special feature

Q&A with Dr Trina Larsen Soles: Doctors of BC President 2017–18

Dr Larsen Soles has practised rural medicine in the small community of Golden for the past 30 years, and it continues to be exactly where she wants to be.

Joanne Jablkowski

You were born in Vancouver, but you grew up in the San Francisco Bay area. Tell me about your background.

I was born at St. Paul's while my dad was in grad school at UBC and my mother was a teacher. In those days they wouldn't let you teach if you were pregnant because they didn't want pregnant women around small children, so my parents lived with my great-aunt on the UBC Endowment Lands as a combination of household helpers and yard workers while my father finished his degree. When I was born we moved to Quebec City for 5 years, and then my father was hired at Stanford University to work on their new linear accelerator (it's a particle accelerator like TRIUMF at UBC, only straight). I lived in California until I finished university and then came back to BC with a bachelor of arts degree in zoology from UC Berkeley. The bachelor of arts option with a science major allowed me to take a lot of history and language courses and other things that I thought gave me a broader education and were interesting. When I graduated I applied to medical school but didn't get in, so I worked for a year for a charitable organization called International Health Services, which worked on innovative health care solutions for underserviced populations—malaria testing, home strep

Ms Jablkowski, BCMJ *associate editor, spoke with Doctors of BC President Dr Larsen Soles 1 month into her presidency. This is a condensed version of their conversation. This interview has not been peer reviewed by the* BCMJ *Editorial Board.*

testing, a nutrition program for teenage moms. During that year I visited my family in BC and applied to grad school at UBC on a whim. When I learned that I was accepted I moved back to BC to do a master's degree in genetics and worked as a teaching assistant in the Microbiology Department. I was accepted to medical school on my third application, and I started in 1982 instead of completing my PhD in genetics. I wound up in a class with people for whom I'd been a microbiology TA as a grad student.

What kept you coming back to medicine?

I was completing my master's degree during the initial wave of genetic engineering progress. Professor Michael Smith was one of my thesis examiners, and I did a few of my experiments in his lab. But I wanted to do something that was more involved with people and was more of a demonstrable helping profession. There was a lot of exciting work being done in that field, but it seemed somewhat abstract.

What do you think of the challenges that students and residents face today?

Medicine has become so competitive. All of us of my generation look at the entrance requirements and say we'd never get in now. The entrance process is different, There are people who've done Nobel Prize–worthy things just to apply to medical school. Previously, you knew you had to meet a certain academic standard and you had to do some volunteer work, but the things people do now are so extreme—start a charity, build a school, invent something and get it patented.

After finishing med school, were you immediately drawn to working in a rural setting?

When I started I had the idea that I'd like to do rural because that's where my family lives in BC. I liked the idea of community and having a variety of things to do in practice. When I did a rural practice elective in Osoyoos in the South Okanagan that really stood out to me. I was in a small clinic with four doctors, and they had a little attached X-ray and lab. I learned to do chest, arm, and leg X-rays; draw blood in the lab; give injections; suture people; and put casts on in the clinic. For hospital needs we'd drive to Oliver, which at that time had a fully functioning operating room and did maternities. And then for bigger procedures we'd go to Penticton. On my first day I got to assist on a cholecystectomy in Penticton—I didn't know how to scrub at that point. All the work was so interesting.

The flip side was that I was single, and there was no social life whatsoever. I was there for 2 months, and I got invited out to dinner twice. Everybody my age was married and had three kids. I came out of that thinking, I love this kind of medicine but I can't go to a town that's so small.

Then I started going out with my husband, Dan, who was a forestry tech in Golden at the time. So I did a rotating internship in Edmonton at the Royal Alexandra Hospital and then went to Golden to do a locum. The deal was that if I didn't like it there we would relocate to another community where Dan could work. But I was very happy there. I had moved into a supportive practice group with a couple of people who were stellar mentors. There was nothing formal about it; they just said, call us if you need us. And I called a lot that first year!

Who had the biggest imprint on your professional direction?

