:42
But unfortunately, and I know I'm not in isolation from talking to colleagues in other provinces, I'm seeing virtual care being used out of – used for the convenience of the physicians and not in isolation, not in small – you know not in small ways. You know physicians have closed their offices, they've you know dismissed their staff. They are seeing patients. Heather, an example is a 60 year old post cabbage having undergone cardiogenic shock, EF 20% and I'm seeing the patient six months later after having seen them early on and they've had one telephone visit with their family doctor who has not – and I know that's like okay, well that's one, but that's just one example of you need to know when patients need to be seen. So that's the dark side, that's one of the dark sides of it. And so that's really my comment.

01:02:53
My question really for the panel is, is the rapid development of virtual care in this time of necessity with COVID, leading to you know fairly rapid growth in privatization, TELUS Health and Maple, what threat or opportunity depending on how you view it does it pose to erosion? I guess my choice of words is getting my view but the erosion or influencing the universal health

care system and leading to a two tier healthcare system because my experience is you pay for it and those who can afford it will pay for it and those who can't aren't. So I'm curious, Domenic (inaudible) your view on so what threat it might have to our universal health care. Yeah, thank you.

01:03:48
Kendall Ho: Thank you. Very thoughtful question. Maybe Katharine, do you mind if I asked you to speak a little bit? And then Dom, welcome your thoughts and then we'll open up to the full panel. Katharine, your thoughts.

01:04:01
Katharine Whitmore: Yeah, I think that's a really – I think all the points you raised are very well taken and I think that's always the challenge in any profession is you're going to have you know people who are – you know the vast majority of people are going to do a great job and the right job and make good decisions and there's going to be people who don't and how do you control for that and make sure that patients are getting high quality care.

01:04:23
Because I think you know the example you gave, I think we all know of examples like that of patients who are not able to get in and be actually seen. Heather and I were actually talking about this while we were the scrutineers that there's no, you know no substitution still in medicine for a good history and physical exam. That is the core of what we do with patients and I think there is a risk if we back away from that too much of people not getting high quality care.

01:04:50
That's certainly been my experience as a pediatrician. I've rarely wished I'd ordered a test, but it's did I listen to what people were telling me and did I look closely at the person in front of me. So I think we need to be cautious around that.

01:05:03
I think there's absolutely also the risk of the proliferation of the virtual walk in clinic style medicine where we have convenience medicine that's low value but being delivered at scale. That's obviously desirable for some – at times for patients but I think when you also are in a system like ours where there's limited resources, you know I think already we're seeing some physicians pulled into that model of care perhaps because it suits them better and it's, you know we're seeing that grow and how much value is that adding in and what's the quality of that type of care? So I think that's an absolute risk.

01:05:39
And I think again it's partly a risk because the infrastructure of care is so poorly supported for so many people in primary care, it's not surprising that people may be choosing to move over here

and do only virtual care because the – you know running the business of medicine has become untenable for them. So it's not a surprising consequence I don't think of a poorly supported primary care infrastructure that some physicians are exiting that and choosing something else and I think that's the risk when the system's neglected.

01:06:11
So I think we have to be mindful of that. And I think you're also right that that space is opening more opportunities around two tiered access. And we know we have that already in the – in our country, we already have people that are buying executive health services, other things, access to physicians. I think that's going to be growing more and more as the access to care issue gets worse, that's clearly an equity issue.

01:06:36
I think we all know that we already have a lot of private public partnerships in medicine, like really any family doctor working fee for service running a small business that's a private public partnership but it's coming exclusively from public dollars. But I think there is more – we are seeing more and more private only options and that is a core issue I think around universality and access to care.

01:07:00
But I also think you know the risk always of not acknowledging the problem in front of you and not acknowledging these very real problems in our system is disruption happens and the system evolves and you're left behind and I think that's the risk of where we find ourselves right now so we can't have our head in the sand about this.

01:07:20
And I also think we have to – part of our challenge in Canada is because our healthcare system is something that's so emotional that when people start trying to – and our fear, I would say our proximity to the US makes us afraid of the word innovation because we think it's code language for an Americanized style of healthcare which I don't think is what anybody in Canada would think is a good idea.

