Gloom season and social isolation

As I write this, it is almost palpable—the grey gloom of a West Coast November. Some love to be out during the dark rainy days of this season, but for most of us it is a challenging time. One primary care tip is to never stop mood disorder medications in the late fall as this commonly leads to clinical deterioration. The number of patients seen with mood disorders, particularly depression, seems to peak during this period of a constant wet twilight.

Personally, I struggle with lower energy and reduced motivation as the leaves fall and the winter season approaches. Leaving for and returning from work in the sprinkling darkness drains my joie de vivre. This is one major reason why I try to book a yearly winter escape to a sunny destination to recharge my batteries for the months ahead.

Due to the pandemic, this will not be happening this year. I realize that not being able to go on a Mexican vacation is a first-world problem, but I can already feel the darkness creeping in, so I am allowing myself to grieve a little. I am trying to remember that just because other people have bigger problems does not mean I cannot mourn my little one.

I do feel a little guilty focusing so much on myself, and in looking for ways to deflect these negative thoughts I choose to look to others. COVID-19 has increased feelings of isolation for so many vulnerable individuals in our society, particularly the elderly and those with disabilities. For these individuals, socializing prepandemic was not always easy either, due to mobility, transportation, and other issues. The knock-on effects of this pandemic—mask wearing, physical distancing, and limiting human interaction—all further increase isolation. At least during the summer (thanks to better weather) some outside contact was possible. I fear that, with the onset of harsher weather conditions, social isolation will deepen, leading to significant deterioration in well-being and mental health.

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All of us are aware of at least a few at-risk individuals through our family, friends, and patient contacts. Perhaps reaching out to them will be a benefit to all. I can think of a few distant relatives, social contacts, and patients in my practice who are particularly at risk of a mental health crisis secondary to social isolation. Awareness is the first step, but is not likely to result in any positive change. Therefore, I am going to strive to contact these individuals over the winter months. A spontaneous phone call does not cost much other than time, and it could make a positive difference in someone's struggle. I am even toying with the idea of creating a network for these people so they can talk with each other through this difficult time.

Thinking about reaching out to others already makes me feel a little better about the upcoming dark months. Maintaining a positive mental attitude can be challenging at times, so let's keep connected and remember that we are all in this together. ■

—David R. Richardson, MD

Private health care will never disappear—it is hardwired into human nature

Natura abhorret vacuum (nature abhors a vacuum), a physics concept attributed to Aristotle, generalizes to biology and is strikingly manifest by the tendency of life forms to colonize and inhabit hostile environments, including deep-sea thermal vents and probably also the waters of Antarctica's subglacial Lake Vostok—believed to have been isolated for 15 million years.

While evolutionary biology offers a simple explanation—passive natural selection—for colonization of the most forbidding ecosystems, human societal evolution is driven by a much more rapid and active mechanism, the tendency of our species to invent new needs when basic biological needs have been met, and our complementary ability to problem solve to meet those needs.

Cooperative problem solving to meet needs and wants is best illustrated by the human propensity to turn to the marketplace, a historic arena where ideas, goods, and services are traded. Our tendency to look to the market to meet needs and wants is so ingrained that black markets have never been eradicated by those in authority. For example, contraband items (e.g., drugs and weapons) and protection networks are well-known features of prison life. Where there is a will there is a way.

Universal health care systems that aim to provide essential care to all citizens regardless of their economic status necessarily impose queues and constraints that restrict choice and serve as barriers to care. While sacrificing choice and rationing care is undoubtedly essential to the greater good, patients who encounter these barriers face a dilemma. Should they passively accept state-imposed wait lists and other barriers or turn to the private market?

Whether driven by free choice or desperation, many turn to the market for private services, even in the face of condemnation from those in authority. Commercial surrogacy and the sale of transplant organs both thrive because individuals perceive that their needs cannot be met by state-controlled health systems.

Recently, a decision in the case of *Cambie Surgeries Corporation v. British Columbia* was rendered in BC Supreme Court following 11 years of litigation. The victory for the defendant was lauded by proponents of the single-payer system determined to ensure that medically necessary health care remains untainted by market forces. A sentiment also championing publicly funded non–user pay health care was recently expressed in the *Globe and Mail* (5 October 2020) by Dr Danyaal Raza, chair of Canadian Doctors for Medicare. In response to the revelation that Ontario patients were being charged $50 to $250 for a COVID-19 test, Dr Raza said, "This is absolutely jumping the queue in a time of crisis . . . it's unconscionable." A representative of the Ontario Ministry of Health agreed: "It has been brought to our attention that some providers are asking patients to pay in order to receive a COVID-19 test . . . this is not permitted."

Notwithstanding such condemnation, there appears to be no shortage of vendors willing to meet the needs of patients willing to pay privately for COVID testing; market forces tend to overwhelm imposed controls.

Such forces are clearly in evidence when one examines perhaps the most obvious health care crisis of our time—lack of access to primary care physicians. While the Cambie Surgery case (launched in 2009) focused on wait times for specialized surgical services, the *Vancouver Sun* reported on 15 September 2020 that 17% of BC residents (780 000) do not have a family physician, notwithstanding increasing numbers of family physicians being licensed. Why is this?

Simply put, more vendors (family physicians) are leaving the primary care market than entering it. While our provincial government recently announced $78.5 million to fund 22 primary health care networks in 13 health regions, this announcement lags well behind the market response (i.e., telemedicine and private clinics where members pay an annual fee to access bundled services including primary care). The provincial government's decision to publicly fund telehealth visits starting in April of this year in the face of COVID-19, a policy change widely expected to outlast the pandemic, likely reflects an acknowledgment by Ministry of Health officials that the market has already paved the way forward.

In any case, a sea change in primary care is afoot. For decades Canadian family physicians in urban and rural settings alike provided longitudinal and hospital care to patients through a simple but functional cottage industry model. Young physicians willingly relocated to locations where a market for their services existed. It is self-evident that few are now choosing this path; instead, they are choosing medical work more suited to their individual and family needs.

One can only wonder what the prevailing mode of primary care delivery will look like in a generation. Will health economists and officials succeed in rolling out continuing care models that are embraced by a majority of providers, including physicians, nurse practitioners, and others? Or will the "best-laid plans of mice and men often go awry," resulting in physicians and patients crafting their own solutions to the crisis in primary care? In my view, Robbie Burns, Scotland's beloved bard (quoted above), will be proven correct. I suspect that the market will lead, while health care planners scramble to keep up. ■

—David Esler, MD