president's comment

An endangered species: How to save ourselves

The North Atlantic right whale. The spotted turtle. The community-based doctor. These are all species at risk.

The signs are clear: long wait lists;[1] offices that move or close;[2] retiring doctors who can't find replacements[3] and orphan their patients; fewer doctors choosing community-based practice, especially those with longitudinal relationships; burnout, incivility, and suicide.

Health care is always dynamic, but it feels like change—and the pressures it brings—is accelerating exponentially. The cost of living and doing business in British Columbia is increasing as both personal and commercial rents are rising faster than the medical payment schedule. While we advocate for networks that allow improved patient access to doctors who know them, relationships are already fragmented by in-person and virtual episodic-care clinics. Executive physicals, wellness spas, and alternative providers further stress our system in the cases of inappropriate investigation, diagnosis, and treatment. All of this leads to the cycle of increased demands for services and more complex visits for doctors.

We have seen new graduates reject traditional styles of practice while longing for a system that supports them to practise the high-quality relationship-based care they were trained for and desire. We can hardly blame our colleagues who choose positions with fewer administrative burdens—don't we all dream of a future free from interminable forms, faxes, and phones?

What we need is a new model that allows doctors, and, for that matter, all health care professionals, to practise to their scope and spend more time with patients. I won't pretend to have the answers for how to reinvigorate community-based care that allows doctors to practise the way we were trained, but here are some principles that I believe could help our species.

New food sources

Traditionally the fee-for-service system has been based on swings and roundabouts: straightforward visits balanced by longer, more complex ones. But with competition for lower complexity services, this survival model no longer holds. Rather than dig in our heels, we should cede this territory and embrace the potential of artificial intelligence, while letting nurse practitioners and physician assistants practise to their scope. This, of course, requires a new way of funding doctors to focus on the valuable types of care that only we can provide. Such an ecosystem would be more harmonious and would allow us to make the best use of our skills. It would likely involve team-based care and may not fit nicely in the fee-for-service box, although we should remain agnostic about the particular funding model while work on this continues.

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Sustainable habitat

Doctors have traditionally taken on the burden for a large part of health care infrastructure, paying for workspace, supplies, staffing, insurance, and other costs. As collaborative practices become more prevalent, we need to look at separating the funding for care from the funding for infrastructure. As always, this should be a choice: some doctors with an entrepreneurial spirit may want to remain involved in day-to-day operations and enjoy the associated business autonomy. Others may want to focus on clinical care and perhaps work part-time in multiple settings that provide rewarding and varied opportunities. Again, we should not advocate for a particular option but rather for doctors to have the autonomy to decide how they balance clinical and administrative duties.

Flock together

We have seen elsewhere what happens when the interests of small groups are put above those of the entire species. While there may be times when we do not get what we feel we deserve on a particular issue, letting smaller disputes erode our overall relationships with each other weakens us as a profession. Our brains are wired to attend to changing stimuli, so we must work hard and not lose sight of the fact that we have much more in common than not. No matter where we practise, what we practise, or our stage of practice, we all work together to care for our patients, our communities, and each other.

We are as strong as we are united. Tribalism and identity politics within our profession are the fastest paths to extinction. Rather, let us come together as a mosaic and encourage diverse thoughts so that we can hear all ideas and respect each other's unique views in the context of a whole profession. We are at a tipping point with

the viability of community medicine in peril. As we stand together in a changing climate there may be some projects we can quickly act on. The divisions of family practice and medical staff associations are acting locally, along with pilot projects through the Joint Collaborative Committees. And while negotiations on the next Physician Master Agreement will address these issues, such change will not be quick.

As an organization, Doctors of BC is working hard to achieve a more positive future. In return for your trust, there is accountability. I personally promise to continue to inform you whenever there is an agreement or announcement that affects you. This also means that between announcements there will be periods of relative silence; please do not mistake these for inactivity.

These are some of my thoughts, and I encourage you to share yours with me. No one person has the answers, but by listening to each other and working better together I am confident we will find the solutions to save our species.

—Eric Cadesky, MDCM, CCFP, FCFP
Doctors of BC President

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in Canada. Diabetes Canada also confirmed this incidence rate[2] and even proposed that by 2020, BC, at 25.4%, will have the second lowest prevalence of diabetes and prediabetes in Canada, after Alberta (23.6%) and will remain below the Canadian average (26%).

BC has the lowest rates of obesity, the highest rates of physical activity, and the highest per-capita consumption of fruits and vegetables in Canada. Perhaps we're already doing well compared to other provinces? Some might wonder, maybe we are not sufficiently screening for diabetes in BC? Not if what Diabetes Canada says is reliable, when they report that among all Canadian provinces, BC has the highest rate of screening for diabetes in Canada.[3] Canada has great variability, across provinces, how many diseases impact the population. In terms of diabetes hospital admissions, Quebec and BC have the lowest rates in the country, below the Canadian and OECD averages.[1]

Dr Ur's article, "Challenges to managing type 2 diabetes in British Columbia: Discordant guidelines and limited treatment options" not surprisingly, is highly critical of the Therapeutics Initiative.

Diabetes is a major cause of morbidity in British Columbia, but there are also myriad other health care issues. It is only reasonable that scarce funds are not wasted on very expensive new patented medications when generic ones may suffice.

—John Sehmer, MD, MSc
Vancouver

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3. Canadian Diabetes Association. Diabetes Charter for Canada. Accessed 11 January 2019. www.diabetes.ca/getmedia/5a7070f0-77ad-41ad-9e95-ec1bc56ebf85/2015-report-on-diabetes-driving-change-english.pdf.aspx.

Author replies

In his letter, Dr Sehmer disputes our assertions regarding the limited treatment options for diabetes in BC, yet he cites epidemiological data on incidence rates, obesity, and physical activity, none of which are relevant to our argument, and none of which we dispute.

British Columbia is indeed fortunate to have a somewhat lower (though still alarming) incidence of diabetes, and complex social, economic, and demographic factors are at play here. The problem is what happens to British Columbians after they are diagnosed with diabetes, and it is simply a matter of public record that therapeutic options for diabetes in our province are limited in comparison to the rest of the country. Of course, even in BC, they are not limited for fortunate individuals like government and university employees who have extended employment insurance benefits that provide them with access to modern evidence-based medications that other provinces offer to their less-wealthy residents.

Those who are excluded in BC are the poor and the old, and I do not believe that offering them additional therapeutic options would constitute wasting scarce funds.

Multiple recent trials have demonstrated outcome benefits (CVD, total mortality) for these newer, more expensive medications. Benefits that have never been demonstrated

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