01:07:41
But that can sometimes prevent meaningful conversations around what needs to transform in the system because we get into this dichotomous thinking of it's this or that and we lose the nuance and I think that's problematic because I think very clearly we're at a place where we need to embrace what needs to change and we can't get into these black and white conversations where you know where it's you're good and this is good and this is bad and you're bad. And sometimes I feel it devolves into that and we're not then having the right conversations about what's working, what's not, what do we scale? What do we mean? What are the principles we want to see and what are the values that need to underlie the system as it changes?

01:08:19
So you know and I think you know with anything new there's unintended consequences and I think we're absolutely seeing that for sure with virtual care. You know there's pros, and there's cons and that's true to everything and that's true for fee for service medicine and all the basic principles of how we've always worked. There's pros and cons, it incentivizes certain things and not others. 01:08:38
And I think what we really need to be thinking about is how can we incentivize the type of care we want to see and the type of system we want to be in and what are the principles that are needed to underlie that and I think if we can sometimes step back and think about those things then we can have more meaningful conversations about where to next, because clearly where we are is not where we need to be.

01:08:58
Kendall Ho: Thank you for that. Dom, you've been asked to comment on that, I'd certainly love to hear your thoughts.

01:09:05
Domenic A. Crolla: I won't say much more because I think it's been really captured in Katharine's comments. But I would say this, make this observation. You know it's very clear that all technology developments create risks and opportunities, problems that need to be solved. And so there's some peculiar ones with virtual care; privacy, security, which products you can use, do they have Health Canada sort of approval. I would only say that physicians need to be very vigilant that they're part of that conversation otherwise it will go around you because this is happening and it's happening fast. So I think if you want to have medical values in the new virtual care system then I think physicians and you really need to participate that in a very vivid way.

01:09:55
Kendall Ho: Maybe we'll take one more comment. Ewan, I just noticed time is flying by, this conversation is so good. Ewan.

01:10:03
Ewan Affleck: So I just thank you for the discourse and the question. I want to compare health care to a plane, to flying a plane. You have to look at what's happening here in Canada. So the pilot in order to ensure – so if we're talking about physicians as providers, the pilot needs to be trained and competent to provide care. The plane also needs to be regulated and safe so it doesn't crash. And we saw what happened with MAX 8's. The MAX 8's were faulted, they were not regulated, Boeing wasn't regulated properly, the pilots actually were – neither made errors in those crashes, they were well trained.

01:10:47

In Canada, when you launch virtual care or any digital health technologies they're largely unregulated other than with respect to privacy and security. What is quite fascinating is what is the regulation or the legal construct around which we ensure that these technologies are safe. It's largely missing. That's a big problem, that's the dark side you know.

01:11:17
So we are launching physicians who are competent, and we have great regulators, a great regulator. I work for a regulator also part time, so and a great boss too. Anyway I won't editorialize. We launch physicians into an environment where the technologies ensure, because we do PIAs and so forth, that they're safe with respect to privacy and security. But do they – are they safe with respect to the quality of care people can provide? That is not tested. So that's my first comment and it's an important one, there's a legislative lacuna there.

01:11:54
So well I'll leave it there kind of like because we're going over time but I think that that's an important point. So we are lacking in a legislated or governance approach to the safety of these technologies that preserve our capacity and it's also contributing to burnout on the part of providers.

01:12:12
Unidentified Male: If I could just follow on from that comment, I think it's such an important comment. There's consumer available where you as the consumer, as a patient you can go out, you can go to the store and you can buy the technology you can start to use that technology. And then there's evidence based technology, and then there's Health Canada approval and regulated technology. And this is where the challenge I think is really happening in the digital health space because there's this massive consumer push because there's a market because everybody wants whatever the latest thing is because their micro saturations matter when they're in space or so the commercial said.

