interview with
the president

Dr Michael Golbey, BCMA president 2005–2006

BC Medical Journal: **Can you tell me about one of your career highlights?**
Becoming BCMA president is a great honor, one that I take very seriously. Doing this job is definitely a highlight for me.

Is there a typical day for you as a physician?
On a normal day I get to the hospital at about 7:30, and I typically have anywhere between two and half a dozen patients to see, and I'm responsible for about half of them. I get to my office at about 8:30, do paperwork till 9:00, then see patients till 6:00, with an hour's lunch, which I take at my desk. Once a week I admit patients to our local detox centre for which our group of four GPs provide medical support.

Are family physicians with hospital privileges more common in smaller centres like Kelowna than in Vancouver?
Yes, I think they are, but it's changing there too, with more hospitalists being hired by the hospitals. Right now there's a real mix of both, which I think is healthy. I would hope that there could be room for hospitalists and family doctors within our hospitals. For those physicians who choose not to continue their full privileges, there should be a mechanism to allow them to still provide supportive care, to allow for continuity, liaison with families, etc. Unfortunately, at present, the MSP fee schedule doesn't allow for this.

What gives you the most professional satisfaction?
When I still did obstetrics I used to really enjoy delivering babies—it was very rewarding. I stopped delivering babies about 8 years ago, and I have to admit that though I miss it sometimes, I wouldn't go back. So now what gives me the most satisfaction is working with families, helping them through difficult parts of their lives—because that's much of what we do, of course, is help people in health crises. End-of-life care is also very rewarding work. It's difficult, and you become better at it with years of experience, but it's very professionally satisfying and appreciated by patients and their families.

Why did you what to become the president of the BCMA?
[laughing] Well, I didn't, initially! The first thing I did for the BCMA was related, not surprisingly, with information technology—I sat on a committee, when PharmaNet was being built, and was introduced as the BCMA president! I said, "Not on your life!" That was quite a few years ago, and as I became more involved with the BCMA the suggestion was made that

I might think of taking on the challenge. I had to think about it, since there have been so many great presidents before me who have made huge contributions to organized medicine in BC, and I wanted to be sure I could live up to that. But I've always enjoyed being involved in organizations, on committees, helping to make a change for the better, so it did seem a natural thing for me.

You've made electronic medical records and technology one of the themes of your presidency. Why has the adoption of technology into clinical medicine been so slow?

Some people look at physicians as being slow to adopt technology, but that's not the case. Physicians were among the first adopters of pagers because they worked, allowing doctors to stay in contact with their patients when they needed to. Palm Pilots, PDAs, are another example. Physicians were very early adopters because it was technology that worked at the bedside, and that's really important. Until now, with computerization, IT, it has not worked at the bedside—it's just getting there now. If you look at technology like CT scans and MRIs, the uptake by physicians has been huge, because it works and provides benefit. Electronic medical records are not there yet. The other reason for the slow uptake of EMRs has been cost. It's still expensive, and most of the benefit goes to the patient and the payer—the government—which is great—but the cost, at the moment, has been borne by the physician, and that is neither fair nor right. So when we come to an agreement with various levels of government as to how it can be funded, there will be huge uptake by physicians.

Is the BCMA in the process of working on this with government?

Yes. It's going to be expensive initially, but it's a win-win situation. There's a report from Allen Hamilton commissioned by Infoway on the costs of EMR, and they're huge, but the benefits are also huge. So we need the upfront investment, then the downstream payoff will be big: there will be improvements in patients' health, including safety, saving lives, and ultimately saving money. But as physicians we're going to need that help on coming on board.

If you look at the HMOs in the US, they've invested very heavily in information technology because they can see the entire cost. They know that if they put in money here, it's going to save money there. Because of the way we provide health care in Canada it's difficult to see that global picture. PharmaNet is a good example. They use reference-based pricing to save money in one very small section—pharmaceuticals—and don't look at the costs elsewhere; increased hospitalization and increased visits to our offices. Somebody needs to look at the total picture with information technology and see that it will save money downstream.

Who would that be?

The BCMA and the Ministry of Health talking to each other.

Is that happening?

