

***Cracks Emerging in Canada's Health Care System:
Can They Be Repaired?****

Introductory remarks

Dr. Jason Berman, CEO and Scientific Director of the Children's Hospital of Eastern Ontario (CHEO) Research Institute and Vice-President Research at CHEO.

Welcome everyone. On behalf of myself and my co-sponsor of this morning's event, Dr. Duncan Stewart, CEO of the Ottawa Hospital Research Institute and VP Research at the Ottawa Hospital, I want to warmly welcome you to Ottawa and this leaders' breakfast and kick-off the event of this year's Henry Friesen Lectureship, awarded by Friends of CIHR.

It's truly wonderful to be able to hold this event in person and meet face to face after two years of limitations imposed by the COVID-19 pandemic.

The pandemic brought into sharp focus the weaknesses in our health care system across this province and across the country. While all of us experienced unforeseen challenges and hardships, the most vulnerable were preferentially impacted: The elderly and frail at the start of the pandemic, when we witnessed, with horror, large numbers of deaths in nursing homes from coast to coast. More recently, at the other end of the age continuum, we saw challenges for children and their parents, as they were the last age cohort to have.

Throughout the pandemic, we have seen the detrimental effects that social isolation, excessive screen time, and lack of physical activity have had on the mental health of adults and youth, compromising access to care for those with pre-existing conditions, while unveiling new travails for others. In so many cases the pandemic will leave indelible marks that will remain for many years beyond the infectious period of COVID-19.

And this brings us to the present, where the weaknesses in the health care system have evolved into cracks, cracks that threaten to erode the access to health care that we enjoy as Canadians, and the subject of this morning's Round Table. From burned-out nurses and physicians in every province to the Emergency Room closures that we witnessed this summer in Ontario and

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Québec, and the fentanyl crisis in BC, we are experiencing an unprecedented time in Canadian health care.

But let's not be forlorn. Let's think like Henry Friesen, always a pioneer ahead of his time, who championed out-of-the-box thinking and the ability to turn challenges into opportunities for discovery and creativity. If the pandemic has taught us anything, it is that research, particularly that done through innovation and collaboration, can solve even the greatest health care problems, and we are poised to contribute to those solutions in the coming months and years.

Dr Lorne Tyrrell, this year's FCIHR awardee, embodies that leadership, imagination, and resourcefulness taught to us by Dr. Friesen. I would now like to call upon Michael Strong, to introduce Dr. Tyrrell.

Dr Michael Strong, president of the Canadian Institutes of Health Research (CIHR) Thank you very much, Jason, it's a real honour for me and a real pleasure to introduce Lorne, our awardee this year. There are a lot of things I could say with regard to Dr. Tyrrell's career. He's a distinguished university professor, he's been seminal in hepatitis treatment, he's been recognized worldwide and in Canada for that,. But I've got to tell a little story of introduction, because you don't often get to do this in my position – and it's a good story.

You don't often get to put a personal spin on an introduction in a talk such as this, but when I was somewhat younger, just about to head off to medical school at Queen's, my older brother was in a motorcycle accident, quite a serious one. We didn't expect him to survive, coming out of it, and he had whole-blood volume transfusions.

He did, ultimately, get through all of this, and became an accomplished cyclist. You have to imagine, he got struck on his left side, it foreshortened his forearm. He's about two inches shorter on one leg. He has lost a lot of his mobility – and he has cycled the world.

One year he comes back, he's just finished cycling from Cairo to Port Hope, and he felt awful. He thought it was "well, I've slept on the ground, and bugs," and I said "I don't think that's it." And his family doctor was superb.

The time window – and you can guess now where the story is heading – was almost 30 years since the accident. Sure enough, he had hepatitis. It was

rampant, and getting him into a lot of trouble. So he came up, and said, “Mike, what are we going to do about this?” I said, “You know, we’re going to treat this.”

I had some really good friends who were hepatologists and got him right in to see them. He started on an oral therapy, and his viral load, along with his platelets, went to zero. But he got through the platelet part, and he’s not had any virus since then.

