Opening remarks and call to order

00:00:00
Jean-Hugues Brossard: (Voice of Translator) Hello everybody. My name is Jean-Hugues Brossard, I'm president of the Canadian Medical Protective Association. The interpreter is having a very hard time hearing the speaker, there is a lot of echo. (End of translation). Welcome to the Association's 119th annual meeting.

00:00:23
(Voice of Translator) Our meeting this year is being delivered virtually and in-person from Montreal and a large part of today's meeting will be in French. This is the first time that this meeting will take place in French. The interpreter is having a very hard time hearing the speaker, there is a lot of echo in the speaker's microphone.

00:00:56
All attendees have access to simultaneous interpretation through the headsets found on your seats or by selecting the appropriate language on your screens. I encourage unilingual in-person attendees to wear your headsets at all times to hear the presentation in the language of your choice.

00:01:18
We are pleased to have with us 113 people today in-person and 225 attendees joining us virtually from across Canada. We also have representatives from a number of health care organizations, and I would like to thank all of you for taking the time to join us today.

00:01:47
The meeting will begin in 10 minutes. First, we will once again have the elder and knowledge holder Amelia Tekwatonti McGregor, who will deliver a welcome speech. My colleague Dr. Lisa Calder and myself will then walk you through some housekeeping matters. We will also confirm the scrutineers for today's meeting, and we will approve the meeting minutes from our last annual meeting. So, let's get started. Lisa, over to you.

00:02:24
Lisa Calder: (Voice of Translator) Thank you, Jean-Hugues, and welcome everyone. I'm Dr. Lisa Calder, CEO of the CMPA. There being a quorum present I hereby declare this meeting to be duly constituted and call it to order. (End of translation)

00:02:41
To begin our meeting, I am going to introduce the revered community leader and knowledge holder Elder Amelia Tekwatonti McGregor. Elder McGregor is a Mohawk from the Bear Clan in Kahnawà:ke Territory. Amelia and I had a chance to chat last night and today, both with her daughter Carol. And I learned about why she is the founding member of the Kahnawà:ke schools diabetes prevention program.

00:03:08
She was inspired by the experience of her mother, who experienced type 2 diabetes. This program was launched in 1994. It was a participatory research project, pioneered in the community as a community outreach effort to stem what we know is a highly frequent disease amongst indigenous communities, type 2 diabetes.

00:03:30
She's been invited to speak around the world about this project and she's inspired similar initiatives in other indigenous communities as well. She was recently recognized by McGill University with an honorary doctorate for her vital contributions to health promotion, community education and expanding fields of indigenous research methodology.

00:03:49
Amelia and I also spoke about storytelling and if you have a chance to speak with Amelia, she has some really compelling stories to tell. And she reminded me that we all have stories to tell. So we will be telling you a story today about the CMPA, to you, our members. I would kindly ask that no one record* with their phones the words that Elder McGregor is going to say to us today. These are words that she is saying in this moment, to us, now, and I encourage you to let those words land with you. Elder McGregor, it is an honour to have you with us today and I turn the floor over to you to open our meeting.

**The "no recording" request refers to personal recordings using cell phones. Elder McGregor granted permission for the CMPA to record and share her welcome address.*

Opening address with Elder Amelia Tekwatonti McGregor

00:00:11
Amelia Tekwatonti McGregor: I was just about to read it. Okay, well you, for those of you that were already here this morning you kind of understand what we're talking about as the CEO mentioned so I will not repeat it again because you've heard it already. So I'm just going to go right into the opening address to creation. (Indigenous language).

**The "no recording" request refers to personal recordings using cell phones. Elder McGregor granted permission for the CMPA to record and share her welcome address.*

A year in review

00:00:00
Jean-Hugues Brossard: So thank you, Elder McGregor for those words. (Voice of Translator). As we gather here today in Montreal, I'd like to acknowledge that the land on which we sit is unceded and unsurrendered Indigenous lands. Tiohtià:ke/Montréal is known as the gathering place for many First Nations, and we recognize the

Kanien'kehá:ka Nation as custodians of the lands and waters on which we gather today.

00:00:31
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 Anishinaabe Algonquin Nation, whose presence here reaches back to time immemorial. We honour and pay respect to these lands, and to all First Nations, Inuit and Métis Peoples throughout Turtle Island. Lisa. (End of translation)

00:01:06
Lisa Calder: (Voice of Translator). Thank you, Jean-Hugues. So I have a couple of details that I would like to share with you. First of all, I'd like to remind you that only active members who are present in person can vote as per the CMPA by-law. Voting will be done by a show of hands. Additionally, only active members can ask questions, and members who ask a question will be identified in the minutes. Members in the room can ask a question by going to the microphones. Members who are online or those who don't want to go to a microphone can ask questions by using the Slido Q&A app. I'd invite you to see the handout found on your seat or click on the Technical Support button on your screen for instructions. (End of translation)

00:02:22
Jean-Hugues Brossard: (Voice of Translator) Thank you, Lisa. Now let me introduce my colleagues, the people who are seated here on this stage, and some of them may be speaking today. You already know Dr. Armand Aalamian, Executive Director, Learning; he moderated the previous session. We also have Domenic Crolla, our General Counsel for the CMPA. He's a lawyer, and he's doing what lawyers do: he's writing right now. Dr. Michael Curry, a CMPA council member and chair of the Audit Committee and he's over there in the room.

00:03:03
There's also Dr. Pamela Eisener-Parsche, our Executive Director, Member Experience, and that's a euphemism to talk about the Medico-Legal Department; Cory Garbolinsky, our Executive Director and Chief Financial Officer, Financial services; and Christine Holstead, Executive Director, Strategy and Operations. You can see Christine there at the end of the table.

00:03:32
Leah Keith, Executive Director, People and Culture; Dr. Birinder Singh, First Vice President, who's seated at the end; and Chantz Strong, Executive Director, Research and Analytics and Chief Privacy Officer. And Dr. Todd Watkins, our Associate CEO.

00:03:59
With us in the room, we have three former presidents of the CMPA with us today, Dr. Debra Boyce, Dr. William Tucker and Dr. Peter Fraser. And as well, we have with us all the members of the CMPA Council. We also have with us Drs John Gray and

Doug Bell in attendance, both former CMPA CEOs. Thank you all for joining us today.

00:04:36
There are two scrutineers who have been identified in advance of today's meeting. They are Dr. Steven Bellemare and Dr. Debra Boyce. In the case of a vote, they will act as scrutineers. If you object to these two being named as scrutineers, in person attendees may proceed to a microphone to share their objection. Thank you for your cooperation. And since there is no opposition, they will now be able to fulfill this task. So, Debra and Steven, you're now scrutineers.

00:05:23
And now I would like us to move to the approval of the minutes from the 2022 Annual Meeting, which were posted on the CMPA website ahead of today's meeting. Please remember only active members in the room can vote, as Lisa has mentioned.

00:05:39
Additionally, if you have amendments to the minutes, please proceed to a microphone in the room. I will leave you a few moments to decide whether or not you would like any amendments to the minutes from last year. So, Susan Chafe has moved approval of the minutes and Gerry Craigen is seconding. We now have a motion moved by Dr. Chafe and seconded by her colleague, and it's now time to vote by a show of hands. Since there have been no changes proposed, I would ask you to raise your hands if you agree with approving the minutes. Please keep your hands up for a few moments. Thank you. The minutes of the 2022 Annual Meeting are approved. Lisa. (End of translation)

00:06:47
Lisa Calder: (Voice of Translator) Thank you, Jean-Hugues. Over the next few minutes, Jean-Hugues and I will share how the CMPA has brought value to the healthcare system by supporting physicians and patients over the past year. Without a doubt this was another challenging year. Physicians, patients and providers continue to face COVID-19, a toxic drug crisis and significant resource restrictions, including the healthcare human resources crisis. And you, our members, face new medico-legal risks in almost every area of practice.

00:07:27
It's not an understatement to say that the healthcare system is strained to the breaking point. Through these difficult times, the CMPA has focused on being there for you with compassionate support. We've modernized the Association and we've done so collaboratively. I will now hand over the microphone to Jean-Hugues to share how we've been there for our members. (End of translation)

00:07:57
Jean-Hugues Brossard: (Voice of Translator) Thank you, Lisa. As you can see from the slide… so I would ask for the slide to be put up, please? There we go. So as you can see from this slide, in 2022, we were there for members with peer support. Their support was provided by physicians, their peers. We received more than 29,000

requests for assistance, and we had over 49,000 interactions with our members.

00:08:36
We provided expert guidance and ethical defence, and we did that in over 5,000 College matters - 5,000 - and close to 2,000 hospital matters and 760 new legal actions. We also continued to provide just-in-time advice on key issues like the healthcare human resources crisis.

00:09:06
But one of the things I'm most proud of at the CMPA is that we have the trust of our members: 93% of members surveyed agreed that speaking with a physician advisor had a positive impact on their practice. We often hear from members who share things like this quote. I'll give you a moment to read it.

00:09:44
We speak to members every day. We know physician burnout rates are at an all-time high. We also know that physician wellness can directly affect the safety of medical care and increase medico-legal risk.

00:10:02
In 2022 we hired additional physician advisors to strengthen our capacity to help and we continue to educate our staff and lawyers to support distressed members. They were doing it before, and they will do it better in future. I'm proud to say that simply speaking to us often helps members decrease their stress and supports the safety of their care. I'll invite you to read another comment from another one of our members who demonstrates how we can help. Thank you, Lisa. (End of translation)

00:10:42
Lisa Calder: (Voice of Translator) Thanks, Jean-Hugues. In addition to supporting physician wellness, another essential role of the CMPA is to provide timely and appropriate compensation to patients on behalf of our members when the care provided is found to be negligent, or fault in Québec. In 2022, we paid $279 million in compensation to patients. Over the past 10 years, we have paid a total of approximately $2.3 billion in patient compensation, for an average of $229 million per year.

00:11:29
One of our main priorities is preventing patient harm from occurring in the first place through our member education, advice, and support. But when it is proven that harm has occurred as a result of negligence, or fault in Québec, both our members and patients can be confident that we're here to provide compensation.

00:11:54
To ensure that we have the funds in place to do this, we took a number of steps, including investing prudently. Speaking of our investments, the performance of our investment portfolio impacts our financial position, which is a major factor when we set membership fees each year. While our investments are carefully managed, they are not

immune to the volatility of the financial markets.

00:12:29
As you likely know, 2022 saw one of the poorest market performances in recent history. And like many portfolios, our returns were less than expected. While we strive to maintain long-term fee stability over time, our ability to do so depends in part on the performance of our investments.

00:12:55
Additionally, our financial position and membership fees are impacted by medico-legal costs which fluctuate from year to year. 2022 saw an increase in medico-legal costs in many regions which include compensation to patients. Medico-legal costs and lower investment returns mean our overall financial position has decreased. You'll hear more about this later when we share our 2024 membership fees.

00:13:35
But the CMPA takes a long-term view of its finances, including when setting its membership fees. Each year we set membership fees to support the financial sustainability of the organization and keep fees as low as possible. We adjust and respond to changes and trends in the investment markets and the medico-legal environments appropriately. Ultimately, our goal is to ensure we have the funds to support members and compensate patients today, tomorrow, and well into the future. We will return to our 2024 membership fees shortly, but now let us continue with our year in review.

00:14:31
I'd like to talk to you about equity, diversity and inclusion, or EDI. EDI is vital to healthcare. We know members and patients experience racism and inequities and that this significantly affects physicians, threatens patient safety, and creates medico-legal risks. As an organization that protects physicians and promotes safe medical care, we have a responsibility to address this risk and help mitigate bias and inequity in the services we provide.

00:15:15
Advancing EDI is an ongoing journey, and we have a number of initiatives underway. Last year we launched our EDI strategy to support this work and recently included EDI as a key component of our strategic plan. Throughout 2022, we provided CMPA Council members and the CMPA leadership team with comprehensive EDI and anti-bias training. To support reconciliation, we've consulted with indigenous leaders and stakeholders, exploring culturally sensitive approaches to the resolution of concerns arising from medical care. We are exploring restorative approaches to healthcare harm in the medico-legal environment.

