Q & A with Dr Charles Webb: Doctors of BC President 2015–2016

The stars have aligned for Dr Charles Webb, a Vancouver-based family physician with a focus on geriatric general practice. A last-minute decision to pursue medicine led Dr Webb from South Africa to northern Manitoba and southeastern BC before he arrived in Vancouver, where after 2 decades of satisfying work running his practice he's also in a role that fulfills everything else he's wanted in a medical career. *BCMJ* Assistant Editor Joanne Jablkowski spoke with Dr Webb 1 month into his presidency about his background, life experiences, and goals. Here is a condensed version of their conversation.

By Joanne Jablkowski

Photo: Raymond Lum

Dr Charles Webb.

Family history

Your family history in South Africa dates back several generations. What is your fondest memory of growing up there?

In terms of personal time with my family, it's the memories of time spent working with my grandfather making electronic devices. I built a 1-amp amplifier followed by a photo-electric cell switch, then a sound switch—you could clap your hands and turn lights on and off. It was wonderful. It was in the age of the earliest integrated circuit.

In terms of South Africa itself, holidays in St. Francis Bay where we still have a family cottage is where I really feel my roots are in terms of my early years. It's located on a beautiful riverbank with a white sandy beach that leads up to the tidal river. We started going there when I was 11. It was about 45 kilometres from the nearest town, and when it flooded in the winter you couldn't get out because the causeways were submerged and you were trapped on a virtual island. I spent all my school holidays growing up in this incredible wilderness. It's a place of great adventure.

Do you still go back to visit?

Yes, whenever I can; sometimes twice a year. My kids love it. I've traveled a lot around the world and this is truly a wonderful place. And within 90 minutes there's a game park called the Addo Elephant National Park where they've got the "big five"—lion, leopard, elephant, buffalo, and rhino. We stay there every year in thatched-roof cottages.

Tell me a bit about your day-to-day family life now. How do you spend your free time?

I have two lovely girls. Laura is 8 and Emilie is 10. They're half-Danish, half-South African, born in Canada. Their school is a very large part of their lives, and my wife is class rep for the grade 3 class as well as being an RN working in my office with me, side by side. Our holidays together are fantastic. The girls have traveled probably more than a dozen times around the world—to South Africa, to London to visit their grandparents—they loved San Francisco and New York. It's marvelous seeing these girls growing up in such an international setting. The only way for them to see extended family is to travel, so that's what we do. The kids are a central part of my existence—they've eclipsed my windsurfing and my kiteboarding.

Professional history

What drove you to choose medicine as a profession?

I grew up with parents who were both lawyers, and my older brother

Continued on page 300

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

Continued from page 299
went into the navy at age 17 and then enrolled in medical school at 18, as did my younger sister. When I was close to graduating from high school, I really liked debating and languages, but I also had a tremendous love of biology and nature. In the end I thought it would be nice to emulate my parents by going to law school, and, being bilingual, I enrolled at Stellenbosch University, close to Cape Town. I was accepted, my train ticket was booked, and then 3 weeks before I had to go I told my father I was having second thoughts after talking with my brother, who was very keen for me to go to medical school. Knowing that I would have to go into the army if I couldn't get into medical school right away, I said that I was prepared to take that risk. But a cancellation came up at the University of Cape Town and at the last moment I was accepted, and I was off to medical school. Choosing medicine was the best thing I did in all my life. I got very involved in student politics, and by the time I was in second year I was volunteering in the trauma unit. There are amazing hands-on opportunities to be had in South Africa.

After you completed your internship you spent some time in the armed forces in South Africa where you undertook a diploma in anesthesia and qualified in aviation and space medicine and diving and submarine medicine. What was your experience in the armed forces like?
Some of the most exhilarating and some of the saddest and most difficult times in my life. One particularly memorable experience was getting in the back of an Impala fighter plane. The second pilot had been incapacitated for some reason so there was space for me. They put me in a g-suit, strapped me into the ejector seat, and we went on a photo-reconnaissance training mission to blow up some flatbed armored trucks and tanks that were left out in a training area. Nothing dangerous, but still exhilarating.

