Dr Geoff Appleton, BCMA President 2007–2008

Setting our house in order

With the Physician Master Agreement concluded, new BCMA president Geoff Appleton believes the time is right for physicians to stop the infighting. His goals—a united profession, productive relations with government, and a closer alliance with medical students—reflect this.

Originally from Lancashire, England, Dr Geoff Appleton is a family physician in Terrace, British Columbia. Since 1974, Dr Appleton has enjoyed the beauty of the Skeena River and the satisfaction he gets from taking care of his patients in this rural community.

Dr Appleton received his medical degree from Edinburgh Medical School, coming to BC for additional training in pediatrics. He spent one year in pediatric residency at Vancouver General Hospital, then accepted a one-year GP locum in Terrace.

He returned to Britain to complete his education and start practice. But after 6 months he realized he'd like to return to BC. He took over a practice in Terrace because of the equality and mutual respect he found among the physicians there, and because working in a more isolated community meant he had the opportunity to branch out into other areas of practice such as general surgery.

During his year as president, Dr Appleton has three areas in which he would like to make a difference. Having a united profession means a lot to Dr Appleton, and promoting this is his first priority. His second priority is to continue improving the relationship physicians have with government. His third priority is to mentor medical students. He wants to help them develop their skills as leaders in their profession and become advo-

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cates for improving health care. And he wants to see them become actively involved with the BCMA.

Jay Draper, *BCMJ* managing editor, spoke with Dr Appleton in July.

What's your favorite part about being a doctor?

Patients, pure and simple. I performed my first delivery in 1975; that baby is now grown up and I've delivered her children as well. That kind of continuity in rural practice, whereby patients can be followed to the hospital, then to the long-term care facility, and so on, is what's kept me in rural medicine. I don't want to just sit in an office—I like the hospital work, the emergency department, performing surgical procedures.

How much time do you spend in the office as opposed to elsewhere?

My work certainly is mostly office based, but if you see a patient in the office in the morning and it turns out that they're quite sick, they can go straight to the emergency, and you can go down at lunchtime to get things sorted out. You can talk to the internist or the surgeon, whomever—they're right there. The downside is that the sickest patients have to go out of town.

Is that your least favorite part of practice—getting that tertiary care?

One frustration is paperwork, forms, the hoops you've got to go through to get your patients what they need. Every insurance company, including Pharmacare, has a different form and regulations. It's also very frustrating to tell a patient that they should see an endocrinologist in Vancouver, but they can't afford the flight, and don't want to take a 24-hour bus trip. Often they have to take a friend because they don't know anything about Vancouver, and so the cost is fairly substantial. Another frustration is when you prescribe medication they can't afford, they don't have coverage, and hope to do it on samples. Of course that's only a temporary solution. Most of these are general practice frustrations, and some of them are rural practice frustrations. And then there's the problem that everyone in BC has, and that's wait lists and bed shortages.

When you first became involved with the BCMA, were you motivated by some issue or problem that you wanted to solve?

I was probably being a bit nosy, wondering about the BCMA, wondering who develops these policies. For example, the Northern and Isolation Allowance—how is that determined? I thought it would be nice to be involved with that. I ran to be the delegate for the northwest, lost, and became the vice-delegate. I came to a couple of Board meetings, ran again, and became a delegate. I got on lots of committees, and for a long time was chair of the Northern and Isolation Committee. The next step was to get more involved with the Executive Committee, so I ran for the position of Board representative to the Executive. I held that position for 2 or 3 years before I decided to run for president.

How many days are you at the BCMA office per week?

Well it's a half-time position, so I'm planning to be in practice Mondays and Tuesdays in Terrace, fly to Vancouver on Wednesday morning, be at the BCMA Wednesday afternoon, Thursday, and Friday, and hopefully home on the weekend. I've been very fortunate to find a relatively new grad, Dr Antoine Gagnon, who is just finishing off anesthetic training as we speak. He's really wanted to move to Terrace for a while, so we offered him this position for a year, with the option of staying on afterward in general practice in our clinic. He jumped at it, so he'll be doing my position half-time, which is fantastic.

