

BCM J

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.

Apathy

Apathy was the word that came to mind as I read the January/February President's Comment [*BCM J* 2015; 57:10]. This was an upbeat summary of the new 5-year plan. The 91% vote in favor out of 3456 is misleading when you realize there are approximately 10 963 practising physicians in BC. Such a discrepancy demonstrates apathy, or perhaps disinterest, on the part of two-thirds of practising MDs.

I feel that the agreement was for too long a duration, and the financial settlement did not even match the projected inflation rates for the next 5 years. As for the promise of collaboration with the health care bureaucrats, history and continual loss of input from the medical profession make this dream unlikely. The usual

reply to any positive suggestion from the profession is deferred "due to budget restrictions."

The development of regional health districts (a bad idea) has made consultation difficult as the head office is often a great distance from many of the hospitals, which keeps the profession and public at arm's length from the many administrators.

The really sad aspect of our current situation is the plight of our patients, who experience unreasonable delays in many treatment programs "due to the system," a frequently used alibi!

While the Minister of Health and various departments are mainly responsible for our present situation, our profession should step up and be more proactive in representing our patients.

The present situation is unsatis-

factory and I'm truly sorry about the poor service many patients receive. I'm also saddened when I recall the loss of the influence the profession used to have in the health care system.

I wish the president and Board of Directors success in their efforts to improve "the system."

—Al Boggie, MD
Vancouver

Dr Cavers replies

Dr Boggie raises some good points. I too would like to see a greater number of members voting in our elections. At the same time, the number of members who voted in the Physician Master Agreement referendum was the second highest on record, exceeded only by the turnout for the contentious 2002 agreement. Dr Boggie interprets the response rate as



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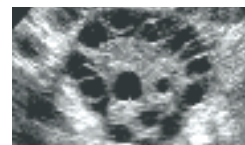
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apathy. But we don't really know for certain. It could be that members are distracted by workload, or they may have confidence that the proposed agreement is a good one and would be ratified. The fact remains that it was passed by a landslide of those who did vote. To quote Winston Churchill, "Democracy is the worst form of government, except for all the others."

Dr Boggie's letter also speaks to his disengagement and disenchantment with the status quo. In fact, our new agreement has funding and supports in place to enable facilities-based physicians to have a stronger voice and greater influence in health authority decision making. Will it be tremendously successful in every location? I believe that some locations will be hugely successful and some will face challenges. The reality is that if we do nothing, the status quo prevails. Our new agreement represents an important step to help us do just that—overcome the status quo and bring about positive change for our profession and for our patients.

—Bill Cavers, MD
Doctors of BC President

Re: Building the business case for allied health care pros

As the professional organization that represents more than half of all physi-

cians in BC, the British Columbia College of Family Physicians (BCCFP) is pleased to support the article authored by Dr Cathy Clelland published in the January/February issue of the journal [Building the business case for allied health care professionals in family physician practices in British Columbia] (*BCMJ* 2015;57:15-17).

The article highlights the importance of the patient's medical home—a model of family practice promoted by the College of Family Physicians of Canada. The system, encompassed by 10 pillars (guiding principles), focuses on the needs of the patient and delivery of comprehensive care in an interprofessional collaborative setting. There is a significant body of research backing the efficacy of the patient's medical home, with benefits including improved patient and provider satisfaction, superior health outcomes, and reduced system costs through decreased reliance on emergency departments.

The BCCFP strongly advocates for interprofessional collaboration where providers work within their scope of expertise. Through the use of effective communication practices and electronic medical records, the information exchange between health professionals can be quick and efficient, resulting in seamless expe-

riences for the patient. As the article points out, when compared to Canadian averages, BC family physicians are more likely to be paid primarily through fee-for-service methods. Innovative payment arrangements, often blended with the traditional fee-for-service model, have been shown to incentivize continuity of care for patients with chronic diseases and multiple comorbidities—emerging priorities for any primary care system.

