Q & A with Dr Bill Cavers: Doctors of BC President 2014–15

Joanne Jablkowski

Born in Port Alice, BC, Dr Bill Cavers received his medical degree from the University of British Columbia and has been practising family medicine in Victoria for the past 34 years. Dr Cavers has worked with Doctors of BC in many capacities since his involvement with the organization began in 1995, including 10 years on the General Practice Services Committee (GPSC) and 8 years as its co-chair. *BCMJ* Assistant Editor Joanne Jablkowski spoke with Dr Cavers 1 month into his presidency about his interests, experiences, and goals. Here is a condensed version of their conversation.

After receiving your medical degree from UBC, you interned in New Zealand and worked in Australia. What drove you overseas for this portion of your career?

While I was in medical school all of my friends went traveling and came back with slideshows of where they'd been—that was back in the days of cameras that took slides, which you looked at using a slide projector. I saw pictures of Europe, Asia, Africa, and I got very itchy feet. When I learned that New Zealand and BC cross-accredited, that part of my travel expenses to get down there would be subsidized (offsetting the fact that it would take 18 months to get my accreditation), and that I would be able to mix travel adventure with training, I was on that plane in a heartbeat. In the year that I graduated, 21 of my graduating class of 80 went to New Zealand.

Ms Jablkowski is assistant editor of the *BC Medical Journal*.

What did you enjoy most about life down under?

I was able to do a lot of medical work in the hospital—things I would not be allowed to do here—I was given a lot of responsibility, and I was given a lot of acknowledgment. I was also able to see a beautiful country and meet many warm and generous New Zealanders. I had a wonderful time.

What brought you back to BC?

Family. Initially my wife and I left New Zealand and we went traveling for several months through Australia, which is when I worked in Cairns doing family practice and worked in the Cairns-based hospital. Then we went to Southeast Asia. It was the only time in my life that I had no responsibilities drawing me back anywhere, so I took 6 months to come home, and I came back because my family and my wife's family were all in BC.

What do you enjoy doing in your free time to relax and recharge?

I ride my bicycle—often my friends and I will ride from Victoria out to Sidney, have coffee, and ride back again. I watch stupid science fiction movies and shows, I read, I walk my dog, and I cook. Oh, do I cook! My ideal Sunday would be to get up, have coffee, go for a bike ride, come back, cool down, do a cryptic crossword puzzle, and start to cook. I do the Sunday dinners for family and friends. I put on jazz, I put on rock and roll, and I start to cook.

Has cooking been a long-held interest for you?

When I was living with a bunch of guys in a communal house I found that knowing how to cook attracted other people. And I really enjoyed the outcome of it. I've got a full complement of good knives, I make my own hot sauce, I make my own bitters. I made Indian lime pickle recently. I love doing it.

What keeps you excited about your profession?

There are two things. First, I think being a family physician is the best gig on Earth. I have the opportunity to get to know people and make a positive difference in their lives. Being able to do that is an essential part of my makeup. I also enjoy the challenge of not knowing what problem a patient is dealing with when he or she arrives—it could be a cardiac problem, it could be a problem with an emotional disorder, it could be anything—and I get a chance to help them. I don't have to worry about why I get up and go to work every day because I get feedback all the time that I'm making a difference. Second, by being involved in medical politics I get to also step outside the frontline trenches and try

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Photo: Diana Nethercott

to make a difference in the system. I've got the best of both worlds—the opportunity to do systems analysis and system redesign and the chance to jump into the trenches and do front-line clinical work.

What do you enjoy least about being a doctor?

Paperwork, and the hours involved in doing it. And, giving people bad news.

Teaching runs in your family. As a doctor, do you consider yourself to be a teacher of sorts?

My family initially thought I was the black sheep because I went into medicine rather than teaching. But I've convinced them that I am a teacher; I just have a much smaller class size. I find teaching to be an integral part of my day-to-day work with patients. They want to know about their condition and they *should* know about their condition—it makes my life easier and it makes their outcomes better when they do. When I can, I also take on a medical student or resident and I teach in that capacity because I think it's important to give back. My ability to teach students and residents has been somewhat curtailed in the past few years because I haven't been reliably present in Victoria as much as I should be. The Island Medical Program has graciously given me a pass and said they won't bug me until I finish my presidency, but I told them that at the end of my term I want a phone call so I can take on another resident.