00:16:13
Finally, we're in the process of hiring an EDI strategic lead, who will directly report to me

and help us strengthen our EDI activities. I look forward to continuing our work and strengthening our ability to provide members with fair, equitable and inclusive support. Jean-Hugues. (End of translation)

00:16:40
Jean-Hugues Brossard: Thank you, Lisa. As part of our efforts to be a modern organization, we're also looking at our governance model. At our last annual meeting, a motion was passed for the CMPA to review our governance processes. This motion was very timely as the Council had already begun working with CMPA management to examine our governance model. In fact, this work is a key area of focus in our new strategic plan.

00:17:21
We know the world is changing and we need to adapt. In order to continue to meet the needs of our members and deal with the challenges that come our way, we need a governance model that is modern and agile. We are now midway through a two-year review process to help us update our governance model. We're looking at everything about our governance including the size, the composition and role of our Council and the makeup and focus of our committees.

00:17:58
To help us, we've hired an expert governance consulting firm, Watson Advisors, who have years of experience helping organizations implement modern practices and strengthen the function of boards and councils. Working with Watson, we've developed a robust business case to modernize our model. We've completed an extensive environmental scan, looked at models for stakeholder and medical malpractice organizations from across Canada, the UK, Australia, and the US.

00:18:45
Our Governance Committee has met regularly 11 times, it appears, and we continue to engage with Council. And we've gotten to the stage where we want your input. Starting this fall, all members will have the opportunity to let us know what they think of our current governance process and what they think should change. You will be able to do this by filling out a survey which will be sent to you by email.

00:19:18
Changing our governance model won't be easy or rapid due to the unique nature of the CMPA, but we are committed to outlining a plan for you to vote on at our 2024 Annual Meeting and we are on track to making this happen. The two key takeaways are that our efforts to modernize our governance model are well underway and that we need member input. Stay tuned for more on this in the fall.

00:20:00
Change of topic. Part of our role is to advocate for the system enhancements that allow our members to focus on providing safe medical care. In a time when governments are contemplating significant changes to the healthcare system, our voice is an important

part of this conversation.

00:20:25
In 2022, we partnered with stakeholders to shape policy on issues impacting patients, physicians and the medical liability system, with a focus on virtual care and medical assistance in dying. We held 397 meetings with stakeholders and sent out 38 submissions to governments and medical regulatory authorities advocating for changes to improve the practice and the practice environments of physicians and the safety of care.

00:21:03
We know that when we collaborate with healthcare organizations we are helping to build a stronger healthcare system and we know that collaboration in healthcare is the way of the future. Lisa. (End of translation)

00:21:27
Lisa Calder: As one of Canada's largest providers of medical continuing professional development, in 2022, we delivered evidence-informed education as a benefit of membership. Our educational products range from fundamental medico-legal concepts to targeted offerings to help members in specific specialties practice safely. We even offer personalized educational advice to members who are facing recurrent medico-legal events.

00:22:08
In 2022, we delivered fundamental medico-legal education to residents at all 17 faculties of medicine in Canada through our CMPA Patient Safety Primer workshop. With the wind down of our subsidiary Saegis, we transferred five learning resources into CMPA's education portfolio, reinforcing our commitment to learning. We continue to modernize the delivery of our learning products to provide members with relevant and easy to access learning resources to help enhance the safety, reliability and quality of healthcare.

00:23:01
Further towards our goal of modernization, in 2022, we used our medico-legal data in new ways and enhanced how we share research and insights with members and stakeholders. We created 66 analytical reports in response to member requests for medico-legal information, supporting patient safety, research and knowledge sharing.

00:23:37
To enhance patient safety, we created a new product called Know Your Risk. This product allows physicians to go to our website and see the main drivers of medico-legal risk for their type of work. The Know Your Risk product also directs physicians to pursue learning opportunities including workshops, eLearning activities or a Good Practice resource.

00:24:08
We also published peer-reviewed articles on medico-legal topics relevant to our members. For example, our research into diagnostic delays in sepsis was published in Critical Care and received significant media pickup, with articles appearing in La Presse Canadienne, La Presse, Profession Santé and Le Devoir. Our aim in sharing our research is to help members enhance the safety of their care and reduce the risk of harmful events. Over to you, Jean-Hugues. (End of translation)

2022 Report of the Audit Committee

00:00:02
Jean-Hugues Brossard: (Voice of Translator) Now let's take a look at our financial information. We'll start with a message from Dr. Michael Curry, chair of the Audit Committee who I will invite to join us on stage. Welcome Michael. (End of translation)

00:00:27
Dr. Michael Curry: Thank you, Jean-Hugues, and good afternoon everyone. (End of translation)

00:00:32
The Audit Committee is comprised of five members of council in addition to two external financial experts all of whom are independent of management. The committee meets quarterly to ensure its duties are discharged in an appropriate manner consistent with good governance and sound operational procedures.

00:00:50
As chair of the Audit Committee I am pleased to report on our activities with respect to the 2022 financial statements which have been prepared by management and audited by the accounting firm KPMG. The audit committee has reviewed these statements with management and with the auditors, KPMG, attest that the CMPA's statements properly present the results of operations in 2022 and the financial position of the Association as of December 31st, 2022.

00:01:26
Our chief financial officer Cory Garbolinsky, has prepared a video which show – which shares our 2022 financial report. Those of you listening in English will hear Cory directly while those of you listening in French will hear the voice one of our translation professionals. Let's watch the video now.

2022 Financial Report

(Video presentation)

00:00:05

Cory Garbolinsky: The CMPA has a responsibility to maintain sufficient funds to support our 109,000 plus members and on their behalf compensate patients proven to have been harmed by negligent care today, tomorrow and well into the future. Today, we will look at the CMPA's unique financial model that supports our long term financial horizon and summarize our 2022 financial performance.

00:00:36
As we discuss our financial model and financial performance today, there are four key principles to keep in mind. One, the CMPA provides ocurrence-based protection. This means that physicians are eligible for CMPA assistance at any time in the future, even when they are no longer active CMPA members, as long as they were members when the care was provided. As a result, we must hold funds to support members and compensate patients up to four decades from the time the care was delivered.

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Two, members pay the expected cost of their protection through yearly membership fees. This means that in 2022, we collected the membership fees needed for the estimated cost of protection for all occurrences taking place in 2022, for the next four decades.

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Three, the CMPA is a not-for-profit member-based organization. As a not-for-profit, we do not seek to generate a profit. Our financial goal is to hold at least $1 of assets for every dollar of liability to appropriately compensate patients and support physicians.

00:01:57
Four, the CMPA financial model is self-correcting. Sometimes our actual year-end results differ from our estimates creating an excess or a deficit in our net assets. As a not-for-profit, we are not allowed to pay dividends to our members, but we can increase or decrease our membership fees from year to year to address the difference.

00:02:22
Our financial model consists of several interconnected components: our net asset position, membership fees, medical legal costs, the assets needed to pay outstanding and future claims, and our investment portfolio. Let's take a look at how they are connected.

00:02:43
Our net asset position is the difference between the total assets of the Association (which is primarily the investment portfolio) and the total estimated liabilities (which is primarily the amount needed for future and outstanding claims) and is a key factor in determining the membership fees in any given year.

00:03:05
Membership fees are used to pay the medical legal costs of supporting our 109,000

plus members and compensating patients on their behalf. The changing trends in medico-legal costs, such as the cost per case and volume of new cases, shape the size of the assets needed for future and outstanding claims. This is the amount of money needed to appropriately compensate injured patients and manage future legal and administrative expenses. Our diversified investment portfolio earns income to ensure we can appropriately compensate patients and fund future medico-legal expenses to support our members.

00:03:50
Now we'll turn to our financial performance in 2022, starting with our net asset position. As of December 31st, 2022, our net asset position decreased by $560 million from 2021 to $1.1 billion. This decline was in part by design as we significantly reduced membership fees in 2022 to lower our net asset position, which was higher than ideal in 2021. The decline was also a result of unplanned loss in our investment portfolio caused by an overall decline in global financial markets. We'll look more closely at the investment loss a little later.

00:04:42
Fee reductions were $99.5 million in 2021 and $200 million in 2022. For the current year reductions were $362 and a half million dollars or a total of $662 million in membership fee reductions since since 2021. The total membership fees collected in 2022 was $416.6 million. Through prudent adjustments to membership fees, we aim to stabilize our membership fee structure over time. We strive to maintain long term fee stability, but our ability to do so is in part determined by the performance of our investments which are managed carefully but subject to market fluctuations.

00:05:33
Membership fees help pay towards medico-legal costs, which we will look at next. Medico-legal costs include compensation to patients injured as a result of proven negligent care, legal and expert fees, safe medical care education programs and the cost to run the Association.

00:05:53
Compensation to patients is the Association's single largest expense. In 2022, on behalf of our members, we paid $279 million in compensation to patients. While the total compensation amount varies from year to year, the CMPA has paid a total of $2.29 billion in patient compensation over the last 10 years, or an average of $229 million per year. The legal costs over this same 10-year period were $1.8 billion.

00:06:33
It's important to note that compensation to patients is not equal across our four fee regions. Ontario represents 40% of our members, but this fee region has the highest legal fees and compensation amounts awarded to patients, so it represents more than 50% of our annual costs.

00:06:55
Due to these regional cost differences, members pay different fees depending on their fee region. Each fee region is independent and there is no subsidization between regions. Therefore, members in Ontario pay higher fees than their colleagues in other fee regions. Similarly, members in Quebec pay the lowest fees in the country due to lower medico-legal costs in that region.

00:07:28
The assets needed for outstanding and future claims are the sum of the estimated future medico-legal costs resulting from the care provided by our members up to and including 2022. For care delivered in 2022, we ensure we have funds available to cover any expense related to care in that year for up to four decades. As of December 31st, 2022, the estimate for all outstanding and future claims was $4 billion, an increase of $36 million from 2021 based on updated cost trends. Compensation to patients accounts for approximately two thirds of this $4 billion amount.

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To provide impartial oversight of our actuarial calculation, we engaged an external peer reviewer, Ernst and Young, to perform an independent calculation which strongly aligned with our own. This was then audited by KPMG as part of their external audit of the CMPA's financial statements.

00:08:42
Our investment portfolio is modelled closely on the estimated payment pattern of future and outstanding claims. We target our investment portfolio to match or exceed a 5% investment return over the long term. However, over the past 10 years, we have achieved exceptional returns on our investment portfolio, earning a 7.96% compound annual return.

00:09:08
In 2022, the investment portfolio had a net value of $5.4 billion, a decline of $485 million from 2021. The reduction in our investment portfolio can be attributed to an overall decline in the financial markets and fee reductions in 2022.

00:09:31
Our positive financial position will help us to weather volatile financial markets, fluctuating medico-legal case volumes and costs, and the recent high inflation environment. We continue to invest responsibly to maintain an appropriate financial position that ensures timely and appropriate compensation to patients on behalf of our members, protection and support to physicians, and safe medical care learning and research to support patient safety. If the financial market volatility continues, our financial position may be further impacted which could lead to future increases in membership fees.

00:10:13

As I conclude my financial update, I'd like to summarize three key takeaways. First, due to our occurrence-based protection, the CMPA operates with a long-term financial horizon of up to four decades, allowing us to protect members and compensate patients today, tomorrow and well into the future. Second, fee increases or decreases are the primary tool used by the CMPA to manage our overall net asset position. And finally, our positive net asset position in 2022 should provide confidence to members and their patients that we are there for them when needed. Thank you.

(End of video presentation)

2024 Regional fee requirements

00:00:02
Lisa Calder: Each year we set membership fees to support the financial sustainability of the CMPA while striving to keep fees as low as possible. Membership fees in each of our four fee regions are set in accordance with the estimated medical legal costs per region and the region's financial position. These medical legal costs are calculated each year and include the estimated costs to compensate patients and support our members for the next four decades. Each region's cost trends combined with the CMPA's overall investment performance influence its financial position. If the cost trends rise above our estimates, then the region's financial position is negatively impacted and vice versa. We are committed to containing growth and medical liability protection costs and aim to support relative long term membership fee stability.

00:01:10
While the CMPA as a whole closed 2022 in a positive financial position, it was lower than anticipated. This is due in part to lower investment returns and increased medical legal costs which include compensation to patients. To ensure that we have sufficient funds to support our 109,000 plus members and compensate patients on their behalf, most 2024 membership fees will increase from their significantly reduced levels in 2023. The exception is Quebec where membership fees will remain the same.
As a reminder we reduced membership fees by 45 to 90% last year depending on the fee region. These reductions were the result of fee credits that we applied due to our very strong financial position in 2021.