It was such a pleasure to be able to say to him, “Lloyd, you know, this is Canadian-made therapy. This is something we should be really proud of. We are able to treat this now because of the insights and inroads that have been made.” And I have waited for years to be able to say Thank you for that. I have my brother because of the research that was done, and because of the investment we make in science in this country.

That’s one of the arguments I make over and over again. You can’t plan what we do, you just have to let us do it, and these things will happen. So for all of the awards and all the accolades, of which you are richly deserving, it is such an honour to welcome you for all the other reasons. So thank you for joining us, and congratulations on the award.

Keynote Address

Dr. Lorne Tyrell, Distinguished University Professor at the University of Alberta and Founding Director of the Li Ka Shing Institute of Virology

Thank you very much, Michael, such a nice introduction. I didn’t realize that Canadians knew how much I worked on hepatitis, but when I went to China, people did, because it’s the number one disease in that country, hepatitis B, and that was a nice way of being known.

Let me just say that I’ve also been extremely concerned about what I’ve seen in the last couple of years in our Canadian health care system. One in ten Canadians work in health care, and we have five million people who can’t access the health care system very easily. Primary health care across the country is in real difficulty, and it’s not getting better. There was pre-pandemic stress on the system; It’s not all related to the pandemic; But I would say that the stress on the system wrought by the pandemic has really brought it to a crisis.

You people hear a lot about what's happening in Quebec and Ontario, but it's across the country. Alberta has got emergency rooms closing for periods of time. I don't know if it's all burnout, or if there is finally – we've seen it worse in August than we've ever seen it before – maybe some people are saying, "I've got to take a holiday, I've got to take a break. My mental health means that I've got to do that." But it brought excessive stress in all aspects. We saw it in long-term care, primary care, emergency care, acute care. Surgeries are delayed, and there's a huge catch-up needed for this system. Wait times have increased, cancer diagnosis and treatments have been delayed, cardiovascular deaths have increased, and for the first time we're seeing some decrease in life expectancy in many parts of the world, related to COVID, but also to the delays that have developed as a result.

Lockdowns were put in place really to reduce that peak, to give some chance for our emergency rooms, ICUs, and our health system to keep up. But as we tried to make sure that happened, of course lockdowns had their deleterious effects, so nicely outlined by Jason, and some of the key things that have happened, in economics, in education, and societal well-being. I've never seen a time where there is such conflict between people in society, and within families. It's really quite remarkable. In Canada's health care work force, burnout begets burnout, and it has increased. Excessive workloads have been seen with the pandemic, and that clearly means many people were working overtime, and excessively hard, and that led to burnout.

What we're seeing now is quiet retirement. We have seen 132,000 people leave the health care work force. Anti-vaxxers, lockdowns. Health care providers have been subjected to more abuse than ever before, and I've seen examples of that that have greatly changed people's attitudes.

I really think we have to say: How do Canadians get access to primary care? When you see a couple in Vancouver whose family doctor retires, and they can't renew their prescriptions, and they put out an ad in the paper to see if they can find somebody so they can renew their prescriptions - this is unbelievable to me. With health care in crisis, we need to be thinking of how we go forward from here.

There's a number of things that have been suggested, and I'm sure we'll come up with some ideas around these. But first let me say that we need to look at scope of practice. I work with nurse-practitioners, with nurses that help us run the clinical trials that we've done. And they are superb. So someplace in this, I think there has to be expanded scope of practice for primary care that includes nursing professionals.

I come from a province where our health minister, because of this problem a few years ago, simply said “Pharmacists are going to have increased scope of practice,” and I can tell you from personal experience that pharmacists are often very, very knowledgeable and give exceptionally good advice. So how is it that we have patients on medications that can’t get a renewal because there’s no way to get back to their physician?

We have looked at a number of solutions, including opening up immigration to bring in more health care workers. There are many issues around this that need to be addressed. It may be a more rapid solution, but the quality of training is certainly variable in this group, and we know there are also some ethical problems because more health care workers are also required in many of the countries where these people come from.

I served on a task force in 1999, a long time ago. But we did look at physician supply in Canada, and at that time – I still remember the numbers – there were 1,576 first year positions in Canada at that time, and when you did the calculation of growth in Canada, we needed about 2,500. Not 1,500. We did see some response, and did increase the number of medical students, but we still are not where we need to be. But that’s a long-term solution because it takes 6–8 years of training.

