Dr. Granger Avery

Canadian Federation of Medical Students: Spring General Meeting

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Check against delivery
Hello everyone and thank you for the opportunity to join you at your Spring General Meeting.

As the president of the Canadian Medical Association, it’s been a pleasure representing more than 85,000 of our physician and physician-in-training members — and an extra honour to be serving in 2017, the 150th year of our association.

The CMA was founded in 1867, just three months after the birth of Canada. A group of 164 physicians came together in Quebec City and felt it was time to have a strong voice for the profession.

A lot has happened in Canadian medicine since that initial meeting. There are so many events and achievements that physicians and physicians-in-training have been part of that continue to ripple through time and affect us still today.

Throughout our history, the CMA has advocated for public health during the Spanish Influenza, the AIDS epidemic and the SARS outbreak. We founded the Canadian Cancer Society as well as the Royal College of Physicians and Surgeons of Canada and successfully advocated for the creation of RRSPs on behalf of self-employed physicians.

On the public health side, physicians were among the first to recognize the devastating effects of cigarette smoking. The CMA issued its first public health warning in 1954, launching what would become a decades-long fight against tobacco.

We pushed for supervised injection sites as part of a harm reduction approach to public health, and represented our members’ views on controversial issues such as abortion and more recently, medical assistance in dying.

There are countless examples of us coming together, stepping up and being ahead of the curve on important issues and in times when the need has been greatest.

Where we’ve come from and how our experiences have shaped us along the way is incredibly important, as an association, as a profession and as individuals.

In terms of my own personal history, I’ve been very fortunate to practice in Port McNeill, a small forestry town on the northern tip of Vancouver Island. When I first arrived there in ‘73, you could only get there by boat or logging road. I had just finished training in the UK, New Zealand and anaesthesia in Vancouver. Talk about going from one extreme to another: Vancouver General was one of Canada’s largest hospitals at the time with 1,200 beds; Port McNeill had no hospital at all. I would take my patients ten miles across the ocean to another island where there was a hospital and one other doctor. Together we would resuscitate, operate and deliver as was necessary. Sure learned in a hurry there too!
What attracted me to Port McNeill and to rural practice? Many things — the vistas, the sea, the mountains. But of course, the people. And the opportunity to learn and develop meaningful practice.

When you live and practice in a small community, you have the opportunity to extend your clinic outside of its four walls, as well as the relationship-building with your patients that goes along with it. You interact naturally with your patients when you bump into them at the grocery store or walking down the street, when they’re not so nervous, when they’re more at ease. I’ve found that to make a huge difference.

What I also love about rural practice is the extreme focus you must have on figuring out and fixing problems. You can’t just walk away from them and leave them to someone else to deal with because there literally is no one else for miles around who does what you do. There’s always a shortage of resources and working around that requires being a good clinician and an advocate for your patients.

It also teaches very quickly that you cannot always be 100% right and that as long as one is open and honest with our patients, this too is OK. Together, we will get the best outcome.

The reason I decided to get involved in medical politics was that I started to experience persistent difficulties getting services that my patients needed — that’s what pushed me into doing something about it. It had become more and more apparent that the system itself was not doing what it should. Neither the physicians nor patients in the system were getting the best out of it. That’s why I threw my hat in the ring for the CMA presidency, to see where I could move things forward at the national level, and see if we could get to some of the reasons and solutions behind this disconnect.

That’s really a Coles Notes version of how I got to be standing here in front of you all today. But there’s no doubt that my path has shaped the way that I look at health care today. Every one of us brings our own unique perspective to the table. But at the same time, there are key tenets and drivers that unite all of us as peers across specialties, regions, generations, even centuries.

Trust.
Collegiality.
Civility.
Collaboration.
Compassion in the service of our patients.

Ever since Abraham Flexner wrote his report on Medical Education in North America 110 years ago, our profession has become increasingly focussed upon reproducible science in medicine. This is essential, and without it we cannot be effective doctors.

