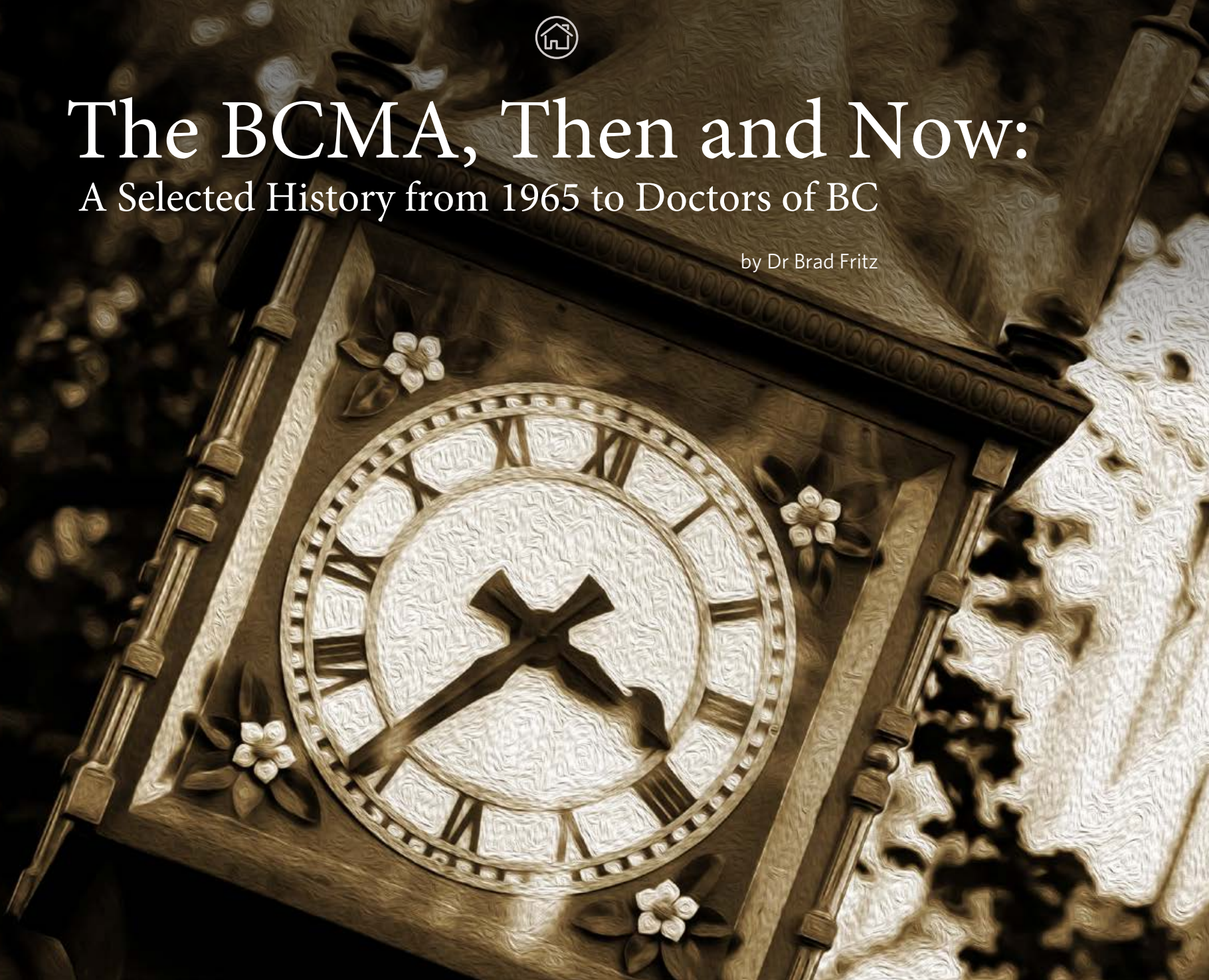




The BCMA, Then and Now:

