Amplifying value

"Don't it always seem to go,
that you don't know what you've got
'til it's gone." —Joni Mitchell

The practice of medicine is evolving at a pace unimaginable in previous times. As this evolution unfolds, we need to take a hard look at the basic tenets of care that, as health care providers, we want to keep and work diligently to maintain, while acknowledging that this likely means excluding other diagnostics or treatments.

Right now in BC the strongest movement afoot is team-based care. This model has been shown to improve access, freeing up physicians to deliver services that only they can deliver. We know longitudinal, community-based care reduces hospital and ER admissions, removes duplication of services, and saves the system money. While the power of longitudinal care lies in the core relationship between the provider and the patient, we need to ensure the care coordination piece is well supported. It takes time to collaborate and build treatment plans across areas of practice to improve the patient's journey and outcomes. That said, our metrics and models of payment are not developed enough to fully capture the value of this type of care in terms of future costs avoided. The value-add evidence is not apparent to the general population.

Increased use of remote telemedicine or virtual care has transformed the way patients may seek and receive care. While remote access to telemedicine makes sense for those who would otherwise have to leave their community to seek care, what happens as health care becomes more consumer-led? Does access to medical services delivered from the phone in your pocket, at any time of day, devalue those providing the long-term committed care? I would say yes. Does the ability to instantly rate or critique the services you receive the same way you evaluate the shop that changes your tires lead to devaluation? Yes. In some communities, social media has been used to aggressively blame and shame health care services in a way that is leading to the societal distrust and devaluation of physicians' knowledge and skillsets. It is difficult to remain dedicated in an often toxic environment. We need to remind our communities that they truly "don't know what you've got 'til it's gone."

Amplifying the value that physicians bring to the health care system is challenging for a number of reasons. Patients are constantly bombarded with conflicting information about best practices, the latest technologies, or procedures from multiple sources, including expanding global social media and celebrity-driven discussion forums. Although patients want to participate more actively in their own care, providers are often not allowed funded time to have the related discussions—discussions that ensure the care provided is the most appropriate, guideline-driven plan for each individual patient. Neither party walks away from these situations feeling well served.

As the practice of medicine evolves, funding for supports and payment model options needs to keep pace.

As the practice of medicine evolves, funding for supports and payment model options needs to keep pace. These systems must reflect the change in how patients want to receive care, and the way in which physicians deliver that care. For instance, do we continue to value episodic or procedural treatments above longitudinal care when we know that episodic care drives use and costs? Do we continue to fund a universal level of basic, evidence-driven medicine, or cater to the will of the individual seeking access to maximal everything for every ailment? Depends on who you talk to. Virtual episodic care is much more likely to address the latter. Current funding models leave those physicians dedicated to longitudinal care struggling to keep the lights on while striving to remain healthy and engaged.

As I have traveled around the province listening to the needs of patients, physicians, and health care management groups, it has become apparent there are gaps—gaps in understanding on both sides of the equation about how more innovative funding and payment models can enhance care delivery. The current situation has been described as the Wild West. No single payment model is perfect, or a fit for every physician, at every stage of their career, or even within the same section. Certain workflow expectations may seem reasonable to physicians or administrators, yet be untenable to others for unforeseen reasons. Where there is a knowledge gap, confabulation and presumption fill the void. Rumor and unfounded assumptions abound.

For our health care processes to remain sustainable and meet the needs of patients, administrators, and physicians, we need to listen to all perspectives. We must work collaboratively to build models of compensation and workload expectations based on the shared understanding of the short-, medium-, and long-term vision for care delivery in each region. We must establish a shared responsibility for cost containment and

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handle the problem now, whereby a drug user gets an unknown white powder, which could be fentanyl or heroin at markedly different LD50s, and that is 90% contaminants, which is then shoved into the right side of the circulation with horrific vascular/septic results. If the drug was clean and the dosage known there would be very few of these patients showing up in the operating rooms, but this is a political, not a medical issue.

Microdosed psychedelics might become a standard anesthetic preoperative medication someday.

—Mark Elliott, MD, FRCPC
Vancouver

Doctor shortage

The current family doctor shortage is a crisis. It is especially bad where I live, in Parksville on Vancouver Island. Why has the situation become so dire? In my opinion, it has happened because of gross incompetence at multiple levels of the medical profession and government. I am a retired family physician. I am a UK graduate. I was in full-time family practice in Alberta for 6 years and BC for 28 years before semi-retiring to Parksville in 2012, where I worked as a rural locum and urgent care physician part-time until I fully retired from practice in 2016, aged 69, after 46 years of medical practice. As far back as the late 1980s and early 1990s, it was well known that the average age of family physicians in BC was in the 50s. It was becoming clear to us practising family doctors that the family practice model we were all working in was becoming less attractive to the next generation of doctors, who were able to work in walk-in clinics, where they could see large numbers of people with relatively minor complaints and would not have to become involved with older patients with more chronic complaints, who require care on a more longitudinal basis. Since then, the Medical Services Plan has made changes to increase the payments for older patients with chronic conditions, which certainly helped, but none of the changes have turned the tide to attract more young physicians to enter full-time family practice. In the mid-2000s one of my partners tragically died in his early 60s of cancer. We were unable to find anybody to take over his extremely large practice consisting mainly of older patients. The only way I could not leave my own patients in the lurch when I retired from my practice was to move my charts and practice to a clinic that was a hybrid walk-in family practice, which took over all my charts so I could walk away.

I believe that action should have been taken over 20 years ago, which may have prevented the crisis we find ourselves in today. Full-service longitudinal family practice needs to become more attractive. Many young physicians do not relish the thought of running a small business, which means acquiring somewhere to develop a medical office, employing staff, ordering supplies, and paying a mortgage or rent, just to mention some of the expenses involved. It appears that many young physicians prefer to work under a different model, such as a salaried system with good benefits, vacation time, and paid continuing medical education in a team-based model with nurses, social workers, and other support workers under the same roof. This model has been shown to be successful in many parts of Canada.

The government and the profession must work harder to find ways to provide every citizen access to a local family physician. It does not appear that this is happening now. Clearly, inadequate numbers of family physicians are being trained, and the trained physicians are not coming to places like Parksville or Qualicum. It is difficult for young physicians who trained overseas to return to Canada, their home, to practise here. Canada is not providing enough places in medical schools to maintain the supply of physicians that the country requires, which is one of the reasons many young Canadians go overseas for their medical education.

Parksville is experiencing a building boom, and in a few years, there will be thousands more people living here. Who is going to look after all of us?

—Jonathan M. Winner, MD
Parksville

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access to appropriate, equitable, culturally safe, timely care. The general population should be made aware of what services, on what timeline, a publicly funded health care system can deliver so they can adjust their expectations.

If British Columbians and our governing bodies are to maximally benefit from the unique knowledge and skillsets physicians bring to the table, then payment models should universally incorporate time for teaching, multidisciplinary simulation training, research, quality improvement endeavors, evaluation, and participation in health care system management.

I believe that with ongoing open dialogue, visioning, and collaboration, we can continue to build a health care system that is sustainable and meets the needs of patients, care providers, and administrators alike. We need commitment on all sides of this shared responsibility to bring this to life. ■

—Kathleen Ross, MD
Doctors of BC President