BRITISH COLUMBIA MEDICAL ASSOCIATION

NEWS

1900–2000 100 BCMA A Century of Caring

AUGUST — Reporting on the business and politics of practising medicine in BC — 1998

Mood at AGM fighting, upbeat

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"The doctors of BC have been, are, and will remain united."

This statement, directed to Mr Clark, Ms Priddy, and all the NDP caucus during new BCMA President Dr Jim Lane's strong inaugural speech, produced an instant standing ovation. Doctors hearing his talk at the annual business meeting were in a fighting mood, more than willing to do what it takes to save medicare. Even the usual resistance to the Finance Committee's request for a dues increase (up to *2 per cent next year*) melted away.

In addition, a request for a one-time dues surcharge during 1999, if required to fund a war chest, was overwhelmingly approved by the nearly 200 doctors present. Only two dissenting votes were spotted. As one doctor speaking in support said, "I would gladly pay 10 times that amount if it got rid of the clawback."

Victoria Conference Centre, scene of the BCMA's 1998 Annual Meeting, with the venerable Empress looming in the background.

The mood at the board and at the AGM was upbeat. Much of this was due to the victory, described as a major one by retiring President Granger Avery, for the Northern and Rural Doctors' Group following their protracted job action.

This settlement was negotiated at the time of the board meeting, requiring several involved BCMA members and staff to spend much of the day in Ms Priddy's office. At least some of the depres-sion so apparent recently has lightened. "The profession has learned to stop being abused," said Avery.

Avery noted there is a degree of chaos present in medicare, and the whole system must be changed. "The BCMA must, and must be seen to, manage this change," Avery said.

Dr Lane echoed him, cleverly alluding to the *Titanic* in a number of ways to illustrate the woes of the health-care delivery system. Like the ship, medicare has too many passengers, is being driven recklessly, and has shortsighted bureaucrats in the crow's nest. Medicare, also like the *Titanic*, is not unsinkable.

Interestingly, this year's convention theme was "Charting New Waters", with a cruise ship motif.

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Colleen Brennan, Communications Manager, told the board about the shift in media attention that has occurred. Recent press coverage has been largely supportive and positive, with reporters now going out looking for stories. Two just-completed polls strongly suggest a major shift in public attitudes about doctors, medicare shortcomings, and government mismanagement.

Consultant Rod Cameron, providing the expertise interrupted by David McPhee's accident, gave the board his interpretation of the government's situation and what the BCMA should do next. He also, later in the day, provided a summary of topics discussed and positions developed at a recent executive retreat, which he moderated.

Virtually all the debate over the next two hours was *in camera* because it concerned plans and strategy. We can report that all doctors, not just the LAC appointees, should be lobbying their own MLAs, particularly those in the NDP government, frequently and with vigor. The MLAs are, theoretically, the key to government action — although their key does not always fit Mr Clark's lock.

After hearing excellent presentations by Cameron and Brennan, as well as by acting Executive Director Dr Mark Schonfeld, the board approved the outline of communication strategy for the rest of 1998 and beyond.

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AGM continued on p. 15

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Aging, autonomy, and ethics

by Susan Baxter

"The principle objection to old age is that there's no future in it."— Anon.

"We treat an older person like a kind of delinquent child. Particularly if they are set on a course of action that we don't think is in their best interest," says Dr Grant Gillett.

Dr Gillett, a rare combination of clinician and philosopher (he's Consultant Neurosurgeon and Associate Professor of Bioethics at the University of Otago in New Zealand), was the keynote speaker at "Ethics '98, Aging Ethical Issues . . . Present and Future", the seventh annual ethics conference presented by the BCMA and the College of Physicians and Surgeons of BC.

"In dealing with older people, it's easy to become subject to a number of illusions," said Dr Gillett. "To romanticize older people, or to think they're all good or all decrepit or all something else." But older people, like everyone else, are individuals: alternately miserable, wonderful — or both.

"What is the freedom to be old about? Well, it might sound terribly obvious, but it's the freedom to be treated as an adult when you are an adult," he said. Rarely do we interfere with a 20-something's foolish or risky action, whether it's skydiving or travelling to Eritrea.

"We allow these people to put their lives at risk, making a decision that perhaps we would not make in that circumstance," said Dr Gillett. Yet if older people do something risky, we call them incompetent.

(Like the elderly man with Parkinson's, described by a Victoria nurse at the conference, who would, against all advice, make his way each day, slowly — very, very slowly — across a busy street to a pub to eat his fish and chips.)

Dr Gillett had a simple test for interference: "Are we going to ignore their will?" he asked. That, too, is a statement of their wishes. "Are we going to overturn their wishes when it comes to how they're going to live?

Ethics continued on p. 15

BCMA

Heidi Oetter joins executive

Coquitlam GP, Dr Heidi Oetter, elected in a three-way race for Honorary Secretary-Treasurer.

Dr Heidi Oetter, BCMA's new Honorary Secretary-Treasurer, attributes her involvement in medical politics to a passion for the health of organized medicine. "Unless you have a significant political body around which to make your statements, you will not be taken seriously," says Oetter.

Physicians are advocates for their patients. Oetter likens this advocacy role to that of a general contractor, steering patients through a maze of services and their providers. She has seen this advocacy role compromised again and again in her 12 years of general practice, and does not want to see non-health-care managers making health-care decisions.

Dr Oetter would like to see the profession build on its unity and strengthen its voice as it faces the combined challenges of massive reform to and inadequate funding of the health-care system. ▲

New patient brochure

Prostate Problems

In response to requests from physicians as well as from patients for information about prostate disorders, *Prostate Problems* is the newest addition to the BCMA's "Since You Asked" series of patient education brochures.

Produced through the Communications and Public Affairs Department, this brochure, reviewed by members of the Section of Urology, will provide answers to the questions patients ask most frequently.

The brochure has been given a new look — this design change will be apparent in new and revised "Since You Asked" brochures to come.

To order this brochure, or for information about other titles in the "Since You Asked" series, contact the BCMA's publications office, phone (604) 736-5551, toll-free 1-800-665-2262, fax (604) 733-7317, or e-mail communications@bcma.bc.ca. ▲

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OFFICIAL SUPPLIERS TO THE BC MEDICAL ASSOCIATION

OVERHEARD

"He is an articulate, aggressive wordmonger."
A delegate supporting Dr Derryck Smith prior to a ballot at the board

"He supported this with documentation, but it managed to get into the laundry and got stuck all over my clothes. It was the only copy he had, so I have to do this from memory."
Dr John McCaw, regarding concern expressed by a Nanaimo doctor over nurses having admitting privileges in Ladysmith

"Anybody with the name MacCarthy is good enough for me."
Dr Scott Wallace, Dr David Bachop gold medallist, at pre-award social gathering

"When you have seen one managed care plan, you have seen one managed care plan."
Phil Nudleman, CEO Group Health Cooperative, Puget Sound, WA. Quoted by Dr Michael Lawrence in a document for future release

"The graph would have the status quo in the cross hairs, if that's a good metaphor."
Darrell Thomson, Director of Economics and Policy Analysis, on possible changes in health-care delivery methods

"We are going to be fighting with government until they are defeated, then we will be fighting the next government."
Dr Ian Waters

"I am going to call the question. I will have to send to the archives to find the motion, it was so long ago."
Board Chair Dr Graham White, following a protracted debate

"A continuing collage of competing interests."
Again, the chair, cogitating over too many agenda items and too little time

"Dr Granger Avery is unique, and it is not exclusively visual."
Dr Dan MacCarthy

"Don Rix goes on and on."
Dr Erik Paterson, commenting on the long service of Dr Rix as chair of the Finance Committee

"That's why we call him Duracell Don."
Dr Granger Avery

"How you could be legislated back to a job you've already left was difficult for us to understand."
Dr Alex Black, describing recent actions of the Northern & Rural Doctors' Gr

"I certainly don't want you sitting out there thinking of me as your big brother or as one of the old boys."
Dr Maureen Piercey, President-elect, College of Physicians and Surgeons of BC

McBURNEY'S POINT

VIEWS & OPINIONS FROM THE MUS

Matching system discourages relationships

by Clare Atzema
UBC Medical Undergraduate Society

A few months ago, I asked a friend how he and his partner were going to deal with the upcoming residency match; he is in his second year of medicine, while she is in fourth year, so the CaRMS residency match could separate them for two to five years.

I asked because I would face a similar situation in a few years — I am in my second year of medicine, while my other half is in his first. It had struck me that the chances of our both getting the residencies we wanted, in the place we wanted, were slim. So I searched out my friend.

He said he had it all worked out. His girlfriend, A., was a great student, both academically and clinically; *therefore, she would get the* residency of her choice. She chose internal medicine here in Vancouver, which was his first choice, as well. That would secure their next two years together, and by then she would know enough people in her department to help get my friend in there, too.

"Also," he said confidently, "you just tell the interviewers your situation, and they'll take that into account when they're choosing." And with that I was temporarily placated.

The day after this year's CaRMS match, my friend walked up behind me and said quietly, "London, Ontario." It was A.'s fifth choice. Two years apart at best, five if my friend had the same luck when he tried to match to London. And instead of choosing internal medicine, he's going to apply to many specialties, all in London, so they can be together again.

What strikes me as ironic about this situation is how medical students are encouraged, verbally, to be well rounded and humane doctors, yet a long-term relationship is condemned by the system. A long-term and intimate relationship teaches one to compromise and to take the point of view of another. It provides support in trying times and challenges one to grow personally. It teaches us lessons that all patients wants their doctors to learn, and yet the profession deters it in practical terms.

My friend's situation brought to the fore the casual talk of commitment that my soon-to-be husband (September 6!) and I had shared earlier. In essence, I would have to take a year off so that we could be in the same year, and thus could match together in the couples' match.

As I have been wanting to be a doctor since I was 14, putting it off by *another* year seems a great sacrifice indeed. Yet, what other option do I have? I could play the odds and end up like my friend, or sacrifice a year to have a guarantee at the end of it. A marriage with five years spent apart is, for me, like no marriage at all; I will take the year off.

The problem does not end with medical students in different years. My friend J. has a boyfriend in law school who has spent the last three years apart from her. He could move here next year and get a job in a firm, but lawyers have to put in their time to move up in a firm, and once she got matched, he'd have to move again. He would probably have to move yet again in another five years when her residency ended, starting afresh at another firm. So the problem is not confined to the roll-call of the medical school.

Based on this information, there are two logical choices left: pick someone from within your class (a selection of fewer than 60) or someone outside medicine who is highly mobile (which cuts out many professional people). Unfortunately, such choices are often not as subject to logic as they are to emotion.

I don't know the solution to this problem. Perhaps the CaRMS computers can take more information into account, or perhaps high tech is not the way to go. But certainly the subject deserves some discussion, as our relationships, and lack of them, play a tremendous role in the people we are and therefore the kind of doctors we are.

The system needs to back up its verbal encouragement by accommodating and encouraging a well-rounded lifestyle. ▲

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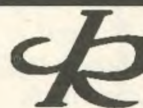

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CPAC

COUNCIL ON PUBLIC AFFAIRS AND COMMUNICATIONS

McPhee responds

In the last issue, Dr Dan MacCarthy reported on the remarkable recovery of David McPhee, Director of Communications and Public Affairs, who has been in rehabilitation since a motor vehicle accident on January 31 of this year ("McPhee on the mend", BCMA News, *June 1998).*

BCMA members and staff were delighted to receive the following response from McPhee, sent by e-mail from G F Strong. ▲

Dear Friends,

You can imagine my surprise and excitement when I read, at the suggestion of my wife, Liz, the commentary by Dr Dan MacCarthy on my stay at G F Strong Rehabilitation Centre.

I have received much support from colleagues and friends at the BCMA. I am confident that the therapy here is well worth while. The nursing staff and all of my therapists have been wonderful, committed to my indepen-dence, and prepared to work with me to this e[nd].

The doctors have been great, prepared to work hard with their brains and their hands t[o] keep me alive and well.

All in all, I have been surrounded by peopl[e] who care, and it counts.

Thank you again to all of you who have wished me and my family well.

David McP[hee]

Dr Alexander Black, Vanderhoof general practitioner and member of the Northern and Rural Doctors' Group that resigned hospital privileges for four months.

In the spirit of Dunkirk

The following presentation was made to the BCMA's General Assembly by Dr Alexander Black on the day after the Northern and Rural Doctors' Group reached a settlement of outstanding on-call issues with the Minister of Health.

Last October, 16 doctors from the northern communities of Vanderhoof, Burns Lake, Fraser Lake, Fort St James, and Mackenzie met as a group. With quantum physics intellect, we identified the 24-hour emergency room coverage as the number-one professional embuggerance of our lives:

- The on call, seven days a week, 52 weeks a year, year after year, that burns doctors out.
- The on-call commitment that often deters recruitment to rural practice.
- The on call that is so poorly remunerated in low-volume emergency rooms under the fee-for-service system.

This of course was not original thinking. We realized at that first meeting that in this province, talking wasn't likely to change anything and that some kind of action would likely be required.

We didn't realize at that time what we were getting into:

- Meetings with our Regional Health Board at which we gave our proposals for on-call stipend and Continuing Medical Education.
- Five meetings with Ministry of Health staff — notably the deputy and assistant deputy ministers.
- Three meetings with [Minister of Health] Penny Priddy and staff.
- Community meetings and rallies.
- Meetings with local mayors, councillors, and MLAs.
- Two meetings with the unilaterally appointed expert on rural health care, Jack Munro, which were quite entertaining but non-productive.
- Meetings with Lucy Dobbin.
- All the letters, phone calls, faxes, and e-mails against a background of resigning total privileges from January 31 from our four community hospitals.

No wonder that at Northern Doctors' Day in Prince George a few weeks ago, a certain amount of battle fatigue was evident, causing us to invoke the Dunkirk spirit:

We shall fight on the beaches, we shall fight on the landing grounds, in the fields, in the streets, and in the hills. We shall never surrender!

Dealing with the government has been quite dreadful up until yesterday. We found them at times deceitful, they changed their minds on matters on which we thought we had reached agreement, and they weren't above the usual dirty tricks, like releasing gross billings to the media.

Indeed, it is difficult to see any peace for this profession in this province with this government and their agenda.

Dealing with the media was quite interesting — they started out giving us quite negative press, but by consistently stating our case for recruitment of new physicians, retention of existing physicians, and relief from intolerable working conditions, and by being readily available to them and indeed building rapport with them, I think we did manage to move them to a much more neutral or even positive position.

We realized at that first meeting that . . . talking wasn't likely to change anything

We developed a fairly massive PR campaign. I should also mention the considerable support from our professional organizations, especially the BCMA.

We kept contact with the College of Physicians and Surgeons and felt the council members and registrars were sympathetic and supportive, although always careful to remind us of our legal obligations. The BC chapter of the Society of Rural Physicians, although still in its infancy and perhaps needing cohesion, did a fine job in keeping the issue in front of the rest of the province and encouraging others to join us.

The stress level for some of our members was quite severe. It wasn't easy doing this in a small town, even though for the most part we had very good public support, and it should not be forgotten that we each suffered a financial loss varying, depending on the size of hospital practice, between $10,000 and $30,000 each.

As you know, a deal is being finalized, and while it won't give us all we wanted, it will be a most useful precedent and a significant first step for further negotiations.

So we can say:

It is not the end. It may not even be the beginning of the end. But it is undoubtedly the end of the beginning.

What we, along with others, achieved was to move an entrenched, ideologically driven Ministry of Health from a position that there was no new money and they couldn't even talk to us, to putting $6 ½ million into rural health care.

So this does create a precedent in BC, and many of the problems peculiar to rural practice have been recognized in Lucy Dobbins' report and are now on the medical-political agenda.

And if it encourages the other 7,000 doctors in BC to draw their own line in the sand and have the resolve to see their own issues through to a conclusion instead of just whingeing, then I would be doubly happy — partly for that, but also because it would give me the opportunity to say:

Never, in the field of human conflict, was so much owed by so many to so few.

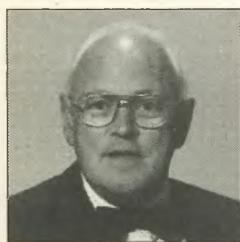
Assuming a deal goe[s] through, we may not ha[ve the] dollars we need to do th[e job] in terms of attracting an[d] retaining doctors in rural areas. Only time will tell. I anticipate that we'll ha[ve to] revisit the problem in th[e] future, hopefully in a m[ore] coordinated, province-w[ide] arena.

But we started things [in] the North, we did what [we] had to do, and saw it through. We took it on t[he] chin for over four mont[hs]. We sacrificed a lot in ter[ms of] time, effort, and money. Although we have some misgivings, we feel rath[er] proud about what the 2[3] members of the Norther[n and] Rural Doctors' Group di[d at the] start and what we, along with others, did accomp[lish].

And so it will come to p[ass] that 100 years from now, [they] will say, "This was thei[r] finest hour!" ▲

if it encoura[ges] the other 7,0[00] doctors in BC [to] draw their o[wn] line in the sa[nd] . . . then I wo[uld] be doubly ha[ppy]

THE PODIUM



What do we know about diesel exhaust particles?

by Dr David Bates
Member, Environmental Health Committee

During the past five years, a large number of studies have appeared that indicate, beyond much doubt, that fine (respirable) particles in urban air are associated with daily mortality: deaths from both respiratory and cardiovascular diseases increase as the concentrations of these particles rise.

Furthermore, the same particles have been shown to be associated with increased respiratory illness in children, aggravation of asthma, pneumonia in the elderly, hospital admissions for respiratory and cardiac conditions, and daily changes in lung function in children and in elderly patients with chronic obstructive respiratory disease.

It is an impressive list; so many different regions have been involved in the studies, and such care has been taken to exclude the influences of weather and different seasons, that we can be reasonably sure the association is "robust".

Diesel emissions are believed to be the origin of a disproportionately high percentage of particles emitted by vehicles. In Vancouver, about 30 per cent of particles in the size range of less than 10 microns are believed to come from diesel vehicles, although these are less than 10 per cent of the fleet.

In London, England, where there are 17,000 small diesel taxicabs, and in Santiago, Chile, where there are many old diesel buses, the air particles emitted from diesels constitutes about 80 per cent of the total. In Europe, diesel vehicles have dominated vehicle production in the past few years. In France, for example, more than half the vehicles produced in the past five years have been diesel-powered.

Although it is commonly believed (and often stated) that our exposure to air pollution has declined over the past 20 years, this is probably not true of diesel particles.

The epidemiological evidence is that particles less than 10 microns in size (PM10) are associated with adverse health effects; smaller particles (less than 2.5 microns, PM2.5) generally show stronger associations.

Diesel particles are less than 1 micron in size. Such particles remain suspended for many days, and can therefore travel long distances. They are also at about the same concentrations indoors as outside — which would indicate that sedentary people are exposed indoors to about the same concentrations that are measured outside.

The mechanisms whereby the particles — even in low concentrations — produce the effects are poorly understood. Animal studies have indicated that they are carcinogenic, and also that relatively low doses of actual city PM10 particles are capable of inducing an inflammatory response in the lung, and also systemic changes. These include mobilization of neutrophils from bone marrow, and electrocardiographic changes.

Some of the recent human observations are particularly interesting. In Provo, Utah, 90 elderly people over the age of 75, 30 of whom were in a residential home and the rest in individual homes, recorded their finger oxygen saturation and heart rate every day. Their oxygen saturation varied with the barometric pressure (which at the altitude of 5,000 ft. varied between 620 and 700 mm Hg), but their heart rate did not. However, the ambient PM10 was associated with an increased heart rate, but not with oxygen saturation.

In six European cities —Amsterdam, Barcelona, London, Milan, Paris, and Rotterdam — hospital admissions for chronic obstructive lung disease were shown to be associated with particulate and gaseous pollution, confirming similar observations from North America. In the Netherlands, the incidence of disease of the lower respiratory tract in schoolchildren, together with decrements in lung function, have been shown to be positively associated with higher exposure to diesel particles by living in proximity to major throughways.

In Augsburg, Germany, where blood samples were taken from random samples of the population during the week of an air pollution episode, there was a significant increase in blood viscosity over the period of the pollution. As this increases the risk of a myocardial infarct, it provided some evidence as to why particulate pollution has been shown to be associated with an increase in cardiovascular mortality as well as in respiratory deaths.

The reduction of diesel particles is likely to be a considerable challenge to the regulators. New diesel vehicles have very low emissions, even under startup conditions. But as they age (and particularly as they become older than about seven years), their emissions increase considerably. These may be reduced by tuning the engine, but in many cases the particles originate from lubricating oil that enters the cylinder.

Choices for emission reductions include statutory limitation of the use of the engine; substitution of natural gas-driven vehicles; or the more extensive use of trolley buses or small electric delivery vans.

If the Kyoto target is to be met, the need to reduce CO_2 emissions from transportation may require strategies that will also reduce vehicle emissions; attainment of the new US EPA standards for PM2.5 may also require similar actions. Although reductions in particulate emissions from industry have been considerable over the past 20 years, the demonstrated adverse health effects from small particles indicate that more must be done.

Wood smoke emissions must be reduced in some areas; industrial emissions should be licensed not, as now, in terms of "kg/hr" but specifically in terms of the permitted emissions of particles in the PM10 range. These steps are particularly important in the interior of British Columbia, as PM10 levels are generally higher in inland cities than on the coast.

The need to control diesel emissions should therefore be viewed within the larger context of the need to reduce current particulate exposures originating from a variety of sources. ▲

Dr David Bates, former Dean of Medicine at the University of British Columbia, is devoting much of his retirement to research of and writing about matters affecting the environment.

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POLITICAL NOTES FROM VICTORIA

He's baack! BC politics in a *nut*shell

by Brian Battison
LAC Consultant

Just when you thought you had seen everything . . . bribes for power projects in Pakistan . . . political schemes to steal money from charities . . . secret Grand Cayman bank accounts for NDP insiders and big-money golden handshakes for political friends . . . along comes "The Zalm" to brighten your TV screen.

A bad penny or the second coming? Depends on your point of view. Love him or hate him, he's back in the hunt, and political pundits, talk-show hosts, and editorial cartoonists are delighted.

But don't get too worked up about the resurrection lest you spoil the fun. He's just one, albeit a big one, in a long list of characters that has graced BC's political stage. Imagine for a moment you're a visitor or a new immigrant, and you want to brush up a little on BC politics. Here's what you'd find out.

A guy named "Wacky"

One man ran this place for 20 years, from 1952 to 1972. They called him "Wacky", friend and foe alike. A furniture salesman turned politician. He was by any definition a builder who had the bright idea to dam the rivers, cut the trees, and build some roads, a lot of roads.

