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: Our impact can live on forever

I found our president's message [*BCMJ* 2022;64:55] fresh, daring, and inspiring. So, I have been contemplating "Why are you?" My logical mind took me all the way from nihilism to eternalism on a somewhat philosophical/spiritual tangent. However, when I stayed with it, I sank into a quieter presence, more relaxed but still precise. Here I seemed to feel the question and opened to it with amazing curiosity as answers came through from a space that was cheerful, uplifted, and unbounded, yet deeply interconnected. So, I thank you, Dr Dosanjh.

I presume this is the inner space of "direct knowing" that drives many Indigenous wisdom-based healing systems, and I wonder if it's time to explore and hopefully enrich both ourselves and our practices by adding this inner, more subjective point of view, along the lines of "Physician, heal thyself," particularly in this time of groundlessness with its accompanying vulnerability and helplessness.

I have a sign in my office drawer that I bring out once in a while: "You can't fix stupid." Maybe it's time the evidence-based double-blind accompanies the Indigenous and more intuitive "Two-Eyed Seeing" view of reality. In Chinese medicine, it is only the heart that can embrace coexisting opposites.

—Jim Tucker, MD
Victoria

"Just a GP"

"Just a GP" is a telling statement that reflects a mindset of inferiority, being second best, and being not that valuable. You do small stuff, write prescriptions, look at sore throats, and refer people to specialists. Who would choose this as a career? Especially when you also have to run a business, something you are clueless about, having spent all your time learning the language of medicine.

By the way, you also have to:

- Be available 24/7/365.
- Manage every patient issue that comes through your door, which includes their examinations, tests, investigations, and procedures, including surgeries, referrals, results, charting, and paperwork.
- In many places, work in your emergency room.
- Visit and care for your inpatients in hospital.
- Help deliver your patients' babies.
- Anesthetize patients for your surgeon.
- Care for your patients in long-term care institutions.
- Make home visits for complex health care.
- Manage your dying patients in palliative care.
- Work in opioid agonist clinics.
- Work in doctor-in-school clinics.
- Work at a Foundry centre (if you have one).
- Provide medical assistance in dying services.
- Provide Diabetes Day Program expertise.
- Provide chemotherapy services.
- Offer group cognitive-behavioral therapy mental health services.
- Offer input to divisions of family practice and medical staff hospital associations.
- Contribute to primary care network development in your community.
- Keep up with your CME to meet your credits and stay up to date on rapidly changing medical knowledge.
- Provide multiple other niche services that fill the needs of the communities, large and small, in which we provide the bedrock of our health care system.

In addition, could you also please increase your patient attachment numbers, because we don't have enough family practitioners to meet the needs of our communities?

You are rewarded with a fee-for-service system that encourages a high-volume practice, so spend as little time as possible with each patient.

We are discouraged, exhausted, and looking for alternatives in this increasingly stifling environment.

Do we, as family doctors, and do our society and our health care system truly recognize and value the critical role we play and have played for generations in this system?

As with everything, we must value ourselves first as creating the bedrock of our health care system with the incredible and creative roles we play in this system.

We are not just GPs. We are specialists in longitudinal comprehensive care. We need to value this indispensable role in our health care system while we also accommodate the other evolving and more specific family physician roles we perform.

Until we believe this, we will allow inequity to continue. Our education system, our health care system, and our society will define us as "just GPs," and our medical students, residents, and practising family physicians will keep voting with their feet by choosing or changing directions to something more encouraging and rewarding.

We are in a time of transition in which physicians are seeking a healthier balance in their lives between satisfaction from their work and whatever creative pursuits and relationships bring them joy in the rest of their lives.

If we want to—and we *must*—increase the work-satisfaction part of that equation, let our voices be heard in valuing our offerings as family physicians, let us embrace the multiple and specific roles we fulfill, and let us reward the essential family physician role of a longitudinal comprehensive community primary-care (and sometimes secondary- and tertiary-care) provider. We are not replaceable, and we provide incredible value for money.

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PREMISE

A new era of care

COVID-19 forced the modernization of our health care system; however, physicians, patients, and policymakers are still struggling to manage the evolving changes in the way we deliver care. As we transition out of the pandemic and into our next normal, we need a collective effort and phased approach to virtual care. Taking a phased approach will smooth the transition through the COVID-19 recovery period for both patients and physicians. It will give physicians time to recover from the strain of providing care during the pandemic. It will allow us to stabilize and support the health care system as we emerge from this collective disruption to our lives.

I believe we need to consider the future of virtual care alongside the reforms necessary to ensure the sustainability of our profession. We need time to focus on system modernization, with associated reform of fee-for-service and other payment models. The pandemic and the resultant explosion in the use of virtual care highlight the need to modernize the Medical Services Commission Payment Schedule to align with current standards of care, advancements in technology, and contemporary service delivery. Maintaining the current virtual care fee codes during the initial postpandemic period will allow for thoughtful decisions about the future of care, by virtual and in-person means.

We cannot go back to our prepandemic normal in health care, because normal wasn't good enough for patients or for physicians. Yet, I do have faith that it is possible to design a modernized health care system based on shared values and priorities. Each small action that we take as we emerge from the pandemic will add up to the world that we're creating.

Now is the time to rebuild, to foster new ways of working together, and to establish new supports for the delivery of health care. The collaborative efforts of physicians, government, and patients are required for the many changes and challenges ahead. Together, we can create a better tomorrow for all British Columbians. ■

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If we do this, the foot-voting will turn back in the direction of family practice, particularly longitudinal comprehensive family practice. If we further increase the satisfaction level of family physicians with business support, with a funding system that rewards comprehensive care while maintaining physician independence, with our primary care networks' efforts of team-based care again, and with a funding and communication system that promotes this teamwork, our chronic problems of access and attachment will naturally start to resolve themselves.

I believe that at this point in time our government understands these issues and is open to addressing our critical needs in family medicine. As our General Practice Services Committee grapples with this and as we negotiate our Physician Master Agreement, please lend your support to the voice of family doctors and fix this crisis in health care that is eroding its foundation.

Let us make family practice an irresistible choice and confirm that we value ourselves and the essential role we play in a system that could not function without us.

We may just start to find real joy again in the amazing work we do.

—Rob Lehman, MD, CCFP, MCISc, FCFP(LM)
Roberts Creek

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

I have been working as a family physician for 45 years, mostly in Nanaimo, BC. I agree with Dr Day's editorial in the March issue of the *BCMJ* [2022;64:53-54]—having to deal with a shortage of hospital beds, overcrowded emergency rooms, long wait lists, and needing to fight for my patients to get proper medical care.

I am frustrated with the several BC governments that have not done anything to address these problems, not taken responsibility for their actions, and not listened to doctors about how to improve our health system.

—Barbara Macleod, Licentiate
Nanaimo

PRESIDENT'S COMMENT

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key stakeholder partners. A working group through the Council on Health Economics and Policy is working on a policy statement on gender equity that will be coming to the Board later this year, part of our commitment to address equity, diversity, and cultural safety/humility.

We are fierce in our advocacy for you and your patients. We are doing this on many different fronts. Let's use our anger to seek solutions together and promote change. We all have a role to play in navigating the challenging terrain ahead of us. We can no longer be silent; our voices will not be muffled, for what we speak of and stand for is the betterment of all our patients and British Columbians. When we mobilize together and act as one, we have our biggest opportunity to make positive change. We must seize the moment, together, now. ■

—Ramneek Dosanjh, MD
Doctors of BC President