Interview with Dr. Danielle Martin

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Dr. Danielle Martin

Dr. Danielle Martin is the Executive Vice-President and Chief Medical Executive of Women's College Hospital (WCH), where she is also a practicing family physician. Dr. Martin is the co-founder of the WCH Institute for Health System Solutions and Virtual Care (WIHV). She is an associate professor in the Department of Family and Community Medicine and the Institute for Health Policy, Management and Evaluation at the University of Toronto. Dr. Martin completed her MD at the University of Western Ontario and her master's in public policy at the University of Toronto.

UTMJ: We would love to get to know a little bit more about your policy work and practice. How did you first become interested in health policy?

DM: The classic trajectory for physicians who become involved in health care policy tends to be that they start with an interest in clinical medicine, and then slowly grow their interest in system level issues as they progress through their careers. My experience was different: I began as someone with an interest in health care policy, health care systems, and health care politics before I went to medical school. As a result of my engagement with health policy issues, I came to realize that I was passionate about improving health and improving health systems, and that one way I could really come to understand how one makes change inside a very complex system is actually to work right on the ground level. That was what led me to apply to medical school, but I've always had an interest in health systems and that's always been my area of focus throughout my whole career.

UTMJ: Do you have any significant interactions or experiences that you can think of that influenced your career trajectory?

DM: My first job out of undergrad was working for a member of provincial parliament. One day a woman came to see my boss as her local MPP. She was a new Canadian who lived in a high rise, low-income housing building. She was there to ask for help getting switched into a different building. There were mice in her apartment which was exacerbating her daughter's asthma. She had been taking her daughter to the doctor and getting prescribed puffers and other medications, but she knew that it had started as a result of the exposure to these animals living in their apartment. One day her daughter went to school and opened her backpack and a mouse ran out of the backpack, in front of the other kids in the classroom. She was so ashamed, and the mom was so ashamed, not being able to protect her daughter from that kind of experience. I was really marked by the extent to which, in this particular case, housing and financial resources were shaping the physical and emotional health of this family. So, I would say that was a particularly early formative experience.

UTMJ: As you still run an active family medicine practice, what does a typical day look like for you?

DM: One of my great loves is the practice of family medicine and the development of relationships with my patients over years and decades. I work in an academic setting, so I have three days a week where I do a half day clinic and then I'm checking my labs and my messages and trying to manage my patients as best as I can from a distance. And I'm really lucky that I work with colleagues in an interprofessional team where we cover each other, so I can make sure that my patients get the care they need when I'm not in the clinic. The rest of the days, I do hospital leadership and healthcare policy work. I've been co-leading my hospital's pandemic response during COVID-19, so that's been very busy. That work has included things like setting up a testing assessment centre, building an inpatient ward, and building a community outreach mobile team. The latter provides testing and other resources in the community to places like schools, shelters and other congregate living settings. We have also built a whole suite of virtual care programs, such as a program called COVIDCare@Home and a program called LTC+ that provides support to long term care facilities. I'm not doing that work myself, the amazing teams who work in this hospital are doing it, but I'm certainly helping to lead it and to figure out how to resource it and support those programs to grow. The goal is always to use whatever resources, people and ingenuity, we've got here in the hospital to respond to the pandemic, which of course every organization in the sector and the broader economy is also trying to do.

UTMJ: Could you tell us more about the COVID-related activities you are currently involved in?

DM: Our hospital is unusual in that we don't have an emergency department and we don't have an ICU or other inpatient beds. So we're not in a position to provide the services that most hospitals in the system are having to do right

now such as taking care of patients who are really sick and need to be admitted to the hospital with COVID-19 and its complications. But in a way that allows us to play a really different kind of a role in the system. We focus on community outreach and keeping people who are infected with COVID-19 but don't need to be admitted to the hospital at home, supporting them so that they can recover safely. This helps to prevent them from unintentionally infecting others, as well as reduces the likelihood of having to come to the hospital or to the emergency department if that can be avoided. We are really thinking about our programs as a set of community facing initiatives: supporting workers in long term care, patients in the home, primary care providers, people working in retirement communities, community health centre partners, shelters, and the list goes on. These are the people who are working closely with our community members and our job as a hospital is to try to support them to do their jobs so that we can reduce avoidable hospital admissions. That is why we call ourselves "the hospital designed to keep people out of hospital".

UTMJ: What kind of broader policy level concerns do you see trickle down to the individual provider/patient level and vice versa?