A Selected History from 1965 to Doctors of BC

by Dr Brad Fritz





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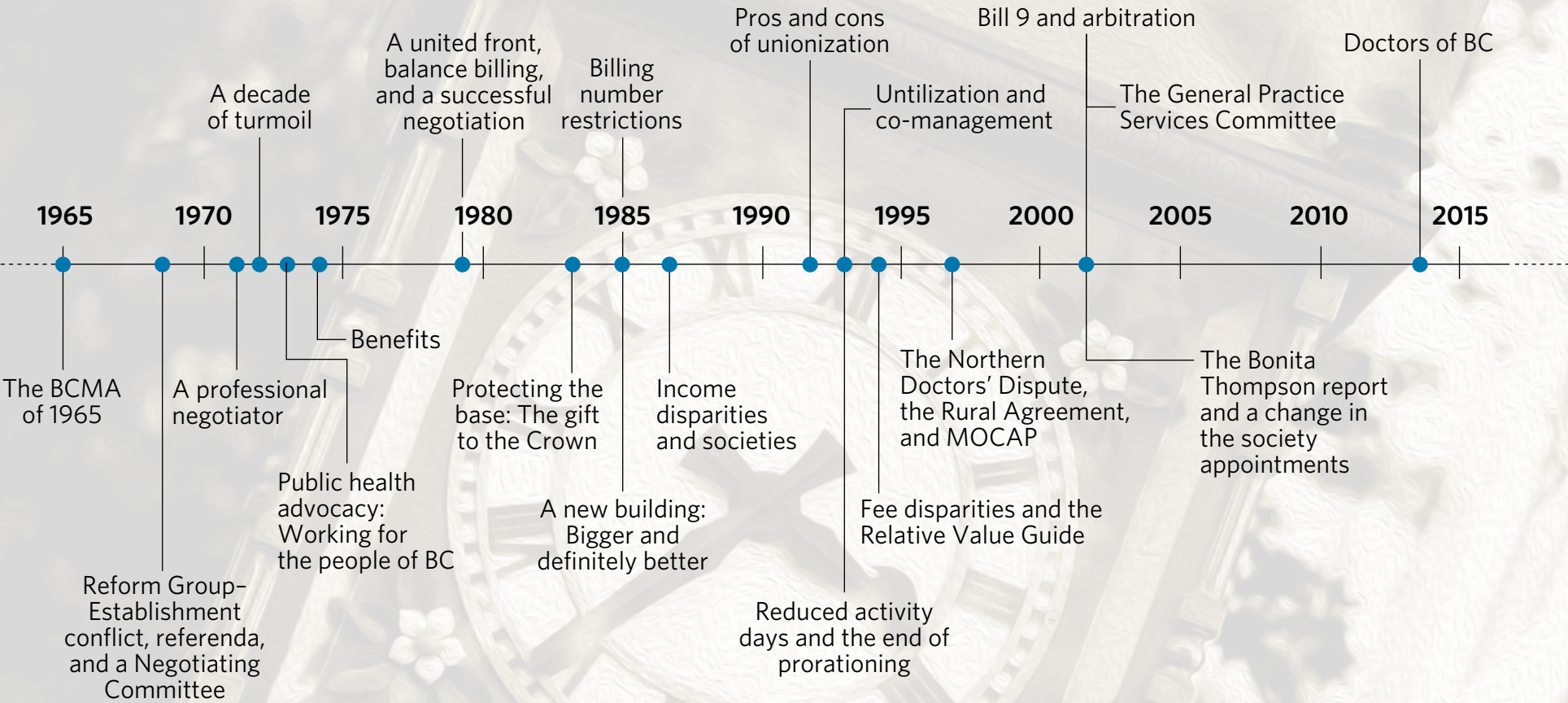
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Timeline





Introduction

by Dr Brad Fritz

I have been involved with the British Columbia Medical Association (BCMA) for almost four decades, having first attended a Board of Directors meeting in 1978. Since then I've served on the Board and the Executive and have sat on many BCMA committees, including the Negotiating Committee, which I chaired for over 15 years.

