BCMJ BC Medical Journal

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Where's Marcus Welby when you need him?

Last June, while attending a meeting of my colleagues, I referenced Marcus Welby to underscore a point I was making in support of full-service comprehensive practice. I was later approached by one of the more youthful GPs at the table who asked, "Who exactly is this fellow, Marcus Welby?" Sadly, it would seem that the quintessential GP who worked more than 80 hours per week, delivered all of his own obstetrical cases, scrubbed in for his patients' surgeries, attended them in the ER, rounded daily on them in their acute care beds, attended them in residential beds, and spent his free time reading textbooks to make those difficult diagnoses that his specialist colleagues frequently missed, is no longer part of the consciousness of our modern-day medical school grads. Gone forever just as surely as the textbooks he studied at night.

For those of us in the UBC Class of 1974 who chose general practice as a career path, Marcus Welby was the role model we aspired to. Many of us who could, even then, read the writing on the wall as urban GPs found themselves being displaced by ERPs, hospitalists, geriatricians, etc., headed to rural communities, which seemed a safe haven for full-service comprehensive primary care. Here we have remained—time-warped in our full-service model—as the fee-for-service system, hamstrung as it has been by a fee guide that underfunded maintenance of fully staffed offices and hospital participation in all its forms, fueled a business model that promoted high-volume low-intensity practice. It's a small wonder that walk-in clinics began to spread like wildfire across the landscape of primary care delivery.

We now find ourselves confronting a veritable tsunami of chronic disease as our baby boomers head into their seventh and eighth decades of life, bringing with them an expectation of living well into their 90s. It would seem likely as we continue to improve our diagnostic and technical abilities that we may soon be achieving life expectancies of a century or more. Now that's a scary thought for those responsible for funding care. We will surely need an army of Marcus Welbys at our disposal.

So for those saddled with the job of revamping the primary care delivery system, the challenge is to increase capacity while continuing to improve health care outcomes, minimize costs, and be vigilant with respect to unintended consequences. Reasonable options include:

1. Expanding medical schools to produce more doctors.
2. Streamlining the repatriation of young Canadians who have completed their medical training overseas.
3. Tilting the playing field to draw new doctors back into comprehensive full-service practice by redirecting fee-for-service support toward the areas of practice where they are most required (complex care, chronic disease, mental health, etc.) and away from high-volume low-intensity practice.
4. Developing new models of care as a collaborative venture funded through the ministry and administered through private campuses overseen by divisions of general practice, wherein GPs would continue to manage offices privately and receive funding directed specifically toward integrating a team of health care professionals who patients would identify as their primary care providers. Such a private-public structure would combine the efficiencies that the private system has in management of human resources, decision processing, and actioning with the social conscience inherent in the public system. Direct support for office overheads such as MOA salaries and rent might also be considered.

These ideas are, for the most part, not new and to their credit the GPSC has accomplished much through their work so far (GPSC fee incentives for complex care, chronic disease, hospital visits, inpatient networks, residential care initiatives, etc.).The playing field, however, continues to be tilted in support of practice styles other than full-service comprehensive care. More needs to be done in this area.

The pressure is on to act quickly.

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To my younger colleagues I would offer the following advice. Beware of new models of primary care delivery that are designed by health care administrators working with non-mainstream physicians and supported by alternate payment schemes. These models invoke relationships that are analogous to that of young adults returning home to live with their parents only to find that the initial enthusiasm and goodwill are slowly replaced by the angst of unforeseen consequences and failed objectives.

Political risks are enormous and the consequences of failure potentially catastrophic. Urgent grassroots involvement is essential to success. As stated by Howard Ruff, "It wasn't raining when Noah built the ark."

—Bruce Nicolson, MD
100 Mile House

Re: Cause of death: Schizophrenia?

I really appreciate the article by Ms Young and Dr Everett [*BCMJ* 2015;57:434-437] and the simplified algorithm for ethical decision making. All too often we are faced with patients who are dealing with mental illness or drug abuse, and it becomes tricky when patients refuse medical treatment that we strongly believe can improve or prolong their lives. Are they making a bad decision due to their mental disorders? Or is it because their judgement of risks and benefits differs from ours? The article's algorithm is easy to read and apply, and will also serve as a useful tool when I teach medical students about these types of situations.

I also think that an in-service for nurses and allied health care professionals on this topic should be made available. Perhaps it already is? If a patient with a history of mental health issues (especially drug abuse) becomes difficult or refuses treatment, I am often asked to have the patient certified so that medical treatment can be forced. I then explain the (in)appropriateness of certification and what we can legally do with certified patients, but an information session may help to decrease the number of these requests.

And, of course, I always appreciate the good services of psychiatry to help us determine competency. Thanks again for the informative article.