Another recommendation we made: There needs to be some flexibility in the system. I really do believe that we match medical students to resident numbers so tightly that there is no flex left there. At the time we did that report, we recommended 1.2 postgraduate training positions for every medical student that graduated. This gives you some flex in the system. In the United States and other places, they have had that flex, and it allows some time for training foreign medical graduates who want to enter the system. At least they then get into the system with some of our training, and we think the Canadian system has very high standards.

The off-loading to Emergency Rooms is unbelievable. You call a family physician’s office after hours, and the answer is “Go to Emergency.” We have the emergency hotlines, and many of those end up with “Go to Emergency.” The hotlines do help, but there is not as much relief as we had hoped. Health care worker fatigue and burnout was high before COVID, and COVID really broke the camel’s back. So I believe we need to look at scopes of practice to help with primary care. I believe that with some careful regulation nurses and pharmacists can provide some relief to the system as well as to many of the people who need access.

Virtual care has become very much an issue. We have seen it during COVID and it has changed the way we practice. Virtual care has some positives, of course. Patients are not traveling as they had to do previously. Examples of virtual care where we have seen tremendous improvement are in fields like dermatology, where you can assess and diagnose patients and I quickly, and there are many other examples. However, I think there is still some concern with virtual care, that you do need to see patients at some point. I know that COVID has interfered with the training of our medical students and residents, and maybe virtual care has to be examined in that context, as well. We need to evaluate what we're doing with virtual care, how it is impacting not only our health care system, but also our educational system.

And there is always the issue of private health care. Private health care is here now. Many physicians practice as independent clinicians that are paid from a common source of payment. The real question here in getting into private health care is a private care with public money to pay for it.

I would say that when we made our report in 1999 we did ask that this be done with a review every two to three years to determine the right numbers. We have not followed through with that plan, and we are paying the price, so it's an important time. I would say that HealthCareCan – which is now the collective voice of the academic health centres, the medical schools, the hospitals – have put together a report, that came out in May this year, to the standing committee on health, and I think it was a very good report, with excellent recommendations. So there's a very good starting point to get to some of the things we need to do. But at the present time we have a crisis, and we have many good people involved around the country. We have to come up with solutions.

It was interesting to see that in the *Globe and Mail* – every *Globe and Mail* that you pick up has something on the health care crisis. Hugh Segal said very recently in an op-ed in that it was time for another Royal Commission. Let me point out that the Hall Commission introduced the present health care system 70 years ago. It has served us very well until recently. But when it was introduced, the population was 16 million, the average age of a Canadian was 28 years, and the life expectancy was 69. Today we have 38.5 million people in Canada. By the way, health care originally only covered hospitals and physicians. We now are looking at problems in long-term care, home care, and many other expanded areas where we expect the health care system to help out. I just think that Hugh's suggestions are that 70 years following the Hall Commission, that maybe we do have to have

another run at how we can come up with a health care system, and design it for the current population and our current needs.

The other one I just want to throw out is that we do have two medical schools, one in Ireland and one in Australia, which train a lot of Canadians who don't get into medical school here. When they graduate, they can't easily get back to our system. They have a harder time than a lot of the immigrant doctors coming into positions here. Why is it that we can't make some adjustments in our training programs so that these individuals have a chance to come back to Canada? Most of them want to. They've gone away and they've trained. There's at least 200 a year, and that's another area where there is the potential for a quicker solution to help with the HR crisis. I think we should be looking at how we can adjust that structure. I see many of those people coming back, they have good training and they have a better chance to come back to Canada.

I believe so much in the Canadian health care system, I hope we can come up with some new solutions. The real issue right now is getting these things together, because we've got to lay all of our interests down, and come in and say, "How do we redesign this health care system to work for Canadians?" I'm not sure that will happen, but I thought it was an interesting suggestion from Hugh Segal. I would think, as somebody said this morning, we could call on David Naylor again, and say "David, will you take this on?" Anyways, I think there's lots to discuss in how we might approach this.

