How's your week so far?

Yesterday was a typical office day in my community family practice. Periodic health/preventive exams, and geriatric and counseling visits had been allotted their usual 20- to 30-minute time frames on my day sheet, and shorter visits were booked in between. I always strive to start on time, arriving early even, to ensure the computer starts, urgent diagnostic reports from the previous office day are addressed, and messages are reviewed. I feel ready. At 8:30 a.m. patients arrive seeking advice from the trusted health care professional that has looked after them for 26 years. I know them and they know me. Despite this long-standing relationship, consultations often run longer than anticipated—sometimes by just a few minutes, but other times by much longer. I don't believe the one-problem-one-visit rule applies in my patient cohort, as patients are rarely just one problem in isolation. A follow-up blood pressure check may end with a discussion about their loss of independence. A diabetes management discussion may end with a lengthy discussion about the deteriorating health of a family member preventing their self-care. A sore throat can turn into a discussion about contraception, HPV vaccination, and safe sex. The clichéd hand-on-the-door complaints, "I've got blood in my urine" or "I have chest pain with activity," that don't make the top of the complaint list still need to be urgently addressed. By 11:00 a.m. I'm already starting most visits with, "Hello. Thank you for your patience." I adopted this phrase years ago when I stopped apologizing for the waits generated by the necessary care of other patients. Most people are very understanding, some less so. The 90-year-old patient giving me heck for running late as she was going to miss a bowling game is an excellent example, "My time is precious too." I am not in a position to dispute this argument from a 90-year-old. So, after 4.5 hours of clinic time, I am meant to have an hour for lunch, except many visits ran over and a sick immunosuppressed patient was fit in at lunch when the waiting room would be virtually empty of potentially infectious folks. There was no time for lunch as my morning finished 10 minutes into my afternoon. I quickly glanced at the diagnostic tests and messages to ensure nothing needed urgent attention before the afternoon clinic started. My afternoon was derailed by similar processes, and I saw my last patient to the door at 6:00 p.m.

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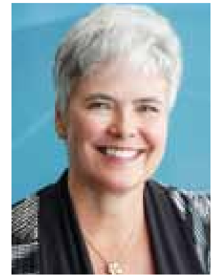
It was a rewarding day full of a variety of complex and challenging diagnostic and treatment dilemmas. I know I made a significant impact. However, it is difficult not to feel beaten down and mentally fatigued—not to mention pretty darn hungry. Next, the document and diagnostic test reviews begin. I call several patients to alter their care or deliver the good news, or often bad news, that they have been waiting on since their test was completed. My spouse is texting by 7:00 p.m. about a delicious plate of real food waiting for me at home. I pack up my computer and more papers than I think a paperless office should hold and head home. After calling to touch base with our elderly parents living on their own, the computer is back on. It is 8:00 p.m. I spend the next hour returning patients' calls and notifying patients of results needing more urgent attention. I am always greeted with the same phrase, "Whoa, working late tonight," followed by expressions of gratitude and appreciation that I am calling at this hour to secure their care. I am "the best doctor ever." Several chart notes, care planning reviews, diagnostic forms, referrals, a nursing home admission, and one Persons with Disability form later, I look up. It is 11:50 p.m. My spouse headed to bed at some point, and as I collapse into bed myself a solution to a patient problem rushes to the forefront of my brain and I jot it down on the note pad by my pillow. I will remember to deal with this tomorrow.



To be a physician is to live a life of sacrifice of any number of aspects of our lives—missed time with family and friends, lack of adequate sleep, exercise, or meal preparation. Yet these often unrecognized sacrifices allow our health care system to function. The time spent on clinical care is what our patients and administrators see and understand. The time spent completing the relentless stream of forms, referrals, requisitions, and various other documents required to manage patients is more obscure. And the time spent considering patient care and researching difficult diagnostic dilemmas or new treatments available is primarily internal and not

obvious to an outsider. Clinicians offering longitudinal care will certainly find that a great deal of time is spent on this latter piece of work, sometimes waking us in the night with the solution.

Sir William Osler said, "The practice of medicine will be very much as you make it—to one a worry, a care, a perpetual annoyance; to another, a daily job and a life of as much happiness and usefulness as can well fall to the lot of man, because it is a life of self-sacrifice and of countless opportunities to comfort and help the weak-hearted, and to raise up those that fall." I most closely identify with the latter, and I believe that Canadian physicians work tirelessly 24/7 to live up to this ideal. We look in the eyes of patients seeking our advice and treatment every day. This is both an honor and a privilege. Unfortunately, in our current environment, multiple barriers routinely get in the way, such as limited access to investigations and treatments or limited clinic time to fully address all of our patients' concerns because of a lack of resources.

Working in this situation is causing a crisis in physician wellness and our ability to deliver the care we want in a timely manner. We feel the weight of this increasingly difficult burden compressing our profession. Doctors recognize that we need support more than ever to do our work. We cannot continue to work alone into the wee hours of the night. It simply isn't sustainable. We need support to tackle the leading health care delivery issues that are preventing access and causing barriers to care.

Over the course of my year as president I hope we will continue to engage all partners within physician groups, health authorities, communities, and of course our patients, families, and caregivers who ultimately receive our care to collaborate effectively to eliminate these barriers. The secret to success now and in the future is to listen to all voices and perspectives. This approach is essential to lead meaningful change and to ensure our profession continues to be a profession of influence both individually for our patients, and generally in the assembly of a sustainable health care system.

—Kathleen Ross, MD
Doctors of BC President

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letters to the editor

Infection control in BC operating rooms

There is little difference between the practice of infection control in an operating room and religious dogma. Here are three examples that are patently ridiculous. Sinus surgery done by an ENT surgeon in the operating room is basically through snot but we make sure that the patient is prepped and draped. Hemorrhoidectomies are done by general surgery on a patient's anus but we prep and drape the patient. Maxillofacial surgeons do mandibular osteotomies where the oral mucosa is cut into, the mandible is sawed in two, then plated with screws and closed, but we prep and drape this patient also. "Antibiotics for the lawyers" are sometimes given in the first example, never given in the second example, and always given in the third example.

In the big picture, the infection control practices in operating rooms have a very bad effect on the planet as most waste winds up either in the ocean or the atmosphere.

Even though much has been written about this, very little has been done about it, basically because the power structures in place in hospitals are just fine with the status quo. And the prime purpose of these power structures is to employ people, not to decrease infections.

A small first step in British Columbia would be to stop the surgical prep and draping for the three aforementioned examples.

The same can be said (i.e., that it is patently ridiculous) about the strict enforcement of dress codes in operating rooms in British Columbia. There is no evidence for this, but signaling who is in charge is very important to the power structures in hospitals, usually under the rubric of standards.

—Mark Elliott, MD
Vancouver

Re: myoActivation for the treatment of pain and disability

Dr Suzanne Montemuro's letter to the editor (*BCMJ* 2019;61:111) states that "[myoActivation] has been shown to be effective in treating chronic pain originating in the soft tissues in the elderly as well as children." However, my searches of PubMed and Google Scholar yielded no studies to support this. In fact, the only publication I could find was the descriptive paper cited in Dr Montemuro's letter, containing only hypotheses and a few

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