What has not always kept pace with these outstanding scientific advances is the — equally necessary — humanity in medicine.
No matter if it’s 1867 or 2017, whether we’re in downtown Winnipeg or remote Port McNeill, our essential duty as physicians remain the same — to best care for our patients, whether it be by helping them stay healthy; ameliorating those with chronic disease or comforting them at the end of life.

Or, as Dr. Edward Trudeau said 200 years ago — some say it was Hippocrates 2,000 years ago — “Cure sometimes; relieve often; and comfort always”.

We can all accept that change is a constant in our profession, and we can all commit to life-long learning and practice improvement.

But we do have unusual pressures currently.

And those pressures are making it hard for us to consistently deliver on our commitment.

We’re witnessing, for example:

- An aging population putting unprecedented pressure on our system.
- Monumental scientific advances and an explosion of medical data.
- Increasing pressure to show the appropriate use of tax dollars and value for money.

While we can incorporate the medical and technical advances into practice, the pressures usually translate into questions around system financing and system management.

These challenges are forcing us to think carefully about how we navigate the path forward.

Also to understand how a change in one area of health care delivery forces change in several others. Secondary change that is mostly unanticipated, and frequently unrecognised as a consequence.

There’s also the question of why Canada sits so disappointingly low in international rankings in terms of efficiency and wait times. As a recent CIHI report has revealed, we’ve now displaced the US, and are in bottom place of the eleven country comparisons in terms of wait times.

And this is despite all of the tireless, professional and focussed work by Canada’s physicians, nurses and other health care professionals.

There’s no question that everybody’s working really hard to make our system run smoothly and to make sure patients can get the care they need. So what’s going on?

Medicine and health care are in a time of transition.

It’s not that people haven’t been trying to find solutions to the challenges facing health care, and health care delivery, for some time now. When you think about all the reports that have come out in the last few decades around trying to improve the system — the Hall Report, the
Kirby Report, the Romanow Commission, the Naylor report, etc. — there’s been little or no response.

These reports were written by committed, concerned and informed people.

Why aren’t we taking up these good ideas?

Where are these reports now?

How many of their recommendations have been implemented?

And this is not simply a Canadian issue. We see that the same problems and responses occur in most developed countries.

Increasing costs and increased demand have been met with partialist, and sometimes desultory, responses by government and health care managers — usually accompanied by some form of increased rationing of health services.

Clumsy attempts to reduce service volumes. A focus on improving efficiency in a small segment of health care (EDs, for example) without changing upstream pressures. Attempts to force downward pressure on physicians’ incomes.

And worse, these changes are frequently one-sided, and imposed, inevitably accompanied by resistance, which – in turn – leads to physician and nurse burnout.

Burnout is a very big issue. This has been clearly underlined by the recent UG survey done by the CFMS – for which I commend you – as well as numerous studies of practising physicians.

As well as individual harm, burnout very obviously leads to system underperformance creating a vicious circle.

There are both individual and system facets to burnout. We must all take responsibility for our personal resilience, and do our best to help others around us. This part is fairly well supported, although we can and must do more.

The system responsibilities in producing and not addressing pressures on physicians, nurses and others who work in the health care world have been badly neglected in Canada and many other countries.

That is why the CMA has undertaken to look deeply into it. In mid-December, your CMA Board of Directors passed a resolution authorising a task force to investigate the system responsibilities for physician burnout.
The CMA has commenced focus groups, surveys and online consultations to lead to recommendations by this fall on what we must do to address the system responsibilities. We look for your active guidance and participation in this work.

So, we must ask — is it fair, or reasonable, that society continues to ask a single sector to take responsibility for continued system improvement?

What’s the issue there?

Policymakers, governments — and most importantly — patients and their families, are looking to us in the face of these challenges to step up, as we’ve done throughout history, and help ensure the system is effective and able to respond to future needs.

They’re looking to us to bring a clear, strong voice to the leadership table and play an active role in health system reforms and improvements.

How do we get there?

The key is partnership and the recognition of our interdependence.

Understanding that no one sector alone holds all the answers, but that together, we can make changes that are impossible when we try to do them alone.

