AMS - CM Ep. 20 - Zayna Khayat & Will Falk - Transcript

Helen 0:00
Well, I have to say I've been looking forward to this podcast for some time. For those of you listening, I'm here with Will Falk, who is AMS board chair and a known AI and public policy leader and Zayna Khayat, Chief program officer, health futurist and adjunct faculty at the Rotman School, which is actually where we're recording this today, and we get to work together quite a bit, but we don't actually see each other in person all that much, so this is a chance for us to actually spend some time together. So apologies to those who are listening, because we're going to have a whole lot of fun in this conversation, and I hope you enjoy it as well. So there's a lot going on in AI, and you two are probably on top of it more than any other people in Canada. You spend your lives thinking about it. I'm on the end of a whole lot of emails, LinkedIn, messages, texts about what's going on in AI. I can hardly keep up. In fact, I'm not keeping up, but you are, which is remarkable. I thought that we would spend our time talking about you and how you got into this space, and then we'll start digging into where are we exactly in the uses of AI, because it's a little hard to tell, and every day there's something coming out. So, look forward to both of your perspectives on that. And then, because we have futurists and future thinking at the table here, we'll talk a bit about where we think this is going and what we need to do to catch up to it or harness it, depending on what your point of view is. How's that sound?

Will 1:35
That sounds great. You know, you say we're keeping up, but I have to tell you, I'm not sure some days that even you is really heating up. Well, I had that experience this last week. Zayna and I were teaching together at Rotman, and I went in a day early, and I listened to two other of our great Rotman faculty delivering three-hour AI lectures and audited it. And you know, I think many of your listeners will know Joe Cafazzo and Avi Goldfarb, and listening to those two and Zayna talk about what's going on, I felt so relieved because so much has happened in December and January that I personally was feeling breathless. You know, we had major announcements from Anthropic and from Open AI. Gemini continued to click along and major regulatory retrenchments in each of the different regulatory environments, the EU, the UK and the US all made major, maybe I shouldn't call them retrenchments, but major announcements. And it was so fascinating because both of those guys were also talking about how they're thinking about it and working on it every day. And it really has become almost day by day change and all that before you even talk about bots.

Zayna 3:06
Yeah.

Helen 3:07

Well, there you go. How are you keeping up?

Zayna 3:10
I'm also not. So, I felt a lot of comfort. You know, a third of my life is a professional like keynote speaker, thought leader, and I'm now at a point where in my contract to speak, I have to have the right up to 40 minutes before I'm on the stage to change my slide, because I'm going to look like a doofus if I don't mention...

Helen 3:30
That's a technical word, people!

Zayna 3:32
So, I think I mean to bring it back to this podcast. You know now, how are you to lead in this sector where this velocity of change is unlike anything I think we've ever seen. I don't even know what it's like that, you know, is like this, and I think that we've got to have a lot of space to talk about that.

Helen 3:50
Yeah, I'll just reflect on my experience during the pandemic, when I think it was Steini Brown came to me and said, How can I help you? I said, I'm always behind. I don't know what's going to happen, and I'm like, three weeks behind, and I'm responding to what happened three weeks ago. So, help me see around corners and what's coming. And that's the genesis of the science table. And I kind of maybe that's...

Zayna 4:13
Great analogy.

Helen 4:14
That's how I kind of love make sense of this. Just you need to have all eyes, all ears, many people kind of scanning in order to stay current.

Zayna 4:22
Yeah.

Will 4:23
I will say that I've been really enjoying your weekly notes on that side, Zayna, just because I pick them up and I can scan what I miss, and find that helpful as well.

Zayna 4:37

So little commercial so I do a weekly bulletin too, I think it grows by 10% every week, of what's going on in AI and healthcare in Canada. And if you'd like to get on that bulletin, send us a note to info@AMShealthcare.ca

Helen 4:52
I have to say, I do love it when you send something and Zayna goes, already got it!

Zayna 4:56
Yeah, yeah.