00:02:13
As mentioned, the CMPA has four unique fee regions in response to the regional cost differences across the country allowing for an equitable allocation of costs. The four regions are British Columbia and Alberta, Ontario, Quebec and Saskatchewan, Manitoba, Atlantic provinces and the territories. Each region is independent and there is no subsidization between regions. For example, if one region is in a positive or negative financial position this does not impact the other regions.
Depending on the financial position of a fee region we apply fee credits or fee debits which you will see shortly. The total cost per region is the amount to be collected in each region. The average fee per member is an illustrative number that is the total cost per

region divided by the number of members in that region. It is only an average and not an actual membership fee. When determining membership fees, we first calculate the total cost for the region and use this as the foundation to determine regional fees based on the type of work.

00:03:38
I will now share the 2024 regional fee requirements starting with British Columbia and Alberta.

00:03:49
The forecast medical legal costs for 2024 in BC and Alberta is, on a per member basis, $5,071. This cost has been relatively stable year over year. After several years of significant fee reductions and recent lower investment returns the financial position of the region is now at an appropriate level.
As a result, you can see that the 2024 average fee per member is now in line with the estimated cost of protection which is $5,071.

00:04:32
When we look at the five-year trend you can see that while the average fee per member is more than last year, it remains less than in 2019 and 2020.

00:04:48
In Ontario, the cost of providing medical liability protection is greater than in any other region and this is reflected in the membership fee.

00:05:06
The cost of providing medical liability protection in Ontario in 2024 is forecast to be an average of $6,853 per member. Again, this cost has been relatively stable year over year though it is trending upwards. The Ontario region is much closer to a deficit position compared to last year so membership fees will increase. This means the average fee per member in Ontario is $7,287.

00:05:43
Looking at the five-year trend, you can see that the 2024 average fee is close to what it was in 2021 and less than in 2019 and 2020.

00:06:01
The Quebec fee region currently has the strongest financial position of all fee regions and its medical legal costs have not weakened its financial position.

00:06:15
Therefore, we are continuing to offer significant fee credits in this region. While the expected cost of protection per member in Quebec is $3,998, once our fee credit of $3,774 is factored in the average fee per member is $224.

00:06:46
This is a 1.5% decrease from 2023 and by far the lowest of all fee regions, it is also significantly less than previous years. For example, in 2019 the average fee requirement in Quebec was $2,387.

00:07:09
I will now turn to Saskatchewan, Manitoba, the Atlantic provinces and the territories.

00:07:20
This region is in a positive financial position, and we are not expecting a significant rise in medical legal costs. The estimated cost of protection in 2024 is $3,703 yet we are able to offer a significant fee credit of $3,008, meaning the average fee per member is only $695.

00:07:50
While this is an increase from 2023, you can see that it is significantly lower than it was in previous years.

00:08:07
As you can see, there are significant regional differences in protection costs with Ontario being the most expensive region. The CMPA is committed to charging members only those fees required to provide effective medical legal protection through a sustainable model that gives our members confidence that assistance will be available to you in the event of a medical legal difficulty. We will continue to modernize and enhance our Member Services to maximize the value we deliver to you, our members.

00:08:46
Having shared the average fees per member, here is an example of the actual membership fees for family physicians practicing in type of work code 35 which is our largest type of work code.

00:09:09
The full listing of 2024 membership fees is now available on our website. You will be notified by email in the fall when the annual invoices are available on our website via the secure CMPA member portal. Our financial sustainability should assure members that we will continue to be there for you and compensate patients on your behalf today, tomorrow, and well into the future. Thank you.

2023 Council election results

00:00:06
Lisa Calder: (Voice of Translator) I have good news; I would now like to share our 2023 Council election results. Each year approximately one third of our Council positions are scheduled for nomination and election. This year nine Council positions were up for nomination and election in seven areas. Voting occurred in Alberta and Ontario. In the

remaining areas, the candidates were elected by acclamation.

00:00:35
It is my sincere pleasure to present the 2023 Council election results. We congratulate and welcome our new members of Council, Jugpal Arneja, Nicole Damestoy, Heather Scott, Jill Cunniffe and Paula Cashin. And congratulations to our re-elected councillors, Wayne Rosen, Katy Shufelt, Birinder Singh and François Mercier.
We welcome the diversity of the candidates who submitted their names for election and thank all who participated.

00:01:15
Now I'd like to thank our six departing council members: Michael Cohen who served as CMPA president, Alexander Barron, Alfred Bent, Patrick Bergin, Victor Huckell and Claude Mercier. It's been a true pleasure to work with each of you and I thank you for your commitment to the Association and to its members during your tenure as CMPA councillors. Over to you, Jean-Hugues. (End of translation)

00:01:52
Jean-Hugues Brossard: (Voice of Translator) Before we move on, I'd also like to express my thanks to our departing councillors. It's been a pleasure and an honour to work with you. I also want to welcome our new Council members; I look forward to working together with you even though it may only be for one year since there is one year remaining to my term. (End of translation)

Q&A for members

00:00:00
Jean-Hugues Brossard: (Voice of Translator) I would now like to move on to the long awaited question period. So if you would like to ask a question please remember that only active members can ask questions. Individuals who ask questions will be identified in the meeting's minutes. If you are here in person, please proceed to a microphone or use Slido on your phone. And if you are joining us online, please use Slido to ask your question. I've asked to Dr. Todd Watkins and Dr. Pamela Eisener-Parsche to assist me in managing questions from the floor and online. So please, as I said, use the microphone if you are here with us and let us know where you're from. And now over to you. (End of translation)

00:01:08
Dr. Todd Watkins: Thanks, Jean-Hugues, and good afternoon everybody. We have a few questions that have come in online, the first is from Dr. Nasser from Ontario, he actually has two questions that are related. The first is taking into consideration the amount of compensation and the cost of medical legal challenges. Can you share if the CMPA gets any income other than that return on investment and the membership fees? That's question one.

00:01:34
The second question is, membership fees are different in the four regions. The question is related to whether or not there are differences in the fees at specialists and different type of work pay across those few regions and that speaks to our risk grouping.

00:01:52
Jean-Hugues Brossard: Yeah, Cory you want to…

00:01:55
Cory Garbolinsky: Sure, I can take the answer to the – or provide the answer to the question on our sources of revenue. So primarily it is obviously membership revenue and the investment returns that we receive on our portfolio. We do have a one third investment in Salas Global along with Hirak and the SOGC. So the share of their net income also represents some of our revenue in the year but it's rather small compared to the other two items.

00:02:28
Jean-Hugues Brossard: And the other question.

00:02:29
Dr. Todd Watkins: So the other question, Jean-Hugues, was related to how the aggregate fees are distributed amongst specialists.

00:02:38
Jean-Hugues Brossard: Yeah, so essentially the fees are agile., Each region are showing the fees among the specialists and general practitioner depending mainly on the risk and the cost for the region in fact. So the structure, there's seven risk group and the cost of each risk group is analyzed by per region and the fees are adjusted for those seven risk group in each region and it's done yearly and it's we have all those analyzes over time to see what are the trend, the change and we're reanalizing those risk group every two or three years to make sure that they are current and we are redistributing specialties among those risk groups depending on the change that are observed.

00:03:38
Question: Hi, thank you. Wayne Rosen, I'm a councillor from Alberta. Thank you very much for the presentations this afternoon. I should know the answer to this but every time I'm impressed by the difference from the Quebec fees to the rest of Canada and I just wonder if you can provide some more colour as to why they're – what is the difference? Is it the number of cases that are brought, the awards that are made, a combination of both? Is there a significantly different culture, a medical-legal culture there that you can use to explain that?

00:04:13
Jean-Hugues Brossard: Yeah, I will begin but maybe other will complete my answer. First I want you to look again at the number that were presented for 2024. The cost of protection in Quebec was not the lowest. In fact the other region, that SMAT region was

a bit lower. So Quebec does not have – they have the lowest fee because the financial position is quite favourable in Quebec and we have an excess of assets that we are pulsing back into the (inaudible) into the fees to decrease that excess of asset.

00:04:53
But in fact the protection here is not the lowest anymore. There's some difference, difference are not mainly in the volume but they are mainly in the level of our work I would say and I don't know if you, Dom, then want to comment on that.

00:05:09
Domenic Crolla: Thank you. I think I would say that the Quebec medical-legal environment is different from the rest of the country. There's a lower frequency and severity in the civil litigation. The regulatory environment is actually conversely more active than some other ones but even there it's different because of the way that regulatory matters are dealt with between hospitals, colleges. So I would say that and yet again evidence of a distinct society.

00:05:42
Jean-Hugues Brossard: Lisa, you want to add something?

00:05:44
Lisa Calder: The only thing I would just emphasize is that eventhough the fees are lower and Jean-Hugues is right in parts it's because that region has been well financed and the costs of medical-legal protection have not gone up as significantly as you've seen in Ontario, for example. But it doesn't mean that we are not actively engaged in Quebec.

00:06:03
So we are actively, and even just you know yesterday had a conversation with the CMQ about you know new legislation coming in that's really going to transform the health care system in Quebec. So we are very much engaged in those conversations with many of the federations and organizations in Quebec and we also offer many learning resources to our Quebec members in French which are benefits of membership as well.

00:06:37
Jean-Hugues Brossard: Something in line – online?

00:06:38
Dr. Todd Watkins: We have another question from Dr. Chowdhury. He asks, it's related to equity, diversity and inclusion. What are CMPA's plans on having physician advisors from different backgrounds including different provinces?

00:06:54
Jean-Hugues Brossard: Pam.

00:06:56

Pamela Eisener-Parsche: (Voice of Translator) I'll start, and good idea. (End of translation)

00:07:02
Excellent question and it is one that we have been discussing and working with for a number of years. In fact for a number of years we have been recruiting physician advisors from across the country and from different disciplines of medicine, it is important that we have diversity in terms of practice location, practice environment and the type of discipline that our physician advisors have practiced in so that we have that deep understanding of members needs. We will continue to do that and we now have a representation of physician advisors who between them have practiced in every province in the country.

00:07:36
In addition to that we have been working hard to increase representation in our physician advisor group and have had some significant success in increasing representation from the perspective of race, gender, gender identity, LGBTQ community membership as well as ability. And so this is something we're continuing to strive for to increase that diversity within the pool and we've seen some significant success in the last couple of years. Thanks.

00:08:07
Jean-Hugues Brossard: Thank you, Pam.

00:08:10
Dr. Todd Watkins: Jean-Hugues, the next question is from Dr. Chude from British Columbia. They're asking what is CMPA doing to advocate for IMGs to transition more easily in a timely manner into the Canadian healthcare system? It might be a good question for Armand.

00:08:25
Jean-Hugues Brossard: I think it's – yeah, it's Armand who is our specialist in that.

00:08:32
Armand Aalamian: Thank you. So that's an excellent question as well. I think the first thing that we have to do is to be a member of the international medical graduate community is to be a member of very diverse community, I think that's the first part is to recognize that and the fact that if you are an international medical graduate it doesn't mean that everybody has the same needs or the same issues that has to be dealt with.

00:08:57
So the first step is for us to make sure that our physician advisors who are in direct contact with international medical graduates understand that complexity, diversity and also address those in a culturally sensitive and appropriate manner. So that's a step that we're taking a very concrete step in terms of addressing that piece.

00:09:17
The second part of that is within learning in terms of trying to understand what are the elements that we need to integrate and to give the tools for international medical graduates depending on what the needs are within that diverse community that I mentioned and this is what we're doing currently, learning, we're doing a needs assessment and trying to understand what are the resources and some of the preliminary results which are not surprising to us is that there are in fact a lot of resources out there that are not coordinated, that are not used in an effective way and there's no one or ones that are taking the responsibility in terms of that coordination.

00:09:52
So what we're doing is in fact trying to see who are the partners that we need to collaborate with, to work with and try to identify for example, some examples would be the Royal College of Physicians and Surgeons, College of Family Physicians, Medical Council of Canada, etcetera, different – and different colleges, medical regulatory authorities in terms of understanding how we can better collaborate so that we can respond to the needs of the international medical graduate community. And as we all know, that number in terms of our IMG colleagues is increasing rapidly and is going to likely increase even more in the short interval as we look at.