Yes, on some levels. We have some joint committees, but it's very, very early and it's not going fast enough, so I would certainly like to see these discussions accelerated at various levels, both at the BCMA and ministry staff level, as well as at the political level, the president and the minister, and everyone in between.

If you could accomplish one thing as president this year, what would it be?

It would be a much better working relationship with government, since that would enable all sorts of useful things. If we could get a really good working relationship, and if I could build a good personal relationship with the minister, we could do so much more.

Improved relations with the Ministry of Health has been a goal for BCMA presidents for years, hasn't it?

It's like a broken record, I guess! We've had this problem for a long time now, but it's a new minister, and a new government that had a chance to do a lot of what it wanted to do. It has a very large surplus, so it has money to do innovative things. So I hope everything is aligned so that we really *can* develop a new relationship. Yes, there are going to be problems—this is a year where we've got two major negotiations occurring. Negotiations are by their very nature adversarial, but that doesn't mean we have to go to war every time. I hope we can come up with a better way of dealing with all parts of our relationship. Everybody will benefit—physicians will feel better about their jobs and enjoy doing their jobs more, our patients won't have to worry about what's going on between the BCMA and government, and government will benefit because it will enable them to do some of the things they want to do.

Are there things we can learn from Alberta?

They've found a way of getting the three major groups together—the medical association, the provincial government, and the health authorities. They have a tripartite discussion occurring, and they've got a very long-term agreement, so it gives stability and lays down the ground rules. If we could come up with something like that, if our Master Agreement could be really long term and really empower physicians, the health authorities, and government, we'd be a long way ahead. So yes, we can learn from them.

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Will BC be the next province to see a challenge to the Canada Health Act?
It could be. There are a number of private clinics operating, and it wouldn't surprise me if one or more of the patients who have availed themselves (or would like to avail themselves) of those services launched a similar suit. My understanding is that the Medicare Protection Act here in BC is very similar to the Quebec charter that was successfully challenged.

Will the Act need to fall province by province, or, once it falls outside of Quebec, does that do it for the rest of Canada?
I don't know the answer to that. It would depend on where the challenge occurred. If the challenge occurred at the Supreme Court of Canada they would have to look at it again. BC is more typical of the provinces than Quebec is, because Quebec has its own charter, whereas BC and the other provinces have the Canadian charter. I would assume that if the same decision was made for BC, it would apply to the rest of Canada, but that's my opinion, not a legal opinion. The judges themselves were evenly split on whether the Quebec ruling applied to the rest of Canada.

What do you think of the federal government's handling of the decision?
I'm disappointed. They should look at it and accept it for what it is—a learned opinion that there are problems in the provision of health care in a timely manner and honestly admit that there are problems. Let's look at the Canada Health Act: it's more than 20 years old, and maybe it was perfect at the time, but it's not now. Let's at least look, instead of pretending that we can fix things within the current Act. We've been trying to fix things this way and they just get worse.

It's very disappointing that the federal health minister, Mr Dosanjh, instead of coming out wanting to talk to the CMA, has tried to browbeat them, saying don't discuss an increased role for private provision of medicine, don't talk about it at General Council. It's the same-old same-old attitude of, "Let's not discuss it," and pretend everything's okay. The Supreme Court says there's a problem; these are wise people, and we should sit down and discuss it in public. Let's get input from physicians, from patients, from government and see what everyone really wants. Let's look at other jurisdictions and see what works well. Maybe we can come up with a made-in-Canada solution that incorporates the best from around the world. Maybe we *can* be the best, instead of being among the worst.

What do you say to people who are concerned that with the introduction of more private medical facilities less-affluent people will be left with inferior care?
I can certainly understand that concern. The BCMA, along with the CMA, has always supported a vibrant, strong, publicly funded universal access health care system, and that hasn't changed and it won't change. What's happing now is that the publicly funded system hasn't been able to keep up with demand, and when you look at other countries where they have developed parallel private systems—and I'm not saying that's necessarily what will happen here—they seem to be able to blend the two systems very well. You take some of the pressure of the public system by doing some of it privately. That may simply mean publicly funded procedures being done in private facilities. It's what I do in my office—it's a private facility where I provide publicly funded health care—it's nothing new. The hospitals, big, expensive, and complex, have difficulty providing the services that are needed. If you're a surgeon, you may only have one-half or one operating day per week in the hospital system. If a private facility can offer you three or four days a week to do what you're trained to do, that takes the load off the hospitals, who will continue to do those operations for those who choose or can't afford to have them done in the private system. As far as procedures are concerned, it doesn't matter whether it's surgical, diagnostic, lab, MRI, or CT, you can take pressure off the public system and allow the system to function better. So I try to assure my patients that what they'll get is actually better service, not worse service, and I base that on looking at how other countries have been able to do that.