During my time on the Board of Directors, I noticed that issues that had been debated in the past often resurfaced, but members who weren't privy to earlier discussions had no easy way to learn about them. Although the BCMA has a robust archival collection, there is little in the way of a written history about the association, beyond an article Dr Ed McDonnell published in the *British Columbia Medical Journal* in 1984.¹ I felt it might be worth documenting some of the BCMA's watershed moments—key decisions or changes that have defined the association's evolution since 1965.

Why 1965? Although the association has existed since 1900, on September 1, 1965, Premier WAC Bennett introduced the British Columbia Medical Plan, British Columbia's first government-sponsored medicare program. This program was rolled into the federal government's national plan in 1968, resulting in medicare as we know it now. Many of the changes in the BCMA's governance and committee structure over the next 40 years developed in response to the introduction of medicare and other government actions.



Although I intended for this history to be a primer for new Board members to understand how and why many of the BCMA's programs and operations developed, I hope it will also inform anyone with an interest in the association's past.

This history is based on over 18 months of research and interviews with many of the individuals at the centre of the events documented here, as well as my own recollections from my long involvement with the BCMA. I've consulted documents from Doctors of BC Archives and past issues of the *British Columbia Medical Journal*, and I've talked to several Past Presidents and Officers, former Board members and Committee Chairs, and past and present staff of the association. Although these documents and recollections have informed my work, the views expressed, unless otherwise noted, are my own and not those of the organization or anyone else. Any errors or omissions are my own.

Over the past five decades, the BCMA has grown in its responsibility to represent the profession, especially during negotiations with the government. This relationship has been adversarial at times, but each triumph and misstep along the way has given the association an opportunity to learn and put in place policies and structures that have ushered in a recent era of cooperation. I hope this history helps members keep those lessons—many of them hard learned—at front of mind. After all, in the words of Spanish-American philosopher George Santayana, “Those who do not remember the past are condemned to repeat it.”²

1 McDonnell CE. A look at the BCMA's origins, its hardships and its triumphs. *BCMJ* 1984;26:672-676.

2 Santayana G. *Reason in common sense*. New York: Charles Scribner's Sons; 1905. p. 284.

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CHAPTER 1

1965—The BCMA of 1965

Negotiations of the day

The BCMA in 1965 was headed by Executive Director and CEO Dr EC “Tim” McCoy. Although medicare did not begin until 1965, the BCMA and the government did have issues to discuss and negotiate before then. Dr McCoy once told me that, because he was a personal friend of Premier WAC Bennett, their discussions often took place over lunch in the dining room of the Union Club in Victoria. Agreements were usually scribbled on a napkin at the end of the luncheon. In addition, “a number of successful negotiations regarding physician payment were conducted between McCoy and Health Minister Wesley Black over a cribbage board.”¹ If (and only if) Dr McCoy wanted someone else present, the BCMA president of the day would accompany him.

Although a few doctors were in salaried positions with private companies or the University of British Columbia (UBC), most doctors relied upon fee-for-service billings for their income.



Premier WAC Bennett and Dr EC “Tim” McCoy at the BCMA.

There were no service contracts or sessional payments. There were no benefits. Because there was no single payer before September 1, 1965, doctors had to bill either their patients or one of many different plans, including Medical Services Association (MSA), Medical Services Incorporated (MSI), Social Assistances Medical Service (SAMS), CU&C Health Services Society, or company plans such as the one the Canadian Pacific Railway had for their employees.



Dr Tim McCoy at work in the BCMA office.

Although the BCMA had been instrumental in setting up MSI and MSA, the association had no formal say in the day-to-day running of those plans. Private offices needed extra clerical staff to handle the large number of bills, and bad debts were common. The major economic focus of the BCMA before 1965 was negotiations between the association and the various private payers to set the BCMA schedule of fees.

