Pinch me

How did I become so jaded and untrusting? I was recently sitting in a meeting discussing the possibility of our local GPs forming a division of family practice when I found myself wondering what the government's real agenda was. On the surface the plan appeared simple. Once a division is formed there is a collaborative services committee consisting of representatives from the division, the Ministry of Health, and the health region. Problems are brought forward by all parties to the committee to be addressed in a collaborative fashion, with no decision being binding. There is money available to address some of these problems like patient attachment, rising medication costs, or other issues identified. Novel approaches could be brought forward and funded on local issues such as medical care for the homeless or mentally ill, for example. This "division" concept came out of information meetings the government had with GPs, and is trying to address, with the support of the General Practice Services Committee (GPSC), the idea of having a local unified family practice "voice" that can be heard. So why do I distrust this process?

There is a saying that history repeats itself, so perhaps it is time for some reflection. When I was in medical school the government decided to limit billing numbers. The prevailing opinion was that physicians create an income for themselves, so if you limit billing numbers you will control costs. Therefore, upon graduation, if I wanted a billing number without restrictions, I would have to practise in an underserviced community somewhere other than the Lower Mainland. This approach was challenged legally and deemed unconstitutional.

Next, I remember a negotiated contract where the doctors of BC were partially responsible for the global physician budget. The government decided early on in the fiscal year that the doctors were going to exceed this budget, so without consultation they started to prorate us and keep a percentage of our billings. They then seemed surprised when we decided not to work for free and took reduced activity days, closed our offices, and did something else.

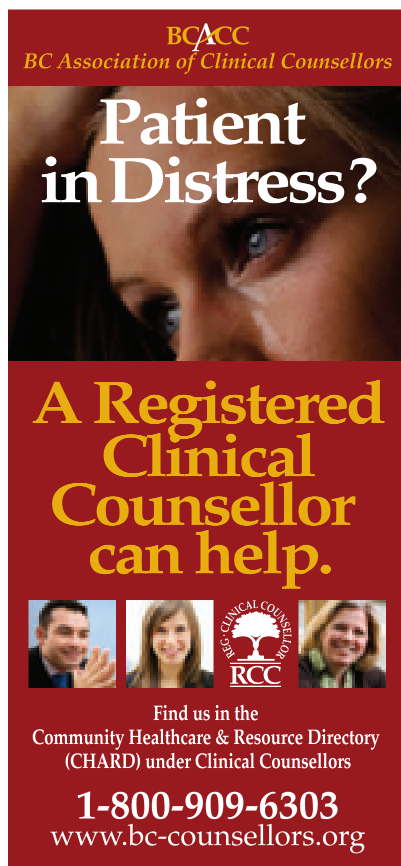
This was followed by signing a contract with the government in which if an agreement could not be negotiated and accepted by both parties then the dispute would go to binding arbitration. Former Chief Justice Allan McEachern was appointed as the arbitrator and then after his decision came out on our side the government ignored his recommendations. I guess the contract was only unilaterally binding.

I still recollect members of government making comments during the fee negotiation process like "Doctors are morally reprehensible and should take a long hard look in the mirror." I would open my newspaper most mornings curious to see what an evil person I was on that particular day of the week.

To be fair, over the last few years things have been changing. Through the GPSC and its initiatives I have come to feel valued as a family doctor. This is a strange feeling and it is difficult to trust. For years I had been told that I was greedy, overpaid, and selfish. Deep down I believed that I worked hard and was actually good value for the money and time that had been invested in me. As more and more evidence mounts that patients attached to a family doctor cost less than unattached patients, I feel somewhat vindicated. Opportunities for education are being made available, incentives for good all-round care of chronic diseases have been established, and I am being paid better—pinch me.

So forgive me if the old feelings of distrust begin to percolate to the surface—they have been well earned. Perhaps the dinosaurs like me will have to die off before a more trusting relationship can be formed between physicians, the government, and health regions. Speaking of which, my health region recently changed, again without consultation, bylaws guiding specialist coverage requiring the BCMA to form a special committee. Damn, there I go again.

—DRR



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How to treat patients

In my regular encounters with medical students during their clinical rotations, I am impressed by their general level of maturity and accomplishment. Like most of my contemporaries, I am extremely grateful that I entered medical school when I did, because today I would have a microscopic chance of making it. By and large I rely on Socratic methods of clinical instruction. That is, I expect that the students with whom I see patients will have a decent understanding of what's happening, without me having to spell it out. Most of the time that expectation is justified, which impresses me even more—when I was a student, what I seemed to say most often was, "I'm sorry, could you repeat the question?" Maybe it's the easy access we all have to information, but they certainly seem to know a lot by the time I meet them.

So I have become used to the idea that there isn't a lot of information that I can impart to these students because they have ready access to better organized resources than me. But what I can do is tell them what I have learned over the years to be important and what is not important. This information comes with qualifiers, of course, because although my clinical experience covers over 40 years, the great bulk of that experience has been in the health care of women—and men are different. But I have insight there as well, so I may be covered. Regardless, here are three general observations that I hope help guide students in their clinical encounters.

Everybody wants to feel healthy

This observation is a vague corollary of the first of Dr Robert Lamberts' Six Rules Doctors Need to Know (cited in the *New York Times*): the patient doesn't want to be in your office in the first place. I would have thought that this was self-evident, but there are nevertheless some patients who seem to enjoy the idea of being unwell. I think that these patients are most likely fulfilling observation number 3. By and large, however, everybody does indeed want to feel healthy—explaining the popularity of alternative care practitioners, who peddle the idea that everyone is inherently unhealthy and needs "treatment" to restore "health." Our job is largely to reassure. However, beyond this we must ensure that, in addition to treating illness, we try to make patients feel well.

Everybody wants to feel safe

This is an expansion of observation number 1. Patients who present with minor symptoms may be apologetic about troubling you with trivial concerns, but in most cases there is a real underlying fear—abdominal bloating is most likely due to poor dietary habits, but it can also be a sinister sign. Is this chest pain due to acid reflux or angina? Patients need to feel secure that you are taking their concerns seriously and can ensure their safety.

Everybody wants to feel special

I am sure this is true, even in the shyest individuals. Hence the importance of spending sufficient time with every patient so that you learn, in poker terms, their "tells"—how they describe positives and negatives—so that you don't miss critical pieces of information in their history. The challenge inherent in this is to keep relevant details for each patient in your head. Sooner or later we all run into patients in Safeway, and they invariably remember every detail of every discussion you ever had—but do you? Give it your best.

The students with whom I spend time are indeed an impressive group. I am happy to entrust the future of our profession to them—but I will continue to remind them of these observations, because at one time or another we're all patients. Strangely enough, that doesn't let us park in the "patients only" section of the hospital car park. Life is so unfair.

—TCR

Medical writing prize: $1000 for best student article

The J.H. MacDermot Prize for Excellence in Medical Journalism comes with a cash award of $1000 for the best article on any medicine-related topic submitted to the *BC Medical Journal* by a medical student in British Columbia.

The British Columbia Medical Association awards the annual prize to the finest medical student manuscript received by the *BC Medical Journal* that year. The prize honors Dr John Henry MacDermot (1883–1969), who became the editor of the *Vancouver Medical Bulletin* at its formation in 1924, remaining at the helm until 1959, when it became the *BC Medical Journal*. He was editor of the *BCMJ* until he retired in 1967. Dr MacDermot was also past president of both the VMA and the BCMA.

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