—Alan Tung, MD
Resident Physician, PGY-1
UBC Department of Anesthesiology, Pharmacology, and Therapeutics

As a consultation-liaison psychiatrist who has practised on the medical and surgical wards of a busy teaching hospital for over 20 years, I thoroughly enjoyed reading the article from Ms Young and Dr Everett regarding an ethical approach for patients who have both life-threatening medical illnesses and severe mental disorders [*BCMJ* 2015;57:434-437]. The algorithm they provided is consistent with my approach.

It was unfortunate that the management of the two complex cases they presented was not discussed in the article. The first case involved a patient who had both schizophrenia and was HIV-positive but denied having either illness and refused treatment for either of them. In my opinion it would be important to treat his HIV infection and reduce his viral load, even if he wasn't certifiable for his schizophrenia, because of the potential harm to society if he was having unprotected sex. His delusion of not being HIV positive could be due to schizophrenia, CNS effects of his HIV infection, or other causes. Regardless, in my opinion the patient could be certified under the Mental Health Act and hospitalized because he has a mental illness and is at risk of harming others, as well as himself, due his delusional thinking and refus-

al to be treated for HIV. The question of whether the HIV infection could be treated against his will under the Mental Health Act would depend on whether his mental state was being significantly affected by the infection. The HIV infection, however, could be treated in hospital if he were found to be incompetent to make medical decisions regarding his care. The more significant difficulty with the case would be whether the patient could be forced to be treated long-term with antiretroviral agents, even if he were found to be incompetent of person and had a designated decision maker who agreed with his medical treatment. His schizophrenia could possibly be treated long-term against his will if he were placed on extended leave following his hospitalization. It is also possible that the patient might develop appropriate insight over time if his psychiatric illness were treated. The authors suggest that highly controversial options, such as deceiving patients (e.g., concealing medication in food), should be considered in complex cases. I agree that deceiving patients may be required in exceptional cases, but should rarely be used. Deception can become a slippery slope whereby patients lose all of their rights and autonomy and essentially become dehumanized. Even certified patients must be informed of the treatment they are being given.

I would like to thank the authors for outlining their thoughtful approach for managing complex medical-psychiatric patients, and I would recommend that input from clinical ethicists be sought in these difficult cases.

—Stephen Anderson, MD, FRCPC
Clinical Associate Professor, UBC
Department of Psychiatry

Authors reply

Thank you for your thoughtful analysis of Jamie's case. It is important to note that Jamie's case is fictionalized, albeit based loosely on actual circumstances, so details about him or decisions made in terms of interventions are not discussed.

We agree that Jamie, as described, could be certified to treat the schizophrenia (and the HIV if his delusions are secondary to HIV) as he is harming himself by not considering treatment for HIV. The goal would be to improve his capacity to make decisions for himself about HIV treatment. Involuntary hospitalization to treat the HIV, if it is not contributing to his delusions, is more problematic. Consent for treatment from a substitute decision maker would be needed and, as you note, there would be significant practical challenges in treating the HIV once Jamie is discharged from hospital. Even with the current advent of highly effective and simple fixed-dose combination regimens, these medications need to be taken daily, and 95% adherence is necessary for effectiveness. This would be virtually impossible to carry out without the consent of the patient. Treating the HIV in hospital, knowing the treatment is short term, would be questionable both clinically and ethically. Partial treatment may render an effective HIV regimen less effective. Treating the cause of his delusions in the hope that Jamie would consent to treatment for HIV would be our first goal.

We acknowledge Dr Anderson's legitimate concerns about harm to the public and suggest that there are other factors to consider. Universal precautions, when engaging in sexual activity, are a public health expectation. It would be difficult to hold Jamie solely responsible for any HIV transmission unless he is a sexual predator or lying about his diagnosis, which we have no reason to believe that he is doing. But, primarily, we return to the goal of improving his capacity to make decisions about HIV treatment. If his capacity is improved it may also resolve the issue of possible harm to

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others—he may gain insight into the need for protection when engaged in sexual activity or recognize that treatment for HIV can decrease his viral load. This would be our first approach to addressing harm to others.

We agree that deception should be a last resort and hiding medication in food is an extreme example of deception. In Jamie's case, even if one were willing to consider concealing medication in his food, this would not be possible unless his food and his intake of it were controlled. But deception can come in many forms, some that are likely more acceptable than others. For example, if Jamie's delusions cause him to believe that he has a kidney infection that will be alleviated by taking HIV medications, would we insist on correcting him? And should he continue to believe he had kidney problems in the face of our correction, would it be deceptive and wrong to proceed with treatment for HIV? We would need to consider if carrying on with treatment is, in fact, deception and, if so, if it is, on balance, ethically acceptable.