Helen 4:57
It's great. No, we're not competitive at all. So I just want to take a little step back and talk about the two of you. I've known both of you for some time, but you know for the audience, how did you get drawn into AI policy? Clearly, it's now pretty exciting, very compelling part of discussion around the future of healthcare, but you saw that before it actually happened. And what is it about it that enlightens your passion?

Will 5:26
For me, look, I've always been a policy wonk first. I mean, I had a professional career that was outside of policy, in management consulting, but I started in policy positions even before I did my graduate degree. So it was natural to kind of come back into it when I returned to Canada, and I've always done that on the AI side, I got pulled into AI when I retired from full time work because I did a lot of board work and a lot of angel investing in venture capital stuff. And three or four of those companies were heavy into the AI space. Several of them continue to be heavy players in the AI space, and a couple of them are amongst the biggest companies in the AI space, and so I've watched that grow, and sensed pretty early on the generative AI in particular, was really something that has been a zeitgeist change. As your listeners will know that change only happened on November 30 of 2022 so you know, we're not even four full years into that change. And I think in the history of human existence, that change will be a 1453, Gutenberg Bible level kind of change, or maybe only an introduction of the PC level change, but it's somewhere in between the PC and the Gutenberg Bible. So having some time on my hands and through my work as a volunteer at AMS, I've been exposed to all kinds of great minds who have been thinking about these issues, and kind of had the chance to get pulled in and formalize some of my stuff on that. So that's kind of been my personal journey, mainly outside of what was my professional career.

Helen 7:41
Yeah, but you've been a voice about the smart use of technology in healthcare for some time, right? This feels like an extension of that and an important voice, given how can I use the word chaotic implementation of technology and healthcare has been in Canada.

Will 7:59
I mean, I have a few systems that are sins on my conscious. I led the teams that built Olus and the wait time system and the drug Profile Viewer, and I've kind of seen from the ground up how those systems work and progress through things. So, yeah, I did that. I will say that kind of moving over to the substance a bit. I will say that I think that generative AI is different in kind from what we've been living through in the digital health world. And what I mean by that, specifically, is that the return of agency to patients and to physicians has been really profound. I think digital health has often made patients and physicians feel powerless, maybe even put upon and it's interesting to see how some of the new AI tools have flipped that. I think that digital health and AI will get solved both separately and together, and we, I'm sure we can come back to that. Yeah, thank you for that.

Helen 9:15
So Zayna, you're probably one of the – well, you are the only health futurist I know! Why don't you talk a little bit about what futurism is and why you think that sort of being a formal futurist, what the skill set brings to the health system.

Zayna 9:30
Yeah. So, I mean, how did I become a health futurist? I have to kind of, I backed into it, I'd say. And so if I hear, Will - you talk about a bit of your leadership journey, I now understand why we complement each other so well. So, whereas Will's interest came from policy, and then I'd say, filling our technical debt of digital tools that we should have had by now, my pedigree came from innovation and emerging technologies. So, that's a bit of how I got groomed through and so I literally backed into futurism, because I had maybe a decade of my formative career time on let's call it this word “health innovation”, which is really about the status quo, doesn't work for patients, for clinicians, and a methodology called “innovation to create a future state” that I often say is 2 to 5x better than the status quo, and you can't do that using a quality improvement methodology. So, when I was like the chief innovation officer, or the equivalent of a large Canadian healthcare organization, I realized if we just innovate the status quo, that's actually also not going to get us to where you know we want to be and where patients want us to be. And so, I self-declared myself a futurist, and that was when I was at SE health, and I've just stuck with it, Helen.

Helen 9:31
I like it!

Zayna 9:31
No one had to give me the title also, by the way, that's a good tip for your listeners on a leadership journey. You know, my style of leadership, or my definition, and I think Will you would agree, is definitely not positional leadership. It's not having the title C-suite or VP, or that is not leadership. For me, my leadership style is impact. And so, a good signal you're on

that journey of leadership is where you know you can't remember the last time anybody gave you a job title.

Helen 9:31
Right.

