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