DM: Certainly, working in clinical practice and seeing my patients keeps me motivated in terms of what I do policy for and why I care about these things. Watching my patients experience things like long wait times for elective services, frustration in trying to navigate the opaque systems that we have in order to access services, the disjointedness of communication between hospital admission and them showing back up in primary care, or the requirements of employers for sick notes are all examples I experience first-hand in my practice. The issues have faces, for those of us who work in clinical practice, we can picture the person we're advocating for when we're advocating for change. And of course, I always worry, as every one of us should, about dividing my attention and spreading myself too thin and not doing a good enough job of the things that I owe to others. On that front I just say every day I try to do my best.

UTMJ: Could you explain for our readers what social determinants of health are and how they are linked to health outcomes?

DM: So, the determinants of health are all of the things that shape a person's individual chances of being healthy or ill, over the course of their lifetime. And what many people don't realize is that most of those determinants do not reside in medical care or the healthcare system. What we call the social determinants of health are all of those other things. So, health care and its availability and its quality is really important, and everyone should have access to it when they need it. But at best it only will determine 20 or 25 per cent of whether a person is healthy or not. What really determines whether we are set up to live a healthy life are things such as our income, our experiences of racism and sexism and other forms of discrimination, our housing, our access to nutrition, our access to education for ourselves and our kids, all of those things, and more. That's really what determines health for people. Some of these are individual determinants but many are also collective or community factors. The ways that social determinants influence health are in some instances, very direct. If I don't have enough money, I can't pay for safe housing, I can't pay for my groceries, I can't be healthy. But also, indirectly, if I can't afford extra-curricular opportunities for my kid they may not develop the broader skills and social networks that can open the door to a good first job that later opens doors to other subsequent jobs. And so, there are direct and indirect ways in which the inequitable distribution of resources shapes people's health and chances in life, which is why healthcare and medicine will never be enough to determine the health of a population; we must always be doing all that we can to strive for social justice.

UTMJ: Addressing the social determinants of health can be challenging and overwhelming, do you have advice for our readers who are looking to influence them at the patient or practice level?

DM: Absolutely. There's so much that we can each do at the practice level or the individual level. There are validated tools that we can use to screen and respond to our patients who struggle with the social determinants of health, such as the Clinical Tool on Poverty that Dr. Gary Bloch and other researchers at U of T [the University of Toronto] developed where you ask patients a simple question like "Do you have trouble making ends meet at the end of the month?" and then respond meaningfully to the information that yields. So, asking and being non-judgmental, opening the door and then helping to solve problems for patients who are struggling is critically important and something that we all need to see as part of our job. And no matter what our role is in the healthcare field, at the practice level, there are a million decisions that each of us makes every day to either be more accessible and equitable in the way we organize our practice, or less so. Where do you choose to practice, where do you locate your office, do you offer access to translation services? What do you do when a patient shows up late? How do you make yourself available outside of regular office hours to people who work shifts or can't come in during the day or during the regular work week? How do you ensure access to social services and support? Do you work in an interprofessional team? The list is long and there are all kinds of things that we can do that are really concrete and not difficult. But that does require some attention to the social determinants. Then finally at the meta level, there's much that we can do to advocate for healthy public policy. And I do think that that is part of our job as practitioners in the health care system, to try to close those gaps that exist. You can't fix the fundamentals by treating one sick person at a time, you have to look upstream.

UTMJ: Often in Canada we compare our healthcare system to that of the US and focus on how we're doing better, but our system is by no means perfect. Specifically, you talk about ways to improve the Canadian health care system in your book "Better Now: Six Big Ideas to Improve Health Care for All Canadians". Can you summarize for our readers what these 6 ideas entail?

DM: For sure. So, I am a big believer in publicly funded health care. I believe that ensuring access to health care is based on need and not ability to pay is a fundamental statement about how we see ourselves as a society and as a community. But I am not interested in defending the Canadian healthcare system in its current state. There is plenty that we do well and there is a lot that we need to do better. There are evidence informed ways that we can do better, and which enhance those fundamental values. So, the purpose of the book really was to try to engage the public in conversations about health system improvement and health system reform. Understanding that there are millions of great ideas out there, I chose what I think are the six most accessible, most evidence informed ideas from the vantage point where I sit. I'm trying to put forward positive solutions to the challenges that we face that don't undermine our values. The book starts with relationship based primary care for every Canadian, something that we know works to improve health equity. The next idea I discuss is the pressing need to expand Medicare to include prescription drugs or pharmacare. In the third big idea, called "don't just do something, stand there", I explore the notion of harmful and unnecessary tests and procedures. I also put forward concrete approaches to reforming healthcare service delivery to reduce wait times and improve outcomes without spending additional money in big idea four. In idea five I highlight the role income inequality plays in our health and propose implementing a basic income guarantee. In the final idea I make the pitch for scaling up successful solutions across the country. Those are the six big ideas. People have challenged whether I picked the right six, which I welcome. I think that the book was a learning experience for me certainly but is also a useful opening for a public conversation, which was what I was trying to do with it.