These are a few of my thoughts around primary care and issues that we need to look at. I still believe we can fix it, but it's going to take a real coming-together of minds from many different areas to say "What are the solutions?" and "Let's get this system redesigned" Thank you.

Conference Speakers

Jason Berman: Our first speaker is Dr Duncan Stewart, who is the CEO and Scientific Director at OHRI and the VP Research at the Ottawa Hospital

Duncan Stewart

Thank you and good morning to everyone. I was asked to comment a little bit about the perspective of academic hospitals, tertiary and quaternary hospitals, and how the recent years have impacted on this sector. I must admit that when I saw my name on the program I was a little surprised. I think there are others that are better suited to talk about this. I checked with the CEO of our hospital, Cameron Love, his perspective is very important, and I did get a little of that. As well, I sit on the senior management team and have had a front row seat over the last many years.

I think that in broad terms there are three main challenges that large hospitals have faced, and all of these are serious problems in their own right. But when they're taken together it's a recipe for real trouble. As Dr. Tyrrell mentioned, these are not new since the pandemic, they are things that have pre-existed, that have been developing over many years of restructuring and cutbacks and change in the system. But certainly the pandemic has turned up the heat on these issues and really opened up some of the cracks in the system.

1. The first major challenge is that hospitals have faced a lack of capacity within the system. It's not rocket science, there are simply not enough beds, and it's not just in acute care, it's in transitional, it's in long-term care. As mentioned earlier, it's also particularly serious in the ICU and in the emergency areas. At the peak of the pandemic, obviously it was the ICUs that were in the headlines. They were overloaded, and getting incredibly full. In fact procedures and protocols for rationing ICU beds were developed, that's how serious it became. Of course, as the pandemic developed, it spread to other areas of the system. It shone a spotlight on long-term care. Patients in long-term care facilities felt the brunt of the pandemic early on. That was a major issue and has continued to be a problem throughout. One of the things we noticed in acute care is that these systems are not independent, they're interconnected, so in any major acute care hospital, we have a sizeable number of what we call alternate level of care beds. These are patients that shouldn't be there, they should be more appropriately housed in a long-term care facility. In our hospital, that's about 20% of our beds taken up by these patients, and that results in our not having 20% of our beds available. It means that we're running at capacity, or over capacity as a norm, and it's just not sustainable to run a facility at over 100% capacity.

2. The second major challenge is the people, and we heard about this earlier from the first two speakers. There is lack of sufficient staff across the board. It's not just physicians, but also nursing staff and allied health staff, and it has been an ongoing challenge for many years, but it has really been put into sharp relief by the pandemic. This is aggravated by burnout. People have been working above capacity for years, and many are now leaving the system. They're taking retirement, they're finding careers in other sectors; so we're losing the people we already have. We have major challenges in replacing these people.

And it has been further aggravated by the way the pandemic has evolved. With the Omicron variants, more people are getting sicker. They can't come to work, and again this impacts the available staff, trying to run a large complex system and find people to cover shifts.

3. The third major challenge relates to education and research, and we heard a little bit about this from Dr. Tyrrell. Teaching and research take a lot of time and effort, but these are of critical importance to an academic hospital, because we need to develop the next generation of care workers, researchers, and leaders. This is incredibly important. We have overburdened physicians, nurses, allied health staff that are having trouble getting through the day. They have less time, less energy to spend on teaching, and this is impacting our education program, not to mention the lockdowns and virtual nature of some of the activities. And while we may not feel the impact of this immediately, we will over the years. We're talking about the next generation of people we need to bring along. The quality of their education, their ability to really contribute to the system, is going to be a challenge.

While the pandemic has put unprecedented stress on the system, it's worth noting that there are also significant challenges posed by coming out of it. That's not going to be easy. In addition to all the tough issues I have described, there's a significant backlog of surgical procedures, radiology procedures, all kinds of other things that have been put off during the pandemic and now have to be addressed. This is not insignificant, and it means we not only have to get the system back up to normal, we have to ramp it up at 120% normal so we can get through all of these backlogs. This comes when we are already working full-time, so it means extending shifts, working weekends, asking people to do more at a time when they

really need to take some time off and recharge batteries for their own mental health. This is not a good situation.