00:10:41
Jean-Hugues Brossard: (Voice of Translator) Thank you, Armand. Any other questions here in the room? (End of translation)

00:10:53
Question: (Voice of Translator) France Proulx, psychiatrist here in Montreal, I'm amongst the lucky few who pay very little in fees apparently. So, thank you very much for holding this business meeting in French, we really appreciate it. My question has to deal with the fact that there will be changes to our governance in 2024, if not 2023. Are we expecting any impact on our administration costs since I assume governance changes could have an impact not only on the ability and agility that we expect from the CMPA, but I'd like to know what impact this will have on our costs. (End of translation)

00:11:42
Jean-Hugues Brossard: (Voice of Translator) It's possible. I would not want to anticipate what those changes will be, will there be fewer committees, a smaller board, we're not quite sure what will happen, but it's possible that some of those changes will have an impact on our governance costs. And I'm not anticipating a larger board or more committees, so if there is an impact on cost it could be trending lower. However, I'll say that overall governance and management costs are a pretty small percentage of our overall costs, I think it's 3 to 5%. (End of translation)

00:12:38
Lisa Calder: (Voice of Translator) One thing I would add is that one item that can have an impact on governance costs is the fact that we adopted a hybrid approach to our meetings. In the past, before the pandemic, everybody came from across the country to

all our meetings and that's quite costly, especially now.

00:12:55
So now we have a hybrid approach. Most of our meetings are virtual, but for important meetings, we have in-person attendance, so this helps us mitigate costs. And we're also looking for approaches that will help us contain costs in the future. But as Jean-Hugues said, we're not sure what to expect from the conversation regarding our governance model, but we are keeping an eye on costs for operations in general because we know that has an impact on our members. (End of translation)

00:13:31
Jean-Hugues Brossard: (Voice of Translator) And our governance costs have been reduced thanks to the hybrid model, and the pandemic taught us that we can do things differently. What seemed impossible in 2018 suddenly became very possible. It's quite incredible. (End of translation)

00:13:53
Dr. Todd Watkins: We have another online question, Jean-Hugues. So from Dr. Shannon Fraser from Quebec asks, could you please elaborate on the 38 government advocacy projects you mention in the report given the context of today's plenary session related to resource deficits?

00:14:11
Jean-Hugues Brossard: Lisa.

00:14:14
Lisa Calder: Actually I was going to hand that over to Todd because (inaudible).

00:14:16
Dr. Todd Watkins: Oh, I can only ask the questions. I don't give answers. No, I'd be happy to. So it's a very good question actually. We have a new department that we created over a year ago called strategic engagement and advocacy led by Dr. Rob Johnson at the back and the intention on creating that department was for us to have a purposeful approach to all of our advocacy efforts and our stakeholder engagement efforts.

00:14:44
Prior to the creation of the department we didn't really have that ability to have a purposeful engagement and we've now been able to do that. So the number of submissions that we've made have increased, our ability to work with you as partners and others has been enhanced.

00:15:00
Specifically related to the advocacy, we have advocacy to governments as mentioned but also to regulators and there are some regulators in the room, and we thank you for being here, as well as medical associations, specialty societies now there's across the

country.

00:15:16
The area where we probably provide the most input is on the deregulatory side. So the the colleges across the country provide consultation opportunities on a variety of issues related to the policies of the regulator and we take those opportunities within our lane and where we feel we have something to say to be able to provide influence.

00:15:38
As it pertains to government there are a variety of different changes that are occurring across the country as well. The MAID legislation was mentioned in the slides, that's one where we've been very, very active over a number of years both in Quebec and federally with respect to the implementation, the changes in the MAID legislation, that will continue.

00:15:57
Bill 60 in Ontario for those who are from Ontario, the as-of-right legislation related to collaborative care, bringing in additional health care providers in the province as well as the opportunity to move care into the communities in public private partnerships have implications for physicians, have implications with respect to safety and those are areas where we've tried to enhance our input into the clarity around that legislation. So there's a variety of different places and I could give you other examples, I'm happy to offline.

00:16:32
Jean-Hugues Brossard: Lisa.

00:16:33
Lisa Calder: Yeah, just to add specific to Quebec is around Bill 15 which our Quebec members are all too aware of. This is something that we have been speaking to all of our partners about and we're actively engaged in conversations with the Quebec government as well as with our stakeholders as to the implications and implementation of this legislation.

00:16:51
So it is something that we are very mindful of. As resources become more restrictive what we're seeing across the country also is changes in scopes of practice. So that's something that we are aware of and where there's opportunity for us to advocate in those areas we will advocate and identify in particular any potential medical-legal risks, we find sometimes there are assumptions that physicians will bear the medical-legal risk for other health care providers and that's an area that we often will provide clarity on.

00:17:26
Dr. Todd Watkins: I think we have time for one more question perhaps?

00:17:28
Jean-Hugues Brossard: Yeah, yeah.

00:17:30
Dr. Todd Watkins: It's related to what are the risks the CMPA sees in the medical-legal environment going forward?

00:17:39
Jean-Hugues Brossard: Oh. Lisa, you want to tackle this one?

00:17:43
Lisa Calder: Oh where to start? You know I think that the one thing I'll say is that we know it is really tough to be a doc right now. And you know the practice environment, the stories we hear from our members every single day certainly give those of us who are physicians pause and think about how do we support our members in this environment. And we very much have a risk orientation, right, that's what we look for, that's what we see.

00:18:09
And I think looking ahead for physicians, you know we had our information session talking about restricted resources, working within systems that increasingly are not functioning the way that they should creates risk. But at the end of the day when you look at our medical-legal cases the recurrent theme that continually leads to complaints both at hospital, the regulatory body and in civil legal cases is around communication.

00:18:36
And what we know as human beings when we're stressed we don't communicate as well. And so that continues to be the biggest risk for physicians moving forward is how you're communicating with your patients, with your colleagues, if you're in a hospital with administrators because we know when you're stressed that your communication may not be your best.

00:18:56
So if anyone's looking at to think about how do I mitigate my medical-legal risk I would encourage you to take a growth mindset and always know we can always become better communicators. We offer education programs on communication, you can also get education on how to communicate better in lots of different places but I encourage you to think about that because that is the leading issue and it will continue to be an issue as the healthcare system struggles.

00:19:26
Jean-Hugues Brossard: Todd, do you want to add something?

00:19:27
Dr. Todd Watkins: Maybe I could just add a couple things and turn to Dom for some concluding remarks on this. As it pertains to the medical-legal environment and what we're facing as an organization I think that it's very dynamic and changing and Dom can speak to this probably changing faster than then we've seen in forever. We've seen as

you've heard growing damages. Thankfully we have not a growing number of cases but those cases are more expensive.

00:19:57
We have increasing costs of defence associated with those cases and our goal is to maintain the quality of defence that we've always had and continue to improve that. But there are many unknowns in that, one would be inflation and the impact of inflation going forward. We haven't fully realized the impact of the pandemic yet with respect to medical-legal costs. We've not seen a big bump as a result, in fact there was a maybe a downward pressure during the pandemic. But across Canada and across our med mal partners across the world we've not yet and they've not yet seen the full impact of the pandemic.

00:20:35
We've talked about collaborative care and collaborative care hasn't driven increased medical legal risk for us but that continues to change and evolve. Of course on everybody's mind is artificial intelligence, the impact that will have on the profession, we don't yet know what will happen there. So there are a variety of drivers that are unknown for us that create uncertainty and maybe Dom wishes to speak to some of the uncertainty in the courts.

00:21:01
Domenic Crolla: Well I'd like to give you a legal smiley face to answer that question but the fact is that we are actually in a period of considerable uncertainty. There are some real signs that the medical-legal environment is undergoing some stress in response to the things that both Lisa and Todd have spoken about.

00:21:23
The legal system takes time to respond to social change and so we are seeing social change, whether it's virtual care or the effects of the pandemic we are starting to see signs of that in the decisions that we're receiving from courts. Certainly severity is up, dollars per case and civil litigation is up in a number of regions in the country.

00:21:48
We are also seeing some novel theories of liability being presented by plaintiff's lawyers and occasionally accepted by courts which is concerning to us because medical-legal principles generally have been thought to adapt well over time. So we're wondering about whether the legal norms are changing.

0:22:10
And if we look outside of Canada it's concerning because there is real evidence of significant increases in damages and theories of liability in the UK, in the US and elsewhere. So on the theory that some of that might spill over here I think we do have reasons to be concerned and that doesn't mean that we need to panic but it means we need to be ready.

00:22:38
Jean-Hugues Brossard: Thank you. (Voice of Translator) One last question from François and then we will proceed. (End of translation)

00:22:49

Question: (Voice of Translator) Dr François Mercier and I am one of the members of the Council for Quebec. We know right now that in Quebec there is a problem with the family physician resources and there have been a number of physicians that have moved to the private market, possibly due to financial incentives. How does the CMPA's senior leadership view this situation, namely the migration of physicians to the private sector that's quite significant? And do these physicians have the same coverage, the same costs and the same legal concerns? And I'm asking this question with respect to the people who are online and in the room listening to us. (End of translation)

00:23:31
Pamela Eisener-Parsche: (Voice of Translator) Thank you, François says Pamela Eisener-Parsche. (End of translation)

00:23:36
(inaudible, crosstalk) question of referencing whether there are changes in the way that the Association assists members who are practicing in a private environment versus a public health care environment. I agree we are beginning to see some of that transition, François, and I understand the reason for the concern.

00:23:52
From the perspective of the protection of the Association where the physician is practicing whether that's private or public does not factor into our decision making as to whether or not we provide assistance for medical-legal issue that arises. If a physician is practicing in a private clinic and has a medical-legal issue, provided they are members of the Association on the date of the occurrence of the issue, they would continue to receive our protection as they would if they were practicing in the public environment.

00:24:20
If they are working in a public – in a private clinic and that private clinic is also named in an action, that would depend very much on the structure of that clinic and whether or not it meets the principles of assistance that the CMPA has for assistance to clinics. Those are available on the website and we would be happy to take phone calls from members who are facing that situation to guide them appropriately with respect to their clinic. Thank you.

00:24:50
Jean-Hugues Brossard: (Voice of Translator) So that concludes the question-and-answer period. Before we adjourn, Lisa is going to share some thoughts on how the CMPA is looking ahead and preparing for the future as well. (End of translation)

Looking to the future

00:00:01
Lisa Calder: (Voice of Translator) Thank you, Jean-Hugues. As you have heard today, the CMPA has taken significant strides to modernize our ability to be nimble and adapt to change that enabled us to continue to support our members and their patients and the health care system. In 2023, we released our new strategic plan, and this plan will guide our course for the next three years.

00:00:30
I'd like to tell you a little more about the plan now and how it will position us to confidently face further challenges that may be in store. The three guiding actions of the plan are support, strengthen and adapt. These actions will allow us to advance key initiatives, such as creating an even better member experience by making our services more accessible, meaningful and simple to use, enhancing our learning resources, strengthen our use of data to drive safe medical care and applying equity, diversity and inclusion principles to all of our services and developing a better understanding of our members' EDI experiences.

00:01:25
As Jean-Hugues mentioned, we will soon be reaching out for your input on modernizing our governance structure. The long-term success of the Association rests on the proper functioning of our governing body, the CMPA Council. So stay tuned, you will receive an email this fall on how you can provide your valuable input. (End of translation)

Closing remarks

00:00:01
Jean-Hugues Brossard: (Voice of Translator) Thank you Lisa, and thank you to everyone who joined us today, both in person and online. If there is no other business, this concludes the annual meeting. I look forward to seeing you next year at the 2024 annual meeting in Halifax, Nova Scotia. So I declare this meeting adjourned. (End of translation). Thank you very much.

Information session: Caring for patients and yourself amid limited resources

00:00:01
Armand Aalamian: (Voice of Translator) Hello and welcome to the 2023 Annual General Meeting's Information Session presented to you by the CMPA. My name is Armand Aalamian, I practised as a family physician for 30 years here in Montréal. I am currently Executive Director, Learning at the CMPA. Today I have the privilege of being

your host and moderator for the next hour and a half (End of translation).

I'd like to introduce the revered leader and knowledge holder, Amelia Tekwatonti McGregor. Elder McGregor is a Mohawk from the Bear Clan, Kahnawà:ke Territory. She's a founding member of the Kahnawà:ke Schools Diabetes Prevention Program.

Launched in 1994 this participatory research project pioneered community outreach to stem the increases in Type 2 diabetes in Kahnawà:ke. Elder McGregor has been invited around the world to speak about the project, inspiring similar initiatives in other indigenous communities.