The BCCFP encourages additional study of the impact of alternative methods of remuneration as well as interprofessional collaboration in the provision of primary care in the context of BC. Experiences in other provinces using care models that align with the patient's medical home have been positive—investigating and implementing innovative solutions in BC should be a priority in our health care system. The A GP for Me initiative is but one innovative approach to advance collaborative practice and access to family physicians for all—similar efforts in backing other patient's medical home practice models will yield the best results for the health of all British Columbians.

The BCCFP will be hosting a symposium on the patient's medical home on 29 April 2015 with an aim to open

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Open ended technique for reduced risk of congestive pain

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up discussion about potential opportunities for collaboration and to identify directions and actions to further its implementation in the province.

- Denise McLeod, MD
 - Louise Nasmith, MD
 - Christie Newton, MD
 - Amy Weber, MD
 - Toby Kirshin
- BCCFP Patient’s Medical Home
Committee Members

**Re: Specialty sections:
Mirroring medicine in
the 21st century**

Ms Lynch-Staunton’s goal in showing the cost of an appendectomy in 1957 vs today isn’t clear [BCMJ 2015;57:28-29]. If it is showing the growth in fees over the intervening time the mark is sorely missed. According to the Bank of Canada Inflation Calculator (www.bankofcanada.ca/rates/related/inflation-calculator/) the equivalent fee in 2015 would be \$1253.36. Physicians’ fees, in real dollars, have indeed changed!

—Mark Masterson, MD
Kelowna

Lynch-Staunton replies

Thank you, Dr Masterson, for your comment about the statement from my article: “Physicians’ fees have changed in the last half century too. The fee to perform an appendectomy for a perforated appendix was \$150 in

1957, while today’s fee is \$495.”

My point was to show that physicians’ fees have changed since 1957—not necessarily for better, worse, or indexed to inflation. In fact, if a \$150 fee in 1957 were indexed to inflation, the fee would have been \$495 in 1981! Your point is well taken.

—Gabrielle Lynch-Staunton,
BFA, BEd

Re: Brace no more

It is gladdening to read DRR’s editorial (BCMJ 2015;57:5) describing his satisfactory progress from a serious bicycle accident. Within his editorial, DRR refers obliquely to what, elsewhere, has been described as the green poultice.

When taking care of patients who have been injured in motor vehicle accidents, I am often amazed at the influence that the potential for compensation has on their presentation, treatment, and recovery, and I think that if there was no gold at the end of the ICBC rainbow patients would recover far faster.

In his earlier editorial, “Forms, lies, and advocacy” (BCMJ 2014;56:213), DRR expressed similar concern about the sorry state of the medical-legal milieu. The present editorial returns to this theme, blowing a welcome waft of fresh air into what, especially for soft-tissue injuries, has become an odious environment. It should remind us of a plethora of dic-

tums, truisms, maxims, etc. that many practitioners seem to have forgotten—perhaps at the expense of their own self-respect but certainly of their patients’ well-being:

- It is more important to get better than to be compensated.
- Patients feel less pain if they have something better to do.
- Adopting illness behavior as a lifestyle choice is akin to a death wish.
- No opinion is better than the evidence upon which it is based.
- Junk science, masquerading as evidence-based medicine, is malpractice.
- Beware your credit rating becoming inversely proportional to your credibility rating.
- Beware inappropriate medicalization of patients, especially with drugs.
- Beware physical therapists (of all stripes) who practise therapeutic hyperbole.
- Tenderness is not an objective finding.
- A patient’s disability may be only proportional to their pain experience, where their pain experience is directly proportional to the accuracy of their self-report. If so, say so.
- Do not write a medical report the validity of which would receive a failing grade in a qualifying examination.
- Never, ever commit perjury.

Comedian John Cleese would add another, “There is no condition so bad it cannot be made worse by an expensive operation.”

I’m sure there are even more, but then I’ve led such a sheltered life!

—Gerard Ponsford, MBBS
White Rock

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