I hope I haven't depressed you too much, and I'd like to end on a more hopeful note. There were some silver linings in the pandemic. Times of war can lead to individuals and institutions putting aside some petty differences and working better together. We can do a lot more of that in various parts of Canada. In Ontario there were structures in place to ensure regional coordination, which have really worked well. We can better leverage the capacity in the system to work effectively together, and work for the patients and the community rather than for ourselves or for the institution. Going forward we will be able to do much more of that, in addition to implementing many of the ideas that Dr. Tyrrell gave us. Hopefully as we move forward we can develop a more resilient and robust system that will withstand not only peacetime needs in, but also the stresses of future health battles. I'll stop there and will be happy to entertain questions and discussion. Thank you.

Jason Berman:

Thanks very much, Duncan. Next I'd like to call up Dr. Kathy Pajer. Kathy is the former Chair of Psychiatry at the University of Ottawa, Chief of Psychiatry at CHEO, and she is the medical lead for our precision child mental health initiative and child and youth mental health care. She'll be speaking on "Child mental health care: high demand, low supply."

Kathy Pajer:

Congratulations, Dr. Tyrrel, on your illustrious career and wonderful accomplishments, which have led us to be here today. Some of what you talked about I am not going to repeat, but I couldn't agree with you more.

When we think about demand and supply – we usually say supply and demand, right? But I have turned it around because all we hear about today is demand. That is because, as you've heard in the *Globe and Mail*, as you've heard on the TV news, our kids are in trouble. But the pandemic is not the problem. The pandemic has shone a spotlight where before we only had a flashlight to see exactly what was going on. The kids are in trouble, they've been in trouble for a while. So demand is what you hear about a lot; and then there's supply. I'm going to unpack both of those.

First I'm going to say that one of the things that's very interesting – I'm from the States, but when I got here, and learned the history about the system 70 years ago, one of the things that struck me was how physician-centric it was. Physician-centric, it makes sense, right? Especially back then, but back then, what we had for psychiatric care, what is now called mental health care. In Canada it was divided into hospitals (academic or general), what we would call state hospitals – here you're talking about provincial psychiatric specialty hospitals – and then some people in the community, but not very many. The way the system was constructed from the beginning was flawed in the assumption that physicians would be the best people to provide mental health care

That's really the root cause. None of the other types of providers, which we now know are critical to the system, were included.

If you also look at supply, you can see the problems with that. Paul Kurdyak's group in Toronto have done some of the best work showing that if you depend on psychiatrists to deliver mental health care, you're in trouble. They just came out with a paper asking the question of when you depend on them to be psychotherapists, which is what the original plan was, do you get bang for your buck? No, you do not. Why is that? First of all, our residency training over the years has decreased the emphasis on psychotherapy – with good reason. Because before it was grounded in psychoanalysis. And I might be offending some people here, but we don't have a lot of good evidence that psychoanalysis was effective.

In addition, while psychotherapy use has gone down, medication use has gone up. So what do we have now? I just looked at a case yesterday, a five-year-old who had had six foster home placements already, a lot of aggression, no attachment figure, and was being given an adult antipsychotic as "the" treatment. Nobody was doing anything wrong, to tell you the truth, except that CAS wasn't getting the kid the care that they needed and a stable placement. You can't use an antipsychotic to fix those kinds of social problems. And a psychiatrist doesn't have much in their toolbox. So that's one example of the problem.

The other problem we're seeing is the reliance on GPs as the gatekeepers. It's failing miserably for a lot of reasons that I won't go into, because they're trying to refer to psychiatrists. We run something called Project Echo for child and youth mental health care. We've trained over 500 primary care providers in Ontario in how to deliver proper child and youth mental health care. But they know nothing about the entire non-medical network of mental health care. They don't know how to access it, and they don't know

how to use it. They don't even know – we teach them – this is how you need to communicate with the therapist. And then there's a shortfall of those therapists. So dependence on physicians to provide care: When we say supply, let's increase the number of psychiatrists. Yes, that could help. But it's not going to happen. People don't go into Psychiatry very often, and part of it is because it's not that rewarding any more. It doesn't bring you joy. I will get to that shortly in terms of what we need.