Every year he would gather friends and family around to burn provincial debt. With a flare for the dramatic, he would load expired bonds and other debt instruments on a wooden raft, pour on some accelerant, push it out onto Okanagan Lake, and light it with a flaming arrow shot from shore.

He balanced the provincial budget year after year, the place boomed, but no one would admit voting for Wacky, although he kept getting re-elected time after time.

"Fat Dave" and the NDP

Wacky was defeated in 1972 by a socialist called Dave Barrett. "Fat Dave", as he was less than affectionately known, was leader of the NDP.

"New Democrats" (they like to call themselves that) are a mixed breed — a coalition of labor unions, social activist groups, and environmentalists who couldn't wait to "fix" BC. In their three-and-a-half years as government, they ran up a huge debt, nationalized the auto insurance industry, and froze development on all "agricultural land".

They did all sorts of other "wonderful" things, including the establishment of a "Super Royalties Tax" on mining companies, virtually killing mineral exploration in BC.

Son of "Wacky"

Then Wacky's son Bill ran the place for a while. He liked to build stuff, too — a driverless rapid transit system that has yet to crash, although it has run over the odd passenger; a big highway from Vancouver to his hometown; a world's fair; a 60,000-seat stadium that now sits empty; and a big coal project that included an electric rail line and a deep-water ocean port.

He changed the way things were built in BC. Before he came along, 70 per cent of all major construction projects, including commercial and residential high-rise buildings, were built by union contractors.

Today those statistics are reversed — 70 per cent of all construction is now done by non-union firms. The catalyst was Expo '86. It was declared an open construction site, open to competition, allowing both union and non-union firms to bid on construction jobs.

A gardener named "Bill"

When Bill Bennett stepped down, we elected a gardener as premier. He was a consummate salesman who had made millions selling flowers, shrubs, and gardening stuff. He lived in a castle in a place called Fantasy Gardens, and we loved him . . . for a while.

He proved to be a bit of a wild card and fell from celebrity to buffoon in spectacular fashion just days after selling his castle to a wealthy Taiwanese businessman. It was ugly. He was charged with conflict of interest and had to resign. The fallout was far-reaching.

Mr Potato Head

Social Credit was wiped out in the next election, winning just six seats out of 75. The NDP were back.

This time the socialists were led by Mike Harcourt, a storefront lawyer and the human equivalent of Mr Potato Head. He was a nice guy but void of imagination and leadership quality. He was dominated by powerful individuals within his own cabinet, one of whom was Glen Clark, a 38-year-old union organizer, an articulate speaker, a skilled debater, and ambitious as hell.

The "New Democrats" ran into their own troubles early in their mandate and floundered badly from one issue to the next. Apparently their party, through much complicated maneuvering and creative bookkeeping, had effectively been stealing money from charities for more than a decade, including the theft of money from a nun, of all people.

The Nanaimo Commonwealth Holdings scandal, as it became known, eventually forced Mike Harcourt to step down as premier.

Little Big Man

Glen Clark (the young, ruthless, skilled orator referred to earlier) took over the "New Democrats". The very day Mr Clark was being sworn in as premier, it was revealed that BC Hydro had established a very cozy relationship with a small private-sector company, the shareholders of which were all "New Democrat" friends and insiders.

It seems this band of highly placed NDPers, through their brethren on the Hydro board (of which Glen Clark was one, as the minister responsible for Hydro under Premier Harcourt), set up a joint venture corporate entity to bid on providing power generation expertise to a foreign (Pakistani) powe project. They had registered related corporate entities in the Grand Cayman Islands t (presumably) avoid paying tax here at home.

So much for the rest of u: who have to pay the exorbitant tax rates they have imposed since coming to office eight years ago. You would think this scandal, in combination with their earli er efforts at stealing money from charities, would be enough to finish them off. Surely we would not be foo ish enough to re-elect these guys. Well, guess what? We did, and we're paying a big price for our foolishness.

There's a saying, "What goes around comes around There's another one too, "I democracy, voters get the government they deserve."

With that in mind, can Vander Zalm be too far behind? It might be fun . . . if it weren't so painful to watch. ▲

MOAA

MEDICAL OFFICE ASSISTANTS' ASSOCIATION OF BC

Seminars benefit MOAs

by Nancy Walker
Vice president, MOAA

As a new executive member of the MOAA of BC, I am honored to follow Debbie deWit in contributing to the BCMA *News* on behalf of our association.

Every year, MOAA chapters host educational seminars in their areas. The seminar schedule for the rest of 1998 is:

Nanaimo, Chapter 3	October 17
Penticton, Chapter 9	October 24
Vancouver, Chapter 1	November 7

For more information about these seminars, contact our public relations liaison, Terry Ratcliffe, at the MOAA phone line, (604) 584-3641. Please encourage your staff to attend.

I had the pleasure of attending an all-day seminar, "Women to Women: A Focus on Women's Health", presented by the Vancouver Branch of the Federation of Medical Women of Canada in April. The two keynote speakers were informative and inspiring, and the benefits were well worth the cost of $50. I would like to suggest that all employers encourage their medical office staff to attend this yearly event, and offer to cover the cost.

More information can be obtained from Dr Laura Jensen at (604) 294-8550.

The MOAA is deep into its plans for participating in the Variety Club Telethon in February 1999, spearheaded once again by Lani Harris of the North Shore chapter. This past February, the association raised another $3,150, and we now have the MOAA's name on six Variety Club buses. ▲

This letter, written by a fellow MOA, appeared in three Lower Mainland newspapers.

Why is it that when Mr Smith finds a product, researches the market through lawyers and accountants, opens a small business, pays rent for the business premises, hires employees, sells his product (for a calculated profit margin), and his gross annual sales reach $500,000 per year, he is applauded for helping the economy and hailed as an innovator, an entrepreneur, and an astute businessman who takes his chances?

Whereas when Dr Smith opens a small business after eight years of schooling (his choice), researches through lawyers and accountants, hires employees, pays rent for his business premises, and his gross annual income reaches $200,000, he is considered to have earned too much money?

Dr Smith pays the same dues and business license fees as any other operator of a small business, plus some hefty professional fees, and the liabilities that go with a medical practice in today's world.

Is there a comparison? ▲

COMMUNITY MEDICINE

What to do for tick bites

by Dr John Blatherwick
Medical Health Officer
Vancouver/Richmond
Health Department

Lyme disease, common in the northeastern United States, can cause symptoms ranging from rashes and flu-like illness to arthritis and chronic neurological syndromes. Diagnosis can be difficult, as can treatment in the later stages.

While few cases of Lyme disease are known to have been acquired in BC, tick testing has found that the causative *Borrelia burgdorferi* spirochete is found in a small percentage of ticks in many parts of the province. Ticks may harbor other organisms, such as the *Ehrlichia* rickettsiae responsible for human ehrlichiosis, a newly recognized and occasionally serious febrile illness. Physicians should be aware of the prevention and management of tick-borne diseases.

Preventing tick bites

- Hike only on cleared trails.
- Wear light-colored clothing.
- Tuck shirts into pants and pants into socks.
- Consider spraying clothing with a permethrin-containing tick repellent and using an insect repellent containing DEET on exposed skin.

When leaving an area where ticks may live, hikers should check their clothing, scalp, and skin, including the groin and axillae, for ticks. Tick bites are painless and may go unnoticed. If ticks are found, prompt and careful removal can prevent the transmission of tick-borne diseases.

Ticks transmit *Borrelia burgdorferi* by regurgitating their stomach contents into the person bitten, which can occur only after at least eight hours of feeding or after inappropriate methods of tick removal. Ticks can be difficult to remove because they secrete a cement-like substance while feeding.

Tick removal

- Grasp the mouth (never the body) of the tick close to the skin surface with a pair of tweezers and pull firmly and steadily.
- Less desirable alternative: Inject a small bleb of saline into the epidermis underneath the attached mouth, to lift the tick off the skin surface.
- Never remove by burning or applying chemicals; these methods can result in regurgitation of the tick's stomach contents.

Tick testing

- The provincial laboratory will test live ticks that have bitten a human for the presence of *Borrelia burgdorferi.*
- Place tick in a urine specimen container or jar with moist gauze and send to the vector-borne diseases lab at the provincial laboratory; include the name of the person bitten, date bitten, and area where the bite occurred.
- Dead ticks can be sent for species identification only, to determine if the tick is of a species known to carry *Borrelia burgdorferi.*

Treatment of tick bites

Patients suffering tick bites must never be treated prophylactically with antibiotics for Lyme disease. The risk of Lyme disease following any tick bite is very low, even in highly endemic areas in the United States. Inappropriate antibiotic use may make subsequent diagnosis difficult. The most appropriate patient management is as follows:

1. Observe the patient for the first month after the bite for signs and symptoms of Lyme disease. Erythema migrans is a skin lesion that is pathognomonic for Lyme disease, but occurs in less than 50 per cent of infected patients. It is a bull's-eye, red lesion with a clear centre, at least 5 cm in diameter, that occurs 2-30 days after the bite. (Earlier lesions likely represent skin irritation only.) Common early Lyme disease symptoms include fever, fatigue, headache, myalgia, arthralgia, and lymphadenopathy. Later symptoms include arthritis and neuralgia.

2. If symptoms develop, obtain bloodwork for Lyme disease serology. False positive and false negative results are common, so treatment must be based on clinical diagnosis only.

3. Treat promptly if symptomatic. Recommended therapy for early, localized disease is oral amoxicillin for six weeks (monitor blood levels and increase dosage as required):

- Adults: 1 gm amoxicillin q 8 h plus probenicid 500 mg q 6 h.
- Pregnancy: 1 gm amoxicillin q 6 h.
- Children: 50 mg/kg/day amoxicillin in divided doses q 8 h.
- Alternative: Cefuroxime axetil for 6 weeks, 1000 mg po q 12 h for adults, 125-250 mg po q 12 h for children.
- Less effective alternative: Doxycycline 100 mg po tid for adults for 6 weeks (may need up to 600 mg daily); cannot be given to children or pregnant women.
- Parenteral therapy required for more advanced infections.

A Lyme disease vaccine may be available in North America within the year. It is unlikely that this vaccine will be recommended for routine use in BC because the risk of Lyme disease is low. It may be recommended for certain travellers. Those vaccinated must still be advised to take precautions to prevent tick bites, as ticks may harbor other disease-causing organisms. ▲

LOCAL ACTION COMMITTEE • LOCAL ACTION COMMITTEE • LOCAL ACTION COMMITTEE

Preparing for fall election?

by Brian Battison
LAC Consultant

A fall election isn't as far-fetched as you might think. Here's the scenario:

The BC Business Council has launched a major initiative to bring together business interests large and small in a business summit. The purpose? To make recommendations on how business can help get BC back on some solid economic ground.

It's a good idea. Obviously the provincial government is incapable of coming up with a plan of its own, so why not get the province's business brains together and come up with some solutions to build some investor confidence, create jobs, and re-establish BC as an economic force in the country?

We've fallen from first to tenth in the nation economically. Surely a business-based plan couldn't do any worse.

But what does Glen Clark do about this obvious slap in the face? Business is essentially saying to him, "You've failed, we can do better, here's what needs to be done." Does he just sit there and take the criticism? I don't think so.

His options: 1) continue with the economic forums currently being held in various towns across the province (to which no one is paying any attention); 2) ignore the business summit altogether; or 3) do the smart thing, embrace the summit, adopt its recommendations, and implement them as his own. And with all the fanfare and spin that Glen Clark is so good at.

Here's how it works. First, an emergency session of the legislature. The sole topic is the economy.

On the table for debate are the BC summit proposals and the legislation to turn them into law, legislation Clark has been secretly drafting for months in anticipation of the summit. After all, it's no secret what the business summit will recommend: reduce the marginal tax rate, reduce/eliminate the corporate capital tax, reduce red tape, streamline regulations, bring some certainty and stability to the native land claim issue, and offer investment incentives and inducements.

By taking hold of the issue, Clark demonstrates decisive leadership, showing he can work with all sides, that he is pragmatic and responsive. Best of all, by joining hands with business, he cuts the legs out from under the Liberals, denying them their voice on behalf of free enterprise, pushing them off ground that would otherwise be theirs. What's left for them to do, criticize government for doing what business wants?

What are the risks for Glen Clark of such a strategy? First, it isn't wise to go to the polls when he is bumping along the bottom, grappling with the lowest support numbers of his career. But it will take something dramatic to turn things around anyway,

Preparing continued on p. 25

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DOCTORS AS PEOPLE

Fear: thief of the moment

by Dr Romayne Gallagher

"There is nothing to fear but fear itself." I saw Franklin Roosevelt's famous quote on his memorial in Washington DC recently. This was from one of his speeches of encouragement to the American people during World War II.

While I think this is a simplistic way of looking at a complex emotion, it does have a point to make. Fear can be useful in that it promotes self-preservation and is likely generated from the most basic genes of any living organism. Fear taken too far results in phobias that can be so severe as to render the person incapable of functioning. But recently I learned to consider fear in a new way.

Fear is most often an emotion that comes from perceiving a future happening or from anticipating the unknown. This new awareness of fear was brought home to me by a patient.

Joseph is a 36-year-old man with a rare mediastinal tumor. I met him after he had been through surgical resection and radiation for the malignancy. This tumor is so rare that there are only five reported cases in the literature. All five cases did poorly.

Being a typical patient of the 90s, my patient had researched the medical literature through surfing the Net, and discovered this dreadful information himself. How did this make him feel? How did he cope, knowing that in all likelihood he would die in the next year or so?

"You must be afraid," I said.

"At times, yes, but not much, because being afraid stops me from enjoying the present."

His answer gave me not only a reply to the question, but much to think about over the last few months. Oftentimes the apprehension or fear of the unknown or an unpleasant experience lasts some days or weeks in advance. The fear can be so unpleasant mentally or physically that you end up not enjoying anything from the moment you begin to anticipate the situation to the moment it is over. And that can waste a lot of time.

More importantly, a lot of pleasant or very pertinent moments or events could be occurring, and I would not be aware of them because my mind was in the future.

I had an opportunity to try this out shortly after Joseph and I talked. I had a situation coming up that generally made me fearful. But before and after it, I had some enjoyable time to spend with my children. When I began to feel apprehensive about the upcoming event, I remembered Joseph's words and concentrated on the present moment and what was enjoyable about it. It actually worked very well. I enjoyed the time with my children, and I reduced the fearfulness of the event.

Joseph has found that meditation has taught him to live in the present and look for the good in each moment. Much of our lives today are lived with half our attention on the present and the other half focused on what might come in the future.

Much of our work these days is rushed and stressed, focusing on time, money, and resources management rather than the pleasure of connecting with and helping our patients. We are told of the wisdom of planning ahead, especially as Christmas or RRSP deadline approaches.

With more work to be done in the same amount of time, we have to do more planning and living in anticipation of the future. We are robbing ourselves of living in that moment, and I believe we reap less enjoyment and fulfillment.

Now the fearful situation I spoke of was nothing at all like the plight Joseph finds himself in. I am not knowingly facing my death in the near future. But what he told me did open up a door to a new way of thinking and behaving. And I know it works.

This is Dr Gallagher's last column in her "Doctors as People" series. She plans to take time from her practice to study, with a view to practising only palliative care. ▲

Pacific Northwest Cancer Foundation

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Faculty

Haakon Ragde, MD
Gerald P. Murphy, MD, DSc
Gordon Grado, MD
Michael Brawer, MD
Kent Landin, RDMS
Bruce Scott, NMT
Doug Schumacher, Physicist
Dianna Davis, RN

Guest Speakers will vary

Location: Seattle, Washington

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In 1987 Northwest Hospital began offering this very popular course on a monthly basis to multi-specialty teams of Urologists, Radiation Oncologists, Physicists/Docimetrists and Registered Nurses with the goal of giving participants both the clinical and organizational knowledge necessary to establish a permanent implant service in their own communities.

Because of increasing demand from all disciplines, we are offering these 2 day seminars on a regular basis throughout the year. Please call (206) 368-3077 for course information, dates and space availability.

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Finding Common Ground: Working Together for the Future

Conference on Fetal Alcohol Syndrome & Neonatal Abstinence Syndrome

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Coast Plaza Stanley Park Hotel

Breast Health Centres: The Team Approach

February 18, 1999

Hyatt Regency Hotel

The nature of this one-day conference is to bring together team members of breast diagnostic centres across Canada. The aim is to highlight academic achievements and to offer a forum in which to share common problems and approaches to improving the care offered to women.

Breast Cancer: Myths & Realities 1999

February 19 & 20, 1999

Hyatt Regency Hotel

This conference will be of interest to: Educators, Family Physicians, Nurses, Oncologists, Physiotherapists, Psychologists, Social Workers, Surgeons, Women Living With Breast Cancer & Family Members. Sponsored by: Continuing Education in the Health Sciences, The University of British Columbia

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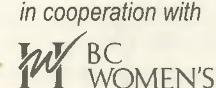

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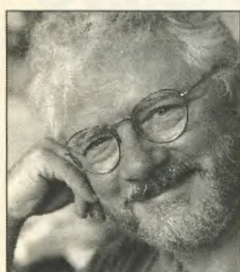
PHYSICIAN SUPPORT PROGRAM



My May odyssey

by Dr Douglas Graham
Clinical Coordinator
Physician Support Program

Daily I talk with doctors whose coping mechanisms are in various states of disarray. The pressures of our working environment having wrought havoc on conscientious, hard-working men and women, who for one reason or another end up talking to me.

One of the most consistent pieces of advice I give has to do with the necessity of taking adequate leave from work. Most of those doctors I talk with have not done this.

About three months ago, my family pointed out that I was exhibiting many of the symptoms I was supposed to be an expert on avoiding. In short, I had become a grumpy man who was not pleasant company.

I then found myself at work talking to a doctor who sounded just like me — an increasing number of seemingly insoluble problems at work, grouchy at home, family runs for cover on his approach. I went through an inventory of holidays he had taken — two weeks here, one week there, often tagged onto a conference, usually able to be contacted or checking in with work when "away".

I heard myself advising it was vital that he take four weeks off, go away with his family, not contact the office, in fact not even think about the office.

"You are not indispensable" I heard myself say. "If you drop dead now, the question next day in the hospital (following brief remarks about what a good guy you were) would be about who is taking your call. You cannot carry on without a significant break."

My wife, bringing some correspondence into my office, overheard the tail end of my talk and commented about how that "sounded like good advice, Douglas."

Okay, okay — I got the message.

I decided to take the advice I had been handing out for years.

My youngest child, my daughter Naomi (I delivered her, I held her when she took her first breath), is still at home and will graduate from high school next year. She is a busy young woman, a serious and accomplished dancer.

She and I have never had a trip together, so I planned one. I decided to try to show her some of the things that are meaningful to me, and I wanted to have time together that would be enjoyable for her. So here's what we did.

I cashed in my frequent flier points and booked two business-class tickets to Heathrow. I took my daughter out of school, as I wanted to be in Europe before the summer season got going.

We had two days in London, two days in Wiltshire, then a week in the Trossachs in Scotland. We traveled via the Chunnel to Paris, where we overnighted, then by Train Grand Vitesse to Nice for two nights. On by train through the Riviera to Venice, where we stayed five days. We left Italy by train through Switzerland to Mannheim in Germany, where we caught the ICE train to Frankfurt and next day flew from there back home to Victoria.

Rushed? Not at all. Selective? Very.

For example, we went to the National Gallery in London to see William Hogarth, some pre-raphaelites, and some Impressionists, especially Vincent van Gogh. It took us three hours to do just that.

We had many adventures, a lot of fun, and some very special moments. We went to evensong at Salisbury Cathedral, celebrated by the cathedral school choir. The building, the acoustics, the musical setting, and the performance conspired to move us both profoundly — what a privilege to be with my daughter for that moment!

Another highlight was also musical — a Vivaldi concert in a gorgeous little Venetian church, which was certainly known to Vivaldi. He probably played there at some time.

. . . my family pointed out that I was exhibiting many of the symptoms I was supposed to be an expert on avoiding.

The handsome young Italian cellist, an impassioned player, caught my daughter's attention, then on coming front and centre to lead the cello concerto, smiled at her and seemed to play the work for her. The whole performance was first rate.

We relaxed on the superb public beaches of Nice and of the Venetian Lido. We had some memorable meals, especially in Venice. My gregarious daughter met lots of interesting people. Above all, we had a lot of time together and really enjoyed each other's company.

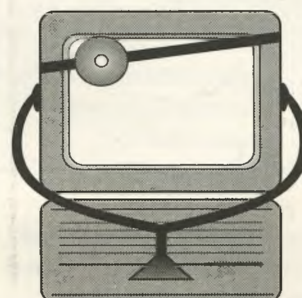
Naomi experienced all I had hoped for and more. She is an intelligent young woman and grasped the interconnectedness of the arts — music, painting, architecture, and literature — with real people, different cultures, languages, emotions, sexuality, with the whole sad, joyous, and messy business that is our life.

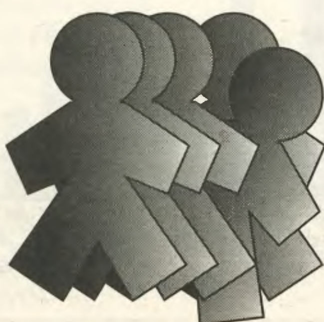
For me, it was a joy and privilege to be with my daughter when she experienced these things, to share her company, and to talk endlessly with her about it all.

In addition, I was away from work. It took me a couple of days to forget all that, and truthfully, I thought little of it for the whole trip. I returned refreshed and relaxed from one of my lifetime highlights.

Back home, back to work, back to reality, I realize that I give very good advice, and there is a new conviction in my tone. It is good to be back in most ways. Naomi is back with her friends and her busy life. I miss her . . .

Visit the PSP Web site at www.psp.victoria.bc.ca. ▲





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CHEPOINTS

by Dr Arun Garg, Chair, Council on Health Economics and Policy

F E A T U R E D

BCMA Waiting List Report —April 1998

◆

BCMA Rural Physician Issues Report

◆

Billing Corner: When to Bill Fee Item 00109

◆

Utilization: Understanding the Issues

◆

Meet Your Staff

CHEP Membership

Dr Arun Garg, Chair
Dr Geoffrey Appleton
Dr Marshall Dahl
Dr Zafar Essak
Dr Brian Gregory
Dr Mike Lawrence
Dr Dan MacCarthy
Dr Jim Rhodes
Dr Patrick Yu

CHEP Quote:

"Sometimes I get the feeling the whole world is against me, but deep down I know that's not true. Some of the smaller countries are neutral." — Robert Orben, Comedy Writer

BCMA Rural Physician Issues Project

The problems associated with medical practice in northern and rural communities in British Columbia have been growing, culminating in the refusal by 23 northern BC doctors to take after-hours call, beginning in November 1997. Professional, social, economic, and personal issues all affect a physician's decision to practise in a rural community.

