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: Changes to compensation for teaching

I read the letter to the editor in your September issue titled "MSP: Changes to compensation for teaching" [*BCMJ* 2015;57:275] with great concern as it contained some significant factual errors that may cause unnecessary confusion among Doctors of BC members.

The letter states that MSP wants to decrease compensation for physicians who teach. This statement is not true and, in fact, recent changes to the rules regarding payment for services by trainees, residents, and fellows have been modified to make it easier for physicians to get compensated for this work.

The rules referenced in the letter have actually been in place for many years and have not changed. The material change to the rules allows supervising physicians to bill as long as they are available in person, by telephone, or via videoconferencing in a timely manner appropriate to the acuity of the service being supervised. Previously they were required to be in the clinical teaching unit and/or immediately available to intervene ("immediately available" means onsite). The requirement to subsequently review and sign off on the service provided by the trainee, resident, or fellow remains the same. The changes to the rules are highlighted in a document that can be found at http://bcmj.org/sites/default/files/pv-Batchelor-reply-attachment-General%20Preamble%20Clause%20C18.pdf.

We are extremely concerned that some members may make a decision to stop clinical teaching based on the erroneous information contained in the letter.

—Brian Winsby, MD
Chair, Tariff Committee

We regret that the original letter was printed without offering the Tariff Committee an opportunity to rebut it. Mea culpa. *–Ed*

Health for our seniors

The 148th annual CMA General Council delivered dynamic discussion and policy formation on several key health issues for Canadians. Despite the efforts of devoted physicians and policymakers, the groundwork for a national seniors' strategy has been slow to materialize. Consequently our health care system continues to be significantly overburdened and backlogged. Essential medical services are stretched! The result: worsening surgical and consultant wait times, particularly in geriatric care, and an increasing number of "orphan" patients. This status quo, with its inadequate number of primary care physicians and long ER wait times, poses serious physical and emotional challenges for a rapidly growing elderly population. Establishing a cohesive and comprehensive seniors' strategy has never been more urgent.

Despite these challenges initiatives exist today that would support such a strategy. For example, reductions in polypharmacy and antipsychotic use are active in the Fraser Health Authority residential care facilities, with one initiative showing a 6% reduction in antipsychotic use over 4 months. More can certainly be achieved with the elderly living in our communities. A community-centred, multidisciplinary strategy encompassing primary care, outpatient hospital services, and community services has the potential to prevent a number of elder-health issues, including fall risk and fractures, delirium secondary to polypharmacy and poor intake, and unmonitored cognitive decline. A number of strategies can curtail the continued dependence on our strained hospital health care system—outpatient preventive health care, polypharmacy reduction, community integrated EMR, and continuity of care for the frail elderly. This early preventive approach has the potential to improve quality of life, allowing seniors to thrive in their communities while reducing the burden on current hospital services. Better care for our elderly not only makes good medical sense, it changes our approach from reactive to proactive, away from temporary quick fixes toward a stable, sustainable strategy.

—Alexander Frame, MD, MHSc
Delta

Acknowledgment

I have had the pleasure of training under Dr Alfred Chafe in residential care, and the experience inspired me to write this letter.

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Re: Respecting a new right

I wish to contribute to the thinking on the developing changes discussed in the COHP article on assisted suicide [*BCMJ* 2015;57:248-249]. It is usually referred to as "doctor-assisted suicide," which implies that the doctors will be doing the heavy lifting. My suggestion is that there is already a functioning bureaucracy in place that could/should take the lead here.

I refer to coroner's officers. They could be in charge of the preliminary paperwork, which would include the involved physician's opinion and clinical findings. They could discuss with the family and, in the event of a decision to proceed, issue the order for a prescription for fentanyl patches, to be applied by the patient or relatives.

Susan Rodriguez would have been happy with such an arrangement.

—John Maile, MBBS
Quesnel

In defence of walk-in clinics (kind of)

This year has produced barren winter mountains and record summer heat; similarly, the climate is changing for the ways that doctors practise. In BC we have a new agreement with the government and unprecedented levels of collaboration as we advocate for health care system improvements. Yet, as I talk with colleagues, I commonly hear a particularly pessimistic theme: the vilification of walk-in clinics. I hear how new graduates are drawn to them and away from general family practice. That they drain the system through inappropriate referrals and duplication of testing. That the quality of the doctors' care is inferior. That there is an *us* and a *them*. And as much as I fear the effects of climate change, the vitriol with which these complaints are laid is equally frightening. We all want to give the best care we can and sustainably maximize the time we spend with our patients and our families. We want a system that incentivizes doctors to provide comprehensive care, that rewards them and their teams for being accessible in person and remotely, and that is efficient enough to increase capacity to attach willing patients to doctors. But until that system exists there will be clinics high on accessibility and low on continuity of care. Blaming them is like judging the cherry blossoms that arrived in February—they exist because the environment allows it. Instead, let's create a system that gives owners and participants in walk-in clinics motivation to participate in longitudinal care. Let's promote innovation, collaboration, a return to generalism, and pride in caring for our patients. Many walk-in clinics have the physical space and human resources to provide true primary care; indeed, the GPSC incentives have already encouraged some toward this transition. There is much work ahead and we need to be collegial. Together we can change the health care climate for the better.

—Eric Cadesky, MD
Vancouver

Students: $1000 writing award

The *BCMJ* invites writing submissions from student authors, and each year awards a prize of $1000 for the best full-length print article written by a medical student, and $250 each for the two best med student blog articles.

The *BCMJ* J.H. MacDermot Writing Awards honor Dr John Henry MacDermot, who served as editor for 36 years (1932–1968), overseeing the publication's transition from the VMA Bulletin to the *BCMJ* in 1959. Dr MacDermot also served as BCMA president in 1926.

For submission guidelines and contest deadlines, please visit www.bcmj.org/jh-macdermot-writing-awards.