

CMA Health Summit Series

REFRAMING HEALTH



THE TIME IS NOW

The **2021 CMA Health Summit Series** consisted of three virtual, interactive events that explored what is needed to reimagine and rebuild health care for the future using lessons learned from the pandemic. The sessions brought together hundreds of participants — health care workers, physicians, medical learners, patients, administrators and policy-makers — to discuss and debate how to improve health, the health system and the health workforce, the three pillars of the CMA's bold, new Impact 2040 strategy.

These session themes were presented through the lens of COVID-19: how it has exposed gaps in the health care system, widened health inequities among marginalized populations and overburdened an already struggling medical profession.

Participants shared the challenges they'd experienced and proposed steps to build a better future of health, including the need to:

- address the social determinants of health such as poverty, housing and education to improve equity;
- integrate the full range of health and social services into the health system;
- partner with and engage patients to improve both individual and system-level care;
- support marginalized communities and encourage them to have their own voice; and
- create a new and improved medical culture to address physician burnout and increase equity and diversity in the profession.

The CMA has put a significant marker in the ground with its new strategy — Impact 2040 — and these conversations and insights will help us advance that work.

DID YOU MISS THE 2021 HEALTH SUMMIT SERIES OR A PARTICULAR SESSION?

CATCH THE VIDEO HIGHLIGHTS HERE

HEALTH SYSTEM

SESSION 1: MAY 18, 2021

CANADA'S UNIVERSAL HEALTH CARE SYSTEM — MYTH OR REALITY?

While COVID-19 sparked rapid innovation in the health system — including the expansion of virtual care and collaboration between areas of health care that previously had often been siloed — the pandemic also underscored many system failures.



Session 1 panellists

Keynote speakers Dr. Nadine Caron and Dr. Danielle Martin discussed the myth of universal health care in Canada in light of the pandemic.

Dr. Caron, a surgical oncologist, talked about how tiny cracks in a generally strong system became chasms during COVID — like expanded wait times for surgery and diagnostic tests. She also stressed the need to address the social determinants of health in any discussion about strengthening health care in Canada.

Dr. Martin, the executive vice-president of Women's College Hospital in Toronto, focused on some positive outcomes of the pandemic, including the collaboration and co-operation between previously siloed hospitals and the innovations around virtual care. She said much of the success in managing the pandemic has been thanks to the decency and reasonableness of the average Canadian.

Panellist and patient advocate Sudi Barre shared her insights on why health care isn't universal — especially for women and racialized communities.

And panellist and Globe and Mail health columnist André Picard talked about what it would take to ensure better care for older adults.

BREAKOUT GROUPS: How can we build a better health care system?

By serving marginalized groups

Ensuring a patient-partnered approach and communicating effectively with communities about their medical needs was seen as a key step to improving the health care system, especially for racialized and other disadvantaged communities.

“Ask people who represent the population what their needs are and try to respond to them.” —Participant

“With Indigenous populations, we need to go where they are. We need to take a leadership role to identify and address the real needs of patients and then shift the system around to make it patient-centric. That’s my dream.” — Participant

Other key insights:

- Empower patients to advocate for themselves.
- Improve health workers’ knowledge of the populations they serve.
- Be mindful of who is identifying gaps in the health system and making decisions to overhaul them, as it is often the privileged.

By integrating health and social services

“If we had a well-integrated health system that cared about, and partnered more closely with, other organizations and parts of society that address the social determinants, we would be better able to serve racialized and other vulnerable populations.” — Participant

“Too much of what we do is done in silos and we often don’t consider the patient as a whole.” — Participant

By making the most of virtual care

The topic of virtual care, both its capacity to increase access during the pandemic and its potential to disrupt in-person visits, was hotly debated.

“I found patients who can’t come to the office for financial reasons are reaching out virtually, especially the younger population, the mental health population, the elderly who are dependent on someone else to drive them. I’m going to continue with virtual care for those populations.” — Participant

“Part of the challenge is that my patients don’t know how to use technology, or they don’t have the bandwidth on their Internet connection to access virtual care or their equipment is so crappy.” — Participant

HEALTH EQUITY

SESSION 2: JUNE 17, 2021

LESSONS LEARNED FROM COVID-19: HOW DO WE CLOSE CANADA’S HEALTH GAP?

