Dr Margaret MacDiarmid, BCMA President 2006–2007

Dr MacDiarmid speaks with frankness and humor on a range of topics, from small-town medicine to big-city medical politics.

The *BCMJ* spoke with Dr MacDiarmid in July.

It looks, from your resume, like you've moved quite a lot.

Yes. My dad was a small-town GP in Shaunavon, Saskatchewan. We lived there for about a year before moving to Salt Lake City, where he did an internal medicine residency. Then we went to England while he did 2 years of research in genetics and I started school there. Then we went back to Salt Lake, and when I was 12 we moved to Winnipeg, where my Dad took an academic position. Then when I was 18 we moved to Newfoundland, where I did my science degree and then I went to Queen's for medicine. So moving all over the place like that, people always ask, "Was your dad one step ahead of the law?"

What has all the moving done for you? Or *to* you…

It was good for me. I wasn't always happy the minute we moved somewhere, but it meant lots of depth and breadth, and I think your horizons can't help but be broadened when you've worked and been educated in three different countries. I feel like I'm a real Canadian because I've come from almost everywhere and I've seen it from other parts of the country. I don't feel like a British Columbian particularly—I don't identify with any province in particular, but with all of Canada.

But the moving around didn't make you an urban person, obviously.
The smallest place I'd ever lived was Kingston, but because it's a university town it's pretty diverse. It was my husband who wanted to move to BC; in Rossland, where we live now, there are 3500 people. So it's quite small, and Trail has fewer than 10 000. We went there initially because of the ski hill, because we were both able to find work, and of course because it's a beautiful little town. Our plan was to try it out for a couple of years; I wasn't sure that I could adjust to a small town, and the work is so different.

Can you describe the differences?
Well, I was working in Toronto for a couple of years before we moved, so I had hospital privileges, which are like courtesy privileges. I didn't do any emerg or any nitty gritty medicine. And when I moved to Trail I didn't do obstetrics, but part of my responsibility was to be the doctor in emerg. I had had some training in the ER, but I'd never had training that prepared me for when they say, "Attention all doctors, code 99 ICU," and what it actually means is, "Margaret, please hustle yourself up to the ICU," because there is literally not a single other doctor in the hospital. Being the only doc there initially caused me quite a lot of anxiety. My strengths are not in that area. I'm not a really good emergency, trauma, catastrophic emergency kind of doctor. The worst part of my job, if I had to pick, would be things that happen in the ER, mostly involving trauma with children where I'd never met the family before and I had to tell them that the child would die. Not knowing them, I felt I didn't have much to offer. I could be informingly kind, but there's no relationship so I find it terrible. If I've got a relationship with the family and the child died, then I have more ability to comfort.

How long was it before you felt good, technically, about having to do everything?
Never, but I got much more confident within a year or two. There's a small fraction of what goes on in the ER that I can do but is very difficult for me, and the rest I think I'm very good at. My colleagues allowed me to come off the call schedule once I became president-elect of the BCMA, so that was very helpful in terms of sleep, schedules, travel, and so on.

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How many colleagues do you have in the group?
There are four of us in my clinic, with two long-term locums. As a small-town GP everybody knows you. Once I was in Shoppers Drug Mart, purchasing a remedy for head lice, which I'd picked up in the ER. So I'm walking around with my head lice treatment and I'm sure I saw at least five of my patients. Nobody commented on it, though I'm sure they noticed. Nobody left the practice, so I think they understand that it's an occupational hazard. When I told the story at a dinner party for my husband's work, he didn't think it was that funny!

You mentioned some of the parts of the job you don't enjoy—on the other side of it, what are your favorite parts?
I have patients whom I met as babies or small children who've grown into adults; I have families with four generations. My practice includes geriatrics, pediatrics, men, women, palliative care—a great variety. I sometimes assist at my patients' surgery, and that's something they greatly value. We know that it doesn't matter greatly who the assistant is, but when a patient knows his or her GP was in the OR for their operation, they feel so cared for. If they know that you're watching and assisting and can tell them afterwards how everything went, they really appreciate it.