One decision from that era stands out for its prescience: in its response to Premier Bennett's move to a provincial medicare program in 1965, the association had the idea of *balance billing* written into the contract with the government—a provision that would become important 15 years later. ▶ [SEE 1979-1981—A UNITED FRONT, BALANCE BILLING, AND A SUCCESSFUL NEGOTIATION](#)

Structure of the association

Although the BCMA had a Board of Directors in 1965, the decision-making power rested with the Executive Committee and Dr McCoy. The Executive Committee dealt with most issues, its deliberations resulting in motions brought to the Board and, if necessary, the General Assembly, to be ratified. The Board rarely challenged or changed these motions. Changes to the Constitution and Bylaws could be made only at a General Assembly.

In those days, there was no Negotiating Committee, no referenda for members to vote on proposed fee changes, and no binding dispute-resolution mechanism. There was no Medical Services Plan and no Medical Services Commission. There were sections that represented different medical disciplines but no Society of General Practitioners or Society of Specialist Physicians (now Specialists of BC) devoted to advancing the interests of specific groups of doctors, such as general practitioners or specialists. ► [SEE 1987-1989—INCOME DISPARITIES AND SOCIETIES](#)

With no mail ballot sent to the general membership, the Officers (President Elect, Chair of the General Assembly, and the Honorary Treasurer) were elected at the annual



Academy of Medicine building, home of the BCMA until 1985. Photo courtesy of the College of Physicians and Surgeons of BC.

meeting. An ordinary member could make a motion at the annual meeting only if it had been pre-approved by the Executive and the Board of Directors.

The BCMA's social events were a significant focus for the members. The annual meeting lasted two to three days and closed with a very well-attended dinner dance.



Drs Tim McCoy (left) and Wallace Wilson at the opening of the BCMA wing of the Academy of Medicine, 1965.

The BCMA did have a robust committee structure. Many of the committees had a health focus. For instance, the Cancer Committee made recommendations for cancer care in the province. The Economics Committee advised the Board on economic issues. There were no Communications or Public Affairs Committees because the Executive Director held these responsibilities. Dorwin Baird, a reporter for CJOR radio, worked part-time doing public relations for the BCMA as his wife, Verna, worked

for the College of Physicians and Surgeons of BC, which at the time shared the Academy of Medicine building with the BCMA. ▶ [SEE 1987-1989—INCOME DISPARITIES AND SOCIETIES](#)

In the BCMA of the 1960s, ordinary members—and even the Board of Directors—had little influence on decision making. As we’ll see in subsequent chapters, the incremental changes to the association’s structure over the next several decades increased member engagement and led to the association of the 21st century.

1 [No author]. Dr Tim McCoy (obituary). CMAJ, May 15, 1997;156:1511.



The BCMA logo in 1965.



CHAPTER 2

1968–1972—Reform Group— Establishment conflict, referenda, and a Negotiating Committee

In the mid-20th century, a shortage of family doctors in Canada prompted provincial governments to launch an aggressive advertising campaign to attract doctors from Great Britain.

Many of the British general practitioners were upset with how the National Health Service (NHS) had developed in the two decades after the end of the Second World War. First, in one year specialists in Great Britain received a 14% increase, while general practitioners received nothing. Second, the top marginal tax rate in Britain was 83%. Third, the NHS had actively recruited doctors from places in the empire such as India and Pakistan to work in many hospitals and clinics. Because these doctors were willing to work at a lower salary than British-trained

GPs, many of the latter group could not get financially rewarding work in Britain and turned to opportunities across the pond.¹

One of the migrants was Dr Euan Horniman, who arrived in BC in 1958. After three years of further training, he went into general practice first in New Westminster and then in Surrey. Dr Horniman was an astute observer of medical economics and over the next decade generated many of the ideas championed by the faction of the



Dr Euan Horniman, intellectual leader of the Reform Group.

