Classic and accessible (just like me)

Life is like that sometimes—one minute you're sitting around the Editorial Board table and the next someone is saying how it's time to make the *BCMJ* more like its editor—classic, durable, and meant to last another 10 to 15 years.

That's not how it really happened, but it *was* time to give our esteemed journal an updated, more contemporary look. This last happened in 2000, perhaps as a celebration of our computers not imploding with the feared Y2K bug. Our web redesign, completed in 2018, focused on providing a simple, clean look, and it was time to bring similar objectives to our print *BCMJ*. Therefore, starting in this July/August issue, every section, page, headline, and byline has been redesigned to reach our goal of providing a fresh look while improving readability. We know you enjoy reading and aren't intimidated by text-heavy pages, but still, we'll be introducing more photos and illustrations where the budget allows.

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We hope you enjoy the three-quarter-inch increase in width, which allows the designers more space to visually open up the pages without adding length to the *BCMJ*. (For you budget hounds, be assured that this change doesn't increase mailing costs.) The layout will remain a three-column grid, which allows the designers plenty of flexibility and good line length for text. Short lines make text choppy to read and everyone finds long lines monotonous (particularly at Disneyland). After a lengthy and exhaustive consultative process, we also decided to change the fonts. Gone is Helvetica Neue for the headers, replaced by Myriad Pro, which as many of you know has clean, open shapes while being readable and accessible (just like me). The font decision for the body text was more complicated, but once a world-renowned mystic stepped in it became clear that Adobe Caslon Pro was our baby. Times New Roman was a thing of the past, replaced by this widely used font (it can be found in *The New Yorker*, so it must be good).

That's probably a little too much about fonts, but we hope you enjoy the changes. We want your reading experience to be a pleasant, educational, and calming. We are so proud of our little magazine, and will continue to make the changes necessary to keep the *BCMJ* the go-to source for the doctors of BC, written by the doctors of BC.

—DRR

The changes in medicine in the last 30 years

This is my first *BCMJ* editorial, so I would like to introduce myself and offer my perspective on the enormous changes I have witnessed in the practice of medicine since being licensed in 1986.

I was born in Williams Lake in 1960. In 1969 my family moved to Victoria, a common scenario for provincial civil servants like my father. Following graduation from high school, I studied music with every intent of becoming a professional jazz musician, but after a few years I switched into pre-med, to the immense relief of my parents, as both were raised in poverty on the farm during the Great Depression and could not fathom why anyone would deliberately embark on a career path that offered no hope of financial security. They slept even better when I gained admission to UBC medical school in 1981.

In the 1980s, graduating UBC med students were encouraged to do a rotating internship and then enter general practice, or use the year to do GP locums and then return, armed with real-life experience in clinical medicine, to residency training to pursue the specialty of their choice. I matched to Montreal for my rotating internship.

When I returned to BC in 1986, influential health economists had concluded that health care expenditures were being driven up by an excess of physicians who "overserviced" patients to pad their incomes. This theory was attractive to politicians, who enacted Bill 41, capping the number of physician billing numbers in the province. Locums were exempt, leading me to practise as a GP locum for 18 months. This proved more than enough time to confirm that I much preferred the hospital to the office environment. I was able to secure a full-time position as an emergency physician in the Lower Mainland in 1988, and I've never regretted my career choice.

I had no idea on entering practice in 1986 that seismic shifts in the delivery of medical care were about to unfold.

The role of established practices

In the 1980s, GPs competed with one another to attract and retain patients in their practices, and specialists competed for referrals from GPs. Retiring GPs in larger cities could sell their practices for a significant sum based on goodwill. It was correctly assumed that most patients would remain in the practice due to inertia, in addition to knowing that their records would continue to reside in the office of their trusted GP, ensuring continuity of care, and that the outgoing physician had carefully selected his or her replacement for compatibility of the practice philosophy. In 2019 the situation has reversed; newly minted doctors do not take over, let alone buy, established practices, and many experienced GPs are retiring, decreasing their work hours, seeking salaried alternatives to fee-for-service primary care, working as hospitalists, or moving on to restricted and specialized medical settings. The College of Physicians and Surgeons of BC no longer publishes its list of GPs accepting new patients, and a growing body of unattached patients rely on walk-in clinics or hospital emergency departments for primary care.