Zayna 10:17
And mine goes back to the first time I kind of decided what I'm going to be called was like 2012 when I led the health innovation platform, actually, at Mars Discovery District. So anyway, I'm a self-declared futurist, and then just, you know, what does it mean? And we can get into a little bit more. But basically, the idea of Futurism is we all now need an ability to see what possible futures might emerge. If you trace out a bunch of vectors of change that have massive uncertainty of speed, of magnitude of direction. And then you know, when you see all these possible futures, we call it the cone of possibilities. Then, as a leader, you can step back to today and say, Huh, what choices do I need to make today? What bets, what investments? How do I allocate resources? Whatever you want to call them. What choices do I need to make today as a leader that are, at a minimum, consistent with this, like ever unfolding future, and even better, my favourite leaders and organizations, what choices can I make today that allow me to be the protagonist of my own future? And that's basically what I do.

Helen 12:21
Yeah. I mean, I like that because, I think again, it gives you -

Zayna 12:25
Control.

Helen 12:26
Agency, gives you an opportunity to really shape the future, as opposed to being solely responsive to it,

Zayna 12:33
Yeah.

Helen 12:34
And when I think about, I've actually worked on a futures exercise earlier in my career, when I was at Cancer Care Ontario, and I think we underestimate how much change could happen in a 20-year period. I don't know whether that would be an observation where we think it's just going to be kind of incremental change, and nothing's really going to change, and maybe someday, all of a sudden, it will, but it doesn't really happen that way. I don't know what your experience is.

Will 13:03
A number of people have said change happens both more slowly and more quickly than you think it does. The other one is the Hemingway quote, which is more negative. It's about how I went bankrupt, and that's slowly and then fast, right? But I think change is the same way sometimes things build, and we see that in the economic literature, a fair bit about how technologies can come in and build, and then things change. You know, we have this idea sometimes that healthcare hasn't changed. And I don't think that's borne out by a real word, looking generational view, and if you think about the number of things that have changed in the last 25 years in healthcare, productivity curves on almost every major surgery, price of drugs once they come off patent, continues to drop really dramatically. Length of stay in hospitals is down. I mean, sure we have very, very big problems. Let's never miss that. But you know, reason we have such a problem in an area like let's pick long term care is because the people who are in long term care now are not the people who were there 30 years ago. I mean, we didn't when we designed our long-term care homes, we didn't design them with the notion that we would have 70% plus dementia rates in long term care. We designed them for, you know, half that. And so our own success sometimes has meant that we're more successful now. We really screwed some things up along the way, right. And then you think about some policy misses over the last generation that I'll blame it on the implementation, but the implementation of Barer–Stoddart, is just a disaster that we're still working our way out of. We have undercapitalized the system.

Zayna 15:07
And maybe just to give all of us a bit of grace, Will pointed to some, an economic theory that explains a bit of these kind of cycle/time disparities between the future and the progress to get there. I think also just if you look at our own human biology, us as humans, as a species, we evolved linearly and locally, right? We had a generation, you know, to decide that we go to another area to get better crops and maybe a genetic mutation in a cycle. So our biology is not at all wired for rapid change. I think that's why this AI phenomenon, particularly, is really coming against some biology. And then the other thing is, as humans and as our species, we actually can't think exponentially. We can't see forward a path of a curve going up the way it's been in the past. And so, in healthcare, because it feels like a glacial pace, because it actually does take time to change policy, change practice. We cannot project forward. And I think this is why some of these shocks and dislocations really, really feel like shocks and dislocations. And I get to hang out all the time and seeing them, so it just comes a little bit more naturally.

Helen 16:19
So Will, you've got a paper coming out with the Canadian Standards Association. I have the benefit of having read it a couple of times. There you make an argument. Hope that's okay we're talking about it. Make an argument that I think is pretty compelling, where some

jurisdictions locked in pretty early in terms of regulation and oversight over AI, I don't think they got it right.

Will 16:41
Right.

Helen 16:42
So maybe can you just talk a little bit about that. So there is a good reason at times to wait and see what happens, and to let the horse out of the barn a little bit, rather than try to get out ahead of it and then find with a fast moving capability, that by the time you've actually passed a piece of legislation, it's already out of date.

