Shelley Ross: BCMA President 2012–13

Dr Ross looks back on her 36-year career as family physician and family practice obstetrician, and forward to her year as BCMA president.

BCMJ Managing Editor Jay Draper spoke to Dr Ross in July, 1 month into her presidency. Here is a condensed version of their conversation.

Can you tell me about your family?
I'm married with a very supportive husband who ran my office since 1991. When we had our second child, he decided he would stay home and be the at-home husband. He stayed home for 5 years, and during that time we decided to move offices so he organized the office and he was the office manager until we closed the office this May. We have two sons. One works in the federal government in Ottawa as a director of parliamentary affairs for a cabinet minister, and the other is a physician who has just gone to Ireland to do an ophthalmology residency. He went directly from high school to Dublin and did medical school and graduated at 23. They have a 2-year rotating internship, so he did the first year in Ireland, in Sligo and Galway, and then his last year in Auckland, New Zealand. He was fortunate to get a position as a resident in ophthalmology, which was his love since he started medical school. He would have loved to be back in Canada doing a residency; there are things we need to fix for Canadians studying abroad to get them back.

What should we be doing?
Helping to solve the IMG (international medical graduate) residency problem is one of the things I'd like to do as BCMA president. I'm acutely aware of this issue because of my son, but I want to point out that since he's now doing a residency abroad there's nothing in it for me. But it's just not right that Canadian citizens who have gone abroad to study medicine—in countries from which we import physicians from the same medical schools—are stymied in their ability to get a residency spot in Canada. This is not proper and needs to be fixed.

So right now, you're considered an IMG if you haven't studied in a Canadian university. So you have to prove that you're a resident of British Columbia, then apply to have a 3-month probation through the IMG program, and of those people who go through the probation, half of them will be chosen to go into the residency spots. So once they're chosen, they have to fill in the rest of that year and then start the residency in the third year. So they've wasted a minimum of 2 years. Many of them have been out of practice for 10 years, which is way too long. There needs to be a seamless ability for Canadians to get back in; I don't discriminate against other international medical graduates, but I believe there is a difference with Canadian citizens.

Manitoba has already improved their IMG residency system, and we need to do the same by working with the government, the health authorities, and UBC to come to a mechanism where there are more residency spots for both Canadian IMGs and foreign IMGs on the basis of merit.

What do you do for fun?
I like to travel, I read, I do different kinds of cross-stitch and quilting and handiwork and things like that. There has never been that much spare time

so I didn't have that much trouble filling it in.

Where do you like to travel?
My two favorite spots are probably Egypt and Kenya.

What was it about those countries?
With Egypt, I love the history, the time of the pharaohs, the archaeology, cruising down the Nile and seeing the Valley of the Kings; it's wonderful. In Africa I find the safari and seeing the animals in the wild just breathtaking. I've been to Africa three or four times and it's troubling, of course, to see the poverty. It's such a shame that it just doesn't seem to get better.

Why did you want to be a doctor?
When I was a toddler my uncle gave me a doctor's kit. It was so early that I can't even remember it, but everybody tells me from that moment on I knew I was going to be a doctor and I never wavered. When I was in medical school I couldn't decide whether to be a family physician, an obstetrician, or an ophthalmologist. The division of family practice had a party for the graduates and that was the deciding factor; they wooed me in. My practice was always half full-service family practice and half obstetrics, so I had the best of both worlds.

What was it about medicine that attracted you?
Oh, I have no idea.

No?
I did not come from a medical family, but I was fortunate to be good in the sciences and did well at school, so I could have a choice of what I wanted to do. It was in my mind I was going to be a doctor and a doctor I became. If I had to do it again, I wouldn't hesitate; I've loved every minute of being a doctor.

You'd take exactly the same path?
Probably, because in family practice you can mold it to what you like. I molded it so that half my practice was obstetrics. So as the rest of my population aged and turned into chronic disease management and so on, I also had the young crowd coming in who would come for the 9 months of the pregnancy and delivery and the postpartum care, and that kept the practice young.