BCMA that became known as the Reformers (so named by Dr Horniman, who referred to his opponents as “the Establishment”).²

Unfortunately, Dr Horniman, by his own admission, could be abrasive and difficult to deal with.³ He often

used personal attacks on those who did not agree with him to make his case. He started the *District 6 Newsletter* and would use it to challenge those in the BCMA establishment who opposed his ideas. Many leaders of the profession attacked Dr Horniman in kind, and he likened it to the way he was treated by the prefects in the boarding schools he attended in England.⁴

The debates between him and his followers and the more established Board members of the BCMA became increasingly strident and personality based. Clearly, Dr Horniman’s ideas were often opposed not on their own merits but because they came from him. As he said in an interview in 2002, “This was a story of personalities and a story of power.”⁵

Over the next several years, he noted that although the BCMA fees increased by an average of 8.7% from 1960 to 1965, the average wage increase across all other sectors in the province was 20.4% He also became concerned with the BCMA’s method of negotiating fee increases under the leadership of Dr McCoy.

In response, he suggested sending all proposed fee agreements to the general membership for a vote, which



he believed would serve as an excellent negotiating tool, as a failed referendum would give the negotiators (at that time Dr McCoy and the President) ammunition to press for a better settlement. In addition, he pushed for the creation of a Negotiating Committee, which would be elected by the General Assembly and would represent the BCMA at negotiations.

He presented the idea for a referendum at the annual meeting of 1968, but the Board and the Executive, likely seeing it as a threat to their powers, opposed this proposal. Dr Horniman persisted and brought it to the floor again in 1969 and 1970, when it was finally adopted at the annual meeting and was voted into the association's Constitution and Bylaws in 1971. The use of referenda subsequently spread across Canada and is now standard in every provincial and territorial medical association.

Dr Horniman was no stranger to controversy. For example, he felt that the more doctors there were, the worse off each individual practitioner would be, because of competition for patients. As a result, he was a firm believer in restricting billing numbers and went so far as to propose a motion at a College of Physicians and Surgeons

meeting in the early 1970s that doctors who moved to BC from outside Canada should have to work for at least two years in an underserved area of the province before setting up practice in their area of choice. The motion was defeated, but this idea came back again and again over the next two decades. ► [SEE 1985—BILLING NUMBER RESTRICTIONS](#)

At the 1972 meeting in Penticton, attended by almost 1,000 members, Dr Horniman advanced another of his ideas—"to turn the Association into a first class collective bargaining unit."⁶ His proposal to have negotiations conducted by a Negotiating Committee, which would be appointed by the Board of Directors and not elected by the General Assembly, was adopted. The General Assembly also passed a motion to use a professional negotiator, although this concept was not acted upon until the end of the decade. ► [SEE 1972-1980—A PROFESSIONAL NEGOTIATOR](#)

Having achieved this success, Dr Horniman immediately made a motion from the floor—without forewarning his supporters—that the General Assembly's decisions would be binding on the Board of Directors.⁷ This change would have been a departure from the usual practice, in which General Assembly motions were only advisory to the



Dr John O'Brien-Bell addressing the General Assembly in 1977.





President Dr Ken Hill at the 1973 annual meeting.





Board. The motion was defeated, and Dr Horniman was heckled by speakers at the head table.⁸ The verbal fighting that followed was furious, and the Reformers made motions to impeach the incoming President.

Dr Horniman's ideas to improve the profession economically had earned him a group of dedicated followers, including Drs John O'Brien-Bell, Bill Jory, and Ken Hill. After a failed attempt to make the Board subservient to the General Assembly, these doctors founded the Reform Group, an entity within—but separate from—the BCMA, to push for further changes. Although Horniman was the intellectual leader, Dr O'Brien-Bell became the communications lead, and Dr Hill was their first successful candidate in elections, becoming President Elect when the Reformers packed the annual meeting in Penticton in 1972. Dr Jory was an excellent public speaker and, as the public face of the Reform Group after Dr Hill's term, went on to be elected President twice.