She was recently recognized by McGill University with an honorary doctorate for her vital contributions to health promotion, community education and to expanding fields of indigenous research methodology. Elder McGregor, it is an honour to have you with us today and I will now turn the floor to you for the opening words and opening of our meeting.

00:02:21
Elder McGregor: You mean to tell me I can't keep that?

00:02:23
Armand Aalamian: You can, absolutely.

00:02:29
Elder McGregor: (Indigenous language). I'm welcoming everybody that's here today to the conference here and (Indigenous language) and I'm hoping that everybody is well and enjoying it for the time that we will be here. I'd like to just say a few words before I do the (Indigenous language), the words that come before all else because I ask that it not be recorded* so that I don't know if anybody mentioned it already but because the words that I was given by the CEO and a few other people that they wanted specific things said and so this is the words that I'm going to be adding to what I'm going to originally say anyway.

**The "no recording" request refers to personal recordings using cell phones. Elder McGregor granted permission for the CMPA to record and share her welcome address.*

00:03:27
And that hopefully it's really in our language that we acknowledge all of creation and that we're always thankful to Mother Earth for all that she's provided for us and that's what's in the words that I'm going to be saying. So just so everybody knows ahead of time.

00:03:51
And so if you don't mind, I'll start and I'll say (Indigenous language). My name is Tekwatonti in our language and that I'm thankful to be here today for this, I had to be invited to be here and also I'm hoping that everybody's in good health and also I'll begin

by saying that (Indigenous language). Done, okay.

00:08:27
So just to let you know that as I was saying, that we're giving honour and responsibility of us how we have to take care of Mother Earth, and that we're always reminded every day of all of what creation and what Mother Earth has provided for us, and that I like to say that (Indigenous language). That means that I have also acknowledged the Creator for giving us the good words that we use whenever we meet each other anywhere and that we're all human beings and how we respect each other and so on and so on. So this is what I put in those words that I've given to you today. So I'm hoping that we have a good conference, and I mean it's good so—it's been you know very good so far. So I thank you very much for the invitation. (Indigenous language)

00:09:52
Armand Aalamian: Thank you very much, Elder McGregor. (Voice of Translator) We are gathered here today in Montréal. I would like to acknowledge that the land on which we sit here is unceded and unsurrendered Indigenous land. Tiohtià:ke/Montréal is known as a gathering place by many First Nations and we recognize the Kanien'kehá:ka people as the custodians of the lands and waters of the territory on which we gather today.

00:10:35
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's Ottawa offices are located on the unceded and unsurrendered Territory of the Algonquin Anishinaabe Nation, whose presence here reaches back to time immemorial.

00:11:09
The theme we've chosen for today's session is based on feedback we've received from you, our members. The theme is: caring for patients and yourself amid limited resources. It's hard to imagine - extremely hard to imagine - a practising physician in Canada today who hasn't faced challenges with healthcare resources.

00:11:44
Underlying this theme are the questions, concerns and requests we receive every day from our members, and even more so since the start of the COVID pandemic. It's a theme that is also reflected in the media as we hear more and more about emergency department closures, lack of access to primary care, delays in surgery and even violence against doctors.

00:12:20
The CMPA is listening, and we know how difficult it is for physicians to provide the care they want and how painful it is for them to feel unable to provide it and to provide it well. And of course, one of the questions our members regularly ask is: will I be held accountable for healthcare failures that are beyond my will and my control?

00:13:05
By the end of our discussion this afternoon, we hope that you will be able to describe the patient safety and medico-legal risks in the face of limited resources; that you will be able to list the tools and resources that can mitigate risks when resources are limited; and that you will be able to explore ways physicians can reduce professional distress when providing care amid limited resources.

00:13:45
Given the complexity of these challenges, it's not surprising that there are no simple answers. Today, we've assembled a panel of experts whose experience and points of view can help physicians provide the kind of care they would like to provide.

00:14:12
Before we begin with our panel of experts, I'd like to highlight a few technical details. First of all, the network is Westin Guest (end of translation) for the internet. (Voice of Translator) So that people online are able to respond to questions, we will be using an online polling application called Slido. Online participants will see the Slido box to the right of the presentation window. That is where you will find instructions on how to use Slido.

00:14:58
You can submit a question which will be reviewed by our production team before being made visible to all. You can also vote for someone else's question by clicking on the thumb's up icon below each question. Feel free to submit your question in English or in French, we are bilingual.

00:15:26
We ask that you limit your questions to the topic of limited resources and that you defer any questions related to CMPA business to the business meeting that follows. This event is accredited for 1.5 Mainpro+ credits, and 1.5 hours of Section 1 credits by the College of Family Physicians of Canada and the Royal College, respectively. On the next slide, you will find our panellists' disclosures, including their potential conflicts of interest. This program did not benefit from financial or non-financial support.

00:16:06
I now have the pleasure of welcoming my friend and colleague of 25 years—hard to believe—Dr. Vania Jimenez. She is a Montréal-based family physician, writer, mother of seven, and grandmother to 14 grandchildren. She is also a visionary and cofounder of La Maison Bleue, a non-profit organization that offers multidisciplinary health and psychosocial services to vulnerable expectant mothers and their families.

00:16:44
We also have the pleasure of having with us Dr. Marie-Chantale Brien, director of intervention, prevention and research for the Quebec Physicians' Health Program, a support program for physicians by physicians. Also joining us: Ms. Andrée-Anne Labbé,

partner with McCarthy Tétrault in Montréal, one of the CMPA's partner law firms. She has many years experience supporting physicians and their medico-legal concerns.

00:17:17
And our very own Dr. Richard Mimeault, respected hepatobiliary surgeon, physician advisor and education expert in the Safe Medical Care Education Department at the CMPA. He has designed and delivered transformative training to CMPA members.

00:17:40
I would like you to ask questions either by using Slido or by going to a microphone on the floor. I will give you a few minutes to prepare your questions. Therefore, I will be asking our colleagues a couple of questions. Our first question is for you, Richard. What patient safety and medico-legal risks does the CMPA see and hear about when it comes to healthcare resources? (End of translation)

00:18:27
Dr. Richard E. Mimeault: (Voice of Translator) Thank you for your questions. I see a couple of questions here. What are we hearing in our environment and what are we hearing as well at the CMPA on this front? I'm going to begin by what we are hearing—and I think that we're hearing the same thing as everybody else. But perhaps I see two slightly different situations.

00:18:53
First of all, the lack of human resources, the shortage of physicians, nurses, of all the personnel in our healthcare system. And because of this shortage, physicians have a workload that's much greater, many more patients and they are spending more time at work. The impact of that workload is that doctors are tired; they're tired mentally, they're tired physically.

00:19:26
We also know—and I think that the literature backs us up on this: a tired physician is more likely to make mistakes, perhaps something that could harm a patient and could trigger a medico-legal event.

00:19:52
The other situation associated with the first is the problem with the long wait lists. We're talking about lists to see a family physician, a specialist, a psychotherapist, an occupational therapist, you name it. There are wait lists now for almost everything.

00:20:13
Obviously, we're worried. We're worried that if a patient has to wait an excessively long time on a wait list, then there could be harm done to the patient. We also know that for many conditions in medicine there are recommendations with respect to the wait times. What is a reasonable wait time? Even before the pandemic in many regions of Canada it was hard to deliver service within the recommended timeframe. Since the pandemic, those wait times have become really excessive; in fact, they have become dangerously

excessive.

00:20:57
As a result, as physicians, we are basically facing a dissonance: we want to work in the best interest of the patient and that's, of course, our ethical, our professional duty. But we can't do that. We don't have control over the system to ensure that we're working in the patient's best interest. And that's what's at the core of the professional distress we are seeing right now.

00:21:39
Professional distress—when it happens time and time again—can obviously have an impact and also lead to burnout. We know that a physician facing professional, emotional distress can face complications, could make mistakes, mistakes that can lead to harm and harm that can lead to a legal situation as well.

00:22:16
A patient who has been on a wait list and has been harmed adds to our professional distress, so it's a bit of a vicious circle. And a physician facing distress will try to reduce his or her workload, perhaps on a temporary basis. Or, now, more and more, we see physicians simply stopping to practise permanently. That simply puts an extra burden on our human resource situation, and the cycle continues. There are all sorts of different variations related to these two problems.

00:22:55
What are we hearing? There are wait lists that are very long and the human resource shortage in Canada is a long-standing problem. It existed even before the pandemic, but it's been even harder since the pandemic. Since we have these long wait lists, of course, logically you would think there's going to be a deluge of patients who will be harmed. Therefore, there will be a tsunami of complaints and legal cases. I'm looking forward to hearing what Andrée-Anne has to say on this front.

00:23:30
In my opinion, we have not seen this tsunami of complaints and legal actions. It could be due to long delays in the court system as well. For now, it's hard to know what the courts will do or decide given the current context. (End of translation)

00:24:01
Armand Aalamian: (Voice of Translator) Excellent, thank you very much, Richard. You summarized our discussion very well. Andrée-Anne, let's speak about the medico-legal point of view. We heard that there are possibly risks, concerns. What are the risks physicians need to be aware of when faced with healthcare resource challenges? (End of translation)

00:24:29
Andrée-Anne Labbé: (Voice of Translator) We could spend an hour and a half speaking about risks and that would simply increase everyone's anxiety levels. But I

want to talk about two risks in particular. First the type of request or demand that you will be facing and are already facing, and that you will see even more of from your patients. When physicians see their patients, maybe they are the only physician they will see over a six or 12-month period. They may have a whole list of things they expect the physician to be able to help them with. But the physician may not be able to respond to those requests as they may not be his or her specialty.

00:25:13
More and more, physicians are faced with these demands, and it's a question of navigating between what you can and want to do for the patient, and what you can do in a safe way. These are challenges we are seeing more and more of and they are being discussed even more. Unfortunately, these are the situations that lead to medico-legal situations, for example, the physician either rightly refused or acted on the patient's request when perhaps he or she shouldn't have.

00:25:48
The other area of increased risks we see increasing is the gap in the safety net physicians can have in their practice for various reasons. Richard spoke earlier about limited human resources. That doesn't only include healthcare professionals, but also the administrative staff being called upon to support you in your work and in how you are providing it.

00:26:17
More and more we've heard, oh yes, the follow-up to that situation was not done because the person who was responsible to bring that to my attention is on leave and is being replaced by somebody else who didn't know the system. So it's that type of problem that leads to the safety net not being as strong as it should be. That can lead to a situation, for example, where there's no follow-up on various tests. We see that more and more and I don't think that this situation is going to be getting better. On the contrary. (End of translation)

00:26:56
Armand Aalamian: (Voice of Translator) Thank you very much. Yes, I also saw those types of situations when I was a practising physician. We have all seen them. Thank you. And the next question is for you, Vania. La Maison Bleue is an excellent example of quality improvement for people working with limited resources. What tools and resources were used to achieve this? And my second question for you: what is the Maison Bleue's secret recipe for success? (End of translation)

00:27:40
Vania Jimenez: (Voice of Translator) I'm going to answer your second question first. There is no recipe, all of the ingredients are there, they're present within the healthcare system. The only thing that I could say is the authority to act will have an impact, that's the only thing that I could say with respect to your question about a recipe. But in fact, there is no recipe.

00:28:17
The Maison Bleue was launched in response to frustration. You were speaking about this frustration earlier, that people felt were powerless—a feeling that I had as a family physician delivering babies in the clinic where you and I were working—about a group of people particularly vulnerable.

00:28:48
I felt that at the Jewish General Hospital things were going fairly well with respect to birthing, but then I felt that I was sort of losing track of my most vulnerable patients. I used to think about that every night at dinner time and I was impatient. And one of my daughters in fact took me aside and she said, “I’m tired of you complaining about things. So, let’s do something together.”

00:29:16
She was working as a daycare teacher—so an early childhood worker—and that’s how we started the Maison Bleue project. There are basically three pillars: an interdisciplinary approach that ensures not only a lower risk of losing track of what’s happening, but also a continuity. At the Maison Bleue, the physicians are only “tourists” in a certain sense. By that I mean that each of us works halftime at the Maison Bleue. The nurse works there on a full-time basis, the midwife is also there full time as well as the social worker and educator. The continuity is our safety net.

00:30:07
And the coordinators of each Maison Bleue know all the families. The secretary knows who is coming into the Maison Bleue so it's very rare that we have what you're talking about is basically the loss of files.