The BCMA Department of Economics and Policy Analysis, in conjunction with the BCMA Rural Physicians Committee, is examining the practice and lifestyle issues affecting BC's rural physicians and is identifying how the BCMA can help address these concerns in the future.

The BCMA Rural Physician Issues Project will examine the literature on the recruitment, retention, and satisfaction of rural physicians. A review of the programs and incentives currently in place across Canada will provide up-to-date information on the effectiveness of alternate solutions. The major component of this project is a survey of rural physicians, to identify the key factors affecting rural practice in BC and how the BCMA can better meet rural physicians' needs.

Once the completed questionnaires have been returned and the resulting data analyzed, focus groups of rural physicians will be used to discuss the implications of the results. Discussions with the focus groups, the Rural Physicians Committee of the BCMA, and potentially other stakeholder groups will result, it is hoped, in practical, workable recommendations to address the specific practice and lifestyle concerns of rural physicians in BC.

We are working toward bringing specific recommendations to the Board of Directors at its November 20, 1998, meeting. ▲

For further information on this project, please contact Mr Michael Epp, Senior Policy Analyst, at 736-1226, local 228.

BCMA Waiting List Report—April 1998

In November 1997, the BC Ministry of Health published its first waiting list report. The minister used this report to support her assertion that waiting times for medical services are "stable and indicate that our health system is meeting the needs of British Columbians, much as it has in recent years."[1] This statement is *not* supportable.

Several critical pieces of information are missing from the 1997 BC Ministry of Health Report, including:

1) No reference was made to either the wait to see a general practitioner or the wait between the general practitioner visit and the specialist consultation.
2) There is no recognition of patients' waiting time to receive diagnostic testing.
3) The ministry's report does not distinguish between elective and urgent procedures.
4) There is no recognition of regional differences in waiting times.
5) There is no discussion of appropriate vs actual waiting time upon which to base waiting list management decisions.

These critical shortcomings of the minister's 1997 report, in conjunction with the growing public and professional concern that patients are waiting excessive lengths of time to receive care, led the BCMA to prepare the first in a series of waiting list reports. The BCMA Waiting List Report was released in April 1998.

Methodology

In December 1997, the BCMA sent questionnaires to all British Columbia specialists in orthopaedics, ophthalmology, cardiac surgery, and rheumatology, a total of 319 physicians. Future BCMA studies will include other specialties. Of the 319 surveys sent, 195 were returned, resulting in a 61 per cent response rate.

Results

The following chart illustrates how long British Columbians are currently waiting for coronary artery bypass, joint replacement (hip, knee, ankle, shoulder), and cataract removal. These results contrast sharply with the information provided by the ministry in November 1997.

Wait times for surgery in BC — April 1998

Total Wait (Elective Surgery)	Wait before consultation +	Wait after consultation =	Total wait
Coronary artery bypass	4 weeks	26 weeks	30 weeks
Joint replacement***	9.5 weeks	19 weeks	28.5 weeks
Cataract removal	5 weeks	14 weeks	19 weeks

Wait After Consultation (Elective Surgery)	April 1998 BCMA Waiting List Report		Minister's 1997 Report
	Reasonable wait*	Wait after consultation	Total wait
Coronary artery bypass	7 weeks	26 weeks	14 weeks**
Joint replacement***	8 weeks	19 weeks	9.4 weeks^
Cataract removal	8 weeks	14 weeks	7.3 weeks

*based on specialists' survey responses **for all heart surgery procedures ***hip, knee, ankle, shoulder ^hip only

The following chart from the BCMA Waiting List Report outlines the regional variations among wait times for elective joint replacement after a specialist consultation. The median wait to see an orthopaedic surgeon for a consultation in BC is 9.5 weeks. "Reasonable wait" is defined as the median response by practising BC orthopaedic surgeons as to what is a reasonable wait for services.

For a complete copy of the April 1998 BCMA Waiting List Report, please contact Ms Alison MacArthur by phone: (604) 736-1226, local 288; fax: (604) 736-4566; or e- mail: amacarth@bcma.bc.ca.

[1] Waiting List Report. Victoria: Ministry of Healt[h] and Ministry Responsible for Seniors, p. 23.

Wait for Elective Joint Replacement (Hip, Knee, Ankle, Shoulder) After Consultatic[on]

Actual Wait After Consultation
Reasonable Wait After Consultat[ion]
Reasonable W[ait]
Median Wait Time in Weeks
60 50 40 30 20 10
British Columbia, Burnaby (17), C V Isld (10), Capital (20), Fr Valley (06), Koot (01 & 02), N Inter (15), N Okanag (03), N Shore (13), N West (13), Richmond (19), S Okanag (04), Simon Fr (08), South Fr (07), Thomp (05), Up Isld (11), Va[n]

Utilization: understanding the issues

In January of this year, the BCMA made a comprehensive presentation to the Medical Services Commission with respect to service utilization. What follows is an excerpt on one aspect of that submission. This excerpt is the third in a series that started in the March 1998 issue of CHEPoints. *Further excerpts will appear in future editions.*

Provincial level analysis

The second excerpt published in the March issue of CHEPoints discussed the trends in provincial level utilization. Utilization per capita was analyzed by breaking it down into two components: patient access and utilization per patient. Between 1992-93 and 1996-97, utilization per capita increased on average by 0.31 per cent per year, and patient access and utilization per patient remained relatively constant over the period.

The following excerpt is the continuation of the provincial level analysis. It further breaks down patient access into practice size and physician supply, and breaks down utilization per patient into utilization per physician seen and the number of physicians seen.

The definitions of the variables included in this excerpt are:

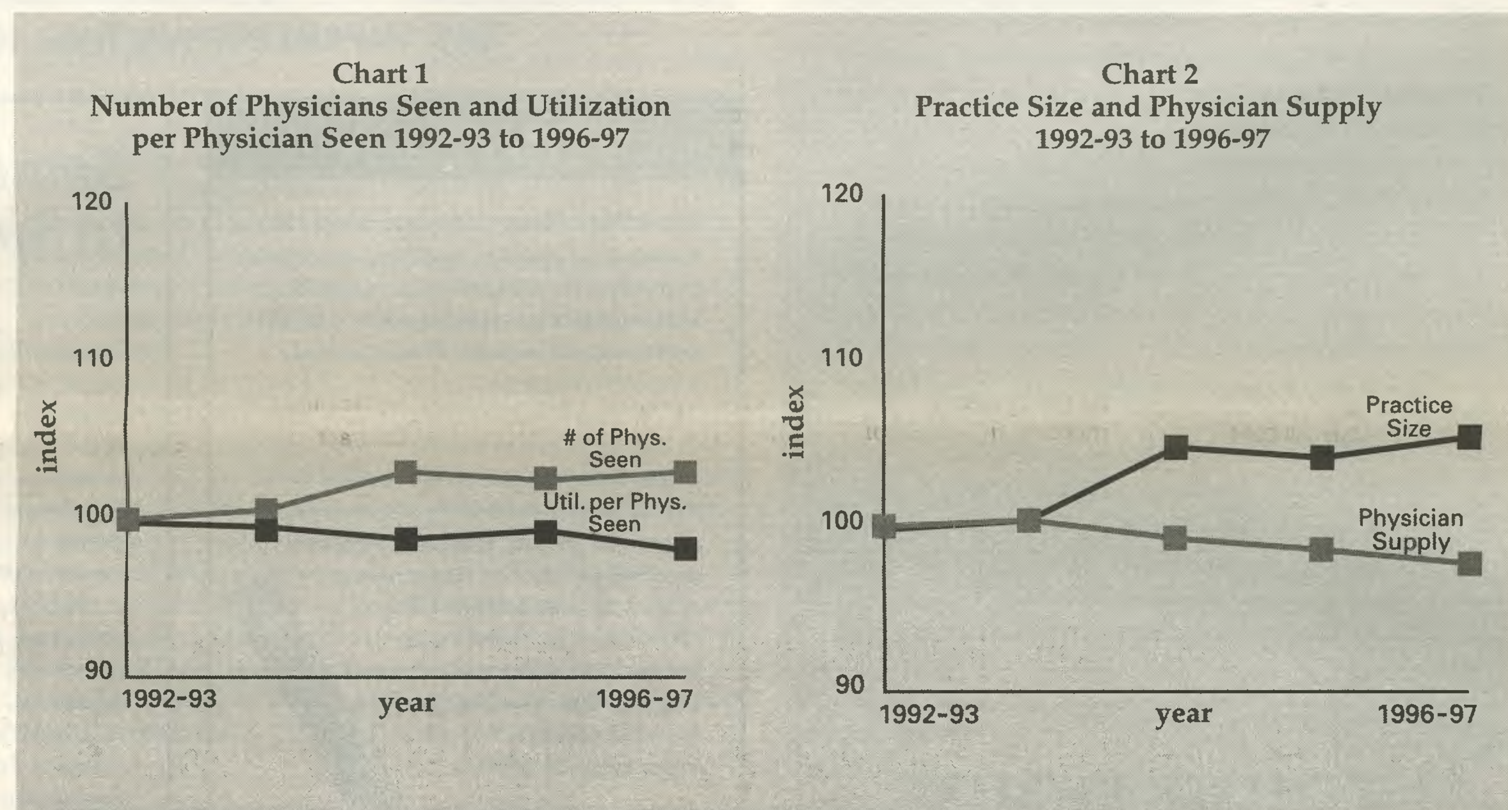
- Utilization per physician seen measures, on average, the cost of treatment for each discrete patient-physician pair.
- Number of physicians seen is measured by the average number of physicians each patient visits.
- Practice size is the average number of discrete patients each physician sees in a year (measured by identifying each unique patient-physician pairing).
- Physician supply is measured by the number of physicians per population. A change in this measure represents a different rate of change in the number of physicians as compared with population change.

Chart 1 shows the trend in the number of physicians seen and utilization per physician seen. Of note is the indication that patients received care from an increasing number of different physicians, seeing 3.2 different doctors in 1996-97, compared with 3.1 in 1992-93, an increase of about 2.65 per cent. This is not an overly surprising result, given the significant increase in the number and use of "walk-in" clinics during this period.

Additional factors contributing to this growth include the increased "sharing" of patients through group on-call coverage, sub-specialization as advances in treatment technology are identified, and the improving distribution of primary care and specialist physicians into previously underserved areas.

At the same time, however, the average utilization per physician seen declined by 2.32 per cent. Although more doctors were seen, each provided fewer services on average, leaving the overall cost of care almost the same over the entire period. The explanation for this is somewhat unclear, but in part it is a testimonial to the previously noted initiative of the BCMA to encourage diligent referral practices and ensure the appropriate forwarding of diagnostic information.

Patient access has been affected by the total size of the population, the rate at which people seek care, and the availability of physicians. Chart 2 indicates that physician supply (relative to population) has shown a slight decline over the period, no doubt as a result of the MSC supply policy. At the same time, however, individual practice sizes have been growing slightly, at the rate of 1.44 per cent per year. This growth is directly attributable to the facts that the rate of patient access is slowly increasing and that existing patients are seeing a larger number of physicians each year for roughly the same amount of care, as noted above. ▲



EPA staff changes

Ms Vishni Peeris, Health Economist, has recently accepted a position with the Ministry of Finance in Yellowknife, Northwest Territories. We wish Vishni every success in her new endeavor, and much luck in the acclimatization process. ▲

BILLING CORNER: WHEN TO BILL FEE ITEM 00109

SCENARIO:

A patient is admitted to hospital "A" by doctor "A". Upon assessing the patient, the physician determines that the hospital (which is small) cannot treat this patient. The patient is then transferred to hospital "B", now under the care of doctor "B".

Q. Does doctor "A" bill 00109 and doctor "B" bill 00108, or can doctor "B" also bill a 00109?

A. If a patient is admitted to hospital, and all other criteria are met, then 00109 is applicable, even if no other hospital visits are rendered by the physician. Both doctors "A" and "B" can bill 00109 and be paid in the above circumstance. Dr "B's" claim should include a note record indicating that the patient was transferred from (name of hospital "A").

Juanita Grant, Economics Assistant ▲

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BRITISH COLUMBIA MEDICAL ASSOCIATION
NEWS

Editor: Dr Bob Young
Publication of the BC Medical Association
The BCMA *News* is a provocative medical/political tabloid whose editorial and/or advertising content does not necessarily reflect the policies or opinions of the BCMA.
The *News* is published to keep you informed. If you have information, suggestions, or tips, please keep us informed — Dr Bob Young, Editor, fax (250) 477-3049 or e-mail docbob@islandnet.com; Ann Paulsen, Managing Editor, fax (604) 733-7317 or e-mail apaulsen@bcma.bc.ca.
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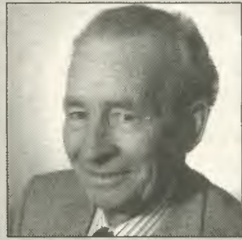
EDITORIALS

Avery never wavered


Dr Bob Young, BCMA *News* Editor

IT WAS COMMON KNOWLEDGE that before the start of his term, the Ministry of Health was alarmed about Dr Granger Avery. The politicians did not know him and did not know what to expect. If they were looking for a laid-back, easy-going country doc with no political savvy, they were sorely disappointed.

He has delivered hard-hitting messages to the press, the public, and to his membership. He has been a particularly diligent touring President, logging more miles than most while undertaking exhausting trips to all parts of the province.

His tour duties have been only part of his responsibilities. Contact with the press has occurred several times a day for his whole term, with many interviews being difficult and antagonistic. He has never wavered from the basic message, and has resisted being baited by "doctors just want more money" accusations.

He has been a strong President, leading and being helped by a potent executive. He has also helped keep BC in the forefront of the national medical scene.

We all owe Granger a vote of thanks for a job very well done. If each individual BCMA member expended just two per cent as much effort in promoting organized medicine, we would have no problems.

Time for a bit of R&R, Granger. You have more than earned it.▲

Turning point ahead

THE CORNER, WE THINK, IS CLOSE BY.

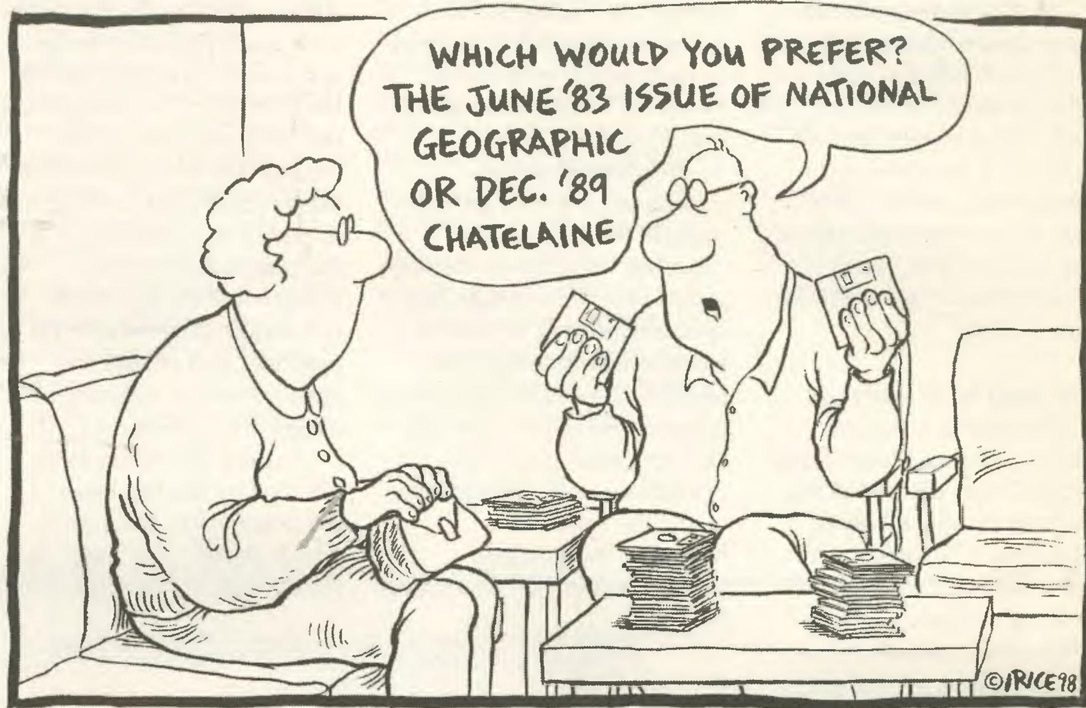
This is the corner that must be turned before problems with medicare, underfunding, and health-care deterioration can be corrected.

We have long held that a major shift in public awareness would be required to accomplish this. If a number of recent polls are to be believed, the shift is well under way. Politicians cannot long ignore the fact that 81 per cent of Canadians now want more money put into health care, and in BC, 75 per cent think more funding is needed.

In spite of expensive and repeated government advertisements blaming doctors, only 4 per cent of those polled thought physicians were responsible for the decline in health-care quality.

The recent settlement with the Northern and Rural Doctors' Group is extremely important for all of us, not just for those directly affected. Not only does it demonstrate the positive effects of united political action, it offers more than a glimmer of hope for other physicians preparing to fight their own battles. It certainly contributed to the sense of enthusiasm shown at the AGM.

While the corner looms and will be reached, the length of the path ahead remains unknown—but at least we will be able to see it.▲

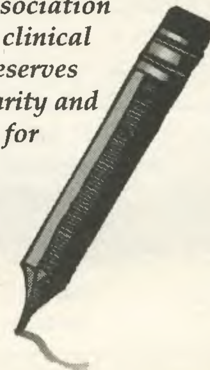


THE PAPERLESS WAITING ROOM.

WRITE ON

The BCMA *News* welcomes letters in the form of spirited opinion, reflective comment, or controversial ideas. Your letter should be typed double-spaced, and reasonably brief. Please include a telephone number.

***If you have a topic to discuss in depth, please submit an opinion piece of greater length, preferably related to medical politics or Association affairs (as opposed to clinical subjects). The News reserves the right to edit for clarity and length. Copy deadline for the next issue is September 29, 1998.*▲**



Spouse to Spouse

Space will be available in future issues of the *News* for letters from physicians' spouses. A project of the BCMA Alliance, "Spouse to Spouse" welcomes stories about the lives of physicians and their families as seen from a unique viewpoint, that of the person sharing the doctor's life.

Feel free to share feelings and anecdotes about good times and bad: letters will remain anonymous, if so requested.

Please write to Nerma Shergill, Alliance President, c/o BCMA Communications, 115 – 1665 West Broadway, Vancouver BC, V6J 5A4, or fax to (604) 733-7317.▲

Continue the plodding

IT CONTINUES TO BE a bit of a grunt, this confrontation with the NDP government. While headway against our adversaries within the walls of power in Victoria has been slow or non-existent, perhaps a more important battle is being won.

It appears obvious that this government has no interest in solving the disputes in any rational manner, instead choosing to delay resolution by commissioning a series of so-far unproductive studies and "site visits". There seems to be little direct contact with the BCMA at present.

There is some encouragement in the fact that influential people within the media (with some die-hard exceptions) are becoming aware of the real issues. They are starting to accept that the health-care system is in deep trouble, that the Northern and isolated doctors are overly stressed, and that access to timely care is now the exception rather than the rule in British Columbia.

What is more, they are increasingly active in getting our message across to their readers and viewers.

BCMA members must recognize that they are not involved in a blitzkrieg. They are engaged in a slow, plodding form of trench warfare, and this will have to continue before there is a breakthrough or victory.

It is easy to become bored, apathetic, or disillusioned during this type of fight, and often the adversary is counting on this to happen. Defeat by attrition is the saddest kind of loss, and the most difficult to reverse.

Now is certainly not the time to be throwing in towels or waving white flags.▲

DR BOB'S CORNER

The end of an (editorial) era

I do not know whether the very first issue of the BCMA *News* that I edited, in the summer of 1979, was particularly tough or just seemed to be.

Few breaking news stories have surpassed the one that faced me when BC's nominee for the position of CMA President, Dr Bill Jory, was rejected by the CMA General Assembly. I knew little about journalism and less about editing, and was faced with the task of guiding the little newspaper through a particularly turbulent medical-political storm.

My colleagues on the BCMA board at the time all felt I was crazy to accept the nomination to edit the then often-controversial BCMA *News*. I said I would do it for a while; "a while" has been 19 years, and it is time to pass the baton, or the word processor, to someone else.

I find, to my horror, that I have reached the stage where I have started telling stories about "when I was an intern", although I can still remember what happened yesterday (I think). It is also apparent that the BCMA's trials and tribulations on a number of fronts are a recurring phenomenon, and I feel I am experiencing the fifth cycle. "Been there, done that" applies, and my *déjà vu* equipment is snapping synapses.

Being editor of the paper has provided an ideal opportunity to observe the ongoing activities of the BCMA. As a delegate and editor (and for many years both), I have attended more board meetings than anyone else, with the possible exception of Victor Dirnfeld and Murray Kliman.

I have had the privilege of knowing a long list of Presidents and other officers as more than just passing acquaintances, and have enjoyed watching the maturation of these men and women as they progressed through the chairs. The firebrands tend to ease off a bit, while the normally mild-mannered become, sometimes, more strident as the responsibilities of their presidency become a reality.

I am amazed and gratified at the consistent high quality of the Association's leaders through the years. Although they differed widely in style, goals, and method, no President has been a disaster. (Some might question this statement when they recall the polarization between the "Reform" and "Establishment" factions within the BCMA in the late 70s, but even then the leaders were effective. It was their philosophies and methods that caused consternation in the opposing camp).

Some of the consistently good performances of our Presidents has been due to the professional training they receive, particularly in the field of media relations, as they move up the ladder. But their successful terms have been due primarily to dedication and good old-fashioned hard work.

I am saddened by some of the changed relationships that have occurred between the membership and the BCMA. The sense of companionship, the loyalty, and the previous unquestioned obligation to support our professional association has eroded to some extent.

Organized groups of almost every kind have difficulty attracting members in the 90s, and the lifestyle of physicians has changed remarkably in recent years, along with their priorities. When membership is more or less obligatory, as is the case with the BCMA, many of those belonging do little more than pay their dues.

Our Annual Meetings, once eagerly anticipated and well supported, are now attended by what can only be called a minuscule percentage of the membership. A sense of fatalism has overcome many doctors — understandably, perhaps, considering the battering we have taken and our apparent inability to alter what is unfolding. Some, depressed over their vision of the future, have adopted a "take the money and run" attitude, intent on getting their share before it runs out.

There is also a tendency at times to criticize the BCMA and its negotiators for their inability to influence what should be recognized as a stubborn, anti-doctor political entity governed by an unshakable ideology.