Will 17:01
For sure. And you know, specifically, kudos to the Ontario government and Ontario MD for being quite forward thinking on ambient scribes in this regard. You know, the CMA and CFIB just published a report saying that we're now 28% scribe usage among Canadian MDs, which is amazing, right? I mean, that's happened so quickly. And you when you see that kind of technology adoption in healthcare, you say, okay, well, where did that come from? And then you look and there's at least two other sectors where we've seen something similar. I mean, this second screen, clinical decision support, set of tools, the OpenEvidence Doximity tools...

Zayna 17:28
Sorry Will, can you just explain second screen?

Will 17:48
Yeah, okay...

Zayna 17:49
Because some people I would....

Will 17:50
No, no, no, fair enough. So, what happened in okay, I make the main point that I'll come back on CDS. The point is, is that that plus consumer adoption has been really fast. Consumers are probably over a third, maybe 50% using AI first now for healthcare questions. So, what's happened is, where a new technology can come in within an existing work process. It's moved very quickly. What we talk about in the paper is the difference between complementary technologies and substitutive ones. And you know, I mean, we see this in AMS, many of our fellows are very concerned about when and how we will substitute artificial intelligence for human intelligence in clinical decisions. And that's a big, hard question, but one of the things about generative AI is that it does really well on smaller

generative questions that can be easily supervised. And so, the interesting thing about the way the scribes have rolled is that, because they come into a physician or a clinician's scope of practice, because certainly my nurse practitioner uses a scribe as well, that when it comes into a clinician's scope of practice, they can supervise the output. They know what the content, because they were part of the conversation, and they can incorporate that into a note and do that properly, just as they would if that had been a human scribe, right? And you know, we forget that human scribes have been quite common for in the US, for example, a human Scribe is an untrained, unlicensed person often paid $12 an hour in the US.

Helen 19:45
Like a court reporter.

Zayna 19:46
Yeah!

Will 19:46
Totally. Well, actually, court reporters have a six month course that they've gone through. So court reporters are up a level, actually interesting tangent. I have a close friend who's a practicing physician in New York who used to scribe, and I got to know what scribes actually were, what human scribes actually were, and they're pre-med students who want to get exposure to medicine, and so they do a few hundred hours, usually from lower income families, because they can't afford to be candy stripers. They're 22 year old undergraduates, and they're doing their best. But the point is no one ever asked an MD whether they checked the work of the 22-year-old, right? And when we turned that into artificial intelligence, which we did it in a way where we created safe harbours for the legal issues, the liability issues, the privacy and security issues. And lo and behold, with a few of the barriers out of the way and some common sense, 28% of Canadian physicians now use the scribes.

Helen 20:09
Yeah, it's amazing. I think it exceeded your own projections.

Will 20:36
Well, I wasn't going to say I was right, but yes, I did predict from the stage at AMS last year that we would be at that and I'm delighted to see it happen. I do think when you look at the CMA numbers, they also report that 42% are planning to use scribes in addition to the 28 so I think we have line of sight of scribes being ubiquitous in primary care first. Several large hospital systems. When I was doing the report, several large hospital systems indicated to me that they will go live house wide with a scribe product in April, so at the start of the Public Service fiscal year. So, I think we're going to see all of the hospitals come on fairly quickly. Why is this important? Because scribes are just a point solution. If you look at the scribes in

market today, most of the leading scribes have been quietly landing and expanding, and they've added other functionalities.

Helen 21:57
So, they're a gateway product.

Will 21:59
Exactly right.

Zayna 22:00
You didn't say drug, but I know you were thinking...

Helen 22:03
I was, actually.

Will 22:04
They're a gateway, drug. Are we allowed to say that? Yes. So we're a starter. I prefer land and expand to drug analysis. But anyway...

Helen 22:15
Point taken.