00:30:29
So this is what I can mention. So the interdisciplinary aspect and that proximity, people can come to us much easily, we're in hybrid mode and we make sure that we keep a strong tie with the institution. There's no Maison Bleue without the GMF behind, without the CIUSSS behind. So there's an NPO that receives the funding, but the services that are provided are centred, are channelled through the health system.

00:31:08
So behind the system is the CIUSSS, which is well guided, and the risk is highlighted at that point and addressed at that level, and everybody in this scenario approach is in charge of the problems within their own organization.

00:31:29
And the third pillar is the idea of empowering people and our clients. And I must say that, and in response to your question earlier on, Richard, when you asked what we understand by the Maison Bleue clients, the vulnerable clients, I think we would hear less from them, most often because they are the highest victims of these scarcity of resources. And that was a question which our group of professionals asked themselves and decided to grab the bull by the horns and decided to not give in to this feeling of

helplessness. I don't know if I addressed your question, but that's what I can say. (End of translation)

00:32:18
Armand Aalamian: (Voice of Translator) Yeah, of course, if I understood you well, one of the recipes for success is communication into the interdisciplinary aspects, understanding who's doing what is that team effort. That's what I think I understand to be the ingredients of your recipe for success.

00:32:37
Before I move on to the next question, I'd like to ask you another question. How many Maison Bleue institutions are there in Québec? (End of translation)

00:32:45
Vania Jimenez: (Voice of Translator) There are four of them in operation and there's a fifth one that is under construction: we should be inaugurating it by the end of the year or early next year. And I must say as well that the only institutions that can be called Maison Bleue are the ones that we approve, but there are 10 projects underway by the Ministry of Health and they had asked Maison Bleue to assist them in these projects. And there was a bid that was put out, and Maison Bleue is assisting them virtually everywhere in Côte-Nord, Gatineau, Abitibi, and we're working on issues of social perinatality. (End of translation)

00:33:33
Armand Aalamian: (Voice of Translator) Thank you. So you started with one Maison Bleue, which is excellent. Of course, I mean we'd like to have one Maison Bleue institution everywhere, and unfortunately this is not the case everywhere, and our colleague talked about moral distress.

00:33:49
Now, Chantale, the next question is for you. And, Chantale, as a PAMQ leader you are very aware of the moral prejudice and the professional distress that arises as a result of medical practice when you are faced with meager resources. What are you seeing, and what can physicians do to look after their own well being at the same time as they care for the patients? (End of translation)

00:34:17
Dr. Marie-Chantale Brien: (Voice of Translator) Well at PAMQ we are seeing a lot of distress, and sometimes you are at war with your own values when you're trying to provide care, and we discuss with physicians every day experiencing challenges of this nature. And I mean, we don't want to go into counselling which would sound like we are blaming the physician and trying to define the level of responsibility when they're already carrying so much weight on their shoulders.

00:34:51
The first thing is to determine what the role of the physician is and what the role of the

community and the system is. And it's never too easy, because culturally speaking we are always tuned in to feel responsible or we have a very high sense of duty in medicine.

00:35:11
So there are three levels of possible actions and means, and personally I think there is a certain level of customization where we speak with our physicians and we try to see with them what is that way that we can get them to commit to give extra commitment to themselves during their practice. And I think when we find a sense of fulfillment in our work that makes us commit even more on a personal level.

00:35:40
And of course, I am not trying to say that this depends entirely on the physician to reduce the impact of moral distress, no, but individually we're just calling on one another to find that sense of duty. And if we're able to find 20% of this sense in our profession, I think it helps us to shield us from burnout and professional moral distress.

00:36:10
Collectively, I think it's important to give a sense of meaning to the community of workers and I think we also need to call out what's not going right, we should name it and discuss this with our hierarchy, the hierarchy with whom we are working. And also from a systemic point of view, I think things should start from there, we should start identifying and acknowledging that there is more of this distress with our physicians, and I think that will be the first step.

00:36:40
The problem sometimes is simply not acknowledging the problem and not acknowledging it as far as our decision makers are concerned. When there's something as important as a moral distress that comes into play, I think we're able to restore some amount of dialogue, we learn to talk to each other because physicians find themselves isolated when they start experiencing this moral distress.

00:37:06
And like it was mentioned earlier on, we start realizing that some of them are opting for early retirement and I think it's important for us to start discussing these mental situations, these problems with one another.

00:37:27
Now in terms of peer support I think we need to have that sense of community in order to support one another, and this starts with a small discussions in the corridor with your hierarchy and further up as well. I think we are here in our program in order to raise awareness, and our role is to communicate with different organizations working with us, federations, the College, CMPA, the CMA and other organizations and medicine schools so that we can be there to bear witness to your problems and challenges and see how we can act at a macro level by reporting on these issues and raising more awareness.

00:38:14
There are peer initiatives at PAMQ that I will come back to later on if given the opportunity. Thank you. (End of translation)

00:38:23
Armand Aalamian: (Voice of Translator) This is – I think you really raised the importance of talking to peers and also talking to the people in our communities. I think I counted a lot on this when I was practicing. And we have a number of questions coming in through our Slido platform and I'll just check with my colleague to see. Dr. Johnston? I can't see other questions on the screen please. Thank you for your patience, we are experiencing a few technical hiccups. So I'll continue with another question as we wait.

00:39:15
We talked about collaboration, we equally talked about interprofessionalism and all, how all of these issues mesh together. Now when we are supervising practitioners or other colleagues, what are the medico-legal risks at that point in time? Maybe I should address the question to you, Richard. Yes, you can share your opinion on the issue. (End of translation)

00:39:50
Richard Mimeault: (Voice of Translator) Well, this is a question that we can of course share amongst ourselves, but I think I would use the example of our learners, because I think it's the same principle when it comes to supervision. When you're working with learners, as the supervisor there's always that potential of shared responsibility.

00:40:16
Sharing of the eventual responsibility will be highly dependent on the context and environment. A learner would evolve during their residency, and as a supervisor I think I have the responsibility to know as much as possible on the resident, on the knowledge and skills in order to be able to delegate and to assign to them the amount of responsibility required. And the resident has the responsibility on their part to inform me about their experience, their qualifications and their skills.

00:41:01
So as things evolve, the resident begins to evolve, the level of supervision has to evolve as well. And I believe that the key here is to be able to have the necessary level of knowledge to be able to determine the level of supervision that is required, of course through our communication, but it is clear that our residents, third year surgery residents don't have the same level of understanding, of knowledge and experience. So it's important to keep track of the knowledge and experience as you carry on with supervision. (End of translation)

00:41:43
Andrée-Anne Labbé: (Voice of Translator) Well I'll add to that that sometimes in a learning environment that the interventions multiplied, you have the senior residents, junior residents, the bosses, when all of them have different shifts, they have different

things come into play, and sometimes you realize that there's always like the transition period which serves as an opportunity, which creates room for a miscommunication and where there's higher risks.

00:42:13
So it comes back to Richard's point where communication is even more important in these situations: we need to talk to one another about what we've gone out in terms of information on the patient and the family, and sometimes you realize in our files that there has been a loss of significant information that was not reported, not documented as it should have been. Thank you very much. (End of translation)

00:42:39
Armand Aalamian: (Voice of Translator) Just to say that I'm going to be asking the questions in the language that they're received. (End of translation). Whether – this question is actually for Richard. Can you discuss whether written disclaimers within the patient chart to explain the context in which care was provided, such as limited resources, no beds or timely access to care, are recommended or appropriate?

00:43:09
Dr. Richard E. Mimeault: So I'm assuming the question is asking about a kind of generic disclaimer basically saying we've talked about it. I don't think there'd be any harm to a generic disclaimer. However, I think the generic disclaimer in the absence of actually having had that kind of discussion with the patient, and the documentation in the chart that, you know, there are no beds to admit the patient to but, some actual documentation of the context that's existing at that point in time, would probably still be necessary.

00:43:50
I think the generic one, and again I'll be curious to see what Andrée-Anne thinks, but I think the generic one would still put you at risk of being just that, generic, like what exactly was the situation, particularly if the outcome was especially bad for the patient.

00:44:10
Armand Aalamian: Andrée-Anne?

00:44:11
Andrée-Anne Labbé: (Voice of Translator) I believe that we should be more practical in our notes, not just mention that there are no resources or no bed. But I think what I prefer to see in the admissions report that I need to defend, I need to see notes mentioning for instance of repeated calls or repeated follow-ups with the person who's in charge of the beds or the admissions into the hospital.

00:44:46
So I believe it is better to focus on your own actions in that context and to document the different steps you took in order to address the resource shortage instead of just condemning the shortage of resources in that file. (End of translation)

00:45:00
Armand Aalamian: (Voice of Translator) Well, maybe we should specify here that it could have really short documentation, and it's not necessary for you to come up with a really long story.

00:45:12
Andrée-Anne Labbé: And sometimes you just mention the hours, you know and… (End of translation)

00:45:17
Armand Aalamian: Next question is for a Vania. We're constantly asked to do more with less resources and adapt. I have struggled with what can be done to increase resources. Any thoughts about that? What can I do? I'm constantly being asked to adapt, to change, to do more and the resources are limited. Help.

00:45:44
Vania Jimenez: I don't think I have an answer for increasing resources. But I have to say that working in an interdisciplinary context multiplies incredibly the efficiency, the number of interventions that we do. At Maison Bleue we have followed since the opening about 7,000 families just this year, we followed about 3,000 persons, and that's we're just coming out of the pandemic as well.

00:46:24
So I would say that rather than increasing resources, which is the old way of thinking, I would go into doing it differently, doing it the way we're doing it. I don't think we have a magic wand to increase resources. But in that situation, you have to think outside the box and see in what way focussing on what you want to attain.

00:46:55
So in some way, and I'm coming back to your question, Armand, which is the learners. I think the thing that Maison Bleue does is really get them out of their usual very piecemeal way of thinking and getting them out of “you don't have to work that way, you can be like in a family”. Like Maison Bleue, the atmosphere is the same sort of chaos or complexity as in a large family when the people come there.

00:47:36
So the learners, they see that there is a way of doing safe medicine in a different way without being stuck in the feeling of impotence that we have. So essentially I would say that, and what we do is – and I realize as I'm presenting – we are very much in prevention. So we are acting, we are effective.

00:48:09
We've had two evaluations which say, and it's epigenetics, that's the reason I did this, what's around influences the DNA of the baby to be, so that's the reason we've done this. We've cut by almost half the late prematurity, almost by half by small for gestation

and age compared to Montréal. It works. And you don't have to put more resources, just do it differently. So that's my – I can't answer the increasing of resources.

00:48:45
Armand Aalamian: You answered beautifully. That's exactly… (Voice of Translator) I really like the emphasis on the new generation of residents so that you can listen and implement these different tips in order to find solutions to complex challenges and problems ahead of you. Thank you very much, Vania. And maybe I'll just follow-up on that question, Chantale, and ask you the following question.

00:49:13
In order to have space to reflect, to brainstorm, and to be able to be creative, I think we need a space to be able to do that. So what do we do? How do we go about it? Sometimes we are so stuck that it is hard to even breathe. So what do you do at that point in time? (End of translation)

00:49:34
Dr. Marie-Chantale Brien: (Voice of Translator) I think you need to take a step back. You really have no choice not to take a step back, to take that time, that space for yourself, that mental space clear, that mental space for yourself to do that. To step away from the chaos and the busy schedules of medical doctors, and it's never an easy thing.

00:49:56
So sometimes we look at the schedule of our physicians and early on they're like well, there's nothing I can cut out of my workload for the week. But when you look closely you see that there's certain things that you can actually cut off temporarily to allow them to get a breath of fresh air, because if you don't do that, you will be too close to reality that you really miss out on a number of obvious things.

00:50:22
And I think it takes a peer that pays attention, that knows what's happening and has that experience and understands how tough it can be to take that step back and to help you. And if I come back to the comment that was made, I think physicians, when they're told "You need to be more resilient, you need to do this or that", this is a discourse that is a bit outdated right now in the sense that individual's resilience is no longer applicable, can no longer fly, we cannot do that.