UTMJ: It has been a few years since you finished and wrote your book, do you have any insights or ideas that you formed after publishing it?

DM: I have reflected on this. I would say that my hope with the book was to start a conversation and get people thinking about improving healthcare. At the time I didn't really think past that, to what would happen next, and how to leverage whatever attention the book might garner into ongoing movements for social change. So, the biggest thing that I learned when the book came out was that people would come up to me and say, "I read your book. I think it's great. What can I do?" and I didn't always have a very good answer because I'm just one person. I'm not a political party, I'm not a social change organization. I didn't have a petition for them to sign or a cause for them to donate to, so my answer was, you can get involved, you can call your MPP, you can volunteer to be on the patient safety council at your local hospital, you can ask better questions of your doctors when they want to send you for a test, but I didn't have a well-organized infrastructure for supporting people who wanted to leverage the enthusiasm that the book sparked in them. That doesn't mean I think that the book wasn't worth doing, of course it was and I'm happy that I did it, but it's a reminder of how much infrastructure it takes to actually sustain a movement for change. And that was an important learning point for me.

UTMJ: Why is it so difficult to actually bring about changes that seem to just make sense? For example, with prescription medication coverage?

DM: It's a really great question and it's one of the things that the study of public policy helps us understand – why seemingly obvious ideas do not see the light of day. And the answer is because evidence, while it's important, is only one input into public policy. Lots of other inputs are also important, and we actually wouldn't want to live in a society where evidence was the only input. Values are also important, feasibility is important, trade-offs are important, and prioritization is important to name a few. Costs are important, public readiness and openness to change is important, capacity to roll things out on the ground is important, all of those things and many more are really critical. That's part of the reason why I wrote the book because I, like many healthcare workers, was feeling frustrated that all of these ideas are out there, and we all know what we need to do, but we can't just go ahead and do it. And part of the answer is because political decision makers will not respond simply to you and me, they need to hear from their constituents. That's called democracy. And we believe in it and we value it and so the way to create an appetite for change is to get people – voters – who care about the health of their families and themselves excited about these ideas, and they need to do the pushing. When you do that kind of public engagement work, that's how you create the appetite for change, in my opinion.

UTMJ: Marginalized communities like the Black and South Asian communities in Ontario have been hit especially hard by COVID-19, what do you think we could have done better in our response to COVID-19?

DM: Absolutely we could and should have done better. We should have demanded better of our leaders and ourselves. We know that there are high level answers to the question of what "doing better" means, notably the need to dismantle systemic racism. We need to protect people who work in low wage jobs and precarious work, so that they don't feel that they have to go to work when they're feeling sick and they don't have to work multiple jobs to make ends meet. We need to eliminate substandard crowded housing. And the

list goes on. These are the structural kinds of underpinnings to the answer that run alongside conversations about anti-Indigenous and anti-Black racism. But there are also things that we can do in the immediate term as part of the pandemic response. We have known for quite some time now about the disproportionate impact of this virus in Black communities, in low-income communities, in long term care, and now unfortunately increasingly among Indigenous communities. And yet the resources haven't flowed to where the need is. So, if we think about immediate questions like, how do you get access to adequate testing, rapid treatment, and better supports for people who are sick and therefore can't go to work? We haven't done an adequate job of putting those supports in place across Canada so that people who are in communities that are hardest hit have a chance to protect themselves and their families. I think our pandemic response will be judged by the ways in which we let those communities down.

UTMJ: With deployment of new SARS-CoV-2 vaccines, do you think social determinants will pose a barrier to immunization programs? If so, how can we address them?

DM: We need to think about our prioritization frameworks. Right now, we're all focused on getting the vaccine to long term care residents and workers and then frontline health care workers. And that's really important, but as soon as we start talking about community-based immunization programs, are we going to prioritize those communities that are hardest hit? Are we going to make it easy for people to access the vaccine or are we going to expect them to get on two buses and stand in line in order to receive it? Are we going to give people protected time and paid time off of work to be immunized, are we going to give people information in their own language in a way that they can understand and through trusted members of their communities instead of just posting things on websites? So, all of the ways that we frame the vaccination rollout is going to be really relevant to our success in the hardest hit communities. These are very concrete examples of how the social determinants play out in the design and implementation of programs.