The emergence of the societies is a symptom of the discontent. To oversimplify, they exist as a defence mechanism. The premise is that if we are unable to extract more from government, we had better see that members of our society (either one) get as much of the pot as possible, or at least keep the other "side" from getting "too much".

The societies have identified and are involved in many other useful functions, of course. It is important they remember that their primary target should be the government, not the other society or the BCMA.

Compounding all this, of course, is the millstone that the Canada Health Act has become. We are, indeed, both as individuals and as a profession, caught between a calculus and an osteoma.

I have enjoyed researching the "ten years ago" pieces. Floods of memories arise as I peruse the old papers. The passing parade of politicians, physicians, and personalities has been endless and has provided, I am afraid, considerably more amusement than erudition. But that is what parades are supposed to do.

We (the editorial one) have attempted to bring some flavor of the board meetings to readers. Production realities for the *News* are such that truly current information is best reported using the President's Letter or e-mail. The *News*, through my efforts and those of a truly enthusiastic group of columnists, now concentrates on providing background material and analyses of the activities of the many facets of the Association. Members seem to appreciate this approach.

I am very proud of the paper. It has won its share of

Dr Bob continued on p. 25

LETTERS TO THE EDITOR

Personal attack seen as divisive

Dear Editor:

I would like to respond to Dr Rhodes' personal attack on the head of the Department of Family Practice at the Children's and Women's Health Centre of British Columbia ("GPs: Take back the departments", BCMA *News*, March 1998). Dr Rhodes does the profession as a whole and family practice, in particular, no favors when he begins to personally attack individuals within his discipline, and when he presents information that is inaccurate and misleading, to say the least.

Midwifery is a legally established practice with an independent college for licensing within the province of British Columbia. Dr Rhodes fails to recognize that women want this choice.

As health professionals, our collective goal should be to ensure that the health of women during pregnancy and delivery and the health of their newborn infants are maximally protected. It is this commitment that Dr Klein has made and which Children's and Women's Health Centre fully supports. He has done this while strengthening the Department of Family Practice and providing strong leadership to family practice maternity care provincially and nationally.

In contrast, Dr Rhodes' divisive letter lends support to an environment of conflict and tension between health-care providers, which can only have a negative impact on the health of women and children in this province. Midwifery is an important option for the women of this province, and at Children's & Women's we believe in supporting the development of this professional discipline, in ensuring that quality care is provided and in advancing our knowledge and understanding about best practice in maternity care.

The fact that midwives have been perceived to have negotiated a better deal than physicians in providing maternity care, or that physicians have failed to convince the BCMA to value maternity care higher, is irrelevant to the focus on quality practice. Family doctors are, and should be in the future, significant deliverers of maternity care.

Dr Rhodes would do well to focus on supporting the further development of maternity care practices among family practitioners, and encouraging and supporting the recruitment of new family doctors to this field, rather than spending his time writing

Letters continued on p. 28

BCMA *News*, #115-1665 West Broadway, Vancouver BC, V6J 5A4: (604) 736-5551, Fax: (604) 733-7317 • Editor: Dr Bob Young • Managing Editor: Ann Paulsen • Chair, Council on Public Affairs and Communications (CPAC): Dr Brad Fritz • Director, Communications and Public Affairs: David McPhee • Design: Just Your Type Graphics Inc. • Printers: Web Press, Charles Kalnin • Photography: Tom Burley Photography, Tom Burley • Advertising: Advertising in Print, Ian Jamieson, (604) 681-1811. ▲

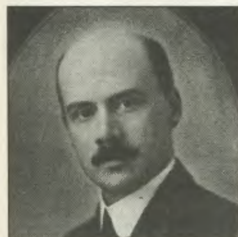
ARCHIVES

Growing pains in the 20s

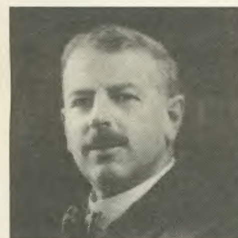
by Dr C E McDonnell
Chair, Archives Committee

Three BCMA Presidents who influenced the Association's development

Dr R E Walker, President in 1902 and again in 1922



Dr J H MacDermot, who served in 1916-17



Dr C H Vrooman, President in 1935-36

The rebirth of the BCMA in 1921 was a bold move by a few visionaries from the local medical associations. The Vancouver Medical Association led the way, with support from Victoria, New Westminster, Nanaimo, and later from Interior associations. As a result, the young provincial association drew heavily on local societies for members. The increased demands on time and the added financial load caused a high delinquency in fee payments, which led to a cash flow problem in the BCMA.

Between 1921 and 1932 the BCMA gradually took over liaison with government, the CMA, and BC's rural practitioners. Relationships with the CMA improved after 1923, with a gradual increase in communications, handled by the members of the executive.

Standing committees were appointed annually to handle current responsibilities in key areas.

The Industrial Services and Health Insurance Committee was kept busy dealing with lodge contracts and medical contracts with large companies, the major controversy being over the care of families of the plan members.

The VMA had already been in negotiation with the major railways, who proved resistant to the idea that provision of dependant medical and surgical care should be open to non-contract physicians. Negotiations were turned over to the BCMA in 1921, and an early settlement was reached with the CNR. The CPR, however, remained resistant. It took several uncomfortable years, often marred by internal disagreement — the surgeons were particularly recalcitrant — before the final settlement favored the BCMA.

The committee also took over the Workman's Compensation Board negotiations from the VMA and continued refining the WCB Act to the point where it became a benchmark for many later contract agreements. One particularly protracted negotiation involved the loggers, who criticized the excessive length of hospital stays and the inadequate completion of forms. The loggers threatened to have their own physicians, but settlement was reached in 1925.

The Education and Publicity Committee's activities varied, but its overall goals were to educate the public and to help busy practitioners keep up to date. Public education was achieved through information pamphlets, newspaper articles, and later in the decade by radio broadcasts.

Physician education was addressed through the VMA summer school and through a postgraduate lecture series given by teams of BCMA and CMA physicians who visited rural centres.

Dr A S Munroe chaired the Historical Committee for most of the decade. This committee accumulated historical and geographical material, thanks to a core of interested physicians scattered over the province. The result of their work appeared in the *Canadian Medical Association Journal* in 1932, under Dr Munroe's name.

The Constitution and Credentials Committee, in addition to processing new members, was responsible for reviewing the constitution. This committee played a great part in the negotiations to amalgamate the BCMA and VMA, as both constitutions required alteration.

The committee was asked to examine the "Alberta scheme" (in 1932 the Alberta Medical Association had successfully amalgamated with the Alberta College of Physicians and Surgeons), and it came back with a strong recommendation that the BCMA follow a similar path with the BC College. Upon completion of negotiations in 1933, the BCMA was left in control of educational and scientific matters, while the remaining functions were turned over to the College.

The Cancer Committee was formed in response to a rising awareness of the prevalence of the disease and the realization that BC was behind all other provinces and many US states in terms of reporting, record-keeping, and treatment services. This committee worked in conjunction with a previously formed VMA committee to encourage the founding of a provincial cancer clinic, compulsory physician reporting, and the inclusion of cancer care in any upcoming health insurance bills. Cancer became reportable in 1931, followed by the development of the cancer institute in 1935 and the cancer clinic in 1939.

No commentary on the BCMA in the 20s would be complete without a mention of Mr C J Fletcher, who was appointed executive secretary of the Association in 1921 at a monthly salary of $250 and travelling expenses, plus a $1 bonus for each new member recruited. He quickly became a travelling organizer for the seven provincial districts, a public relations officer, a negotiator, and the drive behind recruitment. His office in Vancouver also coordinated locum arrangements for most of the rural physicians across the province.

Membership grew from 85 to 450 in five years, and more than one committee chair voiced appreciation for Fletcher's efforts on their behalf. During a prolonged illness in 1928 he was sorely missed but not replaced; on his return in 1929, his salary was reduced by $50 per month; both situations probably reflected the organization's financial state.

The era saw some powerful leaders who laid the groundwork for the organization and who contributed unselfishly to the BCMA during those formative years. Three outstanding Presidents of earlier times are shown in the accompanying photographs. ▲

WOMEN IN MEDICINE

Physician, heal thyself

by Dr Shelley Ross
Chair, Committee on Female Physicians' Participation in the BCMA

In this day and age of health-care reform, regionalization, and claw-backs, to name but a few stresses, the well-being of the doctor is in jeopardy. Doctors have been living their jobs for so long that they forget they have personal worth beyond that of being a doctor.

Female physicians often feel guilty for not working the hours of their male counterparts. They label themselves as working part-time, which means they see fewer patients, but still put in what a normal working person would consider full-time work. Women in specialties are often unable to structure their practices to allow enough leisure time in addition to professional and social demands.

The external stress of health-care reform, with its political and economic uncertainty, is adding to the occupational stress of increasing workload and on-call responsibilities. A relatively recent stress in the last few years has been the inability to change career direction, both in specialty and geographic location.

Unfortunately, these stress factors are not going to disappear. Physicians must take some responsibility for their own well-being by identifying the sources of the stress and doing something about them. There are opportunities to attend stress-management courses, but physicians naturally scoff at the idea that they would need training in such simple matters. Yet coping strategies in times of stress are helpful professional skills.

Having a personal family physician to ensure comprehensive medical care is so basic as to be often overlooked by the practising physician. Physicians tend to drag their feet when dealing with their own physical problems, rationalizing that the problems are of limited importance and certainly not worth bothering a real doctor with such trivia. When the illness falls into the psychosocial field, a strong wall of denial is quickly thrown up.

As a specialist, you ask what a family physician could possibly tell you. The family physician's office provides a place where you do not have to be in charge, where you can safely ask questions out of your area of expertise without fear of humiliation, and where another physician can take responsibility for your care when you are just too sick to be calling the shots.

As a family physician, you ask what another family physician could do that you cannot do. It is reassuring to have a physician with similar knowledge, who can be an advocate for your health care.

Beyond needing a family physician, a doctor needs a colleague who can act as a mentor to shed some light on situations when stress is mounting.

Despite a lack of free time and disgust with the political situation of the times, physicians need to keep involved in a wider sphere than just their own offices. Committee work ensures input into the working of hospitals or political organizations. Sitting in the coffee room and complaining offers no due process for achieving change.

Should stress finally become overwhelming despite various coping mechanisms, seeking help will not result in negative consequences that could be detrimental to a professional career. Who would want to seek psychiatric consultation if it would affect one's ability to obtain insurance,

heal thyself continued on p. 21

BCMA'S 1998 ANNUAL MEETING, VICTORIA

AGM continued from p. 1

Reduced Activity Days (RADs) have been chosen for the next few months — generally the last two business days of each month, with as much warning as possible. Doctors with fixed booking days are asked to swap or share procedure days with colleagues to even the load. It was remarked in passing that "government decrees and lies" are inflaming the membership.

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Dr Mike Lawrence reviewed a draft research paper on managed care, to be released in a few months. It is a companion work to earlier papers on capitation and rostering.

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Our new Medical Services Commission commissioners were selected after considerable careful debate. The *News* will leave the release of their names to the President.

The board also voted to reduce BCMA dues for student members to $5, perhaps as a bit of a peace offering. It is hoped that MD Management might see its way clear to pay CMA dues (currently $12, we understand) for students.

Kris Wiebe, the Medical Undergraduate Society member on the board, stated he had a much better understanding of how the BCMA worked following his three-day experience as a delegate. He implied that the animosity against the BCMA by students was diminishing or gone.

❖ ❖ ❖

Some progress has been made by Dr Gur Singh's group, which is reviewing board structure. A number of models have been examined, and a retreat in July is slated to help advance the project. It is a long-term one that needs to be done carefully, according to Dr Singh.

More urgent is assessing the need for software upgrading, or worse, hardware change in office computers to look after the Y2K problem. Apparently, modifications will be required to allow continued access to Teleplan.

❖ ❖ ❖

Among short items was a resolution passed at the urging of Dr Brian Dixon-Warren that the Association request that BCIT not provide courses leading to qualification in naturopathy, chiropractic, and acupuncture.

Ms Nerma Shergill, president of the BCMA Alliance, announced that the group's video, *Safety and the Health-Care Professional*, is now complete and available through the BCMA's Communications Department at a cost of $30.

The video runs for 22 minutes; CPAC classed it as excellent and recommended it as a "must see" for everyone who has contact with patients. It teaches what to do when violence is threatened or occurs in a medical setting. (See page 22 for information about ordering the video.)

❖ ❖ ❖

Dr Jim Lane, wearing his contract management hat, once again pointed out that government programs are driving utilization. He asked that physicians let the BCMA know of any new programs, which are a drain on the Available Amount.

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A full agenda forced the extension of the Thursday board meeting into Friday, and even then some business was delayed until the first meeting of the 1998–99 board on Sunday. At the latter meeting, new President Dr Jim Lane outlined his interpretation of things that will need attention, dividing them into tasks for the board, issues and potential actions, and his own leadership plans.

Distribution of an important document outlining the responsibilities of directors (board delegates) is a feature of the first meeting of each new board. Also, committee chairs and other positions are filled at this meeting.

Dr Graham White was elected to complete his three-year term as chair of the board, with Dr. Shelley Ross as vice chair. While chairs of most committees remain the same, there were some changes.

Dr Dara Behroozi will replace Dr Bob Young as BCMA *News* editor. Dr Lynn Doyle is the new Contract Management Committee chair, replacing Dr Jim Lane, while Dr Brad Fritz inherits the Council on Communications and Public Affairs from new president-elect Dr Dan MacCarthy. The Membership Committee is now in the hands of Dr Jack Burak, who replaces Dr David Gray, while Dr Ailve McNestry takes over the Pharmacy and Therapeutics Committee from Dr Brian O'Flan-nagan. Dr Hymie Fox is the SGP appointee to the Review Committee, replacing new honorary secretary-treasurer Dr Heidi Oetter.

Long-serving chair of the Tariff Committee, Dr Drew Young, relinquished his position to Dr Brian Winsby. Negotiating was assumed by Dr Ian Waters as Dr Ernie Wigmore goes on to assume other responsibilities within the Association after many years as chair.

Members will likely be pleased to hear that some committees were disbanded, their work done or their need gone. Four (of 16) were erased from the list this year. ▲

Each year, the Board of Directors bestows a prestigious award to the delegate whose vocal cords have exhibited the most stamina. This year's winner was Dr Norman Wale, here presented with the coveted $E=MC^2$ t-shirt by Dr Graham White, outgoing board chair.

"The doctors of BC have been, are, and will remain united."

Ethics continued from p. 1

Are we going to submit the provisions in their will to the same kind of scrutiny?" If not, then we need to seriously reconsider.

Which isn't to say that there cannot or should not be some curtailment, constraining, or boundaries put around an elderly person's freedom at times. If that person's autonomy depends entirely on someone else, a daughter, for instance, whose own life is in tatters because of the pressure of keeping her parents' home intact, it's reasonable to intervene.

Incompetence is a real issue at times, and a person can be a danger to the community. But a home isn't necessarily a permanent solution. Someone who refuses any constraint may well have a change of mind once presented with an alternative.

We live at a time of technological possibilities. Timers, electronic warnings, and other innovative add-ons make it possible for an elderly person to stay safe and independent.

The key, said Dr Gillett, is a "negotiated solution". Unlike the "heavy-handed" solution, imposed rather than discussed, the negotiated solution is messier and lengthier, but it does take into consideration varying points of view. It's one everyone can live with.

"You need to realize that this person has lived on this planet a long time," he said. "They have a lot of wisdom and experience." Sometimes, the old brain is so full that it takes in new information slowly and with difficulty. But if we can contain our impatience, coherence and sense do often exist.

Dr Gillett referred to a study of Alzheimer's patients, where their conversation was taped and then played back at a higher speed. It sounded as rational as anyone else's talk—just slower. But we don't let them talk. We interrupt, finish their sentences. We need to listen.

Cross-cultural problems also require listening. Often, these issues are so shrouded in post-colonial guilt that they, too, become generalizations. While it is true that many indigenous cultures do assign "seniority" to the elderly, Dr Gillett said, "Within every culture there are independently-minded individuals who quite resent the thought that the negotiated solution has passed them by."

Preliminary research by an ethics student at UBC noted that when Chinese people in BC were asked what they thought other Chinese people would want, they all said family involvement was key. Yet when asked what they themselves would want, every single one said they'd like their medical decisions to be a private matter between them and their doctor.

"A reasonably sensitive person can usually determine, in conversation, where that individual person stands and what kind of balance should be struck between individual self-determination and the role of the family," said Dr Gillett, though this may not always be the balance that the family wants. But, he added, "I do think we have a very delicate job of getting to know the person and their cultural situation, finding out what images and myths and metaphors and understandings of the elderly exist in [each] situation."

Advance directives, particularly when issued at a time when the person is well, can be useful, but, stressed Dr Gillett, they must not focus on procedures but on outcomes. Requests for or against treatment should be clear on degree of functionality, not some blind misunderstanding of what constitutes "heroic measures" (e.g., "no CPR").

Many older people understandably fear an undignified death in a large hospital, hooked up to machines. But high-tech surgery can sometimes add years of high-quality life to an aging person's life.

"For a psychiatrist, depression is one of the underdiagnosed diseases of the elderly," said Dr Gillett. "To a neurosurgeon it's cervical spondylosis, which is only too often dismissed as 'just' arthritis." Meningiomas, though rare, do happen in the elderly and can cause helplessness, incontinence, dementia. But CT scans are rarely ordered for the elderly.

High tech is not the issue, said Dr Gillett. Neither is physiology. "Reversing a physiological change, restoring a sodium level to normal, restoring regular heartbeat, has nothing to do with the condition of the patient."

Physiological benefit is not the point. Ethically, clinically, the patient should be the standard. ▲

Susan Baxter is a Vancouver writer who specializes in topics related to health care and medicine.

Dr Granger Avery delivered this address in Victoria, as he looked back at his year as President.

Change in the air — a President's year in retrospect

I came across a piece of folk wisdom in the Rose and Thorn — "Slaves will only remain so while they let themselves be slaves." Obvious, trite, profound, but true.

So it is, of course, with us. And sometimes, in our quest for the truth, we forget the obvious, the trite, and the profound.

But we must never forget that we, as a profession, as an Association, have the power to change our system in a way that ultimately benefits our patients.

Governments come and governments go. Ideologies come and go. Rules come and go. We do not. We will always be here.

Our patients respect and trust us. They believe what we say because of the understanding and skill we use constantly, the sapiential authority we use judiciously, the hard work, commitment, and caring we use inevitably, and because of our respect for our patients and our constant quest for what is right and best for each individual in our care.

We cannot shirk the responsibility that that respect and trust place upon our shoulders: the responsibility to make accurate, ethical decisions when dealing with patients in a system that is inadequate, sometimes dangerously so; to apportion our actions properly between those directed at the individual and those directed at the system; to take unaccustomed and troublesome decisions about political action when logic and reasoned argument do not prevail.

We have had to deal with an ideological, intransigent government and duplicitous bureaucrats — this has not been easy for us. The public, however, has not been slow to grasp the issues.

Sixty per cent of the public believe the quality of health care in BC has deteriorated in the last five years, and 75 per cent of those polled stated more funding is needed for health care. The priorities of this government do not reflect the priorities of the people of BC.

> **Doctors have relearned something: that if we are right, and if we stick together, we can change the system.**

Instead, the NDP have, we estimate, spent over $1 million of our tax monies on misleading advertising — money that should have gone into providing better medical care for the people of BC.

This must stop. We will not stop until it does.

What did we not achieve this year?

We failed to obtain a satisfactory settlement of the Available Amount. By behaving like gentlemen and ladies, presenting the facts honestly and completely, we left ourselves open to the grubby tactics of the street, of fear-mongering, rhetoric and hyperbole. The MSC decision in January was a major disappointment, and, truth-oriented as we are, an unexpected one.

This is now being addressed through arbitration and through political action, and there is a better-than-average chance that we will be successful.

We did not achieve as much as I had hoped in the disparity resolution process. However, the work is ongoing, and it may not be unreasonable to watch and see how others tackle this difficult problem.

What have we achieved?

A satisfactory WCB agreement — not ideal, but certainly satisfactory, and regarded with envy from outside our borders.

A resounding defeat of a bad regionalization mistake on the North Shore, with the dismissal of not only the CEO but also the board. Physicians led that fight, and everyone else followed. Doctors were the only ones in the community independent and strong enough to take on, and beat, the governance structure.

A model set of bylaws that, for the first time, balances the well-known responsibilities of physicians to the regions and hospitals, with those institutions' responsibilities to physicians.

A belated infusion of funds into cardiac surgery, following the unrelenting work of the cardiologists and the cardiac surgeons and the huge publicity following the release of the BCMA waiting list survey.

The Reduced Activity Days, although forced upon us and in no way welcomed by us, have turned out to be a very effective tool in raising public awareness, and they are even being enjoyed by physicians as legitimate, unpaid days off.

Your board has been unanimous. The boards of the SGP and the SSPS have been unanimous, and the profession itself has shown unprecedented unity and solidarity.

Finally, and most hard won, we have turned the government around 180 degrees with the payment of an on-call stipend for rural physicians. The doctors of the Northern and Rural Doctors' Group and elsewhere have completely changed government's oft-declared position of "not one red cent" of new money, and of no money at all to incumbent doctors.

This has been a huge win for the profession, and a tribute to the perseverance of those physicians who took the difficult actions. They deserve our heartfelt thanks.

We have achieved something else, something I think is even more valuable than these tangible benefits.

There is a change in the air in BC and indeed, right across Canada. Doctors have relearned something: that if we are right, and if we stick together, we can change the system. For each of these hard-won achievements, we have had to put aside our differences and work together to achieve a more important goal.

Along with this, I have seen a new sense of purpose and determination sweep through our profession. Gone is the depression, the anger, the feelings of hopelessness and helplessness that used to beset many of us. In their place is not only the knowledge that we can change the system, but the sense that we will change it, and that we will change it now.

In BC we have lit the match, and the fire of determination has swept right across the country.

This has been so rewarding for me, notwithstanding the hours and days away from home, to see physicians retake control of their lives, and to fight for our patients' welfare. To visit a hospital staff and to watch the determination spread through the faces of our colleagues has been a huge reward. It is a time when I am proud to be a physician and to be a part of the BCMA.

I thank you for this opportunity. It has truly been a pleasure and an honor to serve as your President. ▲

> **In BC we have lit the match, and the fire of determination has swept right across the country.**

Dr Michael Ross, a Victoria otolaryngologist, sends along a photo of his contribution to RADs. His office suite faces a main road into town, and this ensures considerable exposure for the sign. Although recognizing that it is too late now, Dr Ross would prefer the acronym BAD (for Budget Adjustment Day), rather than the one chosen by the BCMA.