Do those interactions give you an insight into how students' and residents' perspectives about medicine are changing?

Absolutely. I find it enjoyable for many reasons—their energy and enthusiasm, their different ways of approaching things, their willingness to challenge practices that I've simply accepted as normal. It's wonderful to be faced with questions: Why do we do it this way? Sometimes I can offer a satisfying explanation, but if I don't have a good answer then it's an opportunity for me to rethink my approach. It's also a chance for me to influence how they feel about the profession in terms of how they interact with patients, how they prioritize, and what's important for them to be doing in family medicine.

Can you tell me about a personal achievement that stands out for you—a career highlight?

Being co-chair of the GPSC from 2005 until last year. It was a lot of work, but it was the right initiative at the right time. We did so many fantastic things to improve family practice. It was inspirational to be there.

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Are there any experiences with patients that have had a significant influence on your career?
Too many to list. I've been influenced by the different ways they've approached things; I have ongoing relationships—I would actually call them friendships. You have to be careful in medicine not to get too close to a patient, but if you draw that to the nth degree and you're not involved at all then you're no physician. It's important to have a personal connection with patients because they then have trust in *you.*

Have those experiences shaped the other roles you've taken on beyond family medicine?
Yes. Acting as an advocate for a patient and working on their behalf is no different than being an advocate for your colleagues and working to improve the system—it's an extension of the same principles. That's what attracted me to being on the Board of the Society of General Practitioners when I started in medical politics—back in the last century!

Have you made any mistakes along the way that you were able to turn into opportunities for positive change?
You cannot practise medicine for the length of time I have without making errors of omission or commission. And sometimes it can crush you, but that's when you need to turn it around. I think to myself, if I missed this one, it's not going to happen again.

Have there been people in your life who you've looked to as mentors and role models?
My father, definitely. He was my prime mentor and role model. He was a fantastic individual. He taught me many principles, and I can think of one that I take with me every day: Try to leave something better than when you found it. That's also shaped my career and my involvement with Doctors of BC.

What personal traits have helped you most in your profession?
First, I don't take myself too seriously. Second, I try to use a sense of humor to lighten a tense subject and engage with people. Third, I have a fair amount of energy. And fourth, I like to fiddle with things. I'm curious to try to see things differently. I ask myself, if you could develop something in a perfect world, what would it be? And then, how can you get there? Like with a Rubik's Cube, in family practice and in medicine as a whole there are many ways that things can fit together, and we have to identify which is the best fit—first, for the patients' outcomes and experience, and second, to make our role and responsibilities easier. Medicine is becoming more complex, and we have to continuously challenge how we're doing things to continue to work toward these aims.

That's why I'm so passionate about the idea that information technology needs to serve us, not the other way around. I've run across so-called IT solutions that end up being more complicated than the problems they're attempting to solve. We need to ensure the tools and processes we use make it easier to get to where we want to go—as an individual physician, as a clinic of physicians, as a health authority trying to provide its services, as a province. We know the health care budget is creeping up inexorably, so we need to address that. In terms of making outcomes better, how can we do it more easily and in a cost-effective way? I don't want to spend 10, then 11, then 12 hours a day getting to the same endpoint.

Do you enjoy fiddling the same way when you're cooking?
Oh yes! A recipe is just a suggestion. I often think to myself, no, I'm going to double the cayenne pepper.

You've been involved with Doctors of BC (then the BCMA) since 1995. What has kept you engaged with the association for all these years?
There's always something new happening. The entire system is never going to be fixed—as soon as one issue is addressed, major or minor, something else crops up. I enjoy tackling the new challenges that come along.