Up until the 1972 annual meeting, only members who were present for the General Assembly would vote for the Officers. After Dr Hill was elected, the Establishment moved that elections be held by mail ballot of the entire membership. They likely believed that doing so would

mean they would always win elections, because they had the support of many members in Vancouver, which had the largest number of doctors in BC.⁹ This practice began in 1973, and all elections from then on for Officer and Board positions have been by mail-in ballot.

Dr Horniman's ideas—including referenda and an arm's-length Negotiating Committee, which are now central to the BCMA—were delayed for several years because of the enmity between the Reformers and the Establishment Party. Throughout the rest of 1970s, there was a fierce war within the BCMA between the two groups. The Establishment Party felt that the Reformers' attacks were unprofessional and that the belligerent attitude they espoused would only make dealings with the government worse. Over the decade, the two sides beat each other up while the fee schedule fell further and further behind inflation.

1 McDonnell, CE. An interview with Dr Euan Horniman. BCMA Archives, August 11-12, 2002:1.

2 Ibid.:15.

3 Ibid.:24.

4 Ibid.:1.

5 Ibid.:4.

6 Ibid.:7.

7 Farquhar, D. An interview with Dr John O'Brien-Bell. BCMA Archives, January 30, 2001:11.

8 Ibid.:12.

9 Ibid.:13.



CHAPTER 3

1968–1979—A decade of turmoil

After Premier WAC Bennett established the first prepaid medical insurance program in BC in 1965, the first negotiations with the BCMA created a formula that automatically generated increases to the fee schedule. This formula resulted in generous increases over the first few years of the contract (over 9% in the first year alone).

By 1968, however, the government of BC found that it faced a budgetary shortfall, and, lured by the promise of federal dollars, Premier Bennett agreed to roll the BC Medical Plan into the new federally sponsored national medicare program, with the promise of 50/50 cost splitting between the federal government and the province. Despite this agreement, the growing cost of health care continued to concern the provincial government.

By 1971, inflation in Canada was rapidly increasing, and the relationship between the BC government and the

BCMA had deteriorated. In response to the escalating costs of medicare, Premier Bennett tried to undermine the medical profession by publishing the Blue Book, listing the gross figures paid to doctors through medicare in 1970. He also legislated a temporary cap for individual doctors of \$100,000 on income from the Medical Services Plan (MSP).

Premier Bennett then approached the BCMA with a proposal of a one-year moratorium on fee increases. He explained that if the medical profession set an example for other groups paid from the public purse, those groups



would hopefully moderate their wage and salary demands. Having proven that he could legislate against the doctors, Premier Bennett probably felt he had backed the BCMA into a corner. He promised the Board members that if they cooperated in setting an example, he would make it up to them in future negotiations. The Board sent a referendum to the membership with a recommendation to approve the proposal, which the members did, by a margin of 77.8% to 22.2%. Unfortunately, the government put no real pressure on any other groups to follow suit, and the doctors of the province were alone in taking no increase in compensation that year.

Premier Bennett lost the election in 1972, and the New Democratic Party (NDP) came to power for the first time. Mr Dave Barrett became premier, and his government showed no interest in honouring Mr Bennett's pledge to make up the monies lost in the moratorium.

Between 1965 and the late 1970s the BCMA's schedule of fees increased at the rate of inflation, while the MSP Payment Schedule increased only by amounts determined

in negotiations. By 1979, the rates in the BCMA's schedule of fees were more than 40% higher than those paid by MSP.

Economically, the 1970s were not good for Canadians generally and for the doctors of BC specifically. Inflation always ran ahead of fee settlements. Prime Minister Pierre Trudeau brought in wage and price controls in 1975, further compromising the BCMA's ability to recover the losses in doctors' earning potential.

The infighting between the Reformers and the Establishment dominated BCMA politics, and attempts by both parties to elect the President and control the Board prevented the membership from uniting to fight back in negotiations. This animosity came to a head in 1979, when the BCMA nominated Reformer Dr Bill Jory to be President Elect of the Canadian Medical Association (CMA). The CMA elected Dr Bill Thomas, a candidate identified as belonging to the Establishment Party, and the Reformers walked out of the CMA General Council en masse.



