What about me?

The questions my patients ask me have changed subtly over the years. Initially it was "Do you know you look too young to be a doctor?" Then that became "Why are you always so weird?" And lately it's been "When are you going to retire?" Therefore, as I inch closer to my golden years, I think more about who is going to take care of my future health care needs and what primary care will look like in British Columbia over the next few decades.

There has been a lot of discussion about the lack of family physicians in our province and the vast number of BC residents who are unable to find a doctor. Despite a significant increase in the number of UBC Medical School spots, and programs like A GP for Me, the goal of linking the population with physicians remains elusive.

Invariably, the subject of different physician payment approaches comes up and arguments are made for replacing the standard fee-for-service method with a different scheme. Those against this method of physician remuneration believe it encourages high-volume practices, with as many patients as possible seen in the shortest amount of time, to maximize the physician's income. The concern is that patients are not given adequate time to express their concerns, nor to be examined thoroughly or treated appropriately. I have worked in this fee-for-service environment for 30 years, so I may be a little biased against the alternatives.

Expanding walk-in clinics will only encourage a high volume of brief patient encounters without longitudinal follow-up; therefore, this is not a direction we should explore. Any payment system that involves a for-profit intermediary, whether in a clinic situation or a telehealth model, seems counterintuitive as the best way to fund primary care. In that model, money is siphoned away from health care providers into the pockets of businesspeople. By all accounts, that is a poor use of the public funds used for health care in British Columbia.

A lot has been said about a new model of patient care referred to in our province as the patient medical home, which is part of a larger primary care network. The idea is that a patient becomes part of a family practice where they can access primary care providers such as physicians and nurse practitioners along with other allied health practitioners such as counselors, dietitians, and therapists. All the services a patient might require are available in one location. This model of care sounds ideal, but I wonder about the costs involved. A physical space and administrative staff will be required, and if this is run by the government, I suspect some inefficiencies may creep in. Also, most allied health care providers are not currently publicly funded, so would patients have to pay for these added services, or would this also be funded with health care dollars? Lastly, how would physicians be compensated? If they would work for a salary, the pressure to work quickly and move briskly from patient to patient would be relieved. I suspect that the number of physicians required to treat the same volume of patients would increase within this system.

What I do know is that my colleagues who work in full-service longitudinal care fee-for-service family practices work exceptionally hard, and despite the large volume provide an excellent and highly efficient service.

In conclusion, I really have no idea what the best approach will be moving forward; therefore, I have decided to leave this problem for greater minds than mine to solve. I do know that replacing the current system will be a huge challenge, and I hope this is worked out before my patients start asking, "Isn't it time you hung up your stethoscope, old man?" ■

—David R. Richardson, MD

The evolving crisis in primary care

While the two leading health crises in BC remain opioids and COVID-19, a third—the declining access to primary care—is rapidly gaining ground.

Statistics Canada figures from 2019 indicate that 17.7% of BC residents (897 567) lacked a regular health care provider.[1] The situation in Greater Victoria is of particular note: notwithstanding the ideal climate, natural beauty, and many cultural amenities of the province's capital, it is held that 100 000 residents lack a family physician.[1]

On 20 January 2022, *Victoria Times Colonist* journalist Cindy Harnett explored in detail the resignation of two family physicians practising at Eagle Creek Medical Clinic in View Royal.[2]

The husband-and-wife team "cited burnout, lack of adequate compensation and support, overhead costs, inefficient use of their expertise, and trying to balance the demands of parenting toddlers with the need to work unpaid hours each day."

Dr Chelsie Velikovsky stated, "Having to tell patients, 'Sorry, there is not currently a psychiatrist accepting new patients right now' or that 'you're going to be waiting 18 months to see this type of specialist,' that is just embarrassing. I don't know how else to say it."

In the same article, clinic director Dr David Ward said, "But we're dying out here. We just cannot get doctors to come in and take on patient panels right now. . . . Mark my words, you are never going to see a new privately built family practice in Victoria again."

Nonetheless, recruiting efforts to replace the departing pair are ongoing, with a full-time vacancy currently posted on Health Match BC (VIHA-4788).[3] The job posting indicates that the clinic was built in 2016 and expanded in 2020 to include 17 exam rooms. An RN and social worker practise on site. The fee-for-service split is 70/30, with the option of 75/25 if the applicant can practise from home using telehealth for a couple of days per week. Annual billings are estimated at $400 000 to $500 000. The incoming physician is not required to take on maternity care, ER/hospitalist coverage, or long-term care. Call is 1 month annually and not onerous, with 10 to 15 calls per month.

At first glance, this appears an attractive opportunity. Why, then, would family physicians not line up to work in View Royal or elsewhere in Greater Victoria?

A significant factor is likely the fee-for-service payment scheme, which remains the primary method of physician payment in Canada. The staple of primary care fee-for-service billing in BC remains the venerable "0100," which currently pays $31.62 per visit for adults up to 49 years of age. This fee item, which was $17.65 in 1985, has since fallen behind the average annual Canadian inflation rate (2.34%). Factoring in overhead of 30% to 40%, fee-for-service physicians must see patients quickly and efficiently to make ends meet. Consequently, a degree of rushing is inevitable, contributing to patient dissatisfaction and physician burnout.