Nigel Walton

An Alice in Wonderland experience, captured for posterity at Friday's Fun Night.

Oh, woe on us!

RADs are not to be taken lightly. This point was made in crushing fashion when, by executive decree, one of the more popular pastimes at the BCMA's Annual Meeting was cancelled.

Now everyone knows that, next to studying the *Canadian Medical Association Journal*, golf is a doctor's favorite diversion. The media and cartoonists have promulgated this not entirely mythical truism for decades.

It would therefore be most unseemly to have the media find out that doctors were out playing golf on June 12, a Reduced Activity Day. Even the fact that it was the 40th annual BCMA Golf Classic and part of the AGM would not constitute a sufficient excuse.

Although tee times were in place and prizes ready, the tournament was not to be. Challenges were left unanswered, bets were unmade and uncollected, and docs disappointed.

Better all this, however, than having to face ridicule by a gleeful press. RNY ▲

Nigel Walton

Fun Night magician reveals to Dr Jim Lane the solution to the underfunding problem.

They should stop doing this

There is nothing like the possibility of winning a prize to help entice people to attend the Annual General Meeting, or portions of it. The BCMA has used this tactic on several occasions in recent years. The lottery gods have been unkind to the membership of late, but have smiled on the inner circle.

Two years ago, Dr John Pawlovich won a holiday at a fishing lodge when his ticket was chosen at the AGM fun night. At this year's Council on Health Promotion breakfast meeting, he again won the major prize, a stay at The Hills Health Ranch in the Cariboo. Pawlovich is the hard-working chair of the BCMA Convention Subcommittee.

The second prize went to Dr Brad Fritz, who won a weekend at the Ocean Pointe Resort Hotel in Victoria. Brad at the time was a member of the Council on Public Affairs and Communications, the parent committee of the Convention Subcommittee. Fritz was elected chair of CPAC at the first meeting of the new board.

These were all ticket draws, conducted in a fair and unbiased manner. Maybe next year an "ordinary member" will win. RNY ▲

Drs John Pawlovich and Brad Fritz, lucky winners of resort weekends for two.

Diane Quesnel, Council on Health Promotion Assistant, provides no-smoking information at this year's New Music West 98 festival. The COHP Tobacco and Illness Committee and the BC Doctors' Stop-Smoking Program participated in the event.

Retiring 1997-98 board members line up to receive copies of the BCMA's coat of arms (from left): Drs Graham White, Granger Avery (who will stay on the board as past president), Jim Rhodes, Lynette Thurber, Bob Young, Nigel Walton, Derryck Smith, and Dara Behroozi.

Awards presented

The BCMA's annual awards ceremonies were held in the theatre of the Victoria Conference Centre on June 13, 1998

The David M Bachop Silver Medal was awarded to Dr Julian Fung, while the David M Bachop Gold Medal went to Dr G Scott Wallace. Both awards were presented by Mrs David Bachop.

Dr Arun Garg presented the C J Coady Award to Dr Thomas F Godwin.

Four doctors chose to receive their CMA Senior Memberships in Victoria rather than at the CMA meeting in Whitehorse. CMA President Dr Victor Dirnfeld presented the citations and pins to Drs Gurdev S Gill, Robert S Purkis, John R Scarfo, and Robert N Young. The new senior members were introduced by Dr Leo-Paul Landry, Secretary General of the CMA.

Two BCMA Silver Medals of Service were awarded this year, to Drs Angus I Rae and Ann J Worth. Dr Granger Avery presented the awards following introductions of the candidates by Dr Mark Schonfeld.

Dr Dirnfeld installed the elected officers of the BCMA. They are:
Dr Jim Lane, President;
Dr Dan MacCarthy, President Elect;
Dr Marshall Dahl, Chair, General Assembly; and
Dr Heidi Oetter, Honorary Secretary-Treasurer. ▲

Thanks go to Annual Meeting sponsors

Many groups recognize the benefits of being present at the BCMA's Annual Meeting and providing information to those attending.

The BCMA extends its appreciation to the following organizations, whose generosity and participation added to the success of this year's meeting.

Bank of Nova Scotia
BC Biomedical Laboratories Ltd
Canada Life Assurance Company
Grant Thornton (Doane Raymonnd)
Glaxo Wellcome
Hoechst Marion Roussel
Hoffmann-La Roche (Canada) Ltd
Insurance Corporation of BC
J M Schneider Inc and Yoplait
John Ross Insurance Service Ltd
MD Management Ltd
MDS Metro
Merck Frosst Canada Inc
Mills Printing & Stationery Co Ltd
ProGroup Sales and Leasing Inc
Sea Courses Inc
Workers' Compensation Board of BC ▲

Drs Derryck Smith, Christine Loock, and Fred Bass discussing the resolutions passed at the Council on Health Promotion breakfast meeting.

New drivers to learn in stages

On August 1, 1998, ICBC will begin implementing a graduated licensing program that will greatly change the way new drivers qualify for driving privileges.

The program is a cornerstone of BC's Drive to Save Lives, a comprehensive plan designed to reduce fatalities and injuries on the road and thus help keep auto insurance rates affordable.

Regardless of age, new drivers are almost twice as likely to be involved in a crash as experienced drivers. One in five new drivers will be involved in a crash during the first two years on the road. The common factor in these statistics is inexperience: many new drivers simply don't have the skills or experience they need to drive safely.

A complex task, driving requires a wide range of skills and a particular kind of behavior to be performed safely. Graduated licensing allows novices to expand their driving privileges as they gain experience, master the necessary skills, and develop the attitudes and behavior needed to be safe drivers.

Staged learning

As in the past, new drivers will have to be at least 16 before obtaining a learner's licence. Drivers in the learning stage must: be accompanied by a fully licensed adult; not carry more than one passenger in the vehicle in addition to the supervising adult; not drive between midnight and 5 a.m.

New motorcyclists must: practise in sight of a qualified supervisor until they pass a motorcycle skills test, which cannot be taken for at least 30 days after obtaining a learner's permit; not carry passengers; ride only during daylight hours; not go over 60 km/hr or travel on freeways.

After holding a learner's licence for six months, new drivers will be eligible to take a level-one road test. If they complete an approved driver-training course (see below) and log a minimum of 30 hours' practice-driving time, new drivers may cut this waiting period by three months. New drivers who don't take an approved driver-training course will also be encouraged to complete 30 hours of practice.

After passing a level-one road test, new drivers will graduate to the intermediate stage, which will last a minimum of 18 months. At this point they will be allowed to drive on their own and carry more than one passenger, but they must still display a "new driver" sign and refrain from drinking any alcohol before driving. Drivers in the intermediate stage will not be allowed to obtain a commercial driving licence.

Drivers in both the learning and intermediate stages must: not drive after drinking any amount of alcohol; display an easily visible "new driver" sign, alerting other drivers to be more patient and make allowances for the novice driver; not apply for a licence to drive a taxi, truck, ambulance, or other commercial vehicle until they have earned a full-privilege driver's licence.

Targeted education

Critics have suggested that driver training needs to focus more sharply on the specific skills and attitudes, such as self-awareness, that are known to shape risk-taking behavior. BC's first approved driver education curriculum does exactly that.

Developed jointly by ICBC and the driver-training industry, the new curriculum includes both theory and practice. Because new drivers will attend training courses during the learning stage of the new graduated licensing program, the curriculum specifically emphasizes the skills and attitudes novices require to safely progress to the intermediate stage.

Under the graduated licensing program, ICBC will approve driver-training schools that base their courses on the curriculum.

Enforcement

Police will enforce the rules established under the new graduated licensing program in the same way they enforce other driving laws. Both the "new driver" sign and information on driver's licences will identify new drivers.

Violation of a graduated licensing condition can result in a $75 fine and three penalty points. New drivers who accumulate more than three penalty points for any reason may be prohibited from driving by the Superintendent of Motor Vehicles. The time during which they are suspended will not count toward mandatory time in either phase of the graduated licensing program.

New drivers who violate the zero-blood-alcohol condition can receive an immediate 12-hour roadside suspension or 24-hour driving prohibition. They may also be prohibited from driving for one month for a first violation and for a year for any subsequent violations.

The Insurance Corporation of BC provided this article for the BCMA News. ▲

ICBC urges all drivers to maintain "Road Sense".

BENEFITS BEAT

Updates on BCMA benefits

Contributory professional retirement savings plan

The 1998 notices of entitlement will be mailed out to all eligible physicians in late July 1998, along with an application form and instructions on how to claim. Physicians wishing to receive their first installment (up to 50 per cent of the entitlement amount) must submit a fully completed application form plus proof of a matching contribution by October 16, 1998. Completed applications received after this date will receive payment in January 1998. The BCMA deadline for ensuring that claims will be paid prior to Revenue Canada's 1998 tax-year deadline is January 22, 1999.

Moving?

Please notify Toni Malecki in the Membership/Benefits Department at 736-5551 local 220, or by e-mail at tmalecki@bcma.bc.ca, of any changes in your address or contact information. Please let us know if you would like your mail sent to your home or business, if your new address is on Medi Tran, and if your telephone and fax numbers have changed. Medi Tran provides overnight courier services to medical offices and hospitals in the Lower Mainland and two-day service from the BCMA to addresses on Vancouver Island. To subscribe to this service, please contact Medi Tran directly at (604) 872-5293.

Continuing Medical Education Fund and Computer Hardware Allowance

Physicians who have purchased computers after June 1, 1996, can be reimbursed up to $1,000 every three years for computer hardware. Payment for computer hardware is contingent upon proof of purchase or use of software relevant to CME. Examples of CME software include medical CD-ROMS, journals, or Internet access.

To demonstrate that the computer is used for CME purposes, an Internet user must provide a copy of a medical article, taken from a Web site, that is relevant to the physician's area of practice. User fees associated with on-line access to a medical information system will be reimbursed up to an annual maximum of $150. Word processors, database managers, and other office-related software are not considered CME software and therefore will not be covered.

Medical Office Benefit Program

The BCMA Insurance Department has successfully completed the 1998 open enrollment for the Medical Office Benefit Program. During the enrollment period, 62 new offices enlisted into the program effective May 1, 1998. The Medical Office Benefit Program currently has 1,205 participating medical offices, with a total of 2,745 insured members. ▲

BCMA e-mail addresses

BCMA members can now communicate directly via e-mail with the following departments in the Association offices:

benefits@bcma.bc.ca
Information about membership, members' insurance programs, Physicians' Disability Insurance (PDI), CMPA and CME rebate programs, and the Contributory Professional Retirement Savings Plan (CPRSP)

communications@bcma.bc.ca
Questions concerning communications programs, media and public relations matters, brochure and publications requests, Club MD, Local Action Committee network, annual meeting

journal@bcma.bc.ca
Questions and correspondence concerning the *BC Medical Journal*

postmaster@bcma.bc.ca
Notification of e-mail addresses, new and changed; technical inquiries about online communication

president@bcma.bc.ca
All correspondence to the BCMA President

postoffice@bcma.bc.ca
All other questions, comments, and correspondence ▲

BCMA/ICBC LIAISON

New rates for ICBC forms

by Dr Michael Golbey
Chair, BCMA/ICBC Liaison Committee

Your Board of Directors accepted the Tariff Committee recommendation that fees for non-insured and A-lettered items be increased by 1.7 per cent effective April 1, 1998. As a result, ICBC has agreed to the new rates for common ICBC requested forms as follows:

A00098	ICBC consultation with ICBC adjustor or personnel, meeting or telephone call, per 15 minutes or portion thereof	$46.30
A00169	ICBC CL 19a	$68.10
A00029	ICBC CL 19b	$68.10

ICBC adjustors rely heavily on the information provided to them by physicians in their CL 19 reports to determine the benefits (if any) payable to patients injured in motor vehicle accidents. Please complete these forms as fully as possible so that your patient is not needlessly denied benefits.

ICBC has a committee — which includes physicians — looking at "alternative" therapies. A number of therapies performed by physicians and allied health professionals could be considered controversial. At present, ICBC will usually pay for such therapies if recommended by a physician. This committee is attempting to validate the scientific basis and efficacy of these treatment modalities.

ICBC is planning to contact physicians, for various reasons, in the upcoming months. Physicians will be surveyed regarding their readership of and comments on ICBC's *Recovery* magazine. Another program would ask physicians who have referred patients to ICBC's recovery management program for their input on the program's effectiveness, to determine if changes or modifications are required.

ICBC will also be contacting a number of medical specialists who may be interested in performing independent medical examinations, to produce an updated list of such specialists and their particular areas of expertise.

ICBC states they have always offered to pay for time spent by physicians, and, for example, will pay the BCMA rate of $46.30 per 15 minutes for those physicians interviewed about the recovery management program.

Physicians in private offices are generally coding visits as MVAs appropriately. However, there is some concern that within emergency departments, hospitals, and diagnostic facilities this is not being done as rigorously. Remember, every dollar billed inappropriately to MSP rather than ICBC comes out of every physician's pocket.

Please send your questions or comments about ICBC-related issues to Dr M Golbey c/o the BCMA, or e-mail: mgolbey@okanagan.net. ▲

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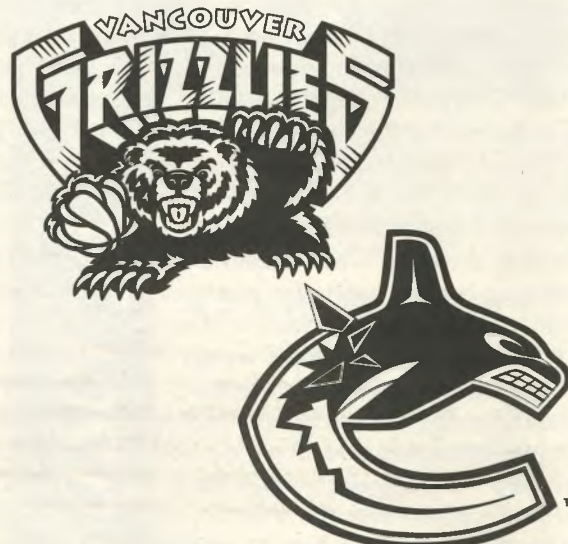


11-Game Paks starting @ $132
For info, call 899 – SHOW

MEDICINE AND THE LAW

Extra billing under the Medicare Protection Act

by Ron A Skolrood

With relatively little public fanfare, the BC legislature in July of 1997 passed certain amendments to the Medicare Protection Act, tightening up the prohibitions against extra billing. The original ban on extra billing was included in the sweeping amendments to the act that came into force in September, 1995. As part of those amendments, the name of the act was changed from the Medical and Health Care Services Act to its somewhat obvious and hackneyed current name, the Medicare Protection Act.

With respect to direct or extra billing, the new provisions operated differently, depending upon a physician's particular status:

- Opted-in physicians under the MSP were precluded from direct billing, except for charges expressly approved by the Medical Services Commission for things such as therapeutic devices and material upgrades.
- Opted-out physicians were permitted to direct bill patients but were prohibited from charging any amount in excess of the applicable amount under the payment schedule.
- Physicians who actually de-enrolled from the MSP (or who had their enrolment cancelled) could similarly bill patients directly, but only for the payment schedule amount unless they

practised outside of a public hospital or continuing-care facility.

Given the relatively small number of opted-out or de-enrolled physicians, the primary impact of the new provisions was felt by opted-in physicians who were practising, or considering practising, in a private facility in which additional facility fees were levied directly against patients. Indeed, when the Ministry of Health announced the changes, the point was expressly made that such facility fees were no longer permitted. In introducing these measures, the government made no secret of its political objective of clearly establishing itself as the "defender of medicare" and a fierce opponent of any form of private or two-tiered medicine.

Notwithstanding the government's position, certain aspects of the original amendments to the act might have led one to believe that the government was more interested in reaping the political benefits of its public stance than in actually stamping out the practice of extra billing.

For example, while it was in theory the responsibility of the Medical Services Commission to enforce the prohibition, the commission was given no real tools to do so. In fact, the primary enforcement mechanism under the new act was to put matters in the hands of the patients who may be subject to prohibited extra charges. Under the new provisions, any such charges were deemed to be a debt owing to the patient, to be collected through court proceedings. So while the act prohibited extra billing, it was really left to the patients to enforce it.

Secondly, the new provisions did not really address situations in which the private facility rendered the extra charge rather than the physician providing the service, or where someone other than the actual patient paid the charge. Again, the various loopholes in the act certainly raised questions as to the actual level of government commitment to eliminate extra billing.

The July 1997 amendments to the act perhaps answer this question, or at least signal a renewed interest in the matter. One amendment beefs up the enforcement mechanisms available to the commission in the event a physician violates the extra billing prohibition.

Previously, the commission's only real recourse was to institute de-enrolment proceedings against the physician, which involved a lengthy, expensive, and ultimately very harsh process.

Under the new provisions (found in Section 15(2)), the commission may order that a physician who has contravened the act be paid at a reduced rate for a specified period. This more flexible enforcement tool may make it easier for the commission to take action.

The second key amendment (found in a new Section 20.1) prohibits extra charges from being levied against third parties who request services on behalf of the patient. This is essentially designed to preclude the "rich uncle" scenario whereby a relative or other third party would request the

Extra billing continued on p. 21

FLASHBACK

On this day, busloads and carloads of doctors wended their way to Victoria to a stimulating study session in the conference centre. Then, like true union members, they marched to the legislative building lawn in their lab coats, with a few singing "Solidarity Forever" along the way.

The second photograph shows the late Dr John Anderson addressing a media scrum on the steps of the legislature, explaining the doctors' disillusionment and disappointment with, if we remember correctly, yet another unsatisfactory negotiated settlement.

The sign on the lectern says "Binding Arbitration is the Solution". John Anderson was BCMA President in 1989-90; we think the MDs' march occurred in the spring of 1990.

RNY ▲

10 years (or so) ago

The summer of 1988 was a time of political turmoil. The Socred government had lost a by-election in Boundary-Similkameen to Bill Barlee of the NDP. Brian Smith and Grace McCarthy had resigned their posts in cabinet.

Government had cancelled our Master Agreement, and there was concern Victoria would be too busy or too distracted to craft a new one with the BCMA any time soon.

The *News* was promoting the Annual Meeting, to be held at the Pan Pacific. Dr Laslo Tabar of the University of Upsalla was to be the Terry Fox Speaker. (Question: What became of that lectureship?) Dr David Blair would be the new BCMA President.

Negotiating compensation for physicians to cover the costs of computerization was finally under way, and 800 people were attracted to a "Computers in the Medical Office" exhibit at the Robson Square Media Centre. It was estimated that 30 per cent of practitioners were using electronic billing.

There was concern over the accuracy of the BCMA's list of non-members. It contained many elderly and long-retired physicians, people who had retired to BC from elsewhere, and others whose numbers artificially reduced the percentage of BC physicians who were members.

Dr Hedy Fry was the new president of the Vancouver Medical Association, replacing Dr Francis Ho.

The BCMA announced that sexual discrimination in its publications would be a thing of the past, with the adoption of politically correct language. A style guide was being developed with this in mind. The increasingly active BCMA Auxiliary (now the Alliance) had co-sponsored (with UNICEF) a successful costume ball at the Four Seasons Hotel. The theme was "Brother, Can You Spare a Dime?", with 1930s era costumes mandatory.

The Association's "Top Gear" bicycle helmet promotion posters had been unveiled — part of a campaign to make helmet use mandatory. The *News* quoted *Hansard,* which recorded Minister of Health Peter Dueck's approval of the campaign in the legislature. The initial poster received considerable positive media coverage.

Dr David Smith, chair of the Emergency Medical Services Committee, and Dr Kathleen Carter, chair of the Mental Retardation Committee (both of the Council on Health Promotion) provided the board with progress reports on their committees' activities.

THE LEADING EDGE

THE COUNCIL ON HEALTH PROMOTION

What makes a quack?

by Dr David F Smith
Chair, Council on Health Promotion

Medical quackery and alternative medicine — can the difference be found?

The term "quack" has traditionally been defined as a fraudulent or ignorant pretender to medical skill. It's not a slang term but a recognized word.

A quack is a person who pretends, professionally or publicly, to skill, knowledge, or qualifications that he (or she) does not possess — a charlatan. Quack medicine, in turn, is presenting oneself falsely as having curative powers. The problem quacks pose include delay of proper treatment, wasting people's money, setting up false hopes, and occasionally causing harm.

It now appears that the so-called quack or the practice of "quackery" may no longer be clearly identifiable. We've moved into an era of more acceptable terminology to describe the medical "outsider". Some fringe practitioners have even entered mainstream acceptance (healing touch, anyone?). How do we separate alternative or complementary medicine from medical quackery?

I became interested in the subject of medical fraud and quackery 16 years ago, following a trip to Boulder, Colorado, where I was a guest speaker at a medical meeting.

The speaker who followed me to the podium, Dr Victor Herbert from New York City, was a hematologist with an interest in nutrition cultism. He had published a book on the subject two years earlier and was treated less kindly than I was by the audience. His words were obviously threatening to some — I suspect mainly those with fringe or paramedical training. I later ordered his book (he was an engaging speaker), and I've found his advice useful over the years.

One solid piece of advice, which I've passed on regularly through the years to doctors in training, has to do with the media. It's very simple. Never — and I repeat, absolutely never — allow yourself, as a physician, to appear on radio or television in a debate with a medical quack. The media loves this type of debating scene (it's great for ratings), but you certainly won't enjoy it as a physician.

Don't allow yourself, as a physician, to compete with a smooth-talking con artist who will be presented as your professional equal, to expound his or her version of some form of nonsensical medical care. Often the debate will create exposure for a book this individual has written — and increase sales as a result.

The audience often can't separate fact from fiction — particularly if the bogus expert carries a meaningless PhD from a "buy-your-own-doctorate" education mill. At one time, virtually any individual in California could set up an unaccredited university for about $50,000. Many such mills offered students a quick PhD, often accompanied with a bonus of a free computer.

Few physicians have time to investigate these phony educational mills — there are simply too many to cover. So the initials "PhD" may be attached to your debating opponent, but their value may be virtually meaningless.

So how can you identify a true quack? I'll outline a few features identified by Dr Herbert.

> ***Don't allow yourself to compete with a smooth-talking con artist who will be presented as your professional equal.***

1. The quack will inevitably advise the public to go out and buy something they would otherwise not buy. Frequently there is a financial interest in the product — it may be indirect, as in book sales.

2. The individual is a "fake" specialist with imposing front titles. Look for the words "director" or "president" of a "society" or "institute" you've never heard of. Watch for words like "world's foremost (health field) consultant". Any legitimate university affiliation is usually absent or bogus.