Changes to continuity of care

In BC's population centres there has been a profound drop in the continuity of care between the doctor's office (both GP and specialist) and the hospital. In the 1980s it was the norm for GPs and specialists to identify a sick patient in the office, send the patient to hospital with orders, attend in person when the office closed, and continue to care for the patient as most responsible physician during the admission. Patients suffering from acute illness reaped the benefit of being cared for by a trusted physician who was intimately familiar with their life circumstance and medical history having provided years of longitudinal care. This care paradigm has declined coincident with the steady and ongoing redistribution of BC's population away from smaller towns and toward urban and suburban communities in the Lower Mainland, southern Vancouver Island, and the Okanagan. Consequently, office-based physicians are spending less and less time practising in the hospital and becoming more distanced from rapidly evolving acute care protocols—the hospital that once represented familiar and safe turf gradually transforming into a strange and forbidding practice environment. Patients understand this and frequently bypass office-based doctors in favor of the hospital when they perceive a need for urgent workup of potentially serious illness.

Shifting physician-patient relationships

Physicians have largely abandoned the notion of "ownership" of patients that was prevalent in the 1980s. While the concept of patient ownership was not sound ethically, it nevertheless provided physicians with a monetary incentive—in addition to the ethical/professional imperative—to do their utmost for their patients; those who

were dissatisfied could readily take their medical business down the street to another doctor. Physician/business owners who singlehandedly or in partnership with colleagues shoulder responsibility for a practice are now being replaced by part-time physician contractors working in clinics owned by nonphysicians and staffed by providers with a variety of health care credentials. The distinct functions of care team members are frequently unclear to patients (now called "clients"), responsibility for clinical decisions is spread among team members, and the concept of most responsible provider is increasingly unfamiliar to both patients and providers. Such care models offer welcome flexibility to physicians with complex and busy lives and are increasingly commonplace in professional and workplace settings. However, they serve to diminish physicians' sense of personal responsibility to their patients, expose patients to the risk of conflicting clinical advice, and discourage the development of mutual trust between doctors and patients.

Physicians and patients are coming to view what was historically recognized as a fiduciary relationship based on mutual trust—one where doctors devoted themselves to patients who reciprocated with loyalty to the physician—into a simple customer service agreement. Demand for physician services in BC currently outstrips supply, and doctors no longer need to compete with one another for primary care patients or referrals. Patients who historically turned to trusted GPs for advice are increasingly likely to visit varying providers, picking and choosing from recommendations from different physicians, and using techniques honed in the consumer marketplace that do not reliably allow for the selection of medical care that serves their own best interests.

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How will we adapt?

Conventional wisdom has long held that the best medical care is delivered in the setting of an ongoing relationship between dedicated physicians providing longitudinal care to loyal and trusting patients. It is difficult to mount a sound argument against a paradigm that incorporates relatedness, fidelity, and interdependence; these are human attributes that have enabled the staggering advance of civilization over a remarkably brief evolutionary time frame.

Nonetheless, such longitudinal, trust-based relationships are increasingly rare. The current era is characterized by universal patient access to formerly proprietary medical knowledge, demand for physician services that exceeds supply, and the commoditization of medical care. Such changes reflect greater societal trends that resist control by patients, physicians, health economists, and politicians; they are best viewed as inevitable consequences of an information age that casts patients in the role of health care consumers forced to choose among conflicting care options provided by detached physicians.

The challenge for newer members of our profession is clear: they must master the art of providing care to a disparate population possessing widely varying levels of medical sophistication in a marketplace characterized by patient skepticism, diffusion of medical responsibility, and fleeting clinical relationships. The ability to help patients move quickly from a position of distrust and fear—caveat emptor—into that of faith in a doctor they have just met has always been a necessary skill for consultants and hospital-based clinicians. Ironically in this era of evidence-based medical care, this critical ability is now poised to serve as the primary determinant of success in the practice of clinical medicine. —DJE