Will 22:16
We all know what we're saying. Actually, again, with Zayna's course, we had a bunch of Ontario health system leaders in a room, mainly Ontario health system leaders. And we brainstormed, I gotta say, three dozen functions that you can put around the scribe. So we say scribe, but within a year, we're going to be talking clinical copilot.

Zayna 22:36
I mean, it's kind of like you still call this thing we hold in our pockets a phone, but it like does our laundry, you know? So, it's similar.

Will 22:44
I love that. Why didn't we use that?

Zayna 22:46
Sometimes I can come up with stuff...

Will 22:46

No, no, no! But why didn't we use that?

Zayna 22:48
I know we should of.

Will 22:49
Because, of course, it's not a phone.

Helen 22:52
No, it's actually the least interesting part of it.

Will 22:57
But it's useful, right? And the point being that once you've got one, you can build and because you've paid the infrastructure cost of putting the thing in place, the marginal cost marginal benefit economics change, because you don't have an incremental capital cost to add capability, you just have a little software cost, which is almost nothing. And so, you know, I think if you look at products like, if you look at like what Ottawa Hospital is doing with Microsoft Dragon, if you look at what Tally is doing in Ontario, or if you look at Doximity in the US, so those are the three I've done a deep dive on. Each of those have now got between 9 and 14 capabilities in market today, some of them are in beta, but they're expanding, and so that layer is coming on top clinical decision support, we usually have thought of as in two ways, either it's best practice support or it's past practice support, meaning we look at old data from our institution, and we say, here's how we did it before. Let's do it again better, and this is what the outcomes were. Or we look to journals and do best practice. In this space, a bunch of companies, including one I was involved with in Montreal, which sold to Doximity last summer, created early fine-tuned AI models and RAGS retrieve augmented, generative AI in which they took a corpus of information. So, the two best known are OpenEvidence and Doximity, there will be more. OpenEvidence started with the NEJM and Jama and Doximity, which was pathway for Montreal, started with PubMed and some drug dosing stuff and other pieces, but in both cases, what they did is they put a corpus of information in that you could query from a best practice. That app, that second screen, clinical decision system, is not tied to patient information, and it's not tied to the EMR, so it's a non EMR, non-PHI app that sits on your phone, which is why I call it second screen. Why is that interesting? Because that adoption pattern was missed by all of us in the CDS world. We all thought that CDS was going to be tied to our information, there was going to be tied to EMRs, and it was going to be tied to patient health information. And this idea that there would be a non-PHI, non EMR thing that would, and there's a report on this, at the end of 2025 reach 50% adoption in two years amongst US physicians. I mean, it's crazy, right? And of course, the reason is, is it replaces yester-tech crap that that's a technical term...

Helen 26:04
Yeah.

Will 26:05
Your tech crap that's like clunky online textbooks that...

Zayna 26:09
or a big binder...

Will 26:10
Or a big binder, or, heaven forbid, an actual textbook, right? So anyway, why did I go on a tangent then? Because I wanted to bring it back to clinical copilots, because all of that's going to be on a second screen, I think.

Helen 26:22
So, talk to me about how we're... whether we're ready for this. What do you think?

Zayna 26:26
Who's we?

Helen 26:27
We the health system. Where are the pockets? You see a lot I just speak you're out there talking to a lot of organizations about their, you know, they obviously have an ambition to be users are involved in AI, if they're inviting you to speak, do they know what we're getting into? Do they... are they worried? Are they...

Zayna 26:48
So, I think there's no one I've met that hasn't mentioned the word AI or isn't somehow touching it or interested in it. So, I don't see anyone under a rock. I would think about, are you AI ready, maybe at four levels. So, you as an individual, whatever your role is in this ecosystem, clinician, administrator, student, whatever pharma exec, your organization is the second level. The third would be your board. Is the board ready? And then last is as a whole system, are we an AI ready health system. So, depending on those layers, there's lots of, you know, ways we can de average it, but I'd say there's kind of four or five things that seem to be the things you should be doing. So you can either, if you're listening, reflect, are we doing these things or, you know, are we about to and if not, maybe go turn a couple of them on, you know, one, and I'm actually going to steal this from Tim Rutledge. He's one of our executives in residence at AMS, the former CEO at Unity. He did an excellent session with our learners at Rotman last week, and he said, 'Do you have an AI positive culture', right? So that's at an org. level...