To make any sort of huge change in the system, to look at real reform and improvement, partnership is essential, a collaboration of all the system players who are experts in their own fields:

- universities;
- the public, with a strong Indigenous voice;
- health care managers;
- governments (federal, provincial, territorial);
- the professions (nursing and medicine, particularly).

We cannot expect to make effective, sustainable decisions about health care organisation and delivery without the involvement of the people who will fund, deliver and receive these services.

Until we achieve that partnership, and we have people working together to achieve a vision, we’re still going to be struggling with the lack of connectivity.

In short, effective and sustainable change cannot come from one side alone.

So what can we, as physicians and physicians-in-training, bring to the table? We can take ownership of those things that are firmly within our domain of influence.
This means innovating across silos and sharing information.

It means taking on greater responsibility and accountability to patients and each other.

It means greater collegiality within and between health professions, improved communication and – always – compassion towards patients.

These are all things that we and our associations can influence. We are expert in these areas.

This is a philosophy that the CMA, and myself as its president, fully embrace. We’re committed to bringing this type of collaborative approach to all the work that we do, whether it be pushing for a national vision to improve seniors care in this country, calling for a strong public health approach in the legalization and regulation of marijuana, or developing solutions to address the current opioid crisis.

As we tackle the current challenges of today and look ahead to another 150 years as the voice of health and health care in this country, it’s so important that you, as the next generation of medicine, are involved in forging our path.

Speaking with students, residents and early-in-practice physicians across the country, I’ve been very impressed with the commitment and wide-ranging interests in health, social and environmental issues. It really is wonderful to see such engagement and determination.

The CMA would like to assist this as much as possible, so for physicians-in-training, there are many different ways that you can get involved and increase your knowledge and expertise.

- Through the CMA Ambassador Program, open exclusively to physicians-in-training and physicians in the first 5 years of practice, you can get involved in health policy, advocacy and leadership. By applying to the program, not only do you have the opportunity to attend the CMA’s annual meeting each August and see the policy-development process first-hand, you have opportunities to become a leader in your own community – by co-hosting local events in your area with the CMA, attending meetings with your Member of Parliament or leading training sessions with your peers. You’ll also gain access to physician mentors who can help you through challenges you may be facing.

- The CMA also offers complimentary advocacy skills training, in-person or via videoconference, so you and your peers can learn more about the political process and become a more effective grassroots advocate.

- Another way that you can regularly provide input and feedback is by joining our e-Panel and responding to short surveys that we send out to members a few times a year.
Physicians-in-training are currently underrepresented on this panel, so I encourage you to join, advise and make sure we’re getting an accurate representation of your concerns and challenges.

You can visit cma.ca/advocacy for more information about all of these programs and ways to provide your guidance.

In addition to making it easy for you to get involved in key issues and to advocate for better care on behalf of patients, the CMA and its companies are here to support you personally and professionally throughout every stage of your career.

Whether it’s by getting peace of mind through the financial planning services of MD Financial Management – who have a team of experts dedicated specifically to physicians-in-training and who know the challenges you face in medical school, residency and beyond – or by accessing free e-textbooks and better, faster answers for your education or patients through Joule’s clinical and point of care tools.

In summary, we must, as a profession, undertake a number of things:

1. Insist on true collaborative health care decision-making:
   a. Visioning
   b. Prioritisation
   c. Management oversight

2. Incorporate generalist principles throughout medicine, including holism, humanity, teamwork and continuity of care across community and hospital.

3. Discard the Triple Aim in favour of the Quadruple Aim, incorporating the essential supports for learners and practitioners in our health care system.

These are exciting times and change is clearly essential.

It must be clearly said, the medical profession is the only group in society that can press effectively for these changes.

It is our privilege, and our responsibility.

We will take this year to celebrate our 150 years of accomplishments and achievements in the service of our patients, and we will improve our future. You are the essential part of this, our next generation of medicine.

I have no doubt that 150 years from now, people will be looking back on our time and our work as key milestones in our country’s history and recognize the leaders among you who stepped up to effect solutions when the need was the greatest.
Thank you and I’d love to take any questions you may have.