The demand has also changed dramatically. There has been demand creep. What I mean, is back 70 years ago, the demand even from child and youth would be for what we call severe mental illness: bipolar disorder, psychosis, major depressive disorder, and there certainly would have been ADHD there. But now, the culture has changed, so that it is "I expect you to make me happy." My job, and a therapist's job, isn't to make you happy, we're trying to promote mental health. So the demand has also changed, but we need to pay attention to that too; and that requires a different type of supply.

If I'm going to make some recommendations about what we can do to help improve child and youth mental health, certainly mental health care could be improved by broadening the list of people who can do the work. Don't depend on the physicians; don't depend on the psychologists, Broaden who can help provide the care. The other thing is we have here is two types of disciplines that are used. Child and youth care workers, their name varies across provinces; and occupational therapists. These are very under-used sets of professionals, who could – if they were able to be paid for by insurance – do a lot of the work with the kids that are symptomatic, but don't yet reach diagnostic or syndromal level.

And the final thing is training, not only for primary care physicians, but also our psychiatrists and psychologists need to do a different kind of care. One of the things that we're learning in precision child mental health is that they have to have evidence-informed care; and I'm telling you, doctors are the worst – "You don't tell me what to do. Thank you very much, I know how to do this." Well, in fact, how do you know your patient is getting better if you're not asking them the same questions every week? And they also don't understand that this power-sharing with patients empowers them, and that's the other thing we need to be training physicians to do- create a therapeutic alliance that does not infantilize, but empowers both the patient and the caregiver.

Those would be my recommendations, some of my recommendations. Thank you.

Jason Berman:

Dr. Sarah Funnell is a family physician, and the founding director of the Centre for Indigenous Research and Education at the University of Ottawa.

Sarah Funnell:

Miigwetch for the invitation this morning. I want to first to welcome you to my traditional Algonquin territory, which we also call Ottawa. I'm a First Nations family physician and public health specialist, Algonquin and Haudenosaunee background.

I wanted to start with a quote by my colleague from Manitoba, Dr. Marcia Anderson, because I think it will help you see where my perspective lies. She says, "From now on, instead of vulnerable people, I'm going to use the phrase 'people we have oppressed through policy choices and discourses of racial inferiority.'" It's a bit longer, but I think it will help us focus on where the problems actually lie. And I always get a little chuckle out of that because Marcia is quite funny, actually.

The other thing I want to acknowledge is that I recognize that no one in this room, or someone that will read this report following our breakfast today, is at fault for the situation that all my relations find themselves in with health inequity. But you're part of the solution. I have a child that loves Spider-man, and we love this quote: "With great power, comes great responsibility." I share that everywhere I go.

I want to start off with a thought-exercise: In your mind, think of a health inequity you're aware of in relation to First Nations, Inuit, and Métis people. What are the things that come to mind when you think of the health of Indigenous people? You might be thinking of infant mortality, maternal complications, diabetes, suicide, substance use. You might be thinking of lower life expectancy. So then ask yourself, why do these inequities exist? Indigenous people, First Nations, Inuit, and Métis people are expected to live 10 years less than non-Indigenous people, just by being born Indigenous. What is that about?

When I teach medical students, residents, and my colleagues, I take them through a root cause exercise, and we ask ourselves why? Why does that exist? Why would Indigenous people live fewer years just by being born Indigenous? Why is an Indigenous woman more likely to go missing or be

murdered than a non-Indigenous woman? When you ask yourself enough “whys”, you get to the root causes of this. And medical students, residents and colleagues tell me all kinds of things. I’ve heard everything you can imagine; and we always get to this idea of racism. And racism, back to Marcia’s quote, is about power and control. And in the Indigenous context, on Turtle Island (which some of you call Canada) it’s about power and control over Indigenous people and our land. Why do you love this nation? It’s beautiful, it’s rich, rich in resources. You love it for the same reason that the early pioneers and colonists loved it, the same reason I and all my relations love it. And that is where the power comes in. It’s power and control over Indigenous people, particularly women, for our land and resources.