Does anything stand out to you as a pivotal change or development within the association since you became involved?
The development of the joint committees, absolutely. We changed from an era in which we were oppositional to government to an era in which we are working cooperatively and making great strides in getting the outcomes they want and the outcomes we want. I'm referring specifically to the formation of the GPSC in the 2002 agreement, the identification of the Specialist Services Committee and Shared Care Committee, and the formation of the Joint Standing Committee on Rural Issues. Those collaborative committees have pivotally changed the way we do business.

Is there a health issue that you think is not getting enough attention—both within the association and outside of Doctors of BC?
Various population health issues exist. Specifically, I think we could do a better job of addressing the numerous barriers to care that exist for First Nations populations—geographical issues, jurisdictional issues. There are things that we as an organization can address. For example, how do we adequately use telehealth issues to provide better outcomes? How do we adjust our payment systems to better support care? How can we engage with First Nations in a more effective way to provide good care in a culturally appropriate manner? Going beyond the First Nations, we could do

a better job of facilitating the care provided to many of the different large ethnic populations in British Columbia in a way that fits with their culture, the language barriers, etc.

Is there a place that comes to mind as doing a better job of addressing these issues?

New Zealand—with the Maori people. Their Aboriginal population is very involved and integrated into the whole system.

Before you became president, what would a typical day for you look like?

I'd be more reliably in my own home and in the clinic. Admittedly, that was modified by my life being a bit chaotic in the last few years with the GPSC due to the long hours that went into developing various initiatives.

How has that changed?

Ultimately, I'm not at home as much and I'm less accessible to my patients, which is a great concern of mine. I'm in Vancouver 2 to 3 days of the week, which will again change dramatically when I go on the President's Tour, when I will be sent where the association needs me. I'll be going to some interesting places and I look forward to it, but it's going to be different. I'm also glad to have locum support coming in to cover half of my practice. I want to maintain a clinical footprint throughout the year, which will increase my workload, but I want to do it. My term as president is only 1 year, and when I finish my term I go back to my day job. I'm a family doc.

Have you started receiving input from members or people in the public who you wouldn't otherwise have occasion to engage with?

Yes, I've had more interactions with students and the graduating residents. I've had more access to my colleagues of different stripes, and I've managed to talk with more people in the ministry and the health authorities as well.

What concerns have you heard most frequently from students and residents?

Debt load. What am I going to do with the rest of my life now that I'm out of school? How am I going to make that transition? Where am I going to live? What personal challenges am I going to meet in terms of expenses and relocating? What professional challenges am I going to experience? Am I up to the job? And on the administrative side of the job, how do I set up my practice? What questions should I be asking in a contract? Finishing school and being asked to go out and *do* something is a major life change. I think students and residents do not get enough training about what happens when they tap you on the shoulder and you're done. What then? I think the association should continue—and consider expanding—its support of students and residents.

Did you face the same concerns when you finished medical school?

Oh yes. I was scared spitless! But I had an out—I had a plane ticket. When I came back dead broke—I had a single $100 traveler's cheque to my name and the clothes I had in one suitcase—I knew one thing: I needed a job. And I got one.

Did the prospect of finding work look different than it does for residents now?

When I started it was difficult to open a practice; it was competitive. After a year or 2 of locum work you would be expected to set up a practice, and you would vie for space or pay someone to take over their practice. Fortunately for me, work sought me out. A colleague of mine was having medical issues so I joined his practice and stayed working with him for the next 25 years. It was much different. I come from the era in which practices were bought and sold, and billing numbers were being restricted because it was thought that there were too many doctors of certain types within health authorities. That has changed dramatically. Now there's a worldwide shortage of physicians, and we're going to have to make changes in the system to accommodate the lack of cavalry coming over the hill in upcoming years.

Has the shortage of physicians been addressed by the increased number of spaces in medical schools?

The number of spaces has increased but right now the number of BC medical graduates still does not match predicted need based on the demographics of physicians. The average age of BC physicians is steadily getting higher. About 3 years ago, the average surgeon in BC was about 55; I think that's gone up to 57. In general, we have far too few young physicians. And when you consider the new graduates' shift toward achieving a better work-life balance, we need more physicians now to fill the same number of spots because people of my vintage are used to working longer hours. It used to be termed the feminization of medicine, but that's not true. Achieving work-life balance is a generational change, and I think it's healthier. I missed far too much time with my kids because of long work hours.