Considering these dilemmas is complex. It is a challenge to know what is in the best interest of someone like Jamie when he has no ability to make an informed decision for himself, and no ability to act in his own best interests. How far we should go, in what may be considered a dehumanizing process, in order to give Jamie the care that most would accept in order to save their lives, is a live question. Working with thoughtful health care teams and substitute decision makers, and keeping the unique character and context of each individual patient in the forefront, is our best approach to grappling with these questions.

—Jenny M. Young, MSW, MA
—Bethan Everett, MBA, PhD

Re: Physician engagement in our health facilities

In the November 2015 President's Comment, Dr Webb states that the 2014 Physician Master Agreement includes a "facility-based physician initiative" that "offers us a unique opportunity to engage with health authorities" [*BCMJ* 2015;57:379]. I agree wholeheartedly that this is an important advance, but I would encourage Doctors of BC to endeavor to make this initiative inclusive of office-based physicians such as dermatologists, allergists, etc., as well.

The Divisions of Family Practice have done a wealth of good for GPs, as former Doctors of BC President Bill Cavers acknowledged in a President's Comment ("Specialists are due their own renaissance" [*BCMJ* 2014;56:319]), not to mention the GP Services Committee, but Dr Cavers called for a renaissance for "specialists and facility-based physicians," not just the latter. Indeed, the Specialist Services Committee has overwhelmingly supported facility-based physicians alone.

Our section, and I am most certain others as well, would appreciate a voiced commitment from the president and Doctors of BC Board to this end, followed by visible and tangible action.

Nonfacility-based physicians deserve it and our patients expect no less.

—Evert Tuyp, MD, FRCPC
President, BC Section of Dermatology

Author replies

Doctors of BC has made it a priority to help physicians improve their involvement and influence in our health system. Members have repeatedly told us this was an issue of great importance to them.

Between the Divisions of Family Practice and the facility-engagement initiative, we've provided avenues for physicians to collaborate with and influence health authorities—avenues that do not exist anywhere else in Canada. Achieved through the Physician Master Agreement negotiations, we now have structures that can or will include all general practitioners and facility-based physicians (including specialists with privileges who have offices in the community) in the province. Opportunities for engagement that apply to nonfacility-based specialist physicians are also available through the Shared Care Committee, whose mandate is to improve the flow of patient care between primary and specialty services. These initiatives support the vast majority of our members.

There is more work to do. We will continue to work with our members, the Ministry of Health, and health authorities to refine our engagement structures to ensure that all physicians, including community-based specialists without hospital privileg-

es, can be supported to engage more effectively with their health authorities and their colleagues.

—Charles Webb, MBChB
Doctors of BC President

Sorry, we don't recognize that user ID. Please try again

I was recently trying to complete my reappointment for Vancouver Coastal Health via a website called AppCentral. I registered with a new ID and password. I tried to complete my reappointment but was asked for my Cactus ID. I tried my newly minted ID. It failed, and I was stuck. I assumed that this was my fault in not understanding the system but, nonetheless, here it was Saturday morning and I was yet again held hostage by IT for the lack of a proper ID.

This brings up a larger issue. For VCH, I have an ID and password to log in to the computer system at our hospital (PRGH). There is another ID and password to log in to our hospital information system (Meditech). I also have separate login credentials for CareConnect. I have another login for webDI. There is a separate login for the ER schedule. There is a separate login with password for the VCH Infection Control module. I used to have (but have forgotten) the login and password for accessing EKGs. I even have a password to make long distance phone calls. The passwords all expire on different schedules.

As an additional frustration, while I was working in the ER 2 weeks ago I attempted to log in to one of the patient information systems (I think it was webDI). My login failed. I assumed that it was due to an error I made. After numerous attempts with different IDs and passwords I called central IT. They told me that my ID had been locked at random as part of a system security check. I'm not sure how this improved security because they reset my password when I told them my name. It did, however, shut down patient care in the ER for about 15 minutes.

My point in writing this letter is to bring attention to the (I think) obvious problem of patient security being so secure that patient care is compromised. I suspect there is an inverse relationship between how onerous it is to access information and our likelihood of using that information. An obvious example is the CareConnect system. It is very laborious to identify a specific patient in CareConnect and the system is very slow to respond with information. Because the system is user unfriendly and time consuming, I intuit that the information in the database is not used as much as it otherwise would be.

It seems to me that every new online program has its own security system. Surely, the ability to integrate IDs and passwords across systems exists. This situation is worsening and it is impeding patient care. I hope this letter helps to galvanize a discussion around this issue.

—Jeff Lynskey, MD
Powell River

Recently deceased physicians

If a BC physician you knew well is recently deceased, consider submitting a piece for our "In Memoriam" section in the *BCMJ*. Include the deceased's dates of birth and death, full name and the name the deceased was best known by, key hospital and professional affiliations, relevant biographical data, and a high-resolution photo. Please limit your submission to a maximum of 500 words. Send the content and photo by e-mail to journal@doctorsofbc.ca.