01:12:48
So everybody wants the thing, but whether that thing has been proven to work in the disease state that the patient is trying to use it in and whether or not the evidentiary bundle has been created and whether or not it has Health Canada approval doesn't necessarily matter for consumers.

01:13:03
Ewan Affleck: So whether we even have – whether we even – hello? Whether we even have evaluation frameworks for any of this. A lot of this is never evaluated with respect to this. And I will just say in defence of the technology companies which we sort of all – they are entering a space which largely crushes innovation in Canada. We crush digital health innovation exceedingly successfully. Do we need it? Desperately. Do we need the innovation? Desperately. Is the health care system looking good? No. Do we support innovation? We crush it.

01:13:40
And part of the reason we crush it is because it's such an ill defined space. The nature of the relationship between the private vendors and the physicians and the professions and the regulators is not defined. It's other than around privacy and security largely, other than that it's just vague and so it's exceedingly hard to play in that space.

01:14:04
Kendall Ho: Thank you. Maybe the problem with the moderator is there's so much good stuff but I recognize there lots of questions, people there and actually reading from Pam's body language you may have got one too. So maybe Nancy, a quick comment and then we'll move on the next question.

01:14:19
Nancy Whitmore: I think the only comment I was – is this mic? Here we go. The only comment I was going to make is around episodic care. So you know episodic care we know is problematic. Walk in care is problematic care and the advent of adoption of virtual care in this model has just really accentuated that issue. You know I mean and it's very different than virtual care in an established doctor patient relationship. So I think it is a unique problem but a significant one. So I just want to comment on that.

01:14:50
Kendall Ho: Thank you. We'll go to mic three and then we'll go on the line. Thank you, Danny. Oh, I think she was there first. I noticed mic four, yes, thank you. We will come here. Sorry. Please go ahead.

01:15:07
Question: I'm Patrick Trudeau, I'm a surgeon in Quebec province. I have a question for the gentleman in the middle. Yeah, sorry, I forgot your name. You mentioned that you had problems beginning with the EMR centred on the patient in your region. You mentioned that everybody was kind of against it from the start. How did the patient react? Was the patient also against the idea or did they jump in?

01:15:43
Ewan Affleck: Again, get him a prize, great question. You know we also suffer from a lack of accountability to patients or involvement in oversight in any of these decisions. So we had long debates about how to engage the patient or the public and that the short answer is no, people were very pleased. The obstacle was from the different individuals and the industry and right across the industry. So this is in the Northwest Territories, but from the government, from the professional groups, from the hos... like different all the different players, and this is old.

01:16:22

What was interesting is that the project took 17 years, it took about 10 years and then everyone switched. We gradually grew this charting system and I call it my Gladwellian(ph) tipping point, it was like somehow a light went off and then everyone thought it was a good idea to have a person centric chart. But it took years and years to change the culture, this view that everyone wanted their own technology for their own service and I would be accosted on the street by colleagues, orthopedic surgeons, whatever, how dare you force your GP chart down my throat? And it was a voluntary thing and furthermore it wasn't a GP chart, it was this patient centric chart but it would be ascribed to whoever and the same population health didn't like the idea. 01:17:18
And the amazing thing was when it switched and people began accepting this notion, many of the same people who were so angry seemed to forget they'd been angry and I'd be at meetings you know sort of ready to get beat up again and the same people, so this is so good and I'd sort of look at them and think, am I crazy or are they? I couldn't figure it out. It's a fascinating socio cultural study in what happened, but I watch it all over Canada. Still we went through that transition there but we have to ask ourselves why we pay lip service to person or patient centricity and explicitly don't practice it in terms of health information design.

01:18:06
Unidentified Speaker: (Voice of Translator) I also have a comment in French, you talked about a turning point when people accept a new technology, I think that with regards to what we heard about some experience than March 2020 a lot of money was put into it and that acts as a leverage to – for patients and physicians to accept virtual care.