00:50:54
Individually it needs to be collective and well-organized resilience that starts with doing what we're doing here today to talk to them, by talking about it, by trying to find solutions together. (End of translation)

00:51:09
Armand Aalamian: (Voice of Translator) Thank you so much. I really like the notion of collective resilience instead of individual resilience, because I think that sometimes colleagues feel guilty because we are accustomed to saying yes to

everything. So it is very important that we bear this in mind. Thank you so much for the comment. (End of translation). The next question is for Richard.

00:51:32
So a question about boundaries. When hospitalists put, understandably so, unreasonably so, caps on the number of patients for whom they can assume MRP due to staff shortages, what is the responsibility of all other services to accept responsibility for the balance of patients?

00:52:02
Dr. Richard E. Mimeault: That's a tough one.

00:52:03
Armand Aalamian: Indeed.

00:52:04
Dr. Richard E. Mimeault: So you know I think it's an example of the complex problems we face in medicine and the fact that there isn't a perfect solution. What we have are I guess intelligent choices to make. And I think it goes back to what Vania and Chantale were talking about, which is around this collaboration and teamwork.

00:52:30
So for sure if we're interested in delivering safe and reliable care, well we have to be aware of what that volume of patients is that we can care for. Now, is it okay to take care of a certain volume and dump the rest on somebody else who is then going to have an excessive volume, then clearly not. And I think that's where that teamwork, collaboration, communication comes in.

00:52:57
And I think the problems we see in medicine often are, you know, that I unilaterally decide we're seeing this many patients, we're done, as opposed to hey, we're seeing too many patients, I know everybody's overwhelmed. How do we make this work?

00:53:12
And I think it again goes back to what Vania was saying about it's not always about more resources but it's about thinking creatively, new ways of doing things, which often means dissolving some of those silos. But I don't think there is a perfect solution, I think there's just choices that we have to make and the choices involve talking to each other and negotiating.

00:53:37
Armand Aalamian: (Voice of Translator) Thank you very much. (End of translation) A question in the room, awesome. Fahimy go ahead please. Go ahead.

00:53:56
Question: (Voice of Translator) Hello, Fahimy Saoud family doctor here

in Montreal. Given the label of scarcity or shortage that we experiencing government has taken over a number of steps and one of which is we are now seeing the study of pharmacological study of patients as well as prescriptions from community pharmacists.

00:54:28
And we are receiving physical therapists who are sending us reports where they are suggesting that some patients go through medical imagery and then sometimes we receive all sorts of reports from psychotherapists such as take antidepressants or other forms of medication and sometimes patients come to consultation with already established expectations and this is without taking into consideration what they've read on Google and the internet.

00:55:06
Now my question is as follows. What would you suggest? What would you advise us in this situation to manage those expectations and what advice can you give us in order to be able to navigate in this primary care context? (End of translation)

00:55:24
Armand Aalamian: (Voice of Translator) Vania, we started with you so go ahead. (End of translation)

00:55:28
Vania Jimenez: If I may I think I will give you a response as a bit cliché but I'll base myself on the patient doctor relationship and everything is expected of me of all things that are asked of me as the main person intervening. It's the idea of the main person intervening I am at the core in most of the institutions that you're addressing, I'm the one who's deciding whether I'm going to carry on with the X ray or whether I'm going to prescribe this or that antidepressant.

00:56:03
And for this to be done it takes time, right. And this brings me back to the notion what we have at Maison Bleue, there's no Maison Bleue without GMF or other specialists. And there's equally the issue of remuneration and time spent with the physician, we have some patients who are quite vulnerable and clearly we cannot be able to meet with five patients in an hour.

00:56:32
So in Maison Bleue sometimes the physicians working there would transfer the way of doing things to an hourly rate, an hourly rate, and this helps them improve things a little bit. I'm not making a political statement here but if I were to advise the Minister of Public Health I would talk of capitulation and changing the way medical doctors are remunerated in order to allow for time for that relationship to be a built and give us the power, give us back that power which you're referring to by me, it's not because the pharmacist has recommended these that I'm just going to say yes, yes, yes. It could be just an additional option which I could have missed out on. But I think I'll fall back on that sacred relationship between a patient and their physician. (End of translation)

00:57:26
Armand Aalamian: (Voice of Translator) Yes please, go ahead. (End of translation)

00:57:29
Marie-Chantale Brien: (Voice of Translator) Well I think you're referring to how can you, you know establish limits in your own practice when those limits have not been clearly defined in general practice and I believe that it depends. You could put a number of limits on certain things and not others and I think it's important for you to inform your patients in different, find different ways of informing them and I have no miracle solution here but this is – there's work that's been done.

00:58:02
There's a working group that has been struck up in order to address some of those issues and discuss with the ministry and I think at FMOQ we are trying to look at this issue and there's a lot of work that has been done in the background as well. But things are not going to get resolved I mean overnight, it's going to take some time. (End of translation)

00:58:26
Armand Aalamian: (Not translated)

00:58:26
Andrée-Anne Labbé: (Voice of Translator) Thank you. Something else on time, sometimes in the discussions that you may have with medical doctors coming to you, sometimes they would ask you how can we avoid this in future? And unfortunately we never know how to say no and sometimes when complaints are sent to the college there's the same situation keeps coming over and over and over and sometimes entering your day you're like well, I need to take 20 extra minutes to discuss with this patient and explain to them why I'm not going to follow up on the recommendations that are coming with.

00:59:06
But I think it's important to build confidence with your patient and maybe the next time it will be a bit easier. And so it's important for you to invest 15 minutes each time you meet with them rather than taking six hours to address complaints that have been sent to the College concerning practice you were involved in.

00:59:25
So I'd like to join my voice to what was already mentioned and I think you have better chances to find yourself in your 20% with your patient but rather be on the phone with us because there are a number of things that were done without any explanations or because certain things went down when they were not supposed to be. (End of translation)

00:59:48
Armand Aalamian: (Voice of Translator) Thank you. We have another question regarding working with other professionals in our team, allied health professionals. We know that everyone has their own responsibility but how can we ensure that everything works well since sometimes as leaders of a team we have a responsibility. So how can we manage that? (End of translation)

01:00:25
Vania Jimenez : (Voice of Translator) I would say just like you do in a family, you have to listen, listen to what other professionals have to say, try and find better ways to communicate and I believe Richard was the one who mentioned this entire idea of power and how a leader sets aside their power.

01:00:58
They never feel challenged from that perspective, they simply try and listen to what is being said to improve the quality of the care received by the patient and that's what it means to work as a team, an interdisciplinary team. We see the patient through each other's eyes. And I can tell you it happens every day at La Maison Bleue that I make a mistake or I don't know that such and such thing happened to the patient. For instance, the social worker may inform me of something that I failed to notice or that I simply didn't know.

01:01:44
So you simply have to put the patient at the heart of their care and that's what we are suggesting to our learners. There are hundreds of people from various professions that come to La Maison Bleue and I can tell you that those who are the most difficult to deal with are the physicians, they're the ones that are most easily frazzled. They're the ones who have a hard time just listening, taking stock and listening.

01:02:16
So there's something about the way we are trained that means that we have a hard time with that aspect of our day to day work experience. It's really interesting, maybe we have to look at our training. How do we speak to our colleagues? How do we listen to them? (End of translation)

01:02:41
Question: Hi, I'm Sanjeev, a family physician in Alberta. So just a comment and a question. So in as we've already discussed the human resource issue is a big problem in terms of medical legal from the fact of continuity of care. So in family medicine the biggest problem is there's lack of family, medical professionals across the country. So in Alberta we have a massive deficit, there's more people coming to the province and just not enough physicians to serve that need.

01:03:13
So one of the issues that comes up with you know the regulators expect continuity, it's part of the standards of practice. Now in terms of the providing continuity, obviously the

intent is to provide continuity but when you've got no capacity to provide continuity as an individual, then you resort to team.

01:03:29
So when you resort to team in a standard traditional practice it's a group practice, just other family doctors, but the problem is they are also burning out, they also don't have capacity and they don't want to see your patients. So ultimately then you're stuck with the risk of having a delay in seeing your patients, for recalls having capacity for those but then those patients who are due to come back in for their regular diabetic checks when they can't come back in then the question then will be asked by if there's a criticism, you haven't seen the patient on time, a patient may come in and say you never called me back or you know I just can't get in to see you so I delayed my diabetic check for six months and now I have a complication, or my A1C is too high but no one checked it and no one asked me to come and I also couldn't get in.

01:04:16
And the other point to make is there is an opportunity to use multidisciplinary teams. We're speaking of this throughout the country and different provinces are looking and reaching out to MDT. But the issue in community medicine is there's no funding for it. We live in an antiquated system unfortunately and the resource funding is only in secondary care, it's not in primary care. There isn't actually much money allocated to paying non physicians to provide family or primary care medicine.

01:04:46
So then if we do use the multidisciplinary team two issues is how do you pay for them because there isn't any money for it unless you think of a novel way of paying for the people that are not physicians. And the other issue is if they do provide continuity of care on your behalf, and so you have you know the medical home providing continuity, where are the risks that lie in terms of you know the criticism that may come from saying well one person is now not only providing care, many people are, so lots of hands in one pot to providing what say one episode of care for a patient. So just your thoughts on that, please. Sorry, a lot of points there.

01:05:26
Richard Mimeault: Another easy situation. You know I think the, I guess I would start by saying that you know what you're describing and the way you're describing it is there are certain levels of complexity. So if you're – if you have such system restraint to a degree that you're describing there's no amount of creativity, of teamwork and collaboration that can actually compensate for it. I mean that's the situation that you're describing.

01:06:03
So you know if you've gotten to that point then you're right, you need the big system changes. But otherwise I think you know what we've talked about here so far you know of looking at you know well what are those other things and how do we go beyond what we've thought of already given that the resources aren't going to change what's the best

we can do?

01:06:26
Now in that place where the system has nothing left to give you it's true that that might still not be, it might not meet the norms that are set by you know Colleges or whomever. And then I think it's important there that everything be well documented, you know that we understand why that's happening, that when a complaint does arise that yeah, you've got something to show that definitely shows that it was unreasonable and impossible for you to achieve that goal.

01:06:58
Not a great answer I realize. I mean the real answer is yes, in some, in many situations you do need to address the system and you do need more resources. But short of that I think that I'd be curious to think what the rest of the panel thinks. (Voice of Translator) Thank you. Vania, could you please provide your take since you talked about La Maison Bleue. What sort of resources did you get? Perhaps you could enlighten us. How did you manage to build this model and how did you advocate to obtain more resources? (End of translation)

01:07:45
Vania Jimenez: (Voice of Translator) Well, the assessment we made is that frankly we started from a group of physicians that were passionate and frustrated as I said earlier by their conditions. And it started with a family medical group that belongs to a CLSC and its primary mission is preventative. So as I said, epigenetics and Michael Meaney's work which was conducted partly in La Maison Bleue showed that there was an impact.

01:08:26
So I started from the idea that there was a financial impact on the healthcare system, you know that a premature baby for instance, will have developmental delays and we convinced the CEO at the time to give us one resource for all of us delivering physicians, we got one nurse and we conducted an assessment. This assessment was done by three different universities, and it demonstrated that in fact we had reduced the number of premature babies.

01:09:04
And based on this knowledge we constructed our cost analysis, and we showed that the system would save a lot of money with very few resources. So unfortunately, we had to raise the financial card and that's what convinced the Ministry. And now, La Maison Bleue has committed to building 10 more Maisons Bleues in the next five years. (End of translation)

01:09:40
Armand Aalamian: (Voice of Translator) So if I'm hearing this correctly, fortunately or unfortunately, you still have to build a business case. You have to demonstrate that there are savings. We can't just say I would really enjoy having this or

it would be good to have, you have to demonstrate why. (End of translation)

01:09:50
Vania Jimenez: (Voice of Translator) Nobody will convince anyone with virtue. We are unfortunately in such a situation, even though we take care to heart, at the end of the day, we will have to fight with ministries to obtain resources and show that we have too little. We don't have enough to provide proper care. The social worker that works for us sees twice as many patients as one that works elsewhere. (End of translation)

01:10:36
Armand Aalamian: (Voice of Translator) Well you worked really hard to obtain those resources and I think that should certainly be celebrated. (End of translation)

01:10:4
So you all get a chance on this one. Please give advice on how to address situations where we're asked by hospital or patients to work outside our scope of practice. In resource poor setting we're asked to do clerical duties, nursing duties, provide medical care and other specialties, for example, and that is very stressful. Anybody? All of you will get a chance to respond. Go ahead.