Helen 27:57
Yeah.

Zayna 27:57
He's like, 'if you don't have that already, don't try to go for too many bananas, right'? So, there's some work you got to do to set up an AI positive culture. I would relate that at the individual level, is, what's your AI mindset like? Do you have an open mind to possibility and excitement, versus, are you going to look for all the problems and all the risks? Because they're there.

Helen 28:19
And some of them were there before.

Zayna 28:20
Oh, yeah, not that it was, you know, roses and motherhood and apple pie before, I think then it's, you know, whatever you want to call it literacy, right. So that's a bit of educating yourself and just getting basic knowledge. There's so many ways to do that, but the next level getting comfort, you know, I think Will you talked about, don't just get your hands dirty with AI, get them filthy. So just some comfort, I'm just gonna quickly give an anecdote about that. So more and more now, anyone taking like a course on AI in healthcare is gonna be actually building a tool at some point. We call that vibe coding. So, we did that last week with a bunch of people in my class. They were incredible. I just posted on our WhatsApp of everybody who took our course, two postings, one from a Canadian doctor and one from a US doctor. Of like, the minute a doctor realized they can vibe code and build the tool they were dreaming of as a clinician in like 10 minutes, it's like this eureka. So, they're all now showing online a video of them, vibe coding. So, I just shared that. So that's comfort, right? And literacy or whatever. So again, get yourself literate. Get your patients literate, your staff, your board, everybody.

Will 29:33
I just want to go on the vibe coding thing for a second, because, like Samir Grover and Josh Landy out at Scarborough, have been all over this, right? And they were, they're running their second summer of vibes, where they bring undergraduate students in. I showed up there last year, and I was, like, blown away by the student projects. And I think that this idea of returning agency to individual people, because, you know, we talk about it from a clinical point of view, but if you're sitting somewhere in a finance department, or actually, for this audience, I'll do research stuff, right, like REB submissions, scoping reviews, where you do a big scoping review...

Helen 30:11
Like clock interview kind of thing.

Will 30:13
And, you know, I don't do scoping, No, but scoping reviews are looking at past literature at a particular area. I don't do scoping reviews personally, but what I now do is I take scoping reviews that were done with a cutoff date at the end of 2024 I drop them into AI, and I have them update the article, scoping review for everything after in 2025 and anything that's on archive so I can find the new stuff, those kinds of processes where you can just make stuff happen much more quickly is really exciting. Yeah, basic stuff and again, not wildly risky stuff here. Okay, we're not talking about predicting chances of death or picking a cancer treatment, necessarily, but we're talking about some stuff that's interesting and important to the functioning of our health system.

Helen 31:03
Yeah, so while we're on that, we talked a little bit about how Canada has approached the policy and regulation issues. What are the policy challenges and how should, as a walk, how should those be addressed? My personal favourite at the moment is figuring out how we're going to pay for some of this stuff, right, and what the incentives are going to be, and then how those incentives are tied to quality care, and making sure that those two things are highly connected. But you might have your personal favourites.

Zayna 31:36
I'll let you weigh in, because this is your thing. Mr. policy wonk. I mean, I wish Helen that any of the policy discourse is what you just described. I think you're one of the people asking about that. I think that's going to be the next frontier. And, you know, I'll just maybe link my answer, and then we'll get to you is like, there's big P policy, like laws and rules tend to be jurisdictional and macro and system versus in my own org. What's our you know, call it AI policy, even though it's not a policy. So, another word for that is our governance framework, our AI framework, our roadmap then, and our strategy, all those, I think, that list I said of like, what do you do now? Like, do you have that? Do you have an AI strategy? Do you have a roadmap, and then do you have something like a policy or a framework that's good enough to get started, and I think that's where I'm seeing a lot of the activity and the action. And I really don't know anyone that's figured it out in Canada or even globally.