Is there evidence from these other countries that the care people receive from each system is equivalent?
It seems that they *are* able to come up with the right balance, but we do need to study it to find how they've done it. Our starting point, however, is that the BCMA supports a strong, well-funded public system.

What about concern that there will be a brain drain to private medicine? Is there a way to ensure docs participate in both systems?
Yes, that could be a problem, so we need to look at ways to ensure that that doesn't happen. We need to ensure that people operate in both systems—and in the British system they do that. Their top surgeons in the private clinics spend some of their time in the public system. We need to find ways to ensure that there's a balance, since that's really what we're looking for.

Doctors aren't fans of being legislated to do things, so I can't imagine that would be a popular decision.
It may not be. All we're saying at this stage is that we should be allowed to look at options. That's what the Su-

preme Court decision has done: given everybody the permission to look at options.

What do you think of the new nurse practitioner legislation?
Well-trained nurse practitioners working alongside us in our offices can only help us provide the better care that we want to provide. We have concerns about the legislation and we don't know just what their standards of practice will be, since they're not available yet. What lab test will they be able to order, what drugs can they prescribe, and so on? We don't have the answers yet. Their numbers are small right now, but it will be interesting to see how that evolves. We hope to be involved in the ongoing development of where they work, what they do, who they report to. As a profession we welcome them into our family practice offices, but there are certainly questions about how they'll be paid, who they'll report to, and so on.

Are there any other big issues going on that you're working on, but aren't getting much public attention?
The new stuff that's coming from the General Practice Services Committee on revitalizing family practice will be a big issue. Increased funding going to general practice is a good start, but it's only a start. How will we encourage people to come into family practice? The new grads don't want to do it, older physicians are looking to retire and a lot of them are getting burnt out. The younger ones who are doing family practice don't want to do full-service family practice—but we need to encourage that. But there are similar issues in other areas of medicine, so I'm not suggesting that the BCMA focus only on that.

The other big issue right now is the agreements we're working on—the Master Agreement and the Working Agreement. Every member of the BCMA needs to understand the Master Agreement, what it does for us, and how vitally important it is that we have a renewed Master Agreement that's strong, that protects us and our ability to provide care to our patients.

What are some of the problems with the BCMA that you'd like to address?
There are things that are not very glamorous, like governance. We need to ensure that our members feel well-represented at all sorts of levels, and Dr Arun Garg's ad hoc Committee on Governance is looking at exactly that. It will be a slow process, but the model we have of a large Board works quite well, but I'm not sure that it provides the individual doctor with the input that he or she needs. The model that we have is quite old, but that doesn't necessarily mean that it's bad and we're going to throw it out, but we're looking at it to see if we can get better input from individual members. For example, I know that some of the sections within the Society of Specialists feel that they don't have the input that they need. Their input is currently through their Society president at the Board—it's probably difficult for one person to provide the input of that diverse group, so there may be better ways of doing it. We have a hybrid model, in which the Board is elected geographically, so people bring the concerns of their region, but once they get to the Board, they're supposed to leave that behind, and supposed to be Board members providing due diligence for the organization, which sometimes makes it hard to bring individual issues. So I'd like to see a model where that could change, perhaps, so that individual issues can be brought forward, but the Board is still responsible for the organization as a whole. Not very sexy, but people do need to be concerned about it.