01:11:18
Vania Jimenez: (Voice of Translator) I'd answer by saying that we should never go beyond our scope of practice, never. We refer to specialists on a regular and vigorous basis, if you'll believe it. We sometimes call ourselves and if it doesn't work then we move up the food chain, we call the director, the head of the service, but we never ever work beyond our scope of practice at La Maison Bleue for nobody.

01:11:18
And in fact there are audits. One of our nurse practitioners was audited and it was a very detailed audit and in fact her work was celebrated but we never work beyond our scope of practice. (End of translation)

01:12:12
Armand Aalamian: (Voice of Translator) Any other colleagues? (End of translation)

01:12:15
Marie-Chantale Brien: (Voice of Translator) I agree. I think that at one point or another one has to have limits and we have to push back. And in fact if some physicians are asked to perform work that they're not supported for or that they're not qualified to do then that should be reported. (End of translation)

01:12:43
Armand Aalamian: (Voice of Translator) So often patients are distressed, they're frustrated, they've been waiting for months and they need something, they really

need something here and now and they want to be heard. So what do we do? As physicians we're there to help. So it's hard to be faced with somebody and say, I'm sorry, I cannot help you, or it's beyond my scope of practice. What do we do in such a situation and what's our medical legal responsibility? (End of translation)

01:13:15
Marie-Chantale Brien: (Voice of Translator) Well I would say don't do harm. That should be your motto. And it's difficult but we have to say no. Beyond that I think that that's more of a legal issue I'm not qualified to answer.

Andrée-Anne Labbé: I will have to repeat what I said earlier in answering a question we got from the audience, it's a question of trust, the trust you build with your patients. It's really rare to have patients that don't understand if things are explained in plain language, the reason why you can't provide what they're looking for, and furthermore why it's not in their interest for you to provide that care because it goes beyond the medical legal risk there's also risks for the patients if you are not qualified to provide the care they're asking for.

01:14:16
So I think that's the key, it comes back to communication, you have to explain things properly and I know that it's not always possible but insofar as possible, try to refer the patient to the proper resource and do what you can in as little time as you can. (End of translation)

01:14:45
Armand Aalamian: (Voice of Translator) Richard? (End of translation)

01:14:46
Dr. Richard E. Mimeault: (Voice of Translator) Well I would say that at the end of the day the interests of the patient have to be first and foremost and we can't let the patient feel like they're being abandoned which is really what Andrée-Anne just explained. We need to have a trusting relationship with the patient and that has to be based on communication and they really shouldn't feel like they're being abandoned.

01:15:18
Armand Aalamian: (Voice of Translator) And I think that's something that has to be taught to our residents how to manage that type of challenge. Sometimes we forget that when we provide training to our students. (End of translation)

01:15:29
And this question is for first for Richard and for Andrée-Anne. For a physician planning to do locum in a hospital in the community what is their responsibility to assess the conditions they will face in that community prior to deciding to provide services there? And this could be for an example hospital, ER patients volumes, equipment available, personnel available, that kind of thing. Like what's your responsibility when you want to – when you're going to do a locum?

01:16:02
Dr. Richard E. Mimeault: Well for the record I've never done a locum but I think if you're going to, I would assume that if you're going to a place to do a locum it's because they already have a shortage of physicians, you're filling in a spot. And so it wouldn't be unreasonable to expect that there's probably a shortage of other resources. I'm not sure the point of the question though, is that in order to decide whether you're going to the place or not or what your risk is once you get there?

01:16:35
Armand Aalamian: I'm going to follow, I'm going to say the following. I'm going to – I don't know what exactly because I don't – we haven't actually interacted with the person who posed the question or persons who posed the question. But I would say before you go up, I mean I did 13 years of locum, the first time Vania and I have done locums in the grand in northern Quebec.

01:16:53
Before I went up there I said, well do you have a place for me to stay? That was probably the only question I asked and went up there and discovered a whole world of challenges in terms of resources, in terms of how to get patients down to a big centre when things went wrong, when the weather went wrong, etc. So there are resource questions that can actually come up.

01:17:16
So I'm interpreting that in that sense, like what are the things you should ask before you go to do a locum rather than just say, yeah, I'm coming. So I think that's the question. This is what I'm hearing from the question.

01:17:30
Dr. Richard E. Mimeault: Well I think you just answered the question. Fairly. Yeah, no, I think you know if you were again understanding that there are going to be resource issues to be I guess prepared to handle them, you know and be prepared to do some of the things that we were talking about today, you know what's that communication and collaboration going to be, look like? What's the teamwork that's available, that sort of thing.

01:17:56
Armand Aalamian: Yeah, I think it's, I'm going to maybe respond to the question myself having done a whole bunch of locums, I think it's really important to understand the context, where you're going and who you're working with. And it's not just the context of medical supplies, it's a cultural context, which culture are you going to be working in? What is the community's approach? How are you going to be fitting in? How long, etc.?

01:18:23
So there are lots of things to think about if you're going to be actually there contributing

to the care in the way most of us would like to which is be there for the patient and be working with the community.

01:18:40
(Voice of Translator) The next question is for you, Chantale. What do you recommend for physicians that were threatened by a patient, especially if there are no colleagues available to provide follow up care? (End of translation)

01:18:54
Dr. Marie-Chantale Brien: (Voice of Translator) Well obviously that depends on the situation. So if we meet this client, we will start by asking if they've spoken to CMPA to see what their recourses are? Obviously the first thing to do is listen and if the physician is not in a position to provide care we'll suggest an alternative. (End of translation)

01:19:24
Armand Aalamian: (Voice of Translator) Great, thank you, Chantale. (Voice of Translator) What – yeah Vania, sorry, go ahead, of course.

01:19:32
Vania Jimenez: (Voice of Translator) We had an experience at my family medical group, a very difficult patient. She was a real burden for the system, for nurses, physicians, everybody, and there was no way to put an end to the situation, and I had to call the College, the ethicist and the CMPA, and at the end of the day we came to an agreement, a two-part agreement.

01:20:13
So we asked her to no longer harass our staff and if ever it happened again… We said it seems you don't appreciate our way of way of working, so you are effectively discharging yourself from our care. (End of translation)

01:20:35
Armand Aalamian: (Voice of Translator) Thank you for this very concrete example. (End of translation) What happens, and Andrée-Anne this is for you. What happens when a patient or patients are sitting in the emergency room without a most responsible person, MRP, despite being admitted. Who is responsible?

01:21:00
Andrée-Anne Labbé: (Voice of Translator) I'll answer what every lawyer answers. It depends. It depends on the facts. Who was aware of what? What was the patient's condition? How were they triaged? When did the physician see them? So in a situation like that one, it could be the responsibility of one person, two people, it could be the responsibility of the hospital, the physician, it really depends. (End of translation)

01:21:33
Armand Aalamian: (Voice of Translator) I'll make it easier. You've got an internal medicine patient who has a cardiac issue. So they have active heart failure and they are

waiting for a bed on a unit. I'm the ER physician, I can't find their most responsible physician and there's somebody across the hall that is in active heart failure. What do I do? (End of translation)

01:22:04
Andrée-Anne Labbé: (Voice of Translator) Well it all depends. Is a nurse monitoring the patient? Is the internist aware? So I could provide you with an algorithm but it really depends. It's too specific to say who is most responsible. Often it takes months for us to come to a conclusion.

01:22:24
So to answer that question we have to see what was documented on the chart, when, where. We have to also ask questions from the physicians, the staff, the family to finally try and reconstruct the story and see if there was an error if it caused harm because perhaps it didn't, and then finally come to a legal conclusion. But I cannot answer your question to put it in a nutshell. (End of translation)

01:22:54
Armand Aalamian: (Voice of Translator) So what I'm hearing is that you have to communicate. Somebody has to speak with somebody and it's important. And it's important not to leave the patient, let them fall between the cracks. (End of translation)

01:23:11
Andrée-Anne Labbé: (Voice of Translator) Exactly. And if you want to build on that, you really should, in a hospital or in an emerg, have workflows. When you've got a patient that's beyond 24 hours, 48 hours in emerg, there should be some sort of workflow, clear responsibilities, who does what, and then that will help determine who's responsible in case of potential harm. (End of translation)

01:23:37
Armand Aalamian: (Voice of Translator) Thank you very much for that answer. Chantale, the next one is for you. (End of translation)

01:23:41
Burnout is the outcome that affects individual doctor, although it's not his or her sole only responsibility, it's a systems failure. What can we ask the local hospital administration to do in order to help prevent burnouts?

01:24:04
Dr. Marie-Chantale Brien: (Voice of Translator) I think this ties back to what I was saying earlier, there are various initiatives that can be taken to better support one another. So we need better equipped managers, we need managers that have leadership skills, that are confident in reducing conflict at work, in providing tools, guides, in fact we have a project with a ministry where we are planning on better equipping managers because if managers have better tools then the team will be better equipped and individually everybody will feel better supported by a team who are better

trained.

Because often as managers we're told well you've been in this department for this number of years, it's your turn to be head of the department where it might not be something you're interested in and you have no training. So that's something we are going to try to implement and I think that that's one avenue.

I think that we need to denounce what's happening. We need to report it. When we speak to physicians individually and we ask them, did you go see the head of your department? Did you go see the Director of Professional Services? And they say no, it doesn't work, I've done it in the past. Well, do it again, call, call the College, mention what you're experiencing, call your association. Explain what you're experiencing.

Because it's when we discuss these things at various levels that we come to the best solutions, support amongst peers as a team. So providing team support that can start in our own teams, we can make room for each other to talk about our challenges, the mistakes we make. You know if we want to have a more just culture at some point we'll have to be open to talking about our mistakes.

I know our lawyers tell us don't talk about it when it happens but if you talk about it in a trusted group of people that you trust that have a friendly ear then it can change things. (End of translation)

01:26:32
Armand Aalamian: (Voice of Translator) Great. Thank you very much, Chantale. Thanks for the clarification and examples. (End of translation)

01:26:39
We have time for only one more question. Time has flown. And Richard, this is for you, you have about two minutes to respond. And if we have time we'll go to Andrée-Anne we'll see, we'll see. We'll try to manage this. Please comment on risk in an ER setting, tests are being sent by a nurse under your name for a patient you've never seen and the patient leaves without you seeing them. This happens more often in our overburdened ERs as the RNs are trying to be helpful. What is your responsibility as a doctor?

01:27:15
Dr. Richard E. Mimeault: So the nurse is seeing the patient that came to your emerg, made some decisions, said that they can – you as a physician were never aware that the patient was even there.

01:27:25
Armand Aalamian: Right? The patient came in, had let's say chest pain, they did some cardiac enzymes and the patient went home without them ever being seen.

01:27:33

Dr. Richard E. Mimeault: Right. Well I think you know the short answer would be you can't do the impossible. So if you weren't even aware that the patient was there then it's unlikely that you would be held responsible. That said, I think if there were policies in the hospital that actually had defined roles and responsibilities in situations like that and ascribe some responsibility to you then I think there's still that potential that you would run into problems but I'm treading on thin ice here I think.

01:28:14
Andrée-Anne Labbé: (Voice of Translator) I would say that regardless of the responsibility that you may have it does increase the risk of a lawsuit because the lawyer representing this patient will see your name on the results and will assume that you ordered those tests and you did not act based on those results.

01:28:41
So it's a way of proceeding that does increase your risk significantly. And I would echo what's been said, emergency departments and hospitals, and I know that it does create tension in all sorts of hospitals, but you really should have procedures for those orphan results that accumulate every day, they should be seen by a physician at some point.

01:29:06
Richard Mimeault:
But if the physician was responsible for follow up for instance for cardiac enzymes even if they didn't see the patient, they potentially would have a responsibility?

Andrée-Anne Labbé:
They might be liable if there's a policy that says that in these circumstances, when a nurse orders something on behalf of a physician, and that she was right to do it on behalf of that physician, and he never reviewed it when he should have, I think there's a risk. (End of translation)

01:29:31
Armand Aalamian: (Voice of Translator) Thank you ever so much to all our experts. This was a really enlightening session and it went by very fast. Thank you once again. We talked about challenges, we talked about potential solutions, but above all else, as I said, it's a very complex problem. So we shall endeavour to continue to work on it together.

01:30:00
Just a reminder, you have evaluation forms to fill out and you will have about 15 minutes now to take a health break after which we will have our business meeting as of 3:45. Thank you very much and thanks for your participation. (End of translation)