Dr Bill Jory at an annual meeting.

As the decade drew to a close, the Reform and Establishment groups realized that fighting each other was counterproductive. Over the next few years, the principals of both parties developed a grudging respect for each other and shifted their focus to better serve the membership.



CHAPTER 4

1972–1980—A professional negotiator

The General Assembly of 1972 passed a motion that the Negotiating Committee “employ a proven expert negotiator to deal with the BC government because recent negotiations with government appear to have been inexpert.”¹

This wasn’t the first time the idea was put forward. In 1930, the government of Premier Duff Pattullo passed legislation that would have established a prepaid medical insurance program for the province. Because of vehement opposition from the BCMA and others, the government never asked for royal assent and the legislation never became law. During the dispute, some members of the association advocated using a professional negotiator. No such move was made, and the idea lay dormant for four decades.

By 1979, after a lean decade for doctors, the Reform and Establishment groups recognized that their fighting

had hurt members’ earning potential. With the end of Prime Minister Pierre Trudeau’s wage and price controls in 1978, the BCMA’s leadership saw an opportunity to present a strong, unified front and make up lost ground in the next negotiation with government.

Although the BCMA had considerable expertise in negotiations—acquired through the training of the Negotiating Committee in the 1970s—and an excellent staff, led by Executive Director Dr F Norman Rigby, Director of Economics Mr Jack Paul, and Director of Communications Mr Jim Gilmore, the association’s

leadership concluded that the members were not prepared to take on the government collectively. The Board of 1979 came back to the idea of using an outside expert to help prepare for the round of negotiations that was to start in 1980.

The Negotiating Committee (of which I was the junior member) was tasked with interviewing candidates and bringing a recommendation to the Board. After an exhaustive search, the Committee interviewed three candidates for the job—two labour negotiators and one who represented management in negotiations, Mr Ben Trevino.

We met Mr Trevino at Armando’s Restaurant on Pender Street and were completely fascinated by his personality and his interest in the upcoming negotiations. Although Mr Trevino’s experience was in representing management in corporate-union negotiations, he recognized that our members would identify both with management, being small business owners, as well as with union members, in our negotiations with the government, and sketched out an approach that showed he understood our situation. The Negotiating Committee recommended to the Board

of Directors that we retain Mr Trevino, and he was hired to advise the BCMA throughout the negotiation.

The association achieved a significant win in that negotiation. Much of the success was due to the expertise of Mr Trevino, who was a brilliant tactician and a great communicator with the Board and the members.

▶ [SEE 1979-1981—A UNITED FRONT, BALANCE BILLING, AND A SUCCESSFUL NEGOTIATION](#)



Dr F Norman Rigby and Mr Ben Trevino, QC, at a Negotiating Committee meeting.