As far as the public-service part, that's due mostly to my dad. My parents were very giving people, very involved in their church, and had a missionary way of looking at the world. It was bred into my bones that if you're blessed you give back. I had a stable family growing up: my parents were married 30-some years until my mother died of cancer, our physical needs were always met, and we had a lot of opportunities for education. My dad is an engineer and a big humanitarian outreach guy. He's 83 years old and is still working. Most of his work now is to do with the SunBlazer solar trailer. It's a utility-trailer-sized thing that unfolds into a small solar generating station. They sell it to local businesses in small villages on microloan plans, and it provides electric power to people who are off the grid. They trialed it in Haiti after the first earthquake, and they've now put it in there as well as Cameroon, South Sudan, Nigeria, Kenya, Namibia, Zambia, and Ladakh, India. Now they are looking at Ghana. So that's been my model. I've got someone who's well into his 80s doing hardware installations somewhere in Africa.

I went to Golden because I thought serving underserviced communities was a good thing to do, and that role modeling is what encouraged me to become more widely involved.

Mrs Chicky Bachop presenting the David M. Bachop Award, Gold Medal for Distinguished Medical Service, to Dr Larsen Soles at the 2017 Doctors of BC AGM.

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Have you encountered other jurisdictions, in Canada or beyond, that are really doing something right? Something that you think should be introduced in BC?

I was recently at a world rural conference in Australia. We in Canada have always looked up to the Australians, thinking that they've figured the rural thing out; they've got a rural college and designated rural training pathways that are somewhat different from what we do here. During the discussions at the conference I discovered that they have exactly the same problems that we do. Parts of their system work better than ours; parts of ours work better than theirs. One thing that's working well here is the BC model of the Joint Collaborative Committee. The structure of having the ministry and doctors on that committee, along with having the RCC—which is sort of an innovation lab that can develop projects—is probably one of the best in the world. We're the right size in BC to do that on a scale that works, and that doesn't mean there aren't a lot of challenges, but people from many other countries were interested to learn about our structures.

The interesting thing is that the challenges are the same all over the world. Everybody is trying to adapt what they do to their local context, but they're all still trying to figure out how to get people into the right primary care in a timely manner, and how to coordinate their specialty care in a timely way.

You've asked members to tell you about the projects and programs they're working on for the benefit of patients. What have you heard so far?

Doctors in communities do so much that nobody knows about. I've met people who are looking at culturally safe seniors care that I'm going to look into. I've talked to a number of people from different divisions of family practice who are going to send me stories from their communities. From off the side of her plate, one of my young colleagues is the consulting doctor for a local search and rescue group in Golden, and goes with them to do educational training because her husband happens to be a guide. Nobody knows about that. It's not officially sanctioned. She's not paid.

You are also setting out to enhance the professional reputation of physicians and their relationship with the public.

The idea is to get more visibility for the things people are doing—people who teach, who volunteer in the school system. In my community, another one of my young colleagues got together with one of the nurses and they decided we need a community CPR program. They started an event called CPR Wars where local teams compete to see who can perform the most effective CPR on a mannequin. We had the fire department, the RCMP, a group of nurses, a group of physicians, lifeguards from a local pool, the search and rescue group involved; anyone could participate for an entry fee. And we held it in a pub of course, so there were libations to go along with it. I have a hilarious video of one of my partners participating. All the money that's raised goes into a fund to put on free CPR courses for the community. The idea is that when somebody drops at the hockey rink, a percentage of the local community will know how to do CPR. Those are the kinds of projects I want to learn about.

Having had a family practice in Golden for 30 years, how has your role as GP and your practice evolved over that time?

It's a lot more humane than it was when I started. When I started there were six of us, and we expanded the group to seven, and eventually to eight. We did 24-hour call shifts. We all covered our own maternity cases. Everybody did emergency. Everybody did OB. Now there are 12 of us, and we are a well-integrated multiskilled rural team. We all do office, we all do emergency; that's our core. Three do anesthetics. Six do obstetrics. Two do surgery. Two do long-term care. We've moved to a team model and we've changed to doing 12-hour emergency shifts instead of 24-hour shifts. So what's the trade-off? We do more comprehensive care for the community. It takes more of us.

Have your patients' expectations changed during your career as well?