For me, general practice is absolutely the best area to work in. You've got variety, you've got longitudinal care. I was amazed, when I was closing the practice, how many people had been with me the full 36 years I'd been in practice. And how often can you have a job where you never know what you're going to see next? So the variety is tremendous. You make a good living, you can influence people to make good decisions, and you have influence in the community at large. It's a very excellent job.

Seeing the same coughs and colds doesn't become routine?
The days of seeing coughs and colds are over, unfortunately—they go to the walk-in clinics. When somebody comes to see me and they say I've got a cold, I say, "Okay, let's see what we can do about that. But why are you really here?" The coughs and colds and ear infections are gone from the general practitioner's office, and I think that we need to bring them back because we need to make sure that people aren't getting fragmented care. We need to make sure general practice can cover the urgent needs, and a lot of our GPSC programs, such as advanced access, are teaching us how to get more people into our office and still give them high-quality care. There's nothing better than having your own doctor look after you.

You mentioned the idea of influencing patients and the community at large. Can you tell me about some of the things that you want to influence as BCMA president?
One issue I want to influence is getting female physicians involved in leadership roles, and I hope to be a bit of a role model for them. I tell young women in medicine to quit saying no; you've got to say yes when people invite you to be on committees and run for office. One obstacle is what is now called home-life/work-life balance. We've got to make changes to the way we invite people onto committees so that it takes into consideration the times of day that they can attend.

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Dr Shelley Ross and her mother Mrs Janet Ross

Photos page 330 and 331 by Karen Tregillas.
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Who's going to look after the children at home while they're attending the committee? So we've got to look at things a bit differently. Young women need to get involved, because, before long, it's going to a female predominant profession and we want to make sure that we have enough leadership in place that medicine does not lose its influence.

Do you think that eventually medicine will become a female-dominated profession?

I think that if you look at the medical school classes, for a number of years, they've been at least 50%, sometimes higher. I think that it's equally important to encourage young men to enter medicine. We don't want to just focus on women. It's important for men to be in medicine as well because I think it's better to have a balance in the profession.

One might argue that since medicine is a caring profession, it might tend to attract more women than men now that so many of the other obstacles are removed.

Yes, women are thought to be kind and compassionate, but I have seen many men who are just as kind and compassionate and empathetic.

What's your favorite thing to do as a doctor?

Deliver babies. It gives me such a sense of accomplishment. Most of the time, it's a happy event—and you never forget who delivered your baby. I wanted it to be a nice experience for them. You hear so many negative things about childbirth. I wanted them to say, "I was really happy with the way I was taken care of and I'm happy how the delivery went."

What's your least favorite thing to do?

Having to tell people bad news. But again, as a general practitioner knowing them well, you're in a position to tell them in a kind way. You get better at it with time and experience and knowing the patient, but it's still always hard to tell people that they're not going to survive an illness.

So after 36 years you have closed your practice.

Yes, but it was a good time in my career to do it. My lease was coming due, I couldn't find anybody that wanted to do a locum or come and take over the practice or come and work with me so I could work part time. That made me realize in a very personal way what a crisis we're in. I had a lovely practice with nice patients, great variety, and I couldn't give it away. So we've got a crisis that we need to fix.

What are some of the things that ought to be done to solve that crisis?

We've got to have a little look at how people want to work nowadays. The idea of being a solo practitioner is passé, and I wouldn't even want it if I had a choice nowadays. When I first started, I was in a group of about five and a half. And then a few retired, one went to be a hospitalist, one went to run palliative care for the region, and one moved to the other side of town. I just couldn't find a suitable partner to replace them.

So you became a solo practitioner by default.

