Keeping the gates

"Doc, can I get a sick note for work? I need one if I'm off for more than 3 days."

"But Bob, you don't look sick."

"You should have seen me last week. I could hardly get out of bed."

"Well, why didn't you come then?"

"I just told you—I was too sick."

As a GP I get numerous requests like this one. Like many of you, I wonder what the best solution is. Should I give him the note, and if so whom should I charge? Should I bill MSP for an office visit or should I have seen him last week even though it wasn't necessary? The patient is just doing what he has been told by his employer. The bigger question for me is, what has this got to do with the practice of medicine?

I became a physician to take care of people and try to help them where I can. I didn't go to medical school and study for many long hours so that I could write notes and fill out forms, but this is what seems to be occupying more and more of my time. I realize I can charge for many of these tasks, but often the expense is born by my patients and not the requesting entity.

I can rationalize that I am the person best suited to fill out many of the insurance forms that come across my desk, but I get frustrated with many of the others that some official has decided should be my duty to complete.

For example, who nominated me to sign a form stating that someone is "physically and mentally fit" to work in various environments? Why do family physicians get to decide who uses HandyDART or gets a disability parking pass? Should I be the one who decides if a patient is qualified for the disability tax credit? Many of these requests put physicians in an uncomfortable position because as our patient's advocate we feel pressure to help our patients and acquiesce.

Many extended health plans require a physician's referral for orthotics, massage, physiotherapy, counseling, and more. Often patients are already accessing these services when the request comes. How do you tell patients that you don't think they need a massage, which makes them feel better, or counseling sessions to help them deal with life's ups and downs?

It appears that when drafting a new form or requirement for their employees or members, many businesses and organizations go with the fallback position of involving the family physician. Again, I realize this is a source of income for many doctors, but in today's world of general practitioner shortages, is this the best use of a limited resource? I recently completed a randomized double-blind study on this issue (i.e., I scribbled on a yellow sticky note) that revealed that I complete about 20 of these types of tasks in a week, many of which are associated with an office visit. I'm not sure what the best solution is, but allowing physicians to see problems that require medical evaluation and not just a signature might go a long way toward freeing up GPs so that unattached patients can actually find a doctor.

—DRR

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Professionalism: Are we passing on our bad habits?

A friend of mine spent some time at our hospital with his child who required medical and surgical care. The child was eventually discharged after successful treatment, but my nonmedical friend hinted to me that there was some controversy over the course of treatment, and differing caregivers opined frequently about what they felt would be the best options. That is all well and good; we all know well the aphorism involving a cat and its skin, but my friend's concern was in the delivery and communication of the opinions. And it seemed that this component of his family's hospital experience, even more than the health care itself, was what he remembered most vividly.

In this era of family- and patient-centred care, complex health care communication in front of the patient occurs in many directions—not just between physician and patient (or patient's family), but also among nursing staff, paramedical staff, teaching hospital house staff, and other consulting colleagues. With all these interactions taking place, messages, plans, and opinions are seldom delivered clearly or face to face. The right hand may not understand or approve of the skill, timing, or judgment of the left hand, and this not-so-positive impression may be passed on to the patient in a way that is not flattering to either hand.

That's where professionalism comes in.

I probably owe many of my students, patients, and colleagues a professional apology and a promise to improve.

Merriam-Webster's Dictionary defines professionalism as "… the skill, good judgment, and polite behavior that is expected from a person who is trained to do a job well." Canmeds gives the medical spin on it: "As professionals, physicians are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behavior." It is difficult to pinpoint when professionalism actually happens—unfortunately, it is much easier to recognize its absence when it is not happening. A recent BCMA policy paper on medical professionalism takes 44 pages to attempt to provide adequate guidelines[1] and even after reading it, it's still pretty ethereal to me.

Some people express professionalism quite effortlessly. Their demeanor and style of communication fits the profile of a caring and effective communicator and colleague. If we can create situations where our young colleagues and trainees are exposed mostly to this type of behavior, and the professionalism component can be pointed out, that may be the best opportunity for the next generation to model it. However, teaching situations where this can occur are fewer and farther between these days, and students can't learn professional behavior from books or screens. It seems our society is moving away from prioritizing politeness, timeliness, and face-to-face interaction, and on top of this, our medical trainees are often pushed and pulled in too many directions to spend extra minutes absorbing

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a professional vibe. We may send them into patient rooms independently, without first modeling what should be done. We may complain to them, often casually or with mild derogatory humor, about a colleague or colleague's opinion in an attempt to inflate our own. We may speak about patients or their families (or administration) in a less-than-flattering light in front of residents. We may model poor time management, brush off meetings, procrastinate filling out forms for patients or students, not keep up with medical records, or keep people waiting longer than necessary. I am listing these behaviors because I know I have been guilty of all of them, even though I really try to be professional and am aware of my role in a teaching hospital. Putting this in writing is actually clarifying a lot of my own bad habits to me, and I realize that I probably owe many of my students, patients, and colleagues a professional apology and a promise to improve. Our young colleagues only have so much time to be with us, and if we send them a signal that these unprofessional activities are normal, these behaviors may be all they have to model. This morning a colleague sent me a cartoon out of the blue with a quote from Robert Fulghum: "Don't worry that your children never listen to you; worry that they are always watching you." Maybe we could turn that worry around and make the watching worthwhile.

—CV

Reference

1. BC Medical Association. Working together: An exploration of professional relationships in medicine. Accessed 6 November 2013. www.bcma.org/files/BCMA_Policy_Paper_Med_Prof_FINAL_WEB.pdf.

in memoriam

Dr Clarence Roger Fernandes 1949–2013

Clarence left us suddenly on 7 October. He left a huge void in the hearts of his family, his patients, and his colleagues.

Clarence came to Canada in 1972 from Uganda, which was politically unstable at the time. He made the move unwillingly, as a lifesaving step, and entered UBC to continue his medical education. Like many of us, he checked out various specialties and loved every branch of medicine, so he chose family practice in order to embrace all aspects of medical practice.

Clarence came to Maple Ridge for part of his residency requirement and, finding that he loved the work and the congeniality of his colleagues Dr Brian Dixon Warren and Dr Bruce Pitt Payne, he decided to stay. That was in 1976. For the following 37 years, with the indispensable assistance of Vienna by his side, he built up a family practice with special interest in fertility.

Clarence was one of the most dedicated doctors I have ever met. He started his work day at 9 a.m. or earlier 6 days per week, working until 8 or 9 p.m. He would attend to his patients in Ridge Meadows Hospital, or at their homes or nursing homes whenever the need would arise. At the end of an office visit Clarence would ask his patient, "Is there anything else you would like to go over with me?" During one of his family vacations, he carried a briefcase full of his patients' charts, so he would not be idle on the plane!

A devoted teacher to medical students, medical residents, and nurse practitioners, he had at least one of them in his practice for the majority of the year.

Clarence was a soft-spoken gentleman with much wisdom. While we, his colleagues, had heated debates in the doctors' lounge, Clarence never raised his voice. He simply made his point and left quietly.

Clarence left some big shoes to be filled in our medical community. He will be sadly missed by his wife, Vienna; his sons, Aaron, Aalton, and Aiden; his staff; his colleagues; and all his patients in Ridge Meadows and beyond.

—Daniel K.C. Wong, MD