3. The quack will often claim that most diseases are caused by a faulty diet and that people are poorly nourished. These statements appeal to fear on the part of the public and are often associated with a push for extra vitamins or additional and specific food or product supplements.

4. If the quack is pushing a so-called treatment, testimonials and case histories support the claim of its therapeutic effectiveness. This process precedes scientific methods and moves us back a century.

5. He or she will often claim that "natural" vitamins are better than synthetic ones. This of course is nonsense, as a vitamin is simply a chain of atoms strung together as a molecule. The two are identical regardless of source.

6. The quack will inevitably claim that "natural" foods are better than those available at the supermarket. The term "natural" is used repeatedly to support an opinion or specific product sales.

Other identifying features include use of the so-called "conspiracy theory" or the "controversy claim". Well known to virtually every physician, the quack claims that organized medicine is against him (or her), because his "cure" can reduce the income doctors make by keeping people sick. In other words, the quack's work is being suppressed, so practising MDs can make more money.

7. There is also a claim of controversy existing between his "work" and that of the establishment. The quack will often clamor for a full medical investigation of his personal claims, but there is in fact no controversy. It's simply a technique used to obtain public and media attention.

8. The last major point can cause physicians some personal inconvenience — the quack is often legally belligerent. This aggressive litigation approach has worked successfully in the United States in stifling legitimate medical opposition to a quack's work, and the reasons are apparent.

A phony cancer cure 15 years ago involving "laetrile" (mainly made up of ground-up apricot pits) generated a billion-dollar industry in the US, Mexico, and elsewhere. With such financial resources to fight the legal battle, few physicians or academic institutions could match the dollars to counteract the lawsuits generated by the fraudulent drug and treatment sellers.

The sheer size of the quackery industry's resources poses a problem for ethical physicians. But it shouldn't stifle vigilance, or the ongoing efforts to keep science — legitimate science — as the basis for the practice of medicine. ▲

Extra billing continued from p. 20

service and pay the additional amount, thus avoiding the prohibited direct billing of the patient.

It is difficult to say what direct impact these new amendments will have, because it is not well known how many physicians, if any, are engaged in private practices in which extra charges are levied. It is also questionable whether the commission will in fact become more involved in this issue, given all of the other issues before it. It is interesting to note, however, that these amendments were introduced at a time of considerable ongoing discussion over increasing waiting lists and decreasing funding.

Whether or not government considers the amendments to be significant or merely housekeeping changes designed to tidy up the act, it is clear that government is still not prepared to consider the potentially valuable and supportive role that private medicine can play in relation to the health-care system. Until the government comes to terms with that realization, the options of both physicians and patients who live entirely within the publicly funded sphere will continue to be limited. ▲

heal thyself continued from p. 14

finish residency, or practise medicine? Here in Vancouver, we are fortunate to have Dr Michael Myers, who has provided a much-needed consultative service to physicians, physicians in training, and their families.

Stress on physicians is definitely at an all-time high in the political, professional, and social arenas. Physicians need to take an active role in ensuring their own physical and emotional well-being. Should the time come when a physician needs to be a patient, a personal family physician should be in place. Should the physician need psychosocial intervention, it must be available free of stigmatization and negative consequences. ▲

BCMA ALLIANCE

Victoria meeting a success; Video and scholarships latest projects

by Nerma Shergill
President, BCMA Alliance

What an exciting annual meeting for our Alliance members — board members attended our wine and cheese party, the weather was perfect, the view incredible, and most of all, everyone had fun.

Dr Martin Collis was our speaker at the educational meeting. He spoke about enthusiasm, love, and laughter, and the importance of respecting our bodies. He made it clear we have choices in our lives at any given moment.

We are not to live in the past or the future, but in the moment. Our attitude in any situation will determine the outcome. Therefore, look within.

There is a definite need for our physicians to hear motivating, uplifting speakers, for the positive reinforcement they need to see them through their hectic days.

The Alliance congratulates Dr Jim Lane as the BCMA's incoming President, as well as Mary Ann Lane, who is on the Alliance executive this year.

Many BCMA board members have spouses or companions who are not yet Alliance members. I will make sure in the next few months that this situation changes — I am now going to be "policing" the board members. Everything starts from the core and then goes out.

I have been asked to stay on as Alliance president for a second term. I am looking forward to working hard for our members. Thanks to all of you for your kind words throughout the year.

We must all focus together in harmony to achieve the positive end result.

Violence video available

The Alliance has completed production of its video about violence, renamed *Safety and the Health-Care Professional.* It will be of interest to all health-care professionals, and will be an asset to clinics, hospitals, and training centres.

This video takes a look at the very real issue of violent situations in the medical workplace. It highlights some real-life interviews and helps individuals prepare for and avoid potential conflicts with patients and their families.

A small booklet will be included in the video package, which is available for $30 (price includes GST).

To order *Safety and the Health-Care Professional,* contact Christine Bartle in the BCMA Communications Department, phone (604) 736-1226, local 207, toll-free 1-800-667-2262, fax (604) 733-7317, e-mail cbartle@bcma.bc.ca.

Scholarships awarded

The Alliance would like to thank all the students who applied for the first BCMAA scholarship. It was indeed a difficult job for the selection committee to narrow the choice down to two students.

The scholarships were awarded to Brianne Norman of Burns Lake and Justin Wilke of Mill Bay. We extend our congratulations to these deserving young people. ▲

Doctors honored as tourism hosts

Two Vancouver physicians were among five recipients of the 1998 Be a Host Legacy Awards, presented by Tourism Vancouver and the Vancouver Trade and Convention Centre. These awards recognize the efforts of community leaders in bringing meeting and convention business to Greater Vancouver.

Dr Nevin Murray, an internist at the BC Cancer Agency, was honored for arranging the World Conference on Lung Cancer, which will bring 4,000 delegates to Vancouver in the year 2003.

Dr Chunilal Roy, a Vancouver psychiatrist, received the award for his work in organizing the 2001 conference of the International Mental Health Association, which will attract 3,500 delegates.

Dr Roy also received the Francisco Fajardo Medal for Promotion of Science, Culture and Arts, presented by the governor of Caracas, Venezuela, in March of this year. ▲

Dr Nevin Murray (l) and Dr Chunilal Roy, both of whom received 1998 Be a Host Legacy Awards.

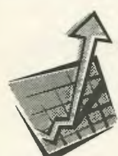
Juvenile Diabetes Foundation Canada

The mission of JDF The Diabetes Research Foundation is to support research to find a cure for diabetes and its complications. In 1997, JDF awarded $39 million to diabetes research worldwide, bringing its cumulative research support to $350 million in 27 years as a voluntary health agency.

JDF gives more money directly to diabetes research than any other non-profit, non-governmental health agency in the world. Its awards are based on the recommendations of the foundation's Medical Science Review Committee and Lay Review Committee, with final approval from its board of directors. JDF's adjudication process is heralded as one of the best and is aimed at funding the best research in the world.

For research information, phone JDF at 1-800-668-0274. Subscriptions to *Countdown* magazine, an informative publication for patients with Type 1 and Type 2 diabetes, are available at a cost of $25. Information packages and posters are now available for doctors' offices and hospitals. To order the magazine or an information package, phone the BC chapter at (604) 931-1937. ▲

JDF
The Diabetes Research Foundation
Juvenile Diabetes Foundation Canada



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NUTRITION MATTERS

Bone up on calcium

by Ramona Josephson, RDN

How often does it cross your mind to ask your patients about their bone health? Probably not often enough. Because statistically speaking, one in four of your female patients over the age of 50 will have osteoporosis. Prevention is the best line of defence. Your patients are never too young nor too old to take steps to improve their bone health.

In 1997, the US National Academy of Sciences, supported by Health Canada, issued a report urging people to consume more calcium. Why the buzz? Because several studies (in countries as diverse as Australia, New Zealand, the United States, and France) now provide strong corroborating evidence that calcium supplements slow bone loss and reverse osteoporosis in postmenopausal women.

The best source of calcium is food, but *many factors* affect the *bioavailability* of calcium. The calcium in milk products is the most bioavailable, providing the Vitamin D and magnesium that are important for building bones.

Calcium absorption is reduced by the presence of oxalic acid (found in spinach, beet greens, sweet potatoes, and rhubarb), phytates (in legumes and grains), fibre, excess protein, and phosphorus (in carbonated beverages), but these are only of nutritional significance in people who have sub-optimal calcium intakes.

I encourage all my female patients, from teenagers to postmenopausal women, to calculate how much calcium they are consuming in a day (see list below for quick reference). If their calcium intake is sub-optimal (which it usually is), I recommend adding calcium-containing foods from the list or supplementing their diet with the appropriate amount of calcium.

Postmenopausal women taking estrogen should still be encouraged to take calcium (up to 1,500 mg daily), because while estrogen prevents bone loss and prompts the body to lay down calcium in the bone, it still needs a source of calcium to build with.

In addition to calcium intake, other factors affect the rate of occurrence of osteoporosis. (This accounts for the low incidence of osteoporosis in some countries, despite low calcium intake.) These include genetics (the incidence of osteoporosis is higher among slim, small-boned Caucasian and Asian women), amount of weight-bearing activity, exposure to sunlight, and Vitamin D intake. Caffeine consumption, excess protein intake, smoking, and heavy drinking are also factors in the development of osteoporosis.

Nutrition nibbles for patients

It is never too early or too late to start building bones. One in four women will develop osteoporosis after menopause. What you eat can make the difference. Here's how:

How do I know if I'm getting enough calcium?

Strive for 1,000–1,200 mg calcium daily and up to 1,500 mg daily if you are postmenopausal. Scan this list of foods high in calcium. Each contains roughly 300 mg. You need at least four servings daily.

1 cup milk
¾ cup yogurt
45 g cheese
7 sardines with bones
½ cup almonds
½ - ¾ can salmon or sardines or with bones
3 cups broccoli
2-3 cups baked beans
2 cups cottage cheese

I can't eat all that — now what?

Food is always your best bet, but supplements work effectively. Use the list above to calculate how much you are consuming. Then estimate how much you still need. This tells you how much "elemental calcium" you require — look for these words on the bottle.

Can I get too much calcium?

The Tolerable Upper Intake Levels (UIs) has been established at 2,500 mg a day for calcium. This is the maximum daily level "unlikely to pose risks of adverse effects" for most people.

Which supplement should I choose?

Calcium

There is no convincing evidence that one kind of supplement is significantly better than another, but some are more concentrated, so you need to take less, as with calcium carbonate in form of an antacid. Take supplements with meals. Doses greater than 500 mg should be spread out. Taking small doses through the day may increase absorption and tolerance.

Vitamin D

Add 400 IU Vitamin D (200 IU if you are under 50) if you do not have 10-15 minutes of non-sunscreened exposure to the sun two to three times a week. Calcium and Vitamin D do not need to be taken together.

Magnesium

Calcium supplements do not appear to increase the need for magnesium. Magnesium deficiency in healthy people is uncommon.

Ms Josephson is a nutrition counsellor at City Square Family Practice, Vancouver, and is the author of The Heartsmart Shopper — Nutrition on the Run. ▲

Free Nutrition Hotline

Greater Vancouver
(604) 732-9191

Toll-free in BC
1-800-667-3438

Monday to Friday, 8 am-5 pm
Services in English, Punjabi, and Chinese

Dial-A-Dietitian Nutrition Information Society

Dial-A-Dietitian operates a free nutrition information line for all British Columbians. Registered dietitians will answer nutrition and food-safety questions and will explain special diets recommended by physicians.

If in-depth diet counselling is required, the dietitians will guide callers to nutrition services available in their communities. Callers can also obtain general guidelines about special diets by fax and mail.

The public, health professionals, educators, and the media ask questions about a wide range of topics. Referrals to Dial-a-Dietitian also come from many other health associations.

Major funding comes from the BC Ministry of Health and Ministry Responsible for Seniors and the Vancouver/Richmond Health Board.

For more information or to order pamphlets, contact Kathleen Quinn, Executive Director: phone (604) 732-9191; toll-free 1-800-667-3438; fax (604) 732-9081.

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Board of Directors' Meeting, June 11, 1998, Resolutions

That the BCMA approve the nomination of Mr Bob Smith as a public commissioner to the Medical Services Commission. *Carried*

That Mr Ben Trevino be appointed as a BCMA MSC commissioner. *Carried*

That the Board of Directors express its gratitude to Drs Bolton, Winsby, and Chacko for their services to the profession as members of the MSC. *Carried Unanimously*

That Drs Derryck Smith and Ernie Wigmore be the BCMA commissioners to the MSC. *Carried*

That the Drs S Hardwicke and G Singh be the alternate BCMA commissioners to the MSC. *Carried*

That the terms of reference and membership of the Information Systems Project Steering Committee be approved. *Carried*

That the revised terms of reference of the Patterns of Practice Committee be approved. *Carried*

That Dr Lorne Verhulst be appointed as an inspector under the terms of reference of the Patterns of Practice Committee. *Carried*

That the BCMA membership fee for BC medical students be $5.00, and that the BCMA explore with MD Management its participation to pay for students' membership in the CMA. *Carried*

That the BCMA recognizes and thanks all doctors who provided emergency room services for our patients on Reduced Activity Days. *Carried*

That the BCMA recognizes the ICBC Alternative Evaluation Committee as an independent scientific body and thanks Dr Lloyd Oppel for representing the BCMA and chairing the committee. *Carried*

That Kelly Gibney, PhD, Mr Garth Evans, and Mr Steven Shrybman be affirmed as members of the COHP Environmental Health Committee. *Carried*

That any CMA economic research initiative, such as "Taking the Pulse", be vetted by the CMA Council on Health Policy and Economics prior to implementation. *Carried*

That the BCMA, through the Council on Health Promotion, join the Coalition for Research and Education on Gambling Expansion. *Carried*

In the era of capped budgets and clawbacks, identification of factors that increase utilization of the Available Amount is an important budget tool. All BCMA members are requested to forward any such issues to the Negotiations Department of the BCMA for collation *Carried*

That the BCMA Tariff Committee review any proposed fee guide changes submitted by the Section of Plastic Surgery, with the understanding that any major changes would be subject to revenue neutrality. *Carried*

That, notwithstanding the fact that all selective fee adjustment proposals were received by March 31, 1998, and approved by April 29, 1998, all revenue neutrality participating sections be given another opportunity to make selective fee adjustments provided that all new proposals become available by June 26, 1998, to the BCMA Tariff Committee for review and approval and that at the same time all documentation requirements are fully satisfied. *Carried*

That the reconciliation adjustment for revenue neutrality commence July 1, 1998. The Board of Directors accepts that for those sections expected to pay back funds as a result of the revenue neutrality process, the reconciliation process be extended from three months to nine months at the option of each section affected. *Carried*

Board of Directors' Meeting, June 14, 1998, Resolutions

That Dr Graham White be the chair of the Board of Directors. *Carried*

That Dr Michael Golbey be a member at large of the Executive Committee. *Carried*

That Dr John Turner be a member at large of the Executive Committee. *Carried*

That Dr Shelley Ross be the vice chair of the Board of Directors. *Carried*

That Drs Shelley Ross, Lynn Doyle, and Brad Fritz be members of the Resolution Committee. *Carried*

That the following members be appointed as chairs and/or members of the standing committees:

Dr C E McDonnell
— Archives Committee
Dr Marshall Dahl
— BCMA Utilization Committee
Dr James Wilson
— Editor, *BC Medical Journal*
Dr R A MacGillivray
— Building Management Committee
Dr David W Jones
— CMPA Rebate Program Committee
Dr Norman Wale
— Constitution and Bylaws Committee
Dr Sharon Dougan
— Continuing Medical Education Fund Advisory Committee
Dr Sharon Dougan
— Continuing Medical Education Fund Trust Committee
Drs Murray Kliman and Jim Lane
— members of the Continuing Medical Education Fund Trust Committee
Dr Arun Garg
— chair of the Council on Health Economics and Policy (CHEP)
Drs Geoff Appleton, Marshall Dahl (Chair of General Assembly), Zafar Essak, Brian Gregory (SSPS Representative), Mike Lawrence, Carole Williams (SGP Representative) and Patrick Yu
— members of CHEP
Dr David Smith
— Council on Health Promotion
Dr Andrew Ross
— Government Salaried Physicians Negotiations
Dr Michael Golbey
— ICBC Liaison Committee
Dr Rod MacGillivray
— Income Tax Committee
Dr Rod MacGillivray
— Insurance Committee
Dr Marshall Dahl
— MSC Search and Evaluation Committee
Dr Marshall Dahl
— member of the MSC Utilization Committee
Dr Graham White
— Patterns of Practice Committee
Dr Ted Kardera
— Physician Support Program
Dr Larry Collins
— Professional Advisory Committee to the Ministry of Health
Drs David Geen and Anne Vogel
— board appointees to the Professional Advisory Committee to the Ministry of Health
Dr Sid Boloten
— Regional Health Boards and Institutions Committee
Dr Ben Anders
— Relative Value Guide Committee
Dr David Doty
— Specialist Board Appointee to RVG Committee
Dr Brad Fritz
— General Practitioner Board Appointee to RVG Committee
Ms Judy Korbin
— Review Committee
Dr William Dunlop
— Specialist Board Appointee to Review Committee
Dr Walter Rebeyka
— General Practitioner Board Appointee to Review Committee
Dr Donald Stark
— SSPS Appointee to Review Committee
Dr Hyman Fox
— SGP Appointee to Review Committee
Dr Geoff Appleton
— Rural Physician Committee
Dr A Kallas
— WCB Liaison Committee
Dr Don Smith
— WCB Salaried Physicians Negotiating Committee

Carried

That Dr Dara Behroozi be the editor of the *BCMA News.* *Carried*

That the BCMA Board of Directors expresses its appreciation to Dr Bob Young for his many years of excellent service as the editor of the *BCMA News.* *Carried Unanimously*

That Dr Ian Waters be the chair of the Negotiating Committee. *Carried*

That the BCMA Board of Directors expresses its appreciation to Dr Ernie Wigmore for his many years of excellent service as chair of the Negotiating Committee. *Carried Unanimously*

That Dr Lynn Doyle be the chair of the Contract Management Committee. *Carried*

That Dr Brad Fritz be the chair of the Council on Public Affairs and Communications. *Carried*

That Dr Jack Burak be the chair of the Membership Committee. *Carried*

That Dr Ailve McNestry be the chair of the Pharmacy and Therapeutics Committee. *Carried*

That Dr Ian Waters be the chair of the Sessional Negotiating Committee. *Carried*

That Dr Jack Burak be the chair of the WCB Fee-for-Service Negotiating Committee. *Carried*

That the following ad hoc committees be reaffirmed with the following chairs:

Ad Hoc Committee to Develop Strategy with Respect to Adult Guardianship
— Dr Heidi Oetter
Centenary Committee
— Dr Dorothy Woodhouse
Ad Hoc Committee on Female Physician Participation in the BCMA
— Dr Shelley Ross
Ad Hoc Committee to Review Board Structure
— Dr Gur Singh
Steering Committee on Disparities
— Dr Granger Avery
MSC Advisory Committee
— BCMA President
Presidents' Committee
— BCMA President
WCB Joint Technology Committee
— Dr Zafar Essak
Information Systems Project Steering Committee
— Dr Mark Schonfeld

Carried

That the BCMA establish an Ad Hoc Committee to Develop Strategy relating to the new Mental Health Act and that Dr Heidi Oetter be the chair. *Carried*

That the BCMA establish an Ad Hoc Committee for Liaison with the Ministry of Children and Families and that Dr Derryck Smith be the chair. *Carried*

BOARD OF DIRECTORS' MEETING, JUNE 14, 1998, RESOLUTIONS *CONTINUED*

That the TASC on Anaesthesia be reaffirmed and that Dr Mary Donlevy be the chair. *Carried*

That the TASC on Narcotics Harm Reduction be disbanded. *Carried*

That the TASC on the Provision of Psychiatric Services in BC be reaffirmed and Dr Larry Collins be the chair. *Carried*

That the TASC on Sleep Labs be reaffirmed and Dr Mary Donlevy be the chair. *Carried*

That Dr Graham Clay be the BCMA appointee to the Hospital Appeal Board. *Carried*

That Dr Larry Collins be the BCMA appointee to the UBC Faculty of Medicine Executive Committee. *Carried*

That the Terms of Reference for the MOH/BCMA Liaison re Primary Care Demonstration Projects be approved. *Carried*

That the BCMA representatives to the MOH/BCMA Liaison re Primary Care Demonstration Projects be Drs Michael Golbey, David Geen, Bob Gregory, and Geoff Appleton. *Carried*

That the BCMA participate in the Western Canadian Waiting List Project. *Carried*

That Mr Rob Hewitt of MD Management be invited to present to the Board of Directors in the fall of 1998. *Carried*

That the BCMA continues to support the practice of laboratory medicine within the scope of medical services funded through the Available Amount. *Carried*

That the BCMA vocally objects to any increase in tuition fees or registration fees for medical students and residents, and will advise the Dean of Medicine. *Carried*

That the Dobbin Report be accepted for information only. *Carried*

That the BCMA does not support Recommendation 13 of the Dobbin Report. *Carried*

That the motion relating to the management of proposed amendments to the BCMA Constitution and Bylaws be referred to the Constitution and Bylaws Committee and to the Executive Committee. *Carried*

Preparing continued from p. 7

right? This may be just the ticket.

But what about big labor and the greens? To say they'll be "miffed" is putting it mildly. What choice do they have — abandon the guy who has delivered settlements with the BCTF, the HEU, and (by then) the BCGEU?

Not likely. They've got nowhere else to go, and besides, Clark has them on a short leash. And the greens, let them squawk. Support for new environmental initiatives is on the wane in the face of BC's worsening economic situation.

For a guy who plays politics for keeps, Glen Clark will make a move for the political high ground, even if it means compromising whatever political principles or philosophy his party has left. After all, it's winning that counts in this game.

LACs are urged to renew acquaintances with their MLAs. With the whiff of an election in the fall air, the silly season may be upon us sooner than you think. ▲

Dr Bob continued from p. 13

awards and is generally regarded as being the best of its type in the country. Talented managing editors and production staff are the ones who have accomplished this through the years and deserve major kudos.

I leave with a sense of satisfaction. I have been able to earn the respect of my colleagues and have succeeded, I think, in keeping my reporting unbiased, honest, and in good taste, avoiding denigrating comment. As important, I have truly enjoyed the experience and deeply appreciate the opportunity the BCMA has given me to follow my avocation all these years.

But all good things must end, and the title "Editor Emeritus" has a nice ring to it.

At least that is my opinion.