One of your goals as president is to continue to increase the close relationship with medical students. How are you going to make that happen?

First, we've got to meet with medical students on a regular basis, and I hope that will include those at UNBC. The same would apply to international medical graduates. I'll want to meet

with them and encourage them to interact with the BCMA. The BCMA should also continue with its new medical student interns program.

When you look around the Board you see a lot of gray hair. That's typical of medicine anywhere—young people have got a different idea of lifestyle. They don't want to work 60 hours per week, they don't necessarily want to earn a whole pot of money; that's not their priority. They want to pay their debts off, but they're happy with a satisfying practice, a rounded practice. They want to take care of patients, and I don't know that they want to be distracted by medical politics. But when they get on the Board they have a vote just like the guy who's 60 has a vote, so if they've got issues to bring forward as young doctors, we need to show them that they can make a difference. We did the same thing before with trying to get female physicians on the Board. We had a lot of success with that, and I think we should do the same with medical students and young physicians.

And IMGs?

Yes. There's a whole pool of IMGs here. The BCMA's in-house counsel, Cathy Cordell, has represented them in the negotiations. So they're in tune with the BCMA, and I think we should keep in close contact with them. If they have problems, they know this is where they can come for help. IMGs trying to get licensed have a lot of hoops to jump through. We can help make sure they have a choice where they go, and be honest with them, because they've got a 2-year commitment—they need to know what they're getting into. If a physician comes from a European city, and goes to, say, Dease Lake, you know there's a lot involved there. And hopefully the health authorities that are hiring them will be up-front, and let them take a flight up there and have a look around first. It's not fair to show them a nice glossy photograph with some mountains and a canoe, and then they find that there isn't even a Tim Hortons in town!

The issue of transparency of the Board came up again this year at the AGM, with some motions accepted. What is the Board going to do to push this issue forward?

In my opinion, the BCMA Board is already transparent and democratic. Members elect us to speak for them, and for the profession; they trust us to make decisions on their behalf. The Board is a democracy, and the majority rules. We're not squashing people who vote for or against a particular thing—but once the Board makes a decision, all Board members are obliged to stand by that motion. That's the way all boards work; they abide by the opinion of the majority. Board members cannot go out and actively campaign against a democratic decision, and to make that clear we developed a Code of Conduct. Every organization has a code of conduct—members can see ours on the BCMA web site (www.bcma.org/members/bcma_information/member_news/pb13%20-%20code%20of%20conduct.pdf). Members should read it, and they'll see that there's nothing in there that says you can't speak for yourself. It just states "don't campaign against majority decisions." So minority views are listened to, but after the discussion we vote, and the majority rules.

But there seems to be some discontent out there. What are you going to do about it?

We have to continue to keep members informed. We've made great strides in opening up communication channels to members. We'll continue to give them the minutes of the meetings on the web site, continue to give them the details of what's been going on, and continue to give them the pros and cons when the membership as a whole needs to make a decision, as they did with the Master Agreement.

The concept of publishing a dissenting opinion, the way that Supreme Court judges do, sometimes comes up. Would that be acceptable?

Yes. Board members are free to comment to BCMA members and the general public, but they're expected to present a balanced view of arguments in favor and against the decision. They need to convey a message of respect for the Board's decision-making process, and a message of acceptance of the decision, even if they voted against it. And, as I said, they can't campaign actively against or undermine a decision of the Board.

At the AGM some Board members removed themselves from the discussion of Dr Dirnfeld's resolution regarding open communication, and the quorum was lost. I'm sure everybody would agree that was an unfortunate chain of events. What can be done to make sure that doesn't happen again?

Those Board members who left were not aware that they would destroy the quorum. It wasn't an engineered event. It was a harsh motion, and was taken by the majority as a vote of nonconfidence. Legally speaking it probably wasn't, but some Board members felt that they should not vote, and that they should absent themselves from the discussion. Rightly or wrongly, that's what they felt, and they left, and of course it turned out that there was a loss of quorum. Most of the Executive stayed, but that motion was kind of personal. It wasn't like saying, "we don't' like your budget," it was like saying, "you haven't been behaving properly." Some Board members felt hurt, felt accused of being something that patently we are not.