The patient profile for the Eagle Creek Medical Clinic vacancy may also dissuade incoming physicians. The successful full-time applicant to replace Dr Velikovsky and her husband is expected to "build a practice panel from the more elderly and complex patients of these two practices (~1500 patients)." While such patients have always been part of general practice, they require considerable expertise, patience, and time to manage, with the latter commodity being in particularly short supply in the fee-for-service setting. Historically, such patients were considered loss leaders in a rounded practice that included the young and healthy—a cohort requiring less time and cognitive burden—who effectively underwrote care of the complex. Committing to a fee-for-service practice panel chosen from the most needful 1500 of 3000 legacy patients poses a significant clinical, professional, and economic challenge to a new physician, and doubtless motivates them to look elsewhere.

Starting a career in such a fashion contrasts sharply with my own debut as a GP locum in 1986. Following completion of a rotating internship, I practised in the Fraser Valley, Okanagan, and West Kootenays. Newly qualified and inexperienced GPs like me were accommodated and mentored by senior colleagues and allowed full run of hospitals. I recall a specialist in Trail stating that his "idea of heaven" was being a GP in Trail. There were enough GPs to allow patients to shop around until they found a simpatico physician, or to part ways if difficulties

arose. The absence of walk-in clinics ensured that quick and simple complaints were managed by a given patient's own GP or clinic colleagues, providing professional and economic relief from the burden of complex cases. GPs served as attending physicians for most hospitalized patients and could assume as much responsibility as they wished. They covered the hospital emergency, performed minor surgeries, assisted at major ones, and practised low-risk obstetrics. It was possible for GPs to develop a defined clinical expertise and focus their practice on areas of interest accordingly (e.g., low-risk obstetrics, sports medicine, dermatology, emergency medicine). Physicians regularly rubbed shoulders at the hospital and were (mostly) on a first-name basis, immeasurably easing the consultation process. Significant knowledge acquisition occurred by osmosis alone, given the need to practise in varied settings featuring face-to-face interactions with GP and specialist colleagues. Practising as a GP in such circumstances was varied, stimulating, and economically viable.

Four decades later, the health care landscape has changed dramatically. The number of available drugs and the use of laboratory tests and diagnostic imaging have mushroomed. Investigatory and management algorithms are more numerous, complex, and detailed, and sophisticated procedural interventions are now routine in specialty care. Clearly, the general licence bestowed on physicians following a year-long rotating internship in BC until 1994 would now be insufficient to permit adequate management of primary care or hospital patients.

In short, the professional opportunities for newly minted GPs wishing to pursue longitudinal care were more attractive professionally and economically when I qualified. Today's GPs are forced to spend more time compiling and sifting through thicker electronic charts. Problem summaries include chronic medical illnesses interwoven with psychiatric concerns, addictions, and psychosocial problems. Such complexity mandates input and co-management by collaborating specialists, but as noted above by Dr Velikovsky, consultation now must frequently be requested from specialists the GP has no rapport with or has never met, and often entails a wait that is clinically unhelpful. Primary care of complex and elderly patients increasingly requires the practitioner to engage in medical social work that goes uncompensated in the fee-for-service environment.

Family physicians are understandably gravitating away from traditional longitudinal primary care and toward employment that entails less responsibility and provides more predictable hours as well as clearly defined deliverables and compensation.

We are witnessing a shifting primary care landscape where patients whose GPs have retired or moved on are left scrambling to find a new GP, while remaining GPs scramble to orchestrate and coordinate care for aging and increasingly complex patients. Ultimately, such a free-for-all must give way to a functionally integrated system using one EMR, incorporating primary medical care, community health, allied health, specialty care, hospital care, and long-term care. Successful and cost-effective models of this kind of care currently exist in the UK, in the US, and elsewhere.

Until that day arrives, we will witness the ongoing exodus of GPs from longitudinal primary care in BC's population centres. As the clinic doors shut behind them, I hear their voices collectively raised in song to the words of the great blues guitarist BB King's "The Thrill Is Gone," crying out that we'll be sorry someday. ■

—David J. Esler, MD

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Letters to the editor

We welcome original letters of less than 300 words; we may edit them for clarity and length. Letters may be emailed to journal@doctorsofbc.ca, submitted online at bcmj.org/submit-letter, or sent through the post and must include your mailing address, telephone number, and email address. Please disclose any competing interests.

Re: The crisis that COVID-19 exposed, highlighted, and worsened (but did not cause)

I read with pleasure Dr Brian Day's lament about the mounting inadequacies of the hospital, physician, and nursing sectors over recent decades [*BCMJ* 2022;64:53-54]. The burning reality in BC, and certainly in Victoria, is the astonishing deficiency of family doctors, which has resulted in more than 750 000 individuals across the province finding basic health care to be inaccessible. Yet nobody is doing much about it.

The recent BC budget failed to immediately increase funding for family doctors' low fees. Were there supplemental overhead cost allowances? Was there an enthusiastic endorsement for a realistic alternative to the fee-for-service salary structure? Could an obligation be created for medical schools to channel and support students entering family medicine residencies? How does our BC government justify collecting taxes to support medical services that are simply unavailable? We seem to have few answers that satisfy.

—Neil Finnie, MD (retired)
Victoria