RNY ▲

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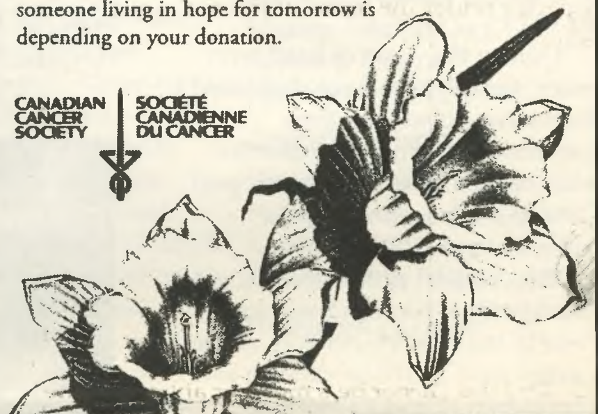

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In addition, MSP provides telephone support for billing queries at:

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The Northern and Rural Locum Program helps general and family practitioners working in approximately 70 small BC communities to secure subsidized vacation relief. It also provides physicians an opportunity to experience rural practice in some of the most beautiful communities in BC. The Program was established in co-operation with the BCMA and is administered by the Northern and Isolation Committee

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Qualifications

In order to qualify to work in the Northern and Rural Locum program, a physician must be:

- eligible to practise in BC
- a member in good standing of the Canadian Medical Protective Association or covered by alternative malpractice insurance
- certified in ACLS or ATLS or willing to obtain certification

For more Information contact:
Northern and Rural Locum Program
Provider Programs
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Medicine and the military in British Columbia

A proud history, a vital future

by Captain Dan Thomas

In the second half of the 19th century, settlers in the frontier towns of Victoria, Vancouver, and New Westminster formed volunteer militia units to protect their communities against a succession of external threats.

After British Columbia entered confederation, these fledgling forces evolved into highly professional units of citizen soldiers who fought with distinction through the Boer War and two world wars. These soldiers earned numerous battle honors in the actions that helped form Canada's reputation as a nation and fighting force, plus 13 of Canada's 95 Victoria Crosses for valor.

During the years of hard-won peace, the reserves have dedicated themselves to serving their communities, providing disaster relief as well as soldiers to support Canada's international commitments.

The medical profession has a distinguished record of service. Prior to the First World War, militia medics were active in Victoria and Vancouver; 11 and 12 Medical Companies perpetuate their traditions in both cities today. The latter unit served in the Second World War as 12 Field Ambulance, part of the 4th Canadian Armoured Division, and had the distinction of holding off an enemy counterattack during the campaign for northwest Europe.

Individually, British Columbia physicians have an equally proud history. Dr Ernie Bowmer, noted tropical disease specialist, earned the Military Cross in 1944 for his courageous treatment of wounded while under fire at the horrendous battle of Monte Cassino, Italy. As Honorary Colonel of 12 (Vancouver) Medical Company, he helps inspire young Canadians to serve community and country.

The legacy continues. Dr Gordon McIntyre, Qualicum Beach general practitioner, is also Medical Officer of The Canadian Scottish Regiment (Princess Mary's). From September 1992 to April 1993, Captain McIntyre served in Croatia with Princess Patricia's Canadian Light Infantry under the United Nations peacekeeping mandate.

"Our role was to treat Canadian and other UN personnel," he relates. "But during the fighting, hospitals were a high-priority target to the opposing sides. The local medical infrastructure was destroyed, so we also treated civilians for mine, machine-gun, and other injuries."

McIntyre cites excellent trauma training and experience, plus camaraderie and challenging field conditions, as key rewards for his military medical service. Canadian infantrymen credit him with saving lives after an ambush.

Dr John Blatherwick, Medical Health Officer for the Vancouver/Richmond Health Department, holds the rank of Commander in the Naval Reserve; Richmond family physician Dr Paul Cervenko trains with 12 (Vancouver) Medical Company. Captain Cervenko enjoys the military environment and its "stimulating challenges": coping with limited resources in the field, for example, and mastering the skills medical soldiers need to protect themselves and their patients.

Medics are often at the forefront of Canada's humanitarian commitments. When the federal government authorizes a domestic or international mission, for example, the elite 1 Canadian Field Hospital is rapidly deployable from its base at Petawawa, Ontario.

The high-tech unit prides itself on its ability to operate in any climate or environment, with an infection rate comparable to a permanent Canadian hospital. Major operations demand a large share of the nation's deployable expertise, however.

Reserve medics are therefore as important as ever to Canada. The regular force has been significantly reduced in size in recent years, leaving reserves an increasing amount of responsibility. The situation in British Columbia is particularly acute because, with the closure of Canadian Forces Base Chilliwack, the reserve units of 39 Canadian Brigade Group are the only Army presence in the province.

When snowstorms paralyzed Greater Victoria and the Lower Mainland in late December 1996, the only ambulances serving the provincial capital for several days were the 4 x 4 vehicles operated by 11 (Victoria) Medical Company.

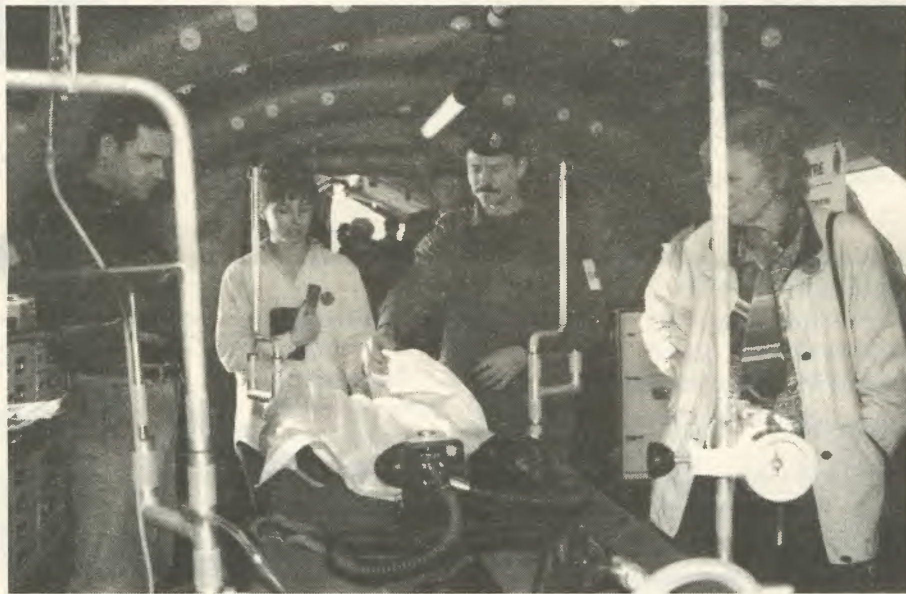
Reservists attend up to four evening training sessions, one Saturday, and one weekend exercise per month. Rank and career qualification courses are scheduled for the summer; medical officers (doctors) attend six weeks of basic Army officer training.

In British Columbia, the March school break is devoted to Exercise Cougar Salvo — a highly popular and successful field training activity in Fort Lewis, Washington. Medics gain access to high-tech, paperless US Army trauma facilities.

Pay rates are based upon rank and seniority and have risen recently, but like other reservists, medical officers value the experience and other intangible rewards more highly than the income.

Vacancies exist for fit, adaptable physicians who wish to dedicate some time to 11 (Victoria) and 12 (Vancouver) Medical Companies or other units across southern British Columbia. For further information on locations and enrolment prerequisites, please contact Major Dan Kuhn, 39 Canadian Brigade Group Personnel Director, phone (604) 666-4033.

Captain Dan Thomas is Public Affairs Officer for 39 Canadian Brigade Group, Vancouver. ▲



November 1997: Members of 1 Canadian Field Hospital demonstrate their equipment to members of the public during the Canadians Remembered Exhibition. Photo: Warrant Officer Colin Blackburn, DND

March 1998: Canadian reserve medics practise casualty evacuation with a US Army Blackhawk helicopter during exercise Cougar Salvo 98 at Fort Lewis, Washington. Photo: Sergeant Ed Dixon, DND

Two examples of efficient and self-contained military first-aid kits on display at "The Army in British Columbia" booth at the BCMA's 1998 Annual Meeting.

What if one day next week you couldn't Walk?
Or maybe you couldn't speak clearly. Or your vision was blurred. That's what it's like to live with multiple sclerosis. But with your help, we can connect with a cure.
1-800-268-7582
Multiple Sclerosis Society of Canada

1998 Vernon medical hockey tournament

y the Resident Ghost Writer

Choose the correct answer:

Ty Domi wins the Lady Byng Trophy.
Vemon Doc are Banting Conference Champions.
DNA testing exonerates Alan Eagleson.

A stunned silence met the ctory of the Vernon Docs, e long-established Chicago ubs of the spring medical ockey tournament. andatory steroid testing is real possibility.

Four divisions take part the conference, with two ams moving up or down nually, as in the British ccer system. This guaran-es close, competitive mes. For organizational reasons, it was decided this year, after the tournament, not to move teams up or down.

Friday was conference round-robin play. Team rankings were determined for Saturday's play-offs.

All games were hard fought. Coquitlam's Brock Pullen was downright stingy, with a goal from Kevin Merth, two-time MVP winner, defeating Bumaby. Winless Penticton lost an overtime game 7-6 to the champion Fraser Valley squad, and Mission had two low-scoring losses. Quack Hawks defaulted to Vancouver Island for lack of MDs.

The Griffith Conference featured two new teams. Prince George started with Jack Wankling in net. Jack had been the tournament MVP 16 years ago in the original Vernon Doctors' Hockey Tournament in Lumby. The new, young Vancouver Island Pylons quickly gained respect by posting two wins in the first day — the second being a hard fought 3-2 win over Vancouver.

The Helmcken Conference featured craft veterans, with Ed Berinstein posting a one-goal average and a well-distributed offence. Meanwhile, hat tricks by Dale Stogryn and Morris Van Andel were New Westminster's margin over a stubborn Oak Bay. Sechelt's Tom Elliott was a logical MVP choice.

On Saturday's play, the Vancouver Island Pylons came from behind to edge Kamloops out, 5-4. Mel Vincent of the Comox line deserved the conference MVP. Prince George was a popular choice for Most Sportsmanlike Team. It takes character to improve from an initial 17-1 loss. The magnanimous spirit of the other teams means that in 2006, Prince George will become eligible for first draft privileges.

In the Banting Conference, the Kelowna Tongues upset the Kelowna Quack Hawks 5-3, enabling the Vernon Docs to end 16 years of futility. Vernon defeated Victoria 5-3, while losing 4-3 in OT on the Quack Hawks' Elwyn Stauffer's goal. An exhausted Len Delair in the Vernon goal earned his MVP with 93 shots per game. The Founder's Trophy was awarded to Gordon Mack. His stint in the Vernon goal made their 16-year record unassailable.

In the Osler Conference, Shaughnessy rallied from a 2-0 deficit to defeat Bumaby by a narrow 3-2. Meanwhile, Fraser Valley's blue line white-washed the Kelowna Quacks 3-0. Kelowna, incidentally, commendably entered three teams in the tournament. The final was out of reach in the first period when Fraser Valley built up a 3-0 lead, ending 7-2. Ian Dugdale "quarterbacked" the Fraser Valley squad as MVP.

The conference third and fourth place was decided in an exciting 4-3 game with Kevin Merth's overtime goal being the winner for Coquitlam over the Kelowna Quacks.

Vernon goalie Len Delair gets help from Grant Pagdin, Paul Anderson, and Bob Henderson, as Kelowna Quack Hawk forward Owen Yashida jumps aside and Brian Martin is checked.

raser Valley goalie Jean-Marie Wilson makes save as Jeff Demetrick and Anthony Della Siega look on and Shaughnessy's lay Baberie looks for a rebound.

ction around Kelowna Quack Hawk goalie Ken Mills: Kelowna's rian Martin slides in help as Mission's Andy Edelson and Arnold hoichet wait for a rebound.

Final standings:

Osler Division
Fraser Valley Fliers
Shaughnessy
Coquitlam Chiefs
Kelowna Quacks
Burnaby Blades
Penticton
North Stars

Banting Division
Vernon Mighty Docs
Victoria Kings
West Kootenay
Horbaig Mighty Docs
Vancouver Island Vipers
Mission Mighty Docs
Kelowna Tongues
Kelowna Quack Hawks

Griffith Division
Vancouver Island Pylons
Vancouver
Kamloops Vipers
Prince George Mighty Moose

Helmcken Division
Sechelt Sharks
Lumby
Oak Bay Wanderers
New Westminster

There is room for new players of any calibre for next year's tournament.

Most committee members survived the last-minute scramble to alter schedules.

The talented 16-year Vernon veteran, Bob Henderson, was unchallenged as Most Sportsmanlike Player. The (Barry) Stanley Cup, a Vernon award, went to Fred Dyck.

With Dave Cameron (Winfield) as Friday's moderator, attendance at the 7:00-10:00 p.m. presentations reflected the pertinence of the topics: "The Role of the Team Physician" (Larry Hancock), "Eye Injuries" (Ron Baldassare), "The Etiology of Childhood" (Stan Szombathy), "Sudden Death in Sports" (Kevin Pistawka), and "Collaboration, Competition, and Change: A Comparison of Canadian and US Health Care" (Bob Halpenny).

The boisterous Saturday night banquet included presentations, entertainment for relaxing (Irwin Barker), and FOOD.

Remember:
March 5 and 6, 1999
UBC players may write to Puck c/o Box 99, Tumbler Ridge. ▲

Vernon's Mark Gale is stopped by Kelowna Quack Hawk goalie Ken Mills.

Osler Conf.	W	L	GF	GA	Pts
raser Valley	2	0	12	5	4
el. Quacks	2	0	9	4	4
haughnessy	1	1	7	6	2
oquitlam	1	1	2	3	2
urnaby Blades	1	1	5	5	2
enticton	0	2	7	12	0
orth Stars	0	2	2	9	0
BC					0

Banting Conf.	W	L	GF	GA	Pts
emon Docs	2	0	12	7	4
ictoria Kings	2	0	14	7	4
V. Kootenay	1	1	4	8	2
el. Quack Hawks	1	1	5	3	2
elowna Tongues	1	1	9	9	2
anc. Isl. Vipers	1	1	3	6	2
lission	0	2	3	6	0
orbaig	0	2	7	11	0

UBC withdrew the week of the tournament. (Did they really desert hockey to watch Jerry Seinfeld?)

Griffith Conf.	W	L	GF	GA	Pts
Vanc. Isl. Pylons	2	0	21	3	4
Kamloops	1	1	16	10	2
Vancouver	1	1	8	8	2
Prince George	0	2	1	28	0

Helmcken Conf.	W	L	GF	GA	Pts
Sechelt	2	0	10	1	4
Lumby	2	0	11	3	4
New Westminster	0	2	1	6	0
Oak Bay Wanderers	0	2	3	9	0

LETTERS TO THE EDITOR, *continued*

Letters continued from p. 13

editorials calling for the impeachment of our head of family practice.

At Children's and Women's Health Centre, family practitioners have worked closely with hospital-based midwives for a number of years. While there will continue to be issues that need to be addressed between the disciplines that provide maternity care, I believe this is best done in an environment of respect, collaboration, and commitment to best practice.

I challenge Dr Rhodes and other detractors to refocus their energy to this end.

Robert W Armstrong, MD, PhD, FRCPC
Vice-President, Medical Services and Quality Promotion
Children's & Women's Health Centre of British Columbia
Vancouver ▲

The News welcomes your letters.
Next deadline is September 29, 1998

Real issue principle, not personality

Dear Editor:

As recording secretary of the executive committee of the Department of Family Practice at BC's Women's Hospital and Health Centre (BCWH), and as a member of the Society of General Practitioners, I would like to comment upon the "editorial" by Dr Jim Rhodes of the SGP ("GPs: Take back the departments", BCMA *News*, March 1998).

My remarks are my own, but I believe they generally reflect those of most members of the executive committee of the Department of Family Practice at BCWH, where Dr Klein has a strong and positive presence.

Dr Rhodes, an invited guest at the January meeting he mentions, rewards his host with an "editorial" based on misinformation and innuendo, laced with bellicose rhetoric, and ignoring the generally accepted oratorical style that stresses principle rather than personality. He chooses to attack personality in the form of the head of the Department of Family Practice at BCWH. He vents his spleen and resentment at midwifery, its payment process, and its support by Dr Klein.

Dr Rhodes would have served his purpose properly had he addressed the real issue, which is underpayment and undervaluing of physicians practising obstetrics (GP and obstetrician alike) by both government and the BCMA — a feature Dr Klein has advocated vigorously and repeatedly.

Historically, hospital-based midwifery has been extant at the BCWH (formerly Grace Hospital) since 1981 and was supported by our department long before Dr Klein arrived on the scene. Legalized midwifery began in BC in January 1998 — largely in order to regulate the growing number of unregulated midwife-assisted births in the province. This is now in keeping with the situation in most other countries, where midwifery is an accepted practice.

Our department head, while supporting this aspect of maternity care, has also been instrumental within our own department in upgrading the skills of our members and improving the department's status within the hospital, physically, academically, and administratively.

In addition, he has done much to upgrade the opportunities of rural physicians practising obstetrics, through such avenues as CME, newsletters, the Advanced Life Support in Obstetrics (ALSO) course, and mentoring. There may indeed be some who question his style (diplomatically speaking), but few who can legitimately challenge his substance on this and other issues.

I believe that Dr Klein's main thrust is the safe and compassionate care of women, especially those in labor, and their babies—nothing more and nothing less. He anticipates—correctly, I feel—a growing attrition in numbers of GPs and obstetricians who will deliver babies in the coming years. He addresses these concerns by promoting FP obstetrics and by promoting midwives who may take up some of the slack and provide choices to women.

To suggest impeachment of Dr Klein (and by association others who embrace his views) sounds an ominous knell for Canada's future laboring mothers and their babies. Even if gains are to be made in the "turf war" envisioned by Dr Rhodes in his self-serving expostulation, such "victories" will be short-lived and pyrrhic indeed.

Perhaps Dr Rhodes could recall that anonymous but time-tested prophecy, "No army is so strong as an idea whose time has come."

Thomas C Gibson, MD
Vancouver ▲

MD Management: heavy hitters?

Dear Editor:

Following my letter, "'Heavy hitter' claims merit scrutiny" (BCMA *News*, June 1998), and the response by Ranga Chand, I am indebted to MD Management for providing me with a copy of Mr Chand's book.

Not unlike other books on the same topic (e.g., *The 1998 Buyer's Guide to Mutual Funds* by Gordon Pape) and notwithstanding the allowances made for volatility, Mr Chand's writings confirm that while some of MD Management's funds (actually three of 11) deserve the appellation "heavy hitter", the majority don't.

If we examine the assets value of the three "heavy hitters" as compared with the total assets of all MD Management funds, they account for about 53 per cent. Thus, 47 per cent of the $6.4 billion (approximately) under MD Management's control is performing less than splendidly.

While some may point to the fact that these are "no-load" funds with unusually low management expense ratio (MER), this may not be of much consolation if an investor could have made an additional 10 to 20 per cent growth, albeit with a more expensively managed fund. In fact, Mr Chand lists as "heavy hitters" a number of Canadian Equity "no-load" funds with below average MERs (although some are now closed to investors).

We can therefore justifiably ask whether we are getting the best bang for our management buck.

Dr Chris Sedergreen
Coquitlam ▲

Leave moral considerations out of training

Dear Editor:

I was somewhat puzzled by the article, "Abortion training — the right to choose", (BCMA *News*, March 1998) by Clare Atzema, a medical student at the University of British Columbia.

When I went through my training (admittedly in the "Ice Age", as my children call it), it was customary to learn about medical and surgical procedures, whether or not one ever planned to carry them out oneself in future years. We simply had to know what was being done, not only for our own information, but also in order to properly answer our patients' questions.

Ms Atzema gets involved in the moral aspects of abortion which, while possibly a guide to practising doctors, should not be of concern to a student learning appropriate treatments.

Or would she argue that students who do not propose to go into surgery should exclude operations such as hip replacements or appendectomies from their training?

She will also discover later that, whether or not she herself believes in or performs abortions, patients will want a thorough explanation of what exactly would be done, especially in these days of informed consent.

No, medical students should not have "the right to choose" if they will be trained to do abortions. In fact, it is incumbent on them to familiarize themselves with the procedure, even if they disapprove of it and have no intention of ever performing it themselves.
That moral decision rests with the doctor and the patient, and is an entirely different matter.

R Walter Dunn, FRCS, FRCOG
South Surrey ▲

Give pro-life equal space

Dear Editor:

Ms Clare Atzema's article ("Abortion training: the right to choose", BCMA *News*, June 1998) demonstrates the illogical thinking of abortionists.

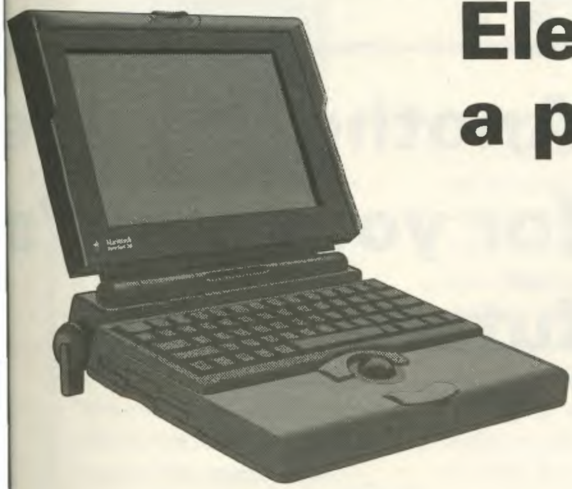
Ms Atzema states, "Those who are pro-choice do not believe the fetus is a life yet." Can she then explain when it becomes a life?

On the same page, the new FAS brochure asks, "Did you know that alcohol can hurt your baby?" I do hope the abortion clinics are going to display this poster. Maybe they could insert, "Before your abortion, do not consume alcohol."

I believe now, as a matter of justice, you must give a pro-life student equal space in a future issue.

Augustine J Cunningham, MB ChB
DPH FRCPC
Courtenay ▲

INFORMATION TECHNOLOGY



Electronic patient records: a physician's view

y Dr Ray Simkus, Member
formation Technology
ommittee

About half the doctors in BC use computers at home — mostly for mail and Internet use — ut hardly any use mputers in the office. For years, I have been keen to e computers in my medical actice, but I am with the 98 r cent who still use paper cords. Physician reluctance not the problem; we will e tools that are of help us.

The hardware is good ough to do the *job. The ain hurdles* now are the ftware and arranging for her offices, the local boratory, and the hospital send reports electronically.