One of the highlights during my time of active service in the operational area itself was an occasion when a child had fallen out of a coconut tree and was brought in deeply unconscious with a dilating pupil. We gave the child anesthetic and we drilled three burr holes and were able to relieve a subdural hematoma. Within hours the child came around and went on to live a fruitful life.

There were certainly difficult times as well; many people were hurt. But the most exhilarating moments involved the work I was able to do for the indigenous population in extreme circumstances. Looking back I think that whatever other nastiness there may have been, that made it all worthwhile.

In 1988 you left for Canada and took a position in northern Manitoba. What were your expectations for what your life in Canada would look like and how your career would be shaped?
A physician who I knew really well—who had been in the army with me—went to Manitoba ahead of me, came back with photos, and introduced me to the idea of going to Canada. My grandfather played a major role in my decision. I indicated to him that I had an enormous amount of dissatisfaction with where things were going; Mandela was still in jail. I knew Manitoba would be very isolated, cold, and snowy, but I also knew I was skilled enough to do whatever was necessary. I'd done extra time in pediatrics and obstetrics and gynecology, and I made sure I was able to do a cesarean section, give anesthetic, and anything else that would be required of me if necessary.

I had my moon boots and my cross-country skis, and when we flew over the area it looked like there was nothing below us, just bush. There was a big health centre in the middle, like something you'd expect to see on Mars, and some houses scattered around, and then nothing. I had expected to be isolated but not *this* isolated. The first day I had off I took a fishing rod to the lake that was very near my house. I started catching beautiful lake trout, one after another, and—before I knew what—the temperature dropped, it started snowing, and a sheet of ice formed across the lake. And so ended my day of fishing!

Do you have a memory of an adventure in the great north that stands out to you?
A few weeks later I had started cross-country skiing, following someone's tracks through the forest behind my house. Very quickly the tracks came up to the frozen lake and continued out onto it. I thought, wow, great! And off I went across the lake. Everything was fine, and then about three-quarters of the way across the lake I heard cracking, felt things heaving, and then I saw water coming up in front of me in the tracks. I threw myself down, spread eagle, like we'd done leopard crawling in the army, and I crawled off the lake with the ice tilting and cavorting and the water sloshing. By the time I finally reached the edge and scrambled up onto it I'd had all sorts of nightmare thoughts about how, after all the arduous experiences I'd been through in the army, this would be my final moment. When I got out it was probably minus 10 and I was thinking, how long have I got? I'd had no experience with hypothermia. I took my wet socks off, put my boots back on, and started skiing again when I heard some shouting. Suddenly, a man appeared, with a patch on one eye, and said, "What are you doing?" And I said, "I don't know, but thank God you're here!" He led me back to my home, I got into a hot bath, and that was the end of that adventure. I thought to myself, I like this place; these people are cool!

Having spent 27 years in general practice, 23 of them in Vancouver, how have you seen primary care evolve over your career?

When I started up north we had a multidisciplinary clinic. We had a nurse practitioner, nurses, LPNs, a social worker, and two assistants in the clerical department (one doing transport, one looking after health records). This was the epitome of what the Ministry of Health is now talking about, if you like. So my first exposure to multidisciplinary care was this incredible team. The nurse practitioner looked after all the birth control and the psych patients that required longitudinal care, because the average stay of a doctor where I was in Leaf Rapids was about 2 to 3 weeks. I stayed nearly 10 months.

I then came down to Creston, BC, where I worked in GP anesthesia, and it was tough. The fee codes for anesthesia were hopeless. If I did anesthesia all night I had to cancel my clinic the next day and someone else saw all my patients. It actually cost me money to do anesthesia. Primary care at that point was not multidisciplinary and it hasn't been ever since. We had a psychologist upstairs, we had the hospital, we ran emerg. I did some deliveries and we initiated an epidural anesthesia service there, which was great because it kept me excited about what I was doing, but on the other hand it wore me out because I couldn't ever be away from town if the other anesthetist wasn't there. So, rural primary care, as it was then, was very stressful and it still is to this day.