The COVID-19 pandemic underscored the fact that good health is about more than simply treating someone who is sick; factors such as race, gender, income level and housing are really what define people’s health.

Keynote speaker Dr. Jane Philpott, dean of the Faculty of Health Sciences at Queen's University, talked about her experience during the pandemic, working at a group home for adults with severe physical, intellectual and developmental disabilities, and how it took days of pleading to get the appropriate medical attention after a COVID-19 outbreak in the home.



Session 2 panellists

“The worst outcomes of this pandemic have been felt by those who have been least able to speak up, or least likely to be heard and taken seriously. We have watched the real-time impact of ableism, ageism, racism and other structures of oppression.”

— Dr. Jane Philpott, keynote speaker

Panellist Dr. Naheed Dosani, a palliative care physician, said improving health equity in Canada will require an investment in social services like housing and mental health care. He also addressed the disproportionate impact of the pandemic on black and Indigenous communities and the need to recognize labour as a social determinant of health.

Panellist and patient advocate Nicole Nickerson talked about the negative impact of COVID-19 on the health of her two grandmothers, in part because of visitation restrictions, and how caregivers need to be part of the health care conversation.

BREAKOUT GROUPS: How can we achieve health equity?

By learning from COVID-19

Many participants reflected on the significant changes caused by the pandemic and the strain that it has placed on the health care system, physicians and other providers, including:

- high levels of staff burnout;
- anxiety of patients and families who have been separated by COVID-19 restrictions; and
- a lack of surge capacity in the health care system to accommodate rapid change.

In spite of the negative impact of COVID-19, one participant observed that there has been a destigmatization of mental health issues during the pandemic and an awareness that we're in this together.

Others highlighted the need to learn from the pandemic.

“The pandemic has made it clear how important things like secure housing, a basic income and the opportunity to take paid sick leave are to the overall health of the population.” — Participant

“This is a point in time now where we really can make some significant differences in the system, so we’ve got to seize that opportunity.” — Participant

By addressing inequities

Other breakout groups focused on the racism still prevalent in society and in health care.

“We will never have equity, unless we are prepared to make radical changes.” — Participant

“We need to recognize our white privileged history and the colour-blind policies that perpetuate inequities. We need urgent actions, explicit conversations and accountability from leadership to integrate equity at all levels.” — Participant

Others suggested collecting race-based data or other data to illustrate inequities.

By serving marginalized communities

How to address the concerns and needs of marginalized communities continued to be a major theme.

“In medical school, I wish we learned more about marginalized communities, how they’re being affected and why their health outcomes are worse than non-marginalized populations.” — Participant

One patient advocate acknowledged that health care advocates need to involve marginalized patients and communities in their decisions about care.

“We’re deciding what they need, what they should have and what they want. And I don’t think we can do that. It’s not easy to find representatives of marginalized groups. We’re not representing them and we know that.” — Participant

Health inequities facing Indigenous communities received a great deal of discussion, including the need to address poverty, housing and other social determinants of health.

“I think it’s really important to ask the First Nations what they need and for us to listen to what the communities need.” — Participant

By adopting virtual care

There was some debate about the services needed post-pandemic to make health care more responsive, especially virtual care.

“I see value in digitalization. Personally, I'm taking better care of my mental health patients, my elderly patients and my infant patients whose mothers cannot drive. Virtual care has given them an opportunity to connect with me and ask questions they could not have dealt with otherwise.” — Participant

The lack of high-speed Internet access in many parts of Canada such as the North was identified as a barrier to the widespread use of virtual care. It was noted that in these communities, Internet access can be very expensive and it is also unreliable.

“It's been incredible to watch my patients that are already quite marginalized, get further marginalized, based on their [lack of] access to good Internet, a phone, or anything that runs Zoom.” — Participant

“There's a digital divide. The homeless and a lot of my mental health patients — who are suspicious and vulnerable — are the least likely to use digital technologies.” — Participant

Through integration

There was a desire to learn from and expand on the success with which public health was integrated with social services during the pandemic. However, concerns were raised about moving from the longitudinal model of care that exists with traditional family practice to a more transactional model of care.