I also like the fact that someone says to me, almost every day, something along the lines of, "You made a huge difference for me, I feel better because I came to see you." I could never say it's a thankless job—I have a very strong sense of having a positive impact. And I'm sure part of that is this longitudinal relationship that I have with people. I know their families, I know their problems, I've been there with their loved ones when they've died. It's a huge thing to be with people in that way. Being a GP is a very rewarding job—I really love it. I respect that not everyone does; for example when my brother—an internist like my dad—came to do an elective in Trail, he said that he could not *imagine* being a GP. And that's okay, it's not for everyone.

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You didn't initially plan to follow in your father's footsteps and become a doctor. Where were headed, and what made you change your mind?
When I was a little kid I liked taking care of people—if any of my cousins or brothers were sick I enjoyed doing nursing-type things for them. I decided, at some point during high school, that I was going to do nursing. Somehow when I read through the curriculum it didn't sound good to me. It had things like sociology and psychology and they didn't appeal to me. I was much more interested in sciences. So I changed to science, and did a joint degree in chemistry and biochemistry. I was leaning toward a PhD, and in my last year of biochemistry my professor said to me, "Do you know how many PhDs in chemistry across Canada got a job last year? One. So if you really think that that's what you want to do but you're also interested in medicine, go and do medicine and then do a PhD, because then you'll be able to get research funding." Of course once I went into medicine I realized being a GP was a much better fit for me than laboratory research.

I understand you play the piano; what's your favorite thing to play?
I play classical music for myself. I play Chopin and Mozart and Brahms. Partly dictated by how bad my playing has gotten over the years. But every now and then I'll practise more and play more and I'll get a bit better and I'll be able to play more difficult music. Some of the music I played as a young adult I can't even begin now.

At the AGM this year there were a number of resolutions passed that boil down to members wanting increased transparency of the Board. What's going to be the follow through on this?
I thoroughly endorse the spirit of those motions. If members want to know more about what the Board is doing and what direction the Board is taking, I think that's fantastic. I'm not sure *everyone* wants a lot more information, but if even just a few of our members want a clearer picture, I think it's great. We've already taken the step of having Board motions going back a year on the BCMA web site. But we'll start doing, from the Communications Department, a more detailed report about what actually transpires at Board meetings.

Some of those motions talked about how to deal with opposing views. So take, for example, the GPSC referendum; the Board approves that it go to referendum and recommends that members accept it. But there are some people on the Board who don't agree with that. How do they get their point of view across? Should we include it in a package, where we give information about the cons as well as the pros? What's the best way to do that? This is something that the Board has to decide. We've not had a chance to deal with this, so some of those motions will go to our September meeting.

What's your schedule as president—are you continuing your practice?
I'm doing much less clinical work than usual. I'm trying to go home for Thursday afternoon and Friday as often as I can, but when we have Board and Executive meetings, those weeks I won't go home, and the airport in Castlegar is often closed by fog in winter. I'll go home when I can, but realistically I know that sometimes I won't get in, so I've got a wonderful locum for a whole year.

What do your patients think of your new role?
I knew it would be a big deal to be a president from the Kootenays, since it's so small. District 14 has only a couple of hundred doctors in it, and my own hospital has about 60 physicians. So it's very small, and as a result, when the *Trail Times* runs a front page story about me being president, everyone knows about it. All the security at the airport, the Air Canada staff at the airport are saying, "Hi Margaret, congratulations." It's a big deal, probably a much bigger deal than for someone in Vancouver. As a result of that, instead of my patients being very cross with me for not being available, they're saying, "I can't believe I got an appointment with you. It's great that you're home and working." But if you're a president from Vancouver, I think there's an expectation that you'll continue to work at your normal rate and fit the presidency around that. In a small town it's a bigger deal, and my patients are very understanding. My patients and colleagues see me as doing something for them.