Returning to your role as president, can you tell me about an experience that will influence how you carry out your term?

When I was president of the Society of General Practitioners in 1999/2000, my colleague and mentor Dr Ken Kolotyluk was the executive director of the society, and when I was elected to the president-elect position, Ken fell into step beside me and said, we need to talk. He helped me immensely to understand the roles, responsibilities, and activities of being the president.

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How would you describe your decision-making style in carrying out these responsibilities?

I like to be inclusive. I like to hear people out. I find that if you hear people out and you work together, it may take more time, but when you achieve a consensus decision it's a stronger decision and it lasts longer. The style I hate to use is top-down. It's unilateral, it's arbitrary. I don't like it.

Does this apply to your leadership style as well?

Yes. And I do the same thing with my patients. What is it that you want? Is this okay with you? If you push people and they don't like it, they will oppose you, and it gets you nowhere. Even though hearing people out and working to reach a consensus is often longer and messier, it's better. There's a saying we used on the GPSC: If you want to travel fast, go alone. If you want to travel far, go together.

You've identified three key areas of focus for your presidency (physician leadership and professionalism, engagement with specialists and facility-based doctors, and physician leadership in IT). In which area do you think you'll make the most progress during your term?

Hopefully all, but I have an expectation of what reasonable progress is. I believe all of these are concerns that will stretch across more than just my term—especially the continued engagement in quality improvement and professionalism. And for me there's no difference between quality improvement and professionalism. If you get down to a one-on-one interaction, the quality improvement at that level is called professionalism. And I hope it's going to be an ongoing investment in perpetuity from the medical profession.

In terms of engaging with specialists and facility-based doctors, that's an important and timely matter. Family physicians have seen a renaissance in family practice over the past few years, and specialists and facility-based doctors are similarly committed to good quality care. They are full of very good ideas, and they need to be heard and to influence how their workflow is conducted. It's very timely because our association has initiatives on the go to facilitate the specialists and facility-based doctors to be better able to interact with health authorities. Would I like this project to be finished by next June? Darn right I would. Do I think it will be finished by next June? No, I think it's going to take a few years.

The IT goal is going to be an ongoing battle as well. Ultimately, I think that in any process that's going to involve information technology in clinical workflow, the IT department needs to engage with clinicians to see what's needed and how it should be formatted at the outset, not at the end of the process.

Has the introduction of IT developments too far downstream been an obstacle in the past?

Have you ever bought a gizmo and found that it didn't do what you wanted?

And were left feeling like you were the guinea pig testing the improvement for the manufacturer?

Yes. If you're going to introduce an IT enhancement to improve clinical workflow, you need to test it properly, in advance. I have to give kudos to the ministry right now for their e-prescribing initiative. The ministry voluntarily brought Doctors of BC representatives onto their e-drug steering committee and was close to rolling out an e-drug, e-prescribing program, but then we recognized there were major flaws with the program and the infrastructure, so it was put on hold. Now the ministry is carefully beta testing this two-way e-prescribing in communities across the province and learning from their findings. When I ask, when is it going to be here? They say, we don't know because we don't know the glitches yet—once we get the glitches fixed we'll roll it out. I think that's an example of the process that IT initiatives should follow. And I don't think the perfect product is going to roll out, but it's going to be an awful lot better than it would have been otherwise.

How have advancements in IT changed your practice and your interaction with patients throughout your career?

I'm in a clinic that's EMR enhanced. Our clinic has been given Meaningful Use Level 3 accreditation and the reason that we can't get to Level 4 is that the infrastructure from the government isn't there yet. I use voice recognition; I do all of my prescriptions in the computer. When I graduated there was no such thing as a cellphone, let alone a smartphone—access to the Internet wasn't there. I predate television remote controls! Imagine the changes that have come into use—computers, videoconferencing, the Internet, smartphones—and what's really changed the landscape is that doctors aren't the only ones who have access to information via enhanced technology. I have patients who are far more informed and far better informed about their conditions. Can it be frustrating? At times. But overall I'd say it's a win because it enhances the conversation, it improves the patient's engagement in the process, and it improves the outcomes.