But as far as attendance at the AGM is concerned, my observation is that when there's controversy, say fee issues, or a big fight with govern-

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ment, people come. If they don't come, I read it as a vote of confidence. Members are very happy with the job the BCMA is doing. In a poll on governance in 2007, 74% of members said the Board was doing a good job overall. We could always do more, and we can always do better. I welcome constructive input from members if they've got ideas.

Physician unity is another one of your goals this year. Can you tell me about that?

This speaks to the feeling of tension between GPs and specialists. A lot relates to income and fees, and I think a lot of people mistake fees for income. Everybody thinks they're hard done by and that the other group is making more money. Everybody thinks their group's overhead is twice as high as the other group's, and it gets ridiculous. Then there's anger that the SSP is going forward with the arbitration. And then below that is the disenfranchisement of urban GPs from specialists in the hospital setting, of GPs being replaced by hospitalists, being made to feel unwelcome. And then the withdrawal from full-service general practice, and the slack being taken up by walk-in clinics.

Now, a lot of these issues are being recognized. The SGP has recognized it, SSP has recognized it, and one way to address that is with fees. The GPSC is making moves that way, with higher fees for complex care, chronic disease management, and so on. Then at the same time they're working on practice management, where they're really promoting an open-access clinic.

The thing that brought me back to Canada was being able to work as a GP in the hospital with specialists. You don't sit in the doctors' lounge anymore because you don't have time. So I can see this relationship sliding, and the last thing I want to do on my watch is to see the separation of GPs and specialists, which would be disastrous.

At the AGM both the SSP and SGP stood up and expressed concerns about not being on the Board in the new governance model. How do you respond to that?

The Committee on Governance and Restructuring developed the proposal over the course of about 3 years, and the consensus was that to improve the Board we have to split governance and representation. The blend we currently have is causing problems. The consultant said, "You've got to do that. There's no other association that does not split those functions." People are sometimes in conflict, especially the presidents of the two societies.

So there's no way that you can have a representative person on a governance board. They can be representative at the representative assembly, and so can all the sections. Governance changes are not about taking away the societies' representative function or the negotiating function or any other function—the point is to improve the BCMA. The societies are doing a good job, and in fact, may need more help to do things. They're doing a huge volume of work, for example, through GPSC. We all respect that. And if the SSP does their internal reallocation to address disparity, it would be fantastic. That's a tough job.

The next step is for the Board to vote on the restructuring proposal; and if the Board votes in favor, we'll bring it forward to the membership. At that point we can all talk about the pros and cons of a new governance structure. There's no doubt it will be tough to pass, since it needs a 75% majority. But as a Board we need to know that we've done our due diligence, not compromised, and brought forward what we believe is the best way to improve the function of the BCMA.

What stands out for you as the most significant changes in the new Master Agreement?

The first big one is the new policies for interaction between the BCMA and government at various levels and through several joint committees.

Second, the arbitration provisions for most (but not all) agreements, as well as local dispute-resolution mechanisms. Third, all the safeguards of the old agreement that continue.

This obviously fits in with your goal of a good relationship with government.

Yes—we need to make this relationship work. We're feeling our way, and sensing a lot better cooperation and involvement. You need to be able to pick the phone up on a day-to-day basis, otherwise things go off the rails. You don't want to be writing missives to one another. I'm not saying we should make side deals, or compromise, or anything like that—I'm just saying day-to-day informal contact prevents problems down the road.

Having a committee structure that works—I think that encapsulates good government relations. When government does something health-related that we feel is wrong, we're able to say so before it goes too far. Let's prevent these outbreaks before they happen. Because invariably what happens when these brushfires get out of control is that patients suffer.

So if you could help with one thing this year, what would it be?

Physician unity. I'm hoping that we can get the SGP and the SSP to a point where they feel that they have the power to represent specialists and GPs in a cooperative way and that they don't end up fighting each other for a piece of the pie.

Let's have a thorough review of the last round of negotiations. We're a long way from any further negotiations—2010, just for the reopener. So we've got lots of time to get our house in order and thrash something out that everyone will find beneficial. If there's a better way of doing it, let's look at it.