Racism operates at different levels. It operates at an individual level - that interpersonal racism where we see people with hate crimes. It operates at a systemic level, and we’ve heard a lot about the system. COVID was originally thought of as the great equalizer, we’re all equally non-immune. But it’s actually the great illuminator. We see these cracks in our system. And for Indigenous people, we’ve been screaming for years before the pandemic that there ‘are lots of problems in our health care system. Truth and Reconciliation calls for action on health pointed them out years before the pandemic. We were perfectly set up for what we’ve discovered - the systemic level. Racism operates there, in all of our systems. If you’re not racialized, if you’re not Indigenous, you can’t see it; but it’s there. It’s in this room too.

But the most tragic and saddest level of racism is when you personalize it. It’s internalized racism. And it’s when someone of a racialized community – Indigenous, First Nation, Inuit, Métis person – hates themselves, hates where they come from, hates their culture, language, and the people in their community. Imagine if you hate yourself. Imagine how you treat yourself. Imagine that you hate your culture, and how you treat people around you. That goal of assimilation, of residential schools, and all of the -isms, and the racism that exists in all of our systems, is meant to assimilate Indigenous people to be *not* Indigenous. That is the end goal - to kill the child, to kill the Indian in the child. That is the end goal of assimilation, and what that means is that we know that assimilation has worked. The final step is when someone hates themselves and where they come from.

So let’s do a thought experiment. What would the health of First Nations, Inuit, and Métis people look like if Indigenous people were leading health care? What would it look like? What would the health care system look like?

Think about that for a minute. And if it frightens you to think that way, then I've unsettled the settler within you. And that's okay, to be uncomfortable. I'm uncomfortable all the time, I'm uncomfortable right now.

But what is our responsibility as health care leaders, what are your responsibilities? Remember the Spiderman quote. We have heard from our previous speakers that there's not one solution, there are multiple complementary strategies, and thank you to Dr. Naylor for his report identifying that years ago, and the Ottawa Charter on health promotion. Senator Murray Sinclair, graduate from Queen's, says with regard to the Truth and Reconciliation Commission, that we've described for you a mountain, and it's up to you to do the climbing.

I'm not going to make up a laundry list of things we need to do to fix the system. The answers lie within the Indigenous people and their community. We're strong, our culture's healing, and the TRC's call to action on health points to that - we need more Indigenous doctors and nurses; we need more traditional healing centres; we need increased knowledge of doctors and nurses and health care practitioners of our history; and we need better data. It's all there, so I don't have to make this up. It's all there, but how do you do it, how do you operationalize it? With benchmarking. The answers do lie in the Indigenous community. So before you go and solve all the problems, you need to talk to people and understand how to operationalize what the Truth and Reconciliation Commission's call to action tells us we need to do.

That's when I say, as a doctor trained in Western medicine, I was taught that I knew what was best for my patients, and it has taken years to undo that tenet. Now I know that we need to move to healing-centred care, and instead of asking our patients and our communities, "how can I fix your problems?"; instead we ask "what is right with you?" and start from there in that more positive aspect of health, so we can build from where we have strength instead of putting band-aids on our deficits.

I will leave it there, I might have exceeded my four minutes, but thanks for your attention. Thank you.

(Applause)

Jason Berman:

Our next speaker is Dr. Erna Snelgrove Clarke, who comes from Queen's University where she's the Vice-Dean of Health Sciences and Director of the

School of Nursing, and she's going to be speaking on "Focusing on tomorrow, taking action today; nursing and health care." Erna.

Erna Snelgrove Clarke:

Thanks Jason, and good morning. I'm really pleased to speak with you this morning and share my thoughts and opinions. As the Vice Dean Health Sciences and Director of the School of Nursing at Queen's, I'm accountable to my community, my colleagues, and to the students for whom we provide an education. With that, I sit in a position of privilege, and with that privilege, I hope to instill change.