Is there a date for Dr Garg's committee to report out?
It's a work in progress, so instead of them coming with a huge set of changes, we're doing it bit by bit. We've already started doing that, so I would expect some changes over the next year or two, some small, some large. Some changes will need to be done by referenda, others will come to the Annual Meeting. I hope that one of the results will be that we can improve the Annual Meeting so that it becomes a forum where people can come and bring concerns that can be acted upon. Perhaps the Annual Meeting will look more like a representative forum, I'm not sure, but I'd like to see it reinvigorated.

Recognizing that change takes time, where would you like to see the BCMA in 10 years?
I'd like to see it be more representative of its members. Not to say we're doing a bad job now, but I think we can do better. The BCMA should *look* more like its membership does, for example more younger members participating on committees, on the Board, on the Executive, as president. All specialty groups, both genders. I hope it won't take 10 years.

Can you tell me a bit about the UBC Medicine site in the Okanagan?
Yes, in 2010 I believe there will be 32 spaces, and everybody in the region is very pleased with that. It fits with the new UBCO, with a true university in the Okanagan. Having a medical training site in the Okanagan is great for the Okanagan, it's great for medical students from the Interior, and it will probably help retain and recruit physicians for the Interior. Despite what some people think, the region has as much trouble attracting physicians as anywhere else in the province.

Students will do their classes there and as much as their clinical work as they can. In fact, Kelowna General provides every service that's provided in Vancouver except open heart surgery. So they'll get the vast majority of their

Litigation MRI: Why lawyers are asking for it and why your patients need it

The key to litigation-driven MRI is not that it is medically necessary, but rather that it is reasonable and necessary for the proper conduct of the proceeding.

Todd Cherniak, LLB

Magnetic resonance imaging (MRI) is presently used relatively rarely as an evaluation or diagnostic tool in personal injury litigation in British Columbia. This is because MRI is a scarce resource in the public health care system that cannot currently fully bear the burden of assessing the seriously ill in our community. In such circumstances, doctors are loath to requisition an MRI except in the clearest of circumstances and lawyers, for fear of intruding on the doctors' sphere of expertise (and be accused of practising medicine), are similarly dissuaded from pressing for a referral.

It does not have to be this way. There are compelling reasons for MRI to be used in practically every personal injury claim in British Columbia in a manner that will be of benefit to the claimant, his or her lawyer and doctor, and will not in any way be a burden on the public health care system.

Why MRI?

As a diagnostic tool, MRI is far superior and safer than X-ray (which measures the absorption of ionizing radiation) and (in many instances) computed tomography (CT) scans. Unlike positron emission tomography (PET), which is a computerized scanning technique using radioactive isotopes, there is no controversy in the British Columbia courts about the admissibility of MRI as evidence.[1] Further, MRI is fully accepted by the insurance industry as objective and reliable.

MRI is universally accepted not only because of its accuracy but also because of the objectivity of its findings. It matters not whether the claimant is sent for the test at the request of the plaintiff or defendant, the resulting report will be the same.

In the United States, where access to MRI is not an issue, sending a personal injury claimant for an MRI is now part of the standard of care (the baseline conduct to which the professional must conform to avoid being negligent) for plaintiff personal injury lawyers. This is so not only because of the usefulness of the findings in the claim but also due to the serious risk of potential liability facing both doctor and lawyer should a latent problem be discovered after the conclusion of the claim that would have been detected had an MRI been conducted.

Due to limitations on access to MRI in British Columbia (both real and perceived), MRI is not yet the standard of care in this jurisdiction. Nevertheless, compelling reasons exist here why MRI should be considered for practically every personal injury claimant.

The current state of access in British Columbia

Access to MRI is limited in British Columbia. While waiting lists for a publicly funded MRI vary, the waiting periods are universally too long, with most people not able to obtain timely access to MRI except in the most serious circumstances.

Though more public funds have been promised for diagnostic imaging, this proposed increase in access is not relevant to most personal injury claimants as they are not currently on, or candidates for, a waiting list. This is because in an effort to control demand, radiology departments in the public hospitals (where all public pay MRI scanners are currently located) typically only accept requisitions from specialists and not from family practitioners. Since (quite rightly) very few of these claimants are referred on by their family practitioner to a spe-

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Mr Cherniak practised civil litigation in Vancouver for 11 years and is currently the president and general counsel of Canadian Magnetic Imaging based in Vancouver, British Columbia.