Some clinics have been perless for many years. ings seem to get off the ound when several doctors thin a clinic wish to go ectronic or when there is a ear business case for doing . When considering the nefits of electronic patient cords, physicians should st recognize the drawbacks paper records: they are pensive to use and aintain; they are hard to ad; information can be difficult to find; paper records follow a fixed format that cannot be reorganized. Doctors who have used electronic records often say they would not go back to paper.

Lab results, imaging reports, and consults are all available electronically now. Access to medications on PharmaNet is expected to be available once legislative changes in Victoria are made — just think of refilling prescriptions with only a couple of keystrokes. (However, written prescriptions will be required until the federal government allows electronic signatures on prescriptions.) The computer could also keep up-to-date problem and medication lists, which would be handy for cross-checking drug interactions for new prescriptions.

Many doctors are waiting for easy ways of entering data before going electronic. When planning how to enter electronic information about visits and examinations, a number of questions must be considered.

Where can the computer and keyboard fit into the examination room? Doctors who use computers in the exam room have noted that patients like to see what is on the screen. The physician should face the screen and the patient, so the patient does not feel excluded.

What about typing skills? These are important, but their need can be minimized, depending on the program used. Some programs use check boxes for data entry, while others involve a lot of typing of free text.

Will you dictate in front of the patient? Even if you plan on dictating, you will still need to navigate with the keyboard, but there are programs that allow voice control.

The physician should be able to zip in and around the program, finding the needed information without being distracted from the patient encounter. Therefore, the program should be well thought out and almost one step ahead of the user, anticipating the next set of data.

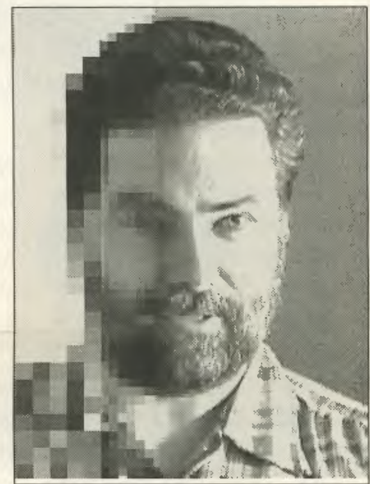
To be comfortable, the physician must be familiar with general computer use. When is the computer just taking a pause, and when is it stuck? How do you get from one screen to another or into a particular reference program to check out a protocol? Good skills can be learned at home, surfing the Web, or using a word processor or spreadsheet.

While the hardware is reliable now, the operating systems and network functions seem to cause problems on a regular basis. An office needs a system it can depend on and should have someone who is available on short notice to deal with any disaster. It may be worthwhile to build some redundancy into a system, so if one computer goes down, a spare can take over.

This is the year BC physicians should find it worthwhile to start on the path of electronic patient records. Lab information and PharmaNet will be key reasons for this change. The Health Information Standards Council of the Ministry of Health is working to streamline the flow of information between hospitals, labs, private offices, and other organizations. HealthNet includes a number of working groups involved with the practical aspects of electronic exchange of information.

Vendors must provide physicians with useful software that takes into account the pressures we must work under. The WCB wants reports sent electronically, and the BC Cancer Agency is interested in electronic communications. Can ICBC be far behind?

What about the cost of these systems? One view suggests that because computers will save doctors money, doctors should pay. The other view is that electronic records will result in tremendous savings to the health-care system, and these savings should be used to fund the computerization of doctors' offices. This has in fact been done in England, Scotland, the Netherlands, and Norway, where more than 80 per cent of physicians adopted electronic records in just a few years. ▲



Self-portrait of Langley GP Dr Ray Simkus.

Related Web Sites

GP network Web page
http://www.gpnetwork.net.au/home.asp

An Australian Web site that includes major papers by IBM consultants
http://doctorsdesk.asstdc.com.au/

Computerized Patient Record Institute(US)
http://www.cpri.org/

An interesting slide show from Australia
http://www.racgp.aone.net.au/papers/paperless_office/sld001.htm

BC MoH Information Resource Management Plan 1998-2003
http://www.moh.hnet.bc.ca/him/moh/irmp/index.html

Testing should be mandatory

Dear Editor:

My golfing partner yesterday was not in good form. A local physician, he was receiving anti-retroviral therapy for a needlestick injury. This was the second time he had faced this situation in the past few years.

The incident had occurred while he was suturing the eyebrow of a young man involved in a brawl. After the incident, the patient volunteered that he was hepatitis C positive. As the patient refused to be HIV tested, my friend had no other option but to undergo prophylactic anti-HIV therapy, with its coincident anxiety.

It is wrong that medical and nursing personnel should be unnecessarily exposed to this not uncommon situation. A signed waiver authorizing appropriate testing should be a requirement before any surgical procedure, and this should have the endorsement of the BCMA.

James E Parker, MB
Abbotsford ▲

CLUB MD

DOCTORS' PREFERRED SERVICES

New AT&T offer proves popular

BCMA members are signing up quickly for the Club MD AT&T Long Distance Services Plan. The response has been overwhelming, with more than 100 members signing up in the first week.

As introduced in last issue's Club MD column, this is an excellent plan for both office and home long-distance calls. Everyone enrolled in this plan is eligible for the discounted group rates 24 hours a day, seven days a week, on all outbound voice, fax, modem, or calling card long-distance calls, as well as inbound toll-free (800/888) usage.

This is a great opportunity to reduce overhead costs in your practice and to save on your residential bills as well. This offer is also available to BCMA members' families and staff — individual bills are sent to each person.

If you would like a copy of the details of this offer, or information on how to sign up, please contact Amanda Strong at AT&T Canada, phone (604) 605-5587, fax (604) 605-5608, or Joan Decker Holman at (604) 736-1226, local 240.

CLUB MD SEASONAL SPECIALS

It's summertime, and the living should be a little easier. Try to make the best of your summer by enjoying beautiful BC.

Whistler — a great vacation destination any time of the year

- 1-800-777-0185
- valid to November 25, 1998
- quote the BCMA Club MD/Powder Resort Properties membership number, 174449

Powder Resort Properties offers Club MD members excellent values for accommodations at properties such as the Radisson Blackcomb Suites, Sheraton Suites, Marriott Residence Inn, Le Chamois, Woodrun, Alpenglow, Timberline Lodge, Lost Lake Lodge, and others.

Studio suites booked within seven days of your stay are available at $79 per night, plus taxes. Accommodations reserved more than seven days prior to your visit are offered at a 30 per cent discount.

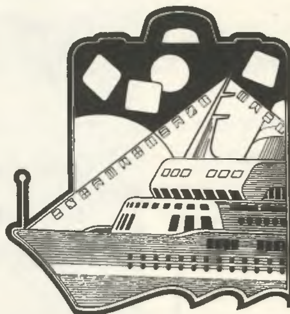
Whistler offers many recreational activities in the summer — hiking, whitewater rafting, golfing, horseback riding, and much more.

Try out the 108 Resort

- 1-800-667-5233
- valid to October 1998
- $298 to $338 for two nights' accommodation for two people, including two days of unlimited golf or a two-hour horseback ride daily

The 108 Resort offers an 18-hole CPGA championship golf course set on the rolling terrain of the Cariboo hills, and over 300 acres of riding trails through scenic Walker Valley and around 108 Lake. Other activities and amenities are also available for a vacation your whole family will enjoy.

Plan ahead to cruise



Sea Courses Inc offers CME at sea. This physician-owned and -operated business offers value-packed CME cruises, individual cruises, or the opportunity to create your own group. Up to 45 per cent discounts and category upgrades are available on most cruises.

The 1999 program offers CME on Holland America ships to:

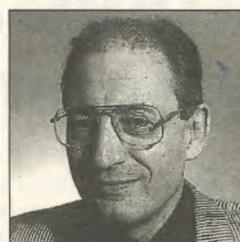
- Western Caribbean — February 21-18
- Panama Canal — March 18-28
- Alaska Inside Passage — May 29-June 4
- Eastern Mediterranean — September 10-22

For further information, contact Dr Martin Gerretsen at (604) 589-6111.

When accessing any Club MD service, please identify yourself as a member of the BC Medical Association and ask specifically for the BCMA rate.

Your input on current services or suggestions for new services are always welcome. Please contact Joan Decker Holman, BCMA Communications and Public Affairs, (604) 736-1226, local 240.

MD MANAGEMENT



Another choice for your child's future

by Dr Ernie W Wigmore
MD Management
Advisory Committee on Benefits, Services and Membership

When it comes to saving for your child's or grandchild's future, MD Management is introducing yet another tax-advantaged option to choose from: the MD RESP.

The new MD RESP is a great starting point for people who don't have a substantial lump sum to invest and who want to start saving gradually for their children's post-secondary education. Though contributions to an MD RESP are not tax deductible, income earned on your RESP investments is not taxed until the money is withdrawn and distributed to the beneficiaries as payments for their post-secondary education.

As well, earnings are taxable to the student, not the contributor. And since students usually have little income, they will likely pay no tax on the proceeds. However, there are limits. The maximum annual contribution is $4,000 per beneficiary, to a maximum lifetime contribution of $42,000.

The greatest advantage of contributing to an MD RESP is that it allows you to take advantage of the Canadian Education Savings Grant. In its 1998 budget, the federal government announced it will begin contributing up to $400 on the first $2,000 of your annual RESP contributions for children up to and including age 17.

The flexibility of RESPs also adds to their appeal. You can contribute to an MD RESP for your child or grandchild, and there are few restrictions on what types of investments an MD RESP may hold. And you can set up either individual plans for each of your children or a "family plan", in which each of the beneficiaries is your relative.

Before considering an RESP you should be fairly confident your children or grandchildren will go on to pursue a post-secondary education. That's because the income from an RESP can be used only to finance the beneficiary's education and can't be put toward benefiting the child in some other way, such as helping to buy a home or start a business.

Considering that putting a child through university in Canada can cost as much as $20,000 per year, you may have to supplement the $42,000 lifetime RESP contribution limit.

MD Management also offers MD Family Trust, another tax-advantaged option for saving for your child's or grandchild's future. There are no maximum contribution limits, and the proceeds of MD Family Trust can be used to benefit a child in any way you see fit.

While MD RESP and the MD Family Trust each have their own distinct advantages, they aren't mutually exclusive. If you have accumulated capital and excess cash flow and you're looking for ways to maximize income-splitting opportunities, don't rule out the possibility of doing both. Many physicians who have already established an MD Family Trust are also considering contributing $2,000 annually to an RESP, to take advantage of the 20 per cent Canada Education Savings Grant.

If you're considering options for saving for your child's or grandchild's future, ask your MD Financial Consultant about MD RESP and MD Family Trust. ▲

Medical writers to meet in Vancouver

The American Medical Writers Association's 58th Annual Conference will be held October 28-31, 1998, at the Hyatt Regency in Vancouver, BC.

Titled *Communicating about Health and Health Care in a Changing World*, this conference will present internationally recognized speakers from academia, industry, and government.

AMWA's annual conference offers an excellent opportunity for members and non-members to update their knowledge, upgrade their skills, explore new options, and expand their network. Activities include plenary sessions and forums, more than 77 comprehensive workshops, and formal networking events.

Emphasis is on scientific writing, editing, audiovisual media, public relations, freelance and pharmaceutical work, as well as teaching biomedical communications.

Contact: American Medical Writers Association, 9650 Rockville Pike, Bethesda MD 20814, USA, phone (301) 493-0003, fax (301) 493-6384; e-mail www.amwa.org. ▲

The side of the road

by Dr David F Smith

One of my last general practice locums was in Kelowna, BC, in the summer of 1972. A classmate had decided to spend his summer in Tanzania and suggested I take over his practice temporarily. It was an enjoyable locum, and on its completion in early August, I headed back to Vancouver.

Proceeding toward Osoyoos on a straight stretch of highway just beyond Penticton, I came upon a number of vehicles parked on either side of the road. These included a police cruiser and a bus from California. There was considerable general confusion, with many people milling about.

I pulled over and got out of the car, clutching my medical bag. A late-model car was upright in the ditch on the opposite side of the road. Judging from the fresh dents on its roof, the vehicle had flipped over 360° at least once before coming to a stop.

A man from the bus, who identified himself as a doctor from California, was kneeling by the side of the car. An injured woman in some pain was in the driver's seat. The doctor, on discovering that I was a physician registered in BC, retreated, leaving me to assess the driver and a passenger who wasn't moving.

I went around to the passenger side, opened the door, and encountered a senior citizen who was cyanotic and not breathing. I saw that his rib cage was no longer attached to his spinal column. With his flail chest, resuscitation was not possible, and I took no further action other than to record the time of death.

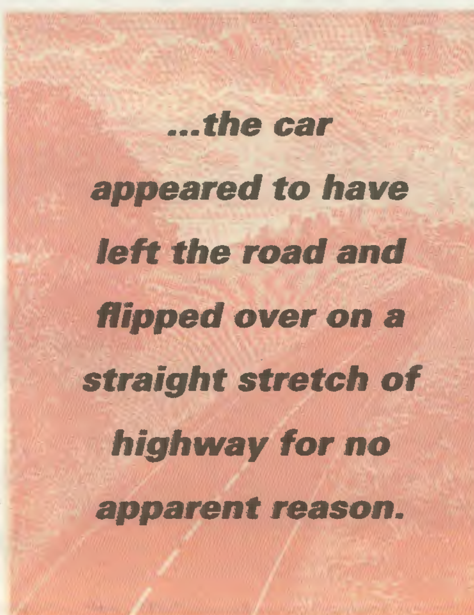
Returning to the driver, who appeared to be in her late twenties or early thirties, I extracted her from the car and placed her on her back in a dry ditch. This proved more difficult than I initially anticipated, as there was broken glass everywhere — beer bottles thrown from passing cars. Canadian ditches can be risky areas in which to place an injured patient.

Examining the patient with as much decorum as possible, considering the number of bystanders hanging around, a head suddenly appeared between me and the patient. A tourist from the American bus had decided to obtain some close-up photographs of the injured driver — presumably to show friends and relatives at home. She must have found my back in her line of sight.

I called for one of the police officers, who quickly directed the woman away. In spite of her escort, she continued to turn and flash pictures as she was taken back to the tour bus.

I made a pointed reference about ghouls, but she either didn't hear me or was too busy with her photography to pay attention.

I was concerned that the patient might have a ruptured spleen; a police officer reported that an ambulance had already been requested from Penticton. I gave the patient a morphine injection for her abdominal pain, and arranged patient transfer with the ambulance crew that arrived shortly.



The accident seemed a bit unusual, as the car appeared to have left the road and flipped over on a straight stretch of highway for no apparent reason. I didn't discuss this with the driver, as she didn't need a physician interrogating her about non-medical issues. The police couldn't give me an explanation for the accident.

On my return to Vancouver, I phoned the Penticton Hospital emergency department to determine the patient's progress. Fortunately, her spleen wasn't ruptured, and the nursing staff informed me she was doing reasonably well. Taking a "Good Samaritan" position, I sent no bill for services rendered, and didn't pursue the event further.

Almost seven years later, while working on staff in pediatrics at the Vancouver General Hospital, I received a phone call from a lawyer. He asked if I remembered an accident at the side of the road just outside Penticton some years earlier. I assured him I recalled the event. He wanted to know if I could remember the specific circumstances of the accident and then directed some rather pointed questions. He sounded reassured when I told him about the photographer and the broken beer bottles in the ditch. He said the driver had been held legally responsible for the accident and her passenger's death, as it was a single-vehicle accident on a straight stretch of road. She had not remembered the circumstances, suffering amnesia for the event.

This woman, however, had undergone hypnosis a number of years later and was able to recall the accident in detail. She remembered an oncoming car in the wrong lane of the highway. Avoiding a head-on collision led to her swerving off the road, losing control of her car, and flipping over.

The lawyer hoped to institute court action before the legal statute of limitations, reportedly seven years, had elapsed — or at least that's what he told me. He also informed me that no testimony elicited by hypnosis had been accepted in court up to that time, and this case could lead to a new legal precedent.

I looked forward to the court case, but I wasn't called again. Either a settlement was made out of court, or the case simply lacked merit and was not carried forward. I thus missed my great legal opportunity.

Stopping to assist an injured motorist can provide late and surprising consequences for a physician. Nevertheless, giving assistance at an accident scene is seldom a waste of time, particularly if an ambulance is some distance away. The odd psychiatrist might provide a contrary argument here — but a physician never forgets all his or her clinical skills.

In Canada, we're also legally protected for our roadside efforts, thus providing a moral incentive to assist accident victims at the side of the road. ▲

Dr Smith is a pediatrician at BC's Children's Hospital.

Water ski doctor recognized

Dr Ross Outerbridge, an orthopaedic surgeon from Kamloops, is the first recipient of the Sports Medicine and Science Award, presented by the Sports Medicine and Science Council of Canada. This award has been established to recognize significant contributions to the training and development of athletes at the national level.

Of the 15 nominees — named by national sport organizations and training centres across Canada — nine were sports physicians. Outerbridge was the only nominee chosen by two different sports (water skiing and diving). He has served as national team physician for Water Ski Canada for the past 12 years, and in August 1997 was one of three physicians attending the World University Games in Sicily, where he worked with the diving team (and other athletes).

Outerbridge's work with Water Ski Canada has taken him to South America five times in the last five years. He estimates his involvement with this organization takes him away from his practice for three months of the year, through attending a variety of meetings (some for non-medical committees) and training camps, or being at events to provide "on-call" lakeside coverage. In addition, he chairs the medical commission of the International Water Ski Federation.

Scratch any sports medicine physician deep enough, and early athletic training is likely to come through. This is true for Outerbridge, who was a competitive water skiier in his teen years, and then a water ski coach for Alberta's provincial team and later for the national team. Once in medical school, it seemed only natural that he would "drift into" the medical side of the sport.

Away from team doctoring, Outerbridge takes photographs, of such quality that sponsors of water skiiers purchase them for publication in sports magazines. ▲

Dr Ross Outerbridge, team physician for Water Ski Canada, makes the sport look easy.

Mitchell – Kamloops Daily News

Reaching out . . . to Tibet

by Dr Isaac Sobol

"We were close to tears."

That was how Dr Lorna Medd described the discovery of an undiagnosed and untreated case of active leprosy in an orphaned and homeless young woman who had lost an arm in an earlier accident. This woman was one of the many patients seen recently by four BC doctors. in their improvised clinic in a modest hotel (no running water, no flush toilets, no sinks) in Yushu, Tibet.

Dr Lorna Medd, Medical Health Officer of the Northern Interior Health Unit, Dr Marcus Lem, resident in community medicine at UBC, Dr Ken Bassett of the Department of Family Practice at UBC, and Dr Isaac Sobol, chair of the BCMA's Aboriginal Health Committee, journeyed to Tibet in May 1998, to visit several projects run by ROKPA International, a Swiss-based charity that operates more than 100 projects in Tibet.

Many of ROKPA's projects involve primary education and training for poor, rural students who would otherwise never receive any formal education. Other projects provide free medical care for poor or homeless people unable to pay even the small fees required for any medical care.

In Yushu, ROKPA funds a free medical clinic run by a respected practitioner of traditional Tibetan medicine. Some patients travelled four days on horseback to reach the clinic.

ROKPA also is providing medicine for treatment of patients in a leprosy hospital on the outskirts of Yushu, where several active cases of leprosy are found each year.

In 1995, Yushu and the surrounding area suffered severe snowstorms, and tens of thousands of animals and hundreds of people died. ROKPA and the local government are now providing housing and food for some of the poorest inhabitants in the area. A small team of Swiss and French volunteers for Médecins Sans Frontières are also coordinating an emergency food relief program in the area.

When the four BC doctors reached Yushu, they were requested to run clinics each morning at the hotel, with the help of an English-speaking Tibetan monk who acted as translator. Word of the clinic spread, and large crowds of potential patients gathered in the hallway, beseeching the doctors from the time they emerged from their rooms until the end of the morning clinic.

Drs Ken Basset (standing) and (seated at right) Marcus Lem and Lorna Medd meet with Tibetan patients outside the hotel-room clinic.

Patients didn't sit politely and wait their turns; they continually crushed against the door, trying to get in. Often several people rushed into the room at once, forcing the doctors to restore order so that patients could be seen individually in privacy.

The medical problems ranged from acute suppurative otitis media to paralysis secondary to polio, from night blindness to suspected tuberculosis. Medicines, from simple analgesics to fluoroquinolones, had been donated to ROKPA from the United States.

The BC doctors visited traditional Tibetan hospitals. They were shown the raw materials for Tibetan herbal medicines and saw how herbs were used for medicinal baths. They also learned of current collaboration between practitioners of traditional Tibetan medicine and practitioners of Western-based medicine as we know it in Canada.

In addition to the medical side of the journey, banquets given by local officials were memorable parts of the trip. Here the doctors were introduced to the local tradition of toasting, using a locally-produced "barley wine" that contained 40 per cent alcohol. The doctors were generally very tipsy by the end of the evening, but, as promised in English on the bottle, they didn't suffer from hangovers or stomach upset the next day. The banquets also provided repeated exposure to dried yak meat, stewed mutton, and yak butter tea.

Patients eager to see the doctors crowd into the makeshift examining room.

The doctors travelled in the company of Dr Akong Tulku Rinpoche, a Tibetan trained as a meditation teacher and doctor. He fled Tibet in 1959, when many of the Tibetan religious establishment, including the Dalai Lama, also fled in the wake of Chinese military actions. He eventually settled in Scotland, where he helped establish and administer a meditation centre. About 10 years ago, he was able to return to Tibet, where he began the initial ROKPA projects.

Dr Akong asked Dr Sobol in 1993 to establish a Canadian branch of ROKPA. ROKPA Canada is now a registered charity and can issue receipts for income tax purposes for any donations received.

All four doctors agreed that the trip to Tibet and their medical experiences there were challenging, educational, and inspiring. They are continuing an investigation of a suspected tuberculosis outbreak at a school in Yushu, and they hope to interest more BC doctors in becoming involved in the work of ROKPA and helping the people of Tibet.

For more information about ROKPA , check out the ROKPA International Web site at www.rokpa.org. For more information about how you can help with ROKPA projects in Tibet, or to request a slide show of the doctors' recent trip there, please contact ROKPA Canada, c/o Dr Isaac Sobol, 3952 West 18th Avenue, Vancouver BC, V6S 1B7, phone (604) 222-0005, fax (604) 221-0015, e-mail isobol@unixg.ubc.ca.▲

From left: Drs Lorna Medd and Marcus Lem, two officials from Yushu Tibetan Medicine Hospital, Drs Isaac Sobol and Ken Bassett.

Dr Sobol, while doing a residency in community medicine in the Department of Health Care and Epidemiology at UBC, has continued as Medical Health Officer for the Nisga'a Valley Health Board in New Aiyansh. He still finds time to moonlight as a family physician in the Nisga'a Valley and Vancouver.