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SUBJECT/SUJET:
The Canadian Medical Protective Association holds an English information session as part of their annual meeting.

File Name: 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.

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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?

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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?

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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Ewan Affleck: Now you can hear me.

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Kendall Ho: Yes, thank you.

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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).

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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

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Nancy Whitmore: Yeah, big evolution and quick evolution.

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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?

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.
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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.

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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.

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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.

00:43:32
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.

00:43:58

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.

00:44:59
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.

00:46:40
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.

00:48:55
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.

00:50:44
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.

00:54:07
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.

00:54:23
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.

00:54:44
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.

00:57:22
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.

00:58:08
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.

00:58:56
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.