The birth of multidisciplinary care for me started with Divisions of Family Practice coming in with A GP for Me, and I realized that I needed to bring my wife, who is a nurse, to work in my office. There is no business case for my wife to work in my office in terms of being able to pay her in any way while I'm on fee-for-service. Luckily, she doesn't mind being there to make me more efficient in order to get me home by 7 p.m.

Photo: Raymond Lum

Dr Webb with his wife, Aase, and their daughters, Laura (L) and Emilie (R).

There is no question that physicians need to be extended in this province, whether with an RN or an LPN, but you need extenders to do blood pressure, to get a patient's basic history, so that when you see them you can get to the job that you desire to do, which is to make decisions in terms of acquired history and baseline measurements. It's happening around us with A GP for Me; it's happening in my clinic. Primary care is undergoing a renaissance in the way we interact with each other. In my first 12 years in Vancouver I worked at St. Vincent's Hospital and I was on the Quality Assurance Committee, and we had a tight-knit community. The hospital was fabulous. Dr Rob Halpenny, now CEO of Interior Health, worked with me at St. Vincent's. He was the liaison between physicians and the administration. This tight-knit little hospital with a multidisciplinary setting was the extension of my practice. I could ship people down to emerg and have them triaged and worked up, and then go down later in the day to either admit them or get them home, and at the same time liaise with the social worker who knew all the associated staff in the community. Today we have megalopolis hospitals and we now realize we need to expand the team-based model because it produces more efficient delivery of care to patients, closer to home. The Ministry of Health has announced it is building a new hospital in Vancouver, which is going to be a campus of care, and I hope will in many ways reflect the elements that made St. Vincent's such a successful community of practice.

Continued on page 302

Continued from page 301

Doctors of BC history

Your participation with Doctors of BC started 6 years ago. What prompted you to become involved?

It started out of the blue with a misplaced phone call for clarification about a president's letter. I contacted my Board rep, who explained everything to me. I had further calls with other Board delegates, which led to my formulating a plan to run for the Board. I felt called to do my part to represent the profession and to improve the quality of care across BC.

What have you learned about the profession and the membership in the past 6 years?

What I realized after my first 2 years on the Board, when we came in with the term-limits referendum, was that the membership is the most important thing about the organization and, behind that, the excellent staff. The membership is slowly becoming increasingly connected, to the point where we had 50% of the membership voting in the recent run-off election. Without good governance you can't establish a vision, reach your goals, and service the aspirations of the membership.

Is there a health issue that you think is not getting enough attention—either within the association or outside of Doctors of BC?

Physician health is particularly important. It behooves every doctor to have their own family physician, and we have an excellent Physician Health Program. Physicians may not be fully aware of how valuable that program can be—it's firewalled, it's safe, it's insulated, and it provides the highest level of service to our colleagues.

Presidency

Tell me about a personal achievement that stands out for you? Perhaps a career highlight.

I've had different highlights within different periods in my career. The first was being appointed head of anesthesia at the Creston Valley Hospital after being in Canada for just over 1 year. That gave me the enormous opportunity to modernize the department with Dr Eugene Leduc and get the epidural service running.

The next highlight was the time I spent at St. Vincent's Hospital working with Dr Enid Edwards on the Quality Assurance Committee, in terms of the progress that we made at the hospital.

And that leads to what will be another highlight, seeing the quality improvement initiative roll out at Doctors of BC through the course of this year.

Another is seeing the Vancouver Division of Family Practice take off. It's remarkable to see it becoming such a strong organization with over 800 members.

And of course the final one is to have spent a year as chair of the General Assembly, and to have led a successful General Council in Yellowknife that year, and then coming into the president-elect position. Through the course of that year the Governance Committee was doing really good work. When I'm done with the presidency we are going to leave the membership, I hope, with a new set of bylaws and a constitution that provides them with a broadly supported governance structure that will provide a channel for every member to be connected up to the highest levels of the organization.

What would you like to achieve in order to feel that you've served a successful term?

I want to see all of the projects that have been started to come to fruition with the fullest support possible from our membership. It's also important to me to get our younger members engaged at every level of the organization; that's critical. And I would like to see progress made on interoperability (one patient, one record), and to see the facility-based physician program working with government and health authorities on a common vision for delivery of services across the province. Never before have we had such an opportunity. Not only the traction and engagement, but also the funding to set up hospital staff associations as separate societies under the Societies Act, with their own budgets and their own executive committees.