Is there a difference between being a small-town medical activist and a big-city medical activist?
Well, in general the small-town doctor job is different from the city doctor. Obviously we do much the same job, but I think in a small town you're high profile in a way that you're not in the city. I remember back in 2000 when we had the dispute over our specialists. We believed we were going to lose anesthesia and possibly general surgery. If one or two of them were to leave, the service wouldn't have been sustainable. We couldn't do 24/7 coverage. It wasn't an empty threat; the environment had become unworkable—we couldn't recruit, we couldn't retain, and our specialists were almost in a position where they were being forced to move. We had to do something, so we closed our offices. Strangers came up to me on the street and said, "Thank you for what you're doing for *me*." We *weren't* getting big push back—it was clear to people why we were doing what we were doing, which is great because otherwise it would've been horribly stressful—making the painful decision to close your office and then getting yelled at. The connection was clear to them. Since the rural agree-

ment came in we've been very successful at recruiting and retaining. So I don't think it's a good way to do things and I hope we never have to withdraw service again, but it was one of those things where we really thought the end justified the means.

What are your thoughts on the hospitalist situation that's just been resolved?
I wish that we could have resolved it within our agreement. I would like us to have an agreement and have trust on all sides—BCMA, members, and government—where we could say, "There's a problem here, how will we resolve it?" Where there's never any question about people withdrawing service or leaving BC, and that you don't have these issues about recruitment and retention. It's a lot to ask for, but that would be the best case scenario, and what we should work toward.

What didn't happen in the process?
The hospitalists, as I understand, did not believe that their needs would be met by going through the process in the agreement. They did not believe that they would get what they needed in terms of remuneration, maybe in terms of working conditions as well, hours and contract and that type of thing. Who knows what would've happened if they had gone through the BCMA? We have an excellent negotiations department, we have a lawyer, and we have a lot of people in-house who successfully negotiate working conditions and contracts for many doctors around the province. It might not be widely known, but it's the case. But in this case the hospitalists decided some time ago that they were going outside the BCMA, and they can do that.

You've been on the job almost a month now—any surprises?
I didn't know what to expect. I spent a fair amount of time here last year, and the BCMA puts a lot of effort into training the president, which is very useful. I've had lots of committee exposure and went to some senior management meetings, but it's like when you get married. You can observe it, you can see a lot of other people who are married, you can talk to them, but then you get married and you think, "What have I gotten myself into?" But I'm really enjoying it (the presidency and being married). I was surprised, at the very beginning of my presidency, to receive what I thought was some unfair criticism based on a misunderstanding of some things that happened at the Board. That surprised me; I didn't expect that on day 1. But in retrospect, I shouldn't have been surprised. I would prefer that if people criticize the BCMA or me personally that it be constructive. If people have a solution, wonderful, I'd love to hear it. The BCMA and the president need to be open to criticism, suggestions, and ideas, and I want to hear from members. The mail from members is very interesting. Some of the situations these dedicated physicians are in, feeling no support, no respect, very disenfranchised by their health authority or by some other system, are very poignant. There are some letters that are very positive about the association or something that's happened—feeling the BCMA is really working for them. It's also interesting to go from talking to the Minister of Health, to the Deputy Minister, to the Dean of UBC, all within a day, and having to shift gears. I'm using a part of my brain that was previously lying dormant, so I'm enjoying it.

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What are some of the issues or problems with the BCMA that you would like to resolve?
The membership surveys done by the Communications Department show that overall, members are satisfied. When associations are getting a good grade, they should want to get a better grade, so we will be looking at the area where members say their needs are not being met, and asking, how can we improve?

The governance review is ongoing, and should be complete by the fall. Whatever the final package of recommendations looks like, it's a matter then of us making sure that members really do understand it. If it looks like a good package and a good way to change, it may be a major shift for the BCMA and the goals are to have the best possible governance and the best possible representation.

Another difficult issue is economic representation. Surveys show that a majority of our members are satisfied with their economic situation right now, but it's not perfect. There are limited resources coming in and there a lot

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of people vying for those resources, and it gets us into conflict. So managing the natural conflict that happens when new money needs to be allocated is always a tough one.