Audre Lorde – and some of you may know who that is – is a Black feminist writer and activist. She once said, "The master's tools will never dismantle the master's house." What she meant, and what I speak of this morning, align. However, I'm going to reframe her quote to speak my thoughts and opinions. We have a crisis in health care. Health care is the master's house. We, as a collective of consumers, decision-makers, health care providers, and researchers, need to dismantle that house. We need to work with others to fix the house. It is not possible to use the tools, the strategies, and the initiatives that have always been used by the master. As Audre Lorde so aptly said, "Our house cannot be dismantled by ways of the past, by the persons of the past. We must seek new ways and new persons."

This morning I propose four strategies, and as my colleagues have said, there are way more. But I'm going to give you four ways that we can use to address our crisis and imagine a way forward. Being willing to support our health care system means that we need to be willing to question ourselves, to be uncomfortable, and to stand up for new and bold initiatives. I'll speak about nursing, because this is my discipline, but my heart is about collaboration, inclusion, equity, and participation for all that are involved in health care. I'm going to speak about showing people we know their worth, we see their worth, enabling people to speak up, to use their voice, needing a mentor, and capitalizing on nurses' competencies, because we can do way more than you know.

1. Showing people we know their worth: In research conducted by Dr Carol Estabrooks, the main determinant for using evidence in practice and behavioural change is our values, our attitudes, and our beliefs. When we have shared values, there's an understanding of how we work together. We collaborate effectively when we communicate and work towards comparable goals. When persons feel valued, they contribute

to an effective and efficient workplace. At present, nurses do not feel valued. This must change.

2. Enabling people to speak up: What is a safe environment? It's an environment where persons feel comfortable to speak up, share their opinions, even if they're different, and are supported when they make mistakes. Nurses as an example are asking themselves, "Does work fit with the rest of my life?". Nurses are reflecting on what they need. Are their employers ready to listen? Traditionally, nurses have not been enabled to use their voices effectively in the workplace. At present, effective use of voice means they are talking with their feet. This must change.
3. Needing a mentor: I recently wrote an op-ed for the *Toronto Star* about what it was like when I began nursing and what it's like today. New graduates are going to environments that are not friendly. They are not being greeted with open arms, and they are not being mentored by senior nurses. Perhaps in an environment where nurses are welcomed by those with experience, they'll feel encouraged to stay. All persons need mentoring. This must change.
4. Capitalizing on nurses' competencies: Long before COVID, as everyone has said today, it was clear that there was a problem. There was a problem in nursing. It was repeatedly reported that nursing numbers in Ontario, nationally, and internationally, were decreasing, decreasing significantly; and today we continue to have a significant number of nurses leaving the profession. One solution is to support nurses. For example, having nurse-practitioners to work in roles where their skill sets can be effectively utilized. It's okay to say we'll increase seats in nursing and other disciplines. However, we don't have the health care rotations, or persons to facilitate these rotations. This must change.

Collectively, we need to communicate. Those making the decisions for tomorrow need to be from the front lines. The front line of practice, education, and research. Nurses want their voices heard, and they want to be included. The house is broken, and the master's tools are not working. Thank you.

Summary Comments, by Dr. Jason Berman

This Roundtable event brought together diverse Canadian experts representing perspectives from Medicine, Research, Nursing, Mental Health, and Indigenous Health to respond and reflect on the comments made by Dr. Lorne Tyrrell in his Keynote address as the FCIHR Friesen Prize Awardee. Dr. Tyrrell discussed many of the health care challenges highlighted by the pandemic, including access to primary care and the gaps in health human resources, and offered some potential solutions, such as expanding the scope of non-physician health care professionals and leveraging technology like virtual care visits. These health care challenges were expanded upon by the Roundtable speakers, who reminded us of the current strain being felt by acute care hospitals; the burden of mental illness affecting young people; and how marginalized populations, including those who are Indigenous, have been preferentially impacted by the pandemic. These difficult times require creative solutions and panelists provided hope by way of innovative thinking: incorporation of artificial intelligence-based solutions; being person- rather than disease or systems-focused; and providing care that is tailored to individual patient needs incorporating all available sources of data from Genetics to Socioeconomic status. The Roundtable ended on a hopeful note acknowledging that we are a health care community that is willing to learn from each other and work together. By embracing new technologies while respecting traditional and cultural ways of life, we have the privilege and the opportunity to improve the overall health of Canadians.