01:18:31
Of course here 90% of virtual care on the telephone but if we stop paying physicians for these telephone appointments they'll just disappear. It'll be as easy as that. So we keep providing and paying them for virtual appointments but if governments decide that there's no money here anymore it'll just stop because people won't work for free and that's an important thing to take into account. In 2020 all of a sudden virtual care appeared everywhere across the board because money was injected into this. (End of Translation)

01:19:13
Kendall Ho: The remuneration and the support remuneration that leads to virtual care and the lack of it leads to it. Maybe a quick comment, I know we only got about less than 10 minutes left so maybe a comment on a very important issue. Thanks for raising that. Anyone want to comment?

01:19:29
Unidentified Speaker: I mean I think creating remuneration codes was essential during COVID to make it fly. So you know they came and they stayed for a while and then they got renewed and they've been renewed again and I think we have to figure out, I mean it comes back to the

discussion we're having, physician remuneration, we need to avoid the dark side of it. We need to make sure that the quality of the care is there.

01:19:56
We have not properly assessed the quality I don't think of virtual care. I haven't seen not published about what does a telephone visit look like compared to a video visit compared to an in person visit? What is the – what's the patient reported experience of that? But remuneration was an absolute requirement along with licencing and of course what we're here to talk about which is the CMPA side of making sure that we're protected when we provide best care was crucial in order for things to fly during COVID. I don't think it would have happened in the absence of remuneration.
01:20:29
Kendall Ho: Yeah. We – okay, Dom, quick one minute and then we'll go on.

01:20:34
Domenic A. Crolla: Yeah, just on that very specific point. From a legal perspective it's concerning to think that remuneration changes whether it's at a scheduled benefits level or something that that would influence the decision on delivery of quality of care. So that's very concerning from a legal perspective, right, because then that's kind of an extraneous issue to deciding which is the best modality of care.

01:20:34
Unidentified Speaker: Just to clarify something to be very clear, I'm not saying that the remuneration decides the type of care provided, but the absence of remuneration for virtual care was an absolute deal breaker I think for most healthcare providers. So that's all I was actually trying to say.

01:21:20
Domenic A. Crolla: Yeah, I get that but I think it's also relevant though to the adoption in 2020 versus today. So if remuneration is removed then one wonders about what that does to the analysis that, you know the professional judegment that people need to make about whether to deliver care virtually or not.

01:21:40
Kendall Ho: Well (inaudible) Ewan I'll give you half minute but maybe, Todd, this might be a very important subject for us for a different conversation, a different day. Ewan.

01:21:49
Ewan Affleck: I'll take 10 seconds. We need a digital age remuneration model, we are trying to retrofit old models into the digital age and they do not work.

01:22:01

Kendall Ho: Thanks for taking 10 seconds. We'll go with an online question and then number four, I haven't forgotten about you.

01:22:08
Moderator: So Ewan's question really addresses numerous questions we have related to the funding model so I won't revisit that at this point in time given the time. But just as said, there are many, many questions here that we will endeavour to try to answer after the event. I'm going to switch tacks a little bit and Mansfield Mela(ph), who is one of our councillors from Saskatoon asks, how has virtual care contributed to physician stress? Has it increased it? Decreased it? What do we know about it?

01:22:39
Kendall Ho: Excellent. Panellists, who would like to take that one? All right, Pam.
01:22:47
Pamela Eisener-Parsche: I think it's a fantastic question and as you know we speak to a number of physicians who are often distressed when they call us. Virtual care has increased the stress level of a number of members we've spoken to for a number of reasons. First of all there is the concern about am I doing this right? Have I asked all the right questions? Where's the patient? Where am I? Is this platform appropriate? Is the patient in the right place? Who else is in the room that I don't know about? All of those issues certainly increase the stress level from the members that we speak to.

01:23:17
I think there's another element that we haven't yet discussed though that many of us went into medicine because we liked being with people. And when you're looking at a screen all day long or talking on a phone all day long that reward that you get from interacting with the patient has been diminished. And we hear that, that sense of disconnect from patients, that sense of disconnect from the value of being a physician and the care that you provide is missing and that does result in that sort of crisis at the end of the day of not feeling like you've done a good thing today, and we're hearing that.