Do you have any concerns for the coming year?

Right now we have a membership that has a very broad spectrum of opinions and that is as it should be. However, one of my concerns and priorities is keeping the profession united despite our different views on issues such as assisted physician death and private health care. Sometimes we will disagree, but we need to stand together to gain positive change for our profession and our patients.

What are members missing by not becoming more involved with the association?

There's a wonderful opportunity for professional development in a doctor's career by becoming involved in what is an extremely egalitarian organization. There is room for all physicians, at every stage of their career, to play a role in this organization, and all should now know that they can access positions, that they will be fairly heard, and that their applications for positions on committees will be fairly considered.

How does that apply to medical students and residents?

Residents are very much a part of the association. They have a vote in all the affairs of the association, and they can participate in elections. Students, though we cover the cost of their dues, cannot vote, but they are very much part of the organization. Both students and residents are very

carefully considered whenever applications come forward for positions at any level—subcommittees, working groups. Their input and innovative thinking is valued.

What do you think Doctors of BC could do better to recognize and empower younger members?
We are developing our new bylaws and constitution, and medical students and residents are invited to make submissions based on the upcoming Green Paper. It's very important that students and residents express their views about how they wish to be included in the organization. Whether students should be able to vote is something that needs to be considered and determined based on the best wisdom the profession can provide.

Is there anything that you think younger members in particular can contribute to the association based on their interests and perspective?
We need to embrace their innovative ideas, their openness to change, which they bring onto committees and working groups, including benefits introduced through the disruptive potential that they bring to certain processes (IT, as an example). The question is how to get them involved in such a way that their voices are heard, their ideas are expanded upon, and the needed changes are made.

Recruitment and retention continues to be an issue in BC. What are your concerns about the future need for doctors in the province?
One of the biggest issues right now is the methodology by which doctors are funded and paid. The fee-for-service structure no longer serves what I think is already a larger part of the profession. There is no question that we are on the road to a more blended-payment structure, and the association is actively looking at that together with government. Our younger members, it is clear, have a huge amount of difficulty setting up and doing what was possible for me to do when I started over 30 years ago on a fee-for-service basis. When I came to BC and arrived in Vancouver, I locumed in a practice and purchased it for $30 000. It was the best thing I ever did. An established practice gave me a basis from which to bill fee-for-service in a sustainable manner. Today, the cost of setting up an office—with the IT and overhead expenses, with a commitment to years with no guarantee of an immediate patient following—is perhaps too risky for many of our younger colleagues. We therefore have to find a way to assist in setting them up in multidisciplinary team environments where they can at least know that there will be food on the table at the end of the day after their expenses have been paid.

We also need to pay some attention to retiring members—how we can accommodate them in their later years in a way that allows them to keep their licences up to grade. Many elder practitioners would like to go into a walk-in service model and, with multidisciplinary teams, access and longitudinal care can be maintained.

What aspect of medical students' careers do you think Doctors of BC is best positioned to assist with?
Firstly, a new model that suits them and into which they should have input. Secondly, mentorship. I would call on all physicians in the province who can affect any current or future medical student in any way possible to serve as an example of what it means to be a true generalist—both in primary care and specialist practice. A doctor is a doctor is a doctor. So while we've gone to a new system in university where we've gotten rid of the rotating internship, we have some issues now. We are creating a generation of physicians who need broad generalist experience. I would tell medical students that one of the ways to overcome the shortfalls of the nonrotating internships is to make sure they travel to developing countries in their electives to get exposure to real-time clinical situations where they are required to act in a generalist sense. So even if they qualify as dermatologists they will finish knowing that they can maintain an airway, that they can keep someone going in terms of fluid requirements, that a child with gastroenteritis in their hands would have a good chance of survival. And I'm working with Dr Ruddiman, our president-elect, on various programs being set up in South Africa to give medical students this opportunity. We can also work with the Rural Coordination Centre to ensure students and residents have these prospects.