The other thing that we're starting up is an increased focus on medical students. We are planning to address their debt problems, and starting to spend a lot more time with them, offering an optional series of workshops in areas that they've identified that they need more information on. Things that they're interested in include the business side of medicine—and they're interested in that very early on in their careers in medical school. In my generation, we didn't actually know there was a business side to medicine! Also, they've identified conflict resolution as something they'd like to have more skills in. Not dealing with difficult patients, because they get taught that—but the other conflicts that come up at work with other health care providers, of all kinds and all positions. Some of them are interested in media training. So we are hoping to develop something where we don't just meet up with the medical students during their first year. We're hoping to have something where the BCMA is visible to the students throughout the four years of medical school. I'm really excited about it. It's going to be fun and really rewarding for everybody.

Med students now have a Family Practice Club—they run it, they own it, they operate it with some funding from the College of Family Medicine. They do dinners and they bring in the speakers they want. Last year they asked me to talk about the future of family medicine and how the new agreement might make a difference. In the question-and-answer period they were asking me questions like, "What are nurse practitioners going to mean to me?" "Can you tell us about the different payment modalities?" "Is there actually going to be family medicine by the time I finish my training?" "Am I going to be like a consultant left with all the most complex stuff, with all the other things, the fun things like well baby care, being done by some other health care provider?" I thought they were amazing questions.

One of the things they said was they really need more information about the business side of medicine. My initial response was, "No you don't. You think you need it but you don't. Medical school is hard enough already. You're already overwhelmed, CARMS is coming up, and you guys are all going nuts. You don't need someone coming in here telling you how to run a business." But different groups of students kept on telling me that they needed this information, and some are making career choices based on their debt, and they're not choosing family practice because no one has taught them to run an office and it sounds too hard. So finally I realized that they actually *do* need to know. They need to know about risk management, they need to know about all the kinds of help available, and they need to know about alternate payments.

Medical students also need to talk to family physicians who love their work. They need to realize there is a reward that is separate from the monetary reward. So they need some positive role models as a contrast to the negative stuff about family practice. My issue is not to get every medical student to become a family doctor, but to make the ones who want to do it, who know it's in their brain and in their gut, able to follow thorough despite the difficulties.

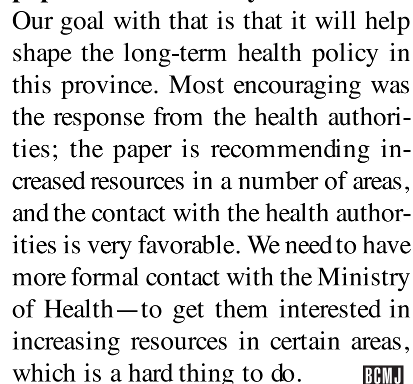
Are there any other big issues that you feel members should know about?

I think the cornerstone of everything is going to be our need to have a different type of relationship with the government. If we can accomplish that then I think a lot of other things in the organization will fall into place. I think that is going to be a tremendous challenge. I believe it is doable, but it's also possible that we will fail. Things are lining up, so it *is* a time of opportunity. We have our agreement. There is a new Deputy Minister. We have the Chaolli-Zelliotis case. So there is a different kind of pressure I think, federally and provincially. We should be able to avoid trench warfare with government; we could change the way we interact, and it could be a lot more positive working relationship. But it's difficult to depoliticize the provision of health care. A massive amount of the federal and provincial budgets ride on it, and there is always the next election, no matter how far away it is. There is the opposition, who are always going to seek opportunities to beat up the government over health care.

Do you think the opposition is a destabilizing factor in the relationship between organized medicine and government?

Only if you allow it to be. The BCMA and the CMA can choose to be nonpartisan, they can choose to be as apolitical as possible. It's much easier for doctors and nurses and other health care providers to be nonpolitical because we're dealing in the realm of the personal. We have our patients, our hospital, our institution, community-based care, or whatever it is. But what politicians have is politics.

Can you tell me about the Wait List paper released in July?



Our goal with that is that it will help shape the long-term health policy in this province. Most encouraging was the response from the health authorities; the paper is recommending increased resources in a number of areas, and the contact with the health authorities is very favorable. We need to have more formal contact with the Ministry of Health—to get them interested in increasing resources in certain areas, which is a hard thing to do. BCMJ