01:23:53
And then there's also you know tapping onto that the expectations that come with virtual care. Well if you can talk to me by phone or you can see me over a video call then I should be able to call you at midnight regardless of whether or not you're on call, regardless of what you know your life entails, so these expectations that come to be available 24/7 and we know they can't do that. We know that physicians need downtime and need to be able to spend time with their own families. So you know a number of things that have really increased the stress level of the physicians we're speaking to who are trying to incorporate virtual care into their lives.

01:24:32

Unidentified Speaker: Yeah, and I would just add the ebb and flow in running a clinic where if you're in with a patient and there's actually something you really need to talk about with that patient and it goes over time you know you have a waiting room and the rest of the clinic ebb and flows around it and as I have a very busy heart failure practice and half, about 40% of my practice is virtual and the virtual are on the set times, it's back to that we don't have a good digital remuneration.

01:24:59
We also don't have – haven't really landed on how to do digital waiting rooms and digital notifications so that – because I'm sorry, my patients don't actually really fit into these really reclusive scribed slots. I mean some patients take longer and some patients take less time and I find the virtual visits, they really expect this. Yes, I know I've had the visits when they're driving and the visits in the grocery store but when they're actually expecting the visit they expect it to be on the set time. And so if the patient before takes longer you're sort of trying to figure out on the fly how you're going to do that. So the same with the remuneration, we need a better digital structure about how to run that type of clinical program.

01:25:38
Kendall Ho: Thank you. I know, we got five minutes, I want to make sure I get to number four and the speaker there and I think you have a question there. By the way, online please continue to feed in your thoughts because we will be looking through it and I think it'll be very, very helpful, thank you. Why don't we go to number four, thank you. Thank you very much for your patience, I appreciate it.

01:26:00
Question: Oh, no trouble. Sorry, I had to sit because I have a bit of a back issue. So and this is probably just as well I'm last because I don't suspect you're able to answer this question. But today we've talked about incentivizing care and meeting patients where they're at, understanding that we're – we have human health resource issues and it's national, it's actually international but we can't help everybody.

01:26:24
We've got burnout, it's everywhere and it's not just in health care, and I understand that I am part of the CMPA council so I really do understand that we are here to look after our members. But that said we're looking at modernizing here. So there are many barriers, just even summarizing it like that, that prevent us giving excellent care.

01:26:46
We talk about having as you call, I'm going to call it digital poverty, I'm going to call it that, because if you don't have the internet, etcetera, you just don't have access to that care. We know that there are areas of high resources and those of much, much less. We talked about how do we get that and we know what's possible. So how do we then incentivize people to

make it work for meeting people where they're at? And that would look like involving people with the patient voice, the local structure so they know what works for them and somehow incentivizing people who want to go to areas of excellence or potential excellence. What might it look like?

01:27:28
What might it look like if you were able to train individuals who work in local areas where it's they're not necessarily physicians but who could help you through some kind of digital platform so you could see, do that exam that you can't do but you need. We know they're doing it now in certain areas, we have ICUs and funky digital stethoscopes but we need more than that, you need hands on? How do you develop that trust? How do you, like Dr. Smart said, get the team based care? Not every doc that works doing fee for service does it because they have a choice.

01:28:06
Does that mean that they're running a small business? Like actually they are running a small business but they're running their asses off if you pardon my French because there's so much to do in such little time. So what are we doing as physicians or as team members or as leaders in so many other areas to work together to make it work for places where they need help where they're at?

01:28:26
Because the solutions are not just one, there are going to be multiple solutions in different areas and how can we work together? Forums like this are excellent because you hear the deep thought and the deep solutions that have worked in other areas, but how you get them all to sort of work together and talk and then spread. And this is nothing new that I'm saying but it just it struck me over and over again that it's not something that hasn't been done before. It shouldn't take monkeypox to move us to the next level. And so I'll leave that to you for your final comments.

01:28:56
Kendall Ho: Thank you very much. We are almost out of time. So I think those are great comments. Maybe I'll draw one or two comments from our panels.