Goals

You've spoken about the importance of collaborative efforts between all health care providers and partners. What specific improvements or opportunities do you think greater collaboration will result in that are currently underdeveloped?
Efficiency requires close-knit cooperation between all members of a team. I used my year off the Board before I became president-elect to build relationships across the board of Vancouver Coastal with home nursing, kinesiologists, and physiotherapists who I could dispatch into people's homes to keep them safely at home rather than having to readmit them to hospital. We're all cut from the same cloth, whether it's the College, Doctors of BC, the health authorities, the medical staff associations, or the divisions. It's one big conglomerate with the same object—quality care for patients.

That plays into your references to technology and its role in how doctors are able to provide quality patient care. What technological advancements would you like to see?
Universally accessible patient records (one patient, one record) for access by

Continued on page 304

Continued from page 303

both clinicians and patients are critical. Right now, for example, in Vancouver Coastal nurses use the PARIS system, which is inefficient and doesn't in any way interdigitate with our office-based EMR structures. The other crucial application is home monitoring. There have been a few very successful trial projects where patients have been on home-monitoring programs, managed remotely, and visited by nurses without having to go into hospital or their doctor's office. Also, telehealth is in its strong beginnings and is also going to explode. Our young, innovative members are going to be the leaders in adoption of these technologies.

In terms of the teams that you speak of, how will your practice be affected by the year you'll spend as president?

I'm fortunate to have my wife, who is a registered nurse trained in psych and general nursing and requalified in Canada, working next to me. So I'm able to extend my practice significantly. And I'm in the process of setting up direct communication between my practice and my office at Doctors of BC through telemedicine. By having a nurse physically present in my office certain hours of the days when I'm not there patients will be able to come in, a nurse will be able to determine the basic parameters of what is the presenting complaint, and I'll be able to talk to the patient via video link to determine if he or she needs to be admitted to hospital. I can quickly get to the hospital on my way home to see them if needed. I'm on my mobile phone all day, sending text messages back and forth with staff about adjusting INRs, instigating referrals, dealing with minor problems.

Recognizing that change takes time, where would you like to see Doctors of BC in 10 years?

We're going to see a different payment system in place in terms of how physicians are funded. I think that in 20 years, as the payment system shifts, every physician in this province, much like in the UK, will have a pension.

We'll be working far more profoundly in teams, remotely connected to additional resources. I think we'll see paramedics in rural areas playing a far greater role in the provision of care as physician extenders. And, of course, we hope to have a new governance structure that best represents our members and that can be easily adapted when change is warranted.

What do your patients think of your new role?

I think patients were a little apprehensive at first, thinking that I wouldn't be there in the same way that I have been for the past 23 years. But with my wife there as a registered nurse and the advent of IT it's been an easier transition. At first it was stressful because they were used to me talking to them one-on-one. They're now warming up to the idea of me dictating using Dragon Medical and realizing that they hear much more information than they would have previously—my findings, the assessment, the differential diagnosis, and the plan for investigation and follow-up.

Do you ever contemplate how you might approach these issues if you'd continued on your path to practising law instead of medicine?

If I'd gone into law I probably wouldn't ever have been able to leave South Africa, or it would have seemed that way. As I left South Africa to go on holiday to Canada on a 1-year ticket, with a plan to do locums, my father moved his practice from Johannesburg to London during the height of the embargo. Nelson Mandela was locked up, the Sullivan code of conduct was in place, and America was preventing any kind of corporate interaction with South Africa.

Photo: Raymond Lum

So I might have ended up in the UK. Would I have ended up in hospital administration? Possibly. I may have ended up doing more or less the same thing but with a different hat, perhaps involved in politics or at a health authority somewhere. Looking at what we have at Doctors of BC, I think the greatest innovation was a break from having a CEO who is a physician to a CEO who is a lawyer, with huge organizational capacity and skill who brings a completely different mindset to problems. For me, having two parents who were lawyers, having thought about that, and then having landed in this organization with quite a few lawyers on staff, it's refreshing; exciting. Perhaps everything I ever thought I wanted in a career when I went into medicine is finally fulfilled in being here in this environment, where all the elements of what was important to me at age 17 have aligned themselves perfectly at the age of 57. BCMJ