It's a bigger, busier patient demographic than it was. When I started, Golden was a little blue-collar logging, mining, CP Rail town, with a bit of trauma because of the highway. Then the local ski hill became a destination, and we morphed into a tourist town. The core patients from the lumber mill, the CPR, the silica mine, are now mixed with tourists from Calgary or Europe and the seasonal tourism workers. And the expectations are different. Tourists from Calgary, who know that they would wait 6 to 8 hours to be seen in emergency in Calgary, are blown away at how quickly they're seen to and how well they're taken care of. Then there are the international tourists who can't believe we don't have a neonatologist or an MRI machine.

You used to be able to run emergency and work in the office; you can't do that anymore. But the model of care has changed too, and that's cultural. I think newer grads expect support and team-based care, and I'm proud of what we've done locally with that. We're also a teaching practice. We always have a resident, we often have a medical student, and I think if you're part of the continuum it's another way of giving back. It's also a recruitment tool. People come, they like how you practise, they stay.

Are the students and residents surprised by how rural compares to an urban setting?

Yes. Initially we were an elective site for the urban family med programs, so everybody came for 8 weeks from the Vancouver or maybe Chilliwack program. We're now part of the rural program so we get them for 4 months at a time. Someone I remember really well came to do her elective for 8 weeks and after the first or second week said to me, "Now I remember why I wanted to do family medicine." Of our group, two grew up in small rural towns, one is northern, and the rest are urban people. We even have someone who's a graduate of the University of Toronto, noted for producing the least rural doctors of any Canadian medical school.

From your perspective of working in a rural community, what are your concerns about the future of family medicine in BC, and what advice would you offer to address those problems?

The principle of how we educate for rural is the principle of how we educate for family, which is that we do way better with community longitudinal placements. It's hard, because you have to have enough volume to train, and there are certain core things you can't do in a small place that you have to be in the city for. Neonatal intensive care nursery, for example. That's kind of useful to know about, but you don't have those in very many places. Figuring out the balance between what you need in the acute care hospital, what size of acute care hospital you should train in—that's all part of it.

When I was at VGH, St. Paul's, Shaughnessy, as a clerk in fourth year, there were still a lot of general internal medicine patients. You learned a lot of basics through the acute care rotations. Now most of those people wouldn't even be in the hospital; we treat them as outpatients with community care nurses, and the hospitals are for transplant recovery patients and complicated surgeries. If we put our trainees in the tertiary care hospitals to train, it educates them well about becoming a potential subspecialist. It doesn't educate them well for being a generalist specialist. We need more people who are comfortable with general internal and with community obstetrics and gynecology. They're talking about splitting obstetrics and gynecology into two specialities. How would that pan out in a community the size of Trail, or Cranbrook? Whether you're urban or rural, specialist or GP, generalism is the thing we need to look at. We need people who are comfortable crossing disciplines. And they're not now. People choose early, and they become one thing, and they may subspecialize in that one thing. And then the hospital doesn't support them to do anything other than that one thing.

I'm also a big fan of the rotating internship. It's gone, and it can't go back to the way it was because of what I said about hospitals. Ideally, if you're hospital-based you're going to put your trainees in smaller hospitals where they get broader exposure, but those smaller hospitals may not have the capacity to absorb the number of trainees we need to replace the people who are going to retire.

Is there a particular health care issue that you think needs more attention right now?

The big picture needs to be addressed, not any one specific part of it. We have an aging population, we're going to have more cancer, and cancer care is challenging for a variety of reasons. People are living longer. Most of the money now goes to people who are well over 85, in their last decade of life, and that's much later than it used to be. We have a looming problem of chronic disease that quickly becomes very complicated, very expensive. We need to look at how much care is reasonable and appropriate—through the lens of what the patient wants. There are too many scenes on television depicting someone who is resuscitated going back to a fully productive life. That mostly doesn't happen. In surveys of what physicians and nurses choose for care versus the general population, physicians and nurses choose minimalist care for certain diseases or conditions, but they don't offer that to their patients. The patient gets everything. And that may mean chemotherapy or other treatments long beyond any chance of a reasonable quality of life.

What do you hope to take away from your year as president, personally?

I want a better understanding of the things I'm not. I understand some of the issues faced by specialists and urban GPs, but I'm not them. I would like to know more about their challenges and what they think are solutions to those challenges. I want to show people the good parts of what we are as a profession, not just the challenging parts. I want to build relationships that will help support, sustain, and improve our profession and patient care. BCMJ