01:29:03
Unidentified Speaker: (inaudible) to make. So one of the most important things about digital health is community based participatory research and I think that's really where you're going which is what is the community's needs and how do we actually tailor the digital health to the communities because different communities have different access and different needs and I think it's a huge area, it’s getting back to creating evidence around what we're doing and looking at the quality and it can be done through QI and PBSA cycles, the work can be done quite quickly.

01:29:31
But what is needed in a remote community in the Northwest Territories is going to be quite different than what is needed in downtown urban Toronto in a – those experiencing homelessness. So I think you do need to understand what the community's needs are and I think we can do that.

01:29:49
Kendall Ho: Nancy, do you mind if I draw you out for the last comment. I apologize, I really – we're running out of time so we have to stop. So thanks for being here. Love to take down a question later. Maybe, Nancy, from a regulatory point of view how do we make sure that we change culture to help to get to patients where they are are, we help them and help them when they need it?

01:30:11
Nancy Whitmore: I mean that's a really simple question. And it's a very complex situation we're in and there's many, many issues that are at play, right? You look at health human resources, the burnout issues, we talked about virtual care, does it help? Does it hinder? I think physicians who have engaged in text messaging and email with patients have very often shut that down as a service because it is just intrusive.

01:30:39
You know we've talked briefly about national standards, national licence, etcetera. I mean certainly that's an ongoing elephant in Canada in terms of you know we have designed our country around provincial legislation in terms of health care and other health delivery systems. And so it's about stepping back and looking at all of those things.

01:31:02
I don't think there is a one size fits all answer, I think it has to be area by area. I'm you know jealous right now of the Northwest Territories that has a unified health record. I mean that would take away a lot of our issues around episodic care would be much, much less if you knew when a patient came into that episodic care environment you had – knew something about their care to that point in time.

01:31:26
So I mean I think this conversation has to continue and it really is about all of the different parts of the health system working together to start to really get to you know some serious solutions or ideas around how we start to build something different. We've we've covered issues here that go from the type of care we deliver, the model by which we deliver the care in terms of a fee structure. And although we'd like to think that fees don't change care delivery we know they do. And so how do we you know look at all of that.

01:31:56

And then the Health Human Resource, anybody who has read the paper recently knows that I've got about four more days to respond to my minister of health to resolve that issue. You know it is a multifaceted problem to solve and we're not going to solve it in five days. But we're at least having a conversation about how we start to look at many of these issues.

01:32:17
And I think the other thing we haven't talked – we've talked a little bit about distribution, but there's a large issue with regard to distribution of health services including physicians. You know we have in some cases more supply than perhaps we need, in other cases much less and how do we start to balance that. It may not just be about number of physicians but also about where they're practicing and what type of practice they are providing. So there was no answers to that but thank you for the very complex question.

01:32:46
Kendall Ho: Wow. Absolutely, thank you. We have to leave it at that. Please, thank you for all your excellent questions and please help me to thank our panellists before I pass it to Dr. Calder. Thank you. Thank you so much. And Dr. Calder, I'm sorry I missed the mark and the timing. Thank you so much for inviting us here.
01:33:04
Lisa Calder: It's totally fine.

01:33:05
Kendall Ho: Over to you.

01:33:05
Lisa Calder: Thank you very much, Kendall, thank you to each member of the panel for coming and spending time with us today. It was very thought provoking. I learned things, I have so many reflections but what I'm just going to say is this. My fear is that we are drifting into a place when it comes into virtual care instead of intentionally deciding what we need to do when it comes to delivering quality virtual care.

01:33:28
I'm inspired by what I've heard today because there is no shortage of great ideas. But it is really about coming together and doing this systematically and effectively so we can deliver safe quality care using these new technological tools in the midst of the technological revolution we are in.

01:33:43
So I do want to flag again, we have a white paper the CMPA has published on our website, please check that out. And also a friendly reminder about CME credits, so there is an evaluation with links to the CME credits which will be emailed to you tomorrow morning, those who

participated so I encourage you to reach out and do those. And thank you again to Kendall and our panellists for an excellent discussion this afternoon. Thank you.