So you're having different conversations with patients now than when you started practising?

Absolutely. When I was working in the hospital in New Zealand it was classic for a patient to show up with his or her prescriptions without any identification of the pill on the label. It would simply say, take one pill 3 times per day. In that era it wasn't consid-

ered important that the patient know what they were taking. That was the cultural norm. Now, with information far more equitable and accessible, technology has changed the way we do business. And so it should.

How do you envision these changes continuing to evolve?

There are a number of things coming together to work synchronously right now. I mentioned that we have a health human resources issue—we do not have enough doctors to work the same way we used to—we don't have enough providers of any type to keep doing the same thing. So we have to work differently in terms of sharing information and responsibilities in a team approach, and we have to expect patients to take more responsibility for their conditions. And patients with access to information want that involvement. They want a place at the decision-making table, and they should be there. I see physicians being ombudsmen; being able to say to patients, you have this issue, here are two or three ways identified to deal with it, here are the pros and cons of each way, which one do you think works best for you? And then facilitating that.

That puts more responsibility on the patient to have good information.

Yes. And we need to be flexible to accommodate patients who don't or can't take on that roll, but we have to be open to providing it to patients who want it. And it makes my life as a physician easier, not harder. When I have that conversation with patients, the next conversation I frequently have is: Here's what to expect, and if things are going well, I don't need to see you. Here are some flags, and if one of the flags crops up, then we need to talk. And talking doesn't necessarily involve coming into my office—it can be a phone call. I've had patients engage with me on FaceTime because they had something to show me, or take a photo of something and send it to me electronically. I've engaged with dermatologists in Victoria by taking a photo of a skin condition, sending it to them, and receiving preliminary recommendations back.

One of my greatest regrets is that I'm not younger. Not just because my joints would hurt less, but because there are so many exciting things happening. And I want to be there to push things a bit further. I told you I like to fiddle!

What do you imagine will be the greatest obstacles to making as much progress as you hope to?

Two things: The first is that everyone wants progress but nobody likes to change. Everybody is in favor of improvements but, when it involves reorganizing the way you do something, that's very difficult intellectually and emotionally. The second is silo funding. We have many examples of good ideas that bridge different allotments of money being difficult to promote because of the effects on individual budgets. If the money came from the same place, it would be a lot easier to effect change.

How will you apply your experience as a family doctor and time spent working with the GPSC to benefit your focus on engaging specialists and facility-based doctors?

Even though these initiatives were spearheaded by the association long before I came in, I think I can help move them forward. Through my work on the GPSC and my collaborative work with the ministry and the health authorities, I hope I have built some credibility that what I'm trying to do is constructive and that the relationships I've formed will be able to open some doors.

Is there anything that you hope to get out of being president personally?

If I finish my year as president and I think that I have made some contribution that makes the medical profession better, then I'll think I've done a good job. This year isn't about me. It is about trying to make things better for the profession. Change is happening and speeding up—we have financial issues, we have health and human resources issues, we have scope of practice issues, and we have information technology coming down the pipe.

Do you have any thoughts to offer colleagues who are not involved with Doctors of BC?

Try it. It's an extension of what you're doing as a physician. By reinvesting some fraction of your professional time in the system you will benefit yourself, your colleagues, and your patients. Should everybody do the same thing? No. I don't think everybody has the same interests—some people have a passion for research, and if that's their way of giving back to the system, so be it. It could be through teaching students and residents, engaging with your health authority in redesigning a program that provides specific care, or giving back to medical administration through your local division or Doctors of BC, but I think physicians should reserve time to give back.

What advice would you share with medical students and residents?

The same thing—get involved. I know the immediacies of life as a student and resident can be overwhelming, but I would strongly suggest saving time to give back to the profession from the get-go. Some of your professional life will be devoted to your sphere of interest, but save time to give back. BCMJ