Other key takeaways on how to achieve health equity included the need for:

- an increased emphasis on preventive care;
- a guaranteed basic income to address poverty;
- clear communication about health issues; and
- greater physician–patient advocacy.

“We learn how to be advocates but we don't often learn how to support patients to be their own advocates, which is central to providing patient-centred care.” — Participant

HEALTH WORKFORCE

SESSION 3: AUG. 22, 2021

THRIVING IN A REIMAGINED CULTURE OF MEDICINE: WHAT DOES IT MEAN TO BE “HEALTHY”?

The pandemic has put medical professionals under an entirely new level of pressure.

Burnout, depression, stress, ethical challenges and struggles with work–life balance are more apparent and the need for solutions and support is more pressing.



Session 3 panellists

Keynote speaker Dr. Jillian Horton, an award-winning physician, musician, writer and podcaster, highlighted the importance of using “new eyes” to imagine a different culture — one that prioritizes wellness in both learning and clinical environments.

Providing a health and safety perspective, occupational medicine expert and panellist Dr. Aditi Amin identified opportunities to learn from existing standards and industries to begin the work of creating safe, inclusive and health-promoting environments in medicine.

And panellist and patient advocate Michelle Hamilton-Page revealed how patients can be powerful allies when it comes to building a culture of physician wellness.

BREAKOUT GROUPS: How can we transform medical culture?

By addressing burnout

Participants shared their experiences with burnout and discussed how to foster physical, cultural and psychological safety in medical work and training environments.

“We need to make our medical schools, clinical departments and all professional workplaces a safe refuge for ourselves and our colleagues.” — Participant

“One of the most powerful things we can do as leaders is to share our own experiences with others. Let others know it’s OK to not always feel OK.” — Participant

Many participants expressed the need for system-level change to improve physician health and wellness.

“Many of us struggle with balancing our duty to patients and the profession with our duty to keeping ourselves well. In reality, we can create systems with moderate work and rest, such that we achieve longevity and satisfaction in our careers.” — Participant

“It is an uphill battle to address wellness only from a personal level. There are system changes that need to occur.” — Participant

It was also pointed out repeatedly that physicians and learners need to be able to express concerns about their mental health without fearing retribution from medical licensing authorities.

By changing medical school culture

Other participants flagged the need to create a healthier culture at the outset of a medical career.

“We need to have medical students understand that it’s OK not to be perfect and that understanding one’s limits is the most important aspect of caring for patients.” — Participant

A neurology resident who joined the discussion after a 26-hour call shift said change was needed at both the regional and federal levels because the level of burnout among residents was affecting not only their well-being but also the care and safety of patients.

“Training a healthy generation of medical professionals is a challenging process given the important cultural safety and policy challenges that patients and medical learners face. It’s important to ensure there is clear leadership, messaging, directionality and collegiality to create a safe learning and clinical practice environment.” — Participant

By finding patient allies

Participants raised the importance of working with patients to improve physician wellness and the work environment.

“The burnout is mutual. Many patients not getting adequate care are also burning out, furthering systemic damage. All of us must change and shift. Together, we can do it.” — Participant

“From a patient perspective, the health of doctors is essential. Without it, the result is poor patient care, personal harm to the doctor and a degradation of the profession. It’s incumbent on all of us to work together to change the scenario.” — Participant

By reflecting a diverse population

Another breakout group focused on how the medical profession needs to better accommodate and reflect the diversity of the Canadian population.

"We need to realize that when we take a very Eurocentric approach, we are placing barriers to seeing other ways of addressing issues and making things better for each other and for patients." — Participant

THE DISCUSSIONS AND IDEAS FROM THE 2021 CMA HEALTH SUMMIT SERIES WILL HELP INFORM THE CMA'S FUTURE WORK.

[VIDEO HIGHLIGHTS OF EACH SESSION ARE AVAILABLE HERE](#)

It's never too late to add your voice to the discussion on how to change health,
the health care system and medical culture.

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