Will 32:29
Yeah, I do think it comes back to this agency point. I do think that we haven't talked a ton about patients yet. Patients are doing a lot of stuff. We have to figure out how to make it safe for patients to do this, but there's no doubt that they are doing it. Same thing for clinicians. Clinicians are doing it. And so when you see a process change system happening in which it's not top down, but much more bottom up, I do think you have to ask a fundamental question that pretty easily set up as lead, follow or get out of the way, and in a lot of the situations right now, this comes back to Tim's comment, like one of the bigger problems that I still see

in places in the Canadian public sector is organizations who have banned using AI entirely, and those people just need to get out of the way, because if they don't, and we now know this for sure from some UK data that was published in December of 2025 when you block usage even If you just do a low level med device rule, all of the usage goes grey and shadow, and then it becomes unknown to you as a system controller. And so, you need to bring everyone onto the field, and you need to have a permissive enough stuff that people can do sensible things. Now, not every organization is going to want to lead on AI, and that's okay. You can follow you can follow vendors. You can follow partners. You can also just get out of the way. You can have an AI positive strategy, tell people that you'll pay simple licensing fee, and have a few straightforward rules about things like PHI and security so that people don't do stupid things, right? And so, I think some of that will happen at the top of government if we screw this up at this juncture. We don't know in this room what Mr. Solomon is going to do. So, I'm hesitant to...

Zayna 34:40
We will soon, though, right?

Will 34:41
We will soon, yes, they've delayed it a couple of times. It's interesting, but I will just say, given our talent base in this country, in AI, and particularly in health AI, if we screw this up, then shame on us.

Helen 34:56
Yeah.

Will 34:57
Because we should really be in a leadership position. Given the work that has been done at the U of T and Montreal and elsewhere in the country.

Helen 35:04
I agree. So, I'm just going to close because this is an AMS podcast talking about what your thoughts are around the human aspects of AI. You know, there are people who have thought that it's going to release time to care, and actually it's going to enhance the relationship between providers and patients and the human part of care. And they're people who think the opposite. Any thoughts on that, as we close, we optimistic?

Zayna 35:37
Of course, I'm a techno optimist. I think we can do our work without the optimism. You know, I think Helen, what you just laid out is classic paradox, right? So that there are two possible truths that actually can exist at the same time. Again, as humans, we love to be reductionist, and our tendency, of course, in health, is to find the fear and the risk. So, we're

going to lean towards, you know, AI is going to destroy the humanity and healthcare. It's going to, you know, widen inequities. So, you know, we just need to remember, any technology, any new practice, can amplify compassion, but it can massively erode it, right? And that's our job as leaders, is to set up the conditions, the kinds of things will and I have been talking about that can maximize these incredible gains and really, really minimize those downside risks. So, you know the answer is, yes.

Helen 36:32
Got it. Will?

Will 36:34
So, I don't know, and this, this may surprise you, but I am not sure at a societal level, that I love everything that's going on. I made the personal decision two and a half years ago that whether AI is a great thing for my 20 something son or not, that for me as a 60 something retiree who's trying to make the world a better place, that being a polymathic super user in AI is probably a good thing and something I should do. So, I've charged in. But I really do pause and wonder on things. I, at a societal level, I will say the one thing I'm not uncertain about is the application in health care. Our problems in health care are so profound and they have lasted for so long. And I mean, you know this better than I do, that the next 15 years are simply not solvable unless something changes, and I personally think that AI will be the thing that changes. On the compassion side, I've seen so many patients who've told me the personal stories of how they're using AI right now, probably, though, the biggest gain I've seen so far is on the physician side, the number of physicians who talk about it, thinking of one Toronto physician in particular who like teared up while presenting talking about reclaiming her life and her time and not having pyjama time all the time. So you know, I think we have to have compassion for our providers and our patients first, and I think that they're voting with their feet.

Helen 38:27
Thank you. This has been a pleasure, and now our listeners can understand why I love this job. I get to work with you all the time.