A solo practitioner 24/7, unable to get locum coverage, so when I went away I just had to close the office. That's why when I knew I was going to take on the presidency role, I didn't want to do a poor job at both because if you're trying to run a practice by yourself and you're trying to be president, you're always in the wrong spot at the wrong

time. I thought it's better to make a clean cut, do the presidency and then see what clinical opportunities come up. I could see myself working at a maternity clinic doing a shift here and there, doing a locum. I love clinical practice, it's not that I've tired of that, but I just wanted to be able to do this job properly.

Can you tell me one of the highlights of your career as a physician?
One highlight was when I was awarded the fellowship in the College of Family Physicians of Canada. It was an award where your name was put in and you were selected for your outstanding work as a family physician. The other thing would be becoming president of the Federation of Medical Women of Canada, where I could stand up for women physicians across Canada. Then I was president of the Medical Women's International Association. I have so many nice memories in patient care that it's hard to pick just one. There's the day-to-day satisfaction of feeling you've done something for somebody. When I was getting all my cards as I was retiring it was absolutely heartwarming to see how much people appreciated what I did, things I'd long since forgotten, but they remembered.

In the future we'll look back at today and think . . .
There's no doubt that when they look back 50 years from now, people are going to say that the absolute greatest advance in women's health (and men's health too), was the development of the HPV vaccine. When I was in medical school, they didn't know what caused cancer of the cervix and then they found it was HPV and then they developed a vaccine against it. How often do you get a prevention for cancer? It's going to change the face of cervical cancer. And of course in the developing countries where HIV is so prominent, they die so often of cancer of the cervix because it is an infectious disease. The reason I say it's not just for women is that HPV also causes other cancers, cancer of the penis, cancer of the throat.

What living physician do you most admire?
Dr Gro Harlem Brundtland, from Norway, who was the past director general of the World Health Organization. She's very wise. One of my favorite quotes from her was when she pointed out that there's no country, either developed or developing, that treats their women the same way they treat their men. Now there's a good one.

Is the president's job what you expected?
I'm finding my way into the job. It's a political job, and I'm glad I've developed thick skin over the years because you're bound to collect your own bit of hate mail from different people who feel that you're not doing the job properly. It's a job that is going to evolve over the year and you never know what crisis might come, so you need to be ready for the unexpected. Fortunately we got the PMA negotiated before I took over because I certainly would have hated to be the president who got them no money!

Speaking of things going wrong, can you tell me about something the BCMA did wrong recently and how it could have been done differently?
The one that comes to mind is the referendum on the term limits. We wanted the message to come across that as an elected board, we look at both sides of an argument. And when we put out a referendum, it has been our policy to put out the reasons why we think the referendum should be supported. With all the feedback we've received, what I would suggest is that next time we should put out the opposing view so that the membership feels that they have a balanced view. We can always make improvements, and that's one thing that as president I would like to see—that we give members both sides of the argument.

Does the BCMA get enough credit for the work that it does?
When you look at the outstanding work of committees like the Council on Health Economics and Policy, I think no, we don't get nearly enough credit for the outstanding papers they produce. It's changing though. When we do surveys to see who is using this information, we find that it's more and more common for people to check and see what the BCMA has to say on an issue. This is another thing I want to accomplish as president—when there's anything that's health related or related to physician workforce or health care provision, I want people to automatically say, "We need to know what the BCMA thinks." One of my jobs as president is to get out and rebuild connections in the community with all health organizations.

The NDP is widely expected to form the next government. Is that going to make any difference to the BCMA?
The BCMA can work with any government. Our focus is on patient care and we will work with whoever's in power to make that work. I think that you have to make sure that you're working for common goals, and you keep it professional. My own MLA is with the NDP and she and I have a very good working relationship.

Any final thoughts?
A goal that I've not mentioned yet, and it will probably be my biggest job, is to leave this office in a year's time with a united profession. I'll do my best to work with everybody so that they feel that the BCMA is working on their behalf. Although we don't always get the outcomes that we want, members need to know that we have their best interests at heart. My door is always open to meet with whoever would like to come and visit with me. BCMJ