Staying humble

"How did your appointment with the specialist go, Mrs Smith?"

"He told me that he is the best physician west of the Rockies, which makes me wonder if he really is."

The best definition I've found for humility is "an admirable quality that not many people possess. [A humble] person may have accomplished a lot, or be a lot, but doesn't feel it is necessary to advertise or brag about it."

When perusing social media I am reminded of the erosion of this quality. So many Facebook posts involve boasts about personal and family achievements. I have no problem with people sharing life details with their "friends," but is it necessary to post how important you are? A not-uncommon Facebook phenomenon is to post amazing workouts or race results. While your Facebook acquaintances may want to hear if your race went well, they don't want to hear about your splits, power output, average speed, or placings.

Could you imagine if surgeons starting sharing this way through social media? "My laparoscopic cholecystectomy was amazing—completed in 35 minutes through portholes the size of a 25-gauge needle. I got that apple-sized gallbladder out through a keyhole and never broke a sweat."

Or financial advisors: "Even though it was an easy day, pushed through a deal every 20 minutes, making a million by the early afternoon."

Or even carpenters: "We got that frame up in no time. My nail-gun rate was unbelievable."

In 2003 I volunteered in the bike lot at Ironman Canada. As the evening wore on, the weary finishers collected their bikes. Close to midnight I checked one young man's bike out of the lot and asked him how his day had been. He relayed that he was happy and took the time to thank me for volunteering. As he was leaving, a fellow volunteer pointed out that I had just asked the race winner, Raynard Tissink, if he'd had a good day.

Mr Tissink's response is a perfect example of humility.

Lesson of the day: if you are good at something you don't have to tell everyone, because someone else will.

—DRR

Lacking a healthy influence

As we say goodbye to 2015 I would like to reflect on the impact and influence that our national, provincial, and territorial medical associations have on our health systems. I use the plural because there is no such thing as a Canadian health system.

The predictions of the CMA, as outlined in a letter sent to physicians by a visionary former president, Dr W.D.S. Thomas, over 35 years ago have become a reality (www.charterhealth.ca/news/cma-wds-thomas/). There was a time when our input was valued and respected. Tommy Douglas, for example, insisted that the medical commissions that oversee provincial health care should be "free from political interference and influence" and that "the chairman shall be a physician."

Politicians here and abroad have lost their respect for (and fear of) physician organizations. A former British health minister once said that Margaret Thatcher, who stood up against the Red Army and the Soviet Union and had no qualms about sending Britain's entire army, navy, and air force to the Falklands War, would draw the line at adopting a major adversarial position against the doctors of Britain. It appears that, over time, physicians' efforts at collaborating with government have become distorted and evolved into appeasement.

The CMA tried, but failed, to make health an issue in the recent federal election. None of the main parties wanted to feature health as a campaign topic. Perhaps, based on the constitutional role of the federal government in health care, they were justified. Canada has 13 provincial and territorial ministries of health, and the primary responsibility for managing our system rests with them. It would arguably be contrary to the agreement at the time of Confederation if the federal ministry assumed a more authoritative role. Indeed, there are many who believe that the Canada Health Act (1984) violated the spirit of the1867 Constitution by interfering in the provinces' domain. It is not, in my view, a coincidence that the Canada Health Act heralded the onset of major rationing and long wait lists in Canada.

The federal government's role in matters of public health, such as when there are threats of nationwide epidemics or health hazards, is undisputed. And I would support a primary role for the federal government in all areas of health care funding and delivery on one condition: that the 13 other ministries were disbanded. That scenario would require a change in the Constitution and, even though it would allow billions of dollars to be directed away from bureaucracies into direct patient care, it would never happen. Canada has 11 times the number of public health bureaucrats as Germany on a per capita basis. Is it a coincidence that Germany does not have the access problems we see in Canada? Alternatively, perhaps the correct strategy is to eliminate the federal ministry. After all, there is no federal education minister—another area that is constitutionally under the jurisdiction of the provinces. Maybe it's just a coincidence that there are not massive wait lists for access to schools.

When the CMA tried to make seniors' care an issue in the election, only the NDP took the bait and the strategy did not boost their popularity. Our aging population will add greatly to pressures on our health system, and as the number of seniors increases so will the already unsustainable inflation in costs. Seniors lack access to home care support, nursing homes,

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BCMJ BC Medical Journal

Letters of less than 300 words are welcomed provided they do not contain material that has been submitted or published elsewhere; they may be edited for clarity and length. Letters may be e-mailed to journal@doctorsofbc.ca, submitted online at bcmj.org/content/contribute, or sent through the post and must include your mailing address, telephone number, and e-mail address.

Re: October 2015 cover image

I was quite surprised to see the cover "photo" on the October 2015 *BCMJ*. The nature of this graphic picture is simply unprofessional, coming from a medical journal. If the intention was to shock, who were you actually trying to target? Physicians?

—Kirily Park, MD
Ladysmith

It looks as though the journal hired a skilled painter to document a girl being maltreated in front of a bright light for the cover of the October issue. The artist should have dropped his brush and helped the girl. Please use the cover for page 1 of the table of contents, not for artwork.

—Robert Shepherd, MD
Victoria

I am offended by the graphic depiction of child abuse that appears on the cover of the *BCMJ*. I find it objectionable to use this imagery. The reality is bad enough. Contrived violence on your cover is no better. I see it as equally exploitative.

—Lorne Verhulst, MD
Victoria

Thank you for your letters regarding the cover art on our October issue. The BCMJ *Editorial Board and the authors of the two-part series on child maltreatment agree that this image is very disturbing. But the issue of child maltreatment is equally unpleasant. The cover image is meant to draw attention to this topic so that as physicians we remain ever vigilant in protecting our youth. The image was based on a humanely staged photo, which was then computer manipulated to create the disturbing facial expression.* —ED.

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and long-term care. They sometimes occupy acute hospital beds and limit access for those needing such care. Perhaps there is little incentive for government to solve this problem. It would improve access and reduce wait lists, but there would be a short-term price to pay. Spaces made available because of the early discharge of low-cost elderly occupants from acute hospitals would be taken by patients needing expensive procedures.

Two-thirds of the wealth of Canadians is held by those over age 65, and their net worth is almost 20 times greater than that of the under-35 group. It makes no sense to force the less wealthy to support the wealthy. One might argue that we seniors have created the current problems because of our failure to plan for the long term. We should not expect younger citizens to reward us in our retirement years for our negligence. Instead we should seek programs that direct support to those in need, regardless of age. In Canada the 6.7% poverty rate among the elderly is much lower than the poverty rate among working-age adults or children. The Conference Board of Canada reported that we outperform 14 of 17 developed nations with regard to seniors' poverty. Child poverty in Canada is a more serious problem, and we tolerate a situation where two-thirds of children wait a medically inappropriate amount of time to access hospital care. All five priority areas targeted in the 2004 Health Accord were for conditions that primarily affect the elderly. A cynic might opine that political pressure to direct resources and support to seniors is based on the fact that, unlike children, we seniors have a vote. Rising health costs are a reality, and we must encourage the diversion of resources to those with the greatest needs. That includes embracing the morally justified approach of means testing.

It's time to regain the influence that physician groups once had and to use that power to reassert our efforts as advocates for the rights of all patients regardless of age, sex, or wealth. Developments in the last 35 years have demonstrated that if we don't do it, nobody—least of all governments—will. **—BD**