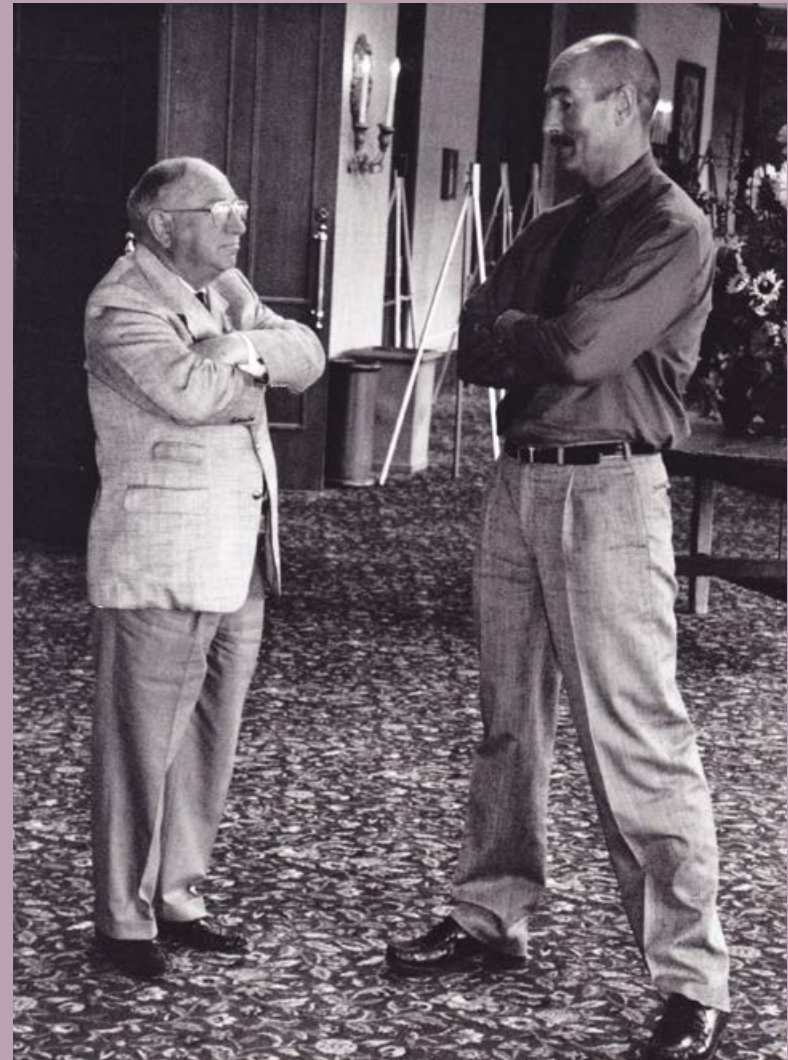
Mr Ben Trevino, QC, at a Negotiating Committee meeting.

When Mr Trevino retired from his law practice in 1996, the BCMA decided to continue using a professional negotiator and hired Mr Geoff Holter as Director of Negotiations. He developed the Negotiations Department, which has supported the membership in negotiations between the BCMA and the government, and between members and health authorities and hospitals.

The BCMA was the first provincial association to use a professional negotiator and to develop a Negotiations Department to support members in negotiations big and small. After our success in 1980-1981, every provincial and territorial association has followed our lead.

Just as we all use specialists to help our patients when such expertise is beyond our personal ability, our members have benefited from the expertise of professional negotiators and other experts outside of medicine.

1 General Assembly minutes, 1972. BCMA Archives.



Long-time Negotiating Committee member Dr Murray Kliman and Chief Negotiator Mr Geoff Holter.



CHAPTER 5

1973–1995—Public health advocacy: Working for the people of BC

Although the BCMA has advocated for the welfare of the people of BC and advised the government on health policy since before 1957, when the Board of Directors established the Health Planning Council,¹ its first public relations efforts were not especially sophisticated. After the first salary dispute with the provincial government in 1970, the association realized it would have to improve its communications with the public and show British Columbians how invested the province's doctors were in their health and well-being.

The BCMA hired Mr Jim Gilmore in 1973 to be the first full-time Director of Communications, and it undertook campaigns and longer-term projects to inform the public and the government about health issues. Mr Gilmore set up an effective communications structure to relay the association's messaging to the press, public, and government. He reorganized the office, improved the look of the *BC Medical Journal*, and had a new logo produced for the BCMA.

In the early 1970s, the press in Vancouver often asked the association for comments about issues and got little response from organized medicine. Media leaders such as Mr Jack Webster complained about their ability to even get a quote, let alone an in-depth interview. Mr Gilmore, who felt that "fighting with the media is like kicking a skunk,"² recognized that the ability to sway public opinion through the Websters of the world was essential for the BCMA to win any disputes with the government. Under

his direction, the association scheduled interviews, gave backgrounders, and bought tables at all the fundraising dinners for political parties and media events.

Compared with the 1960s, the Boards in the 1970s were much more proactive about advocacy. The Board relied on input from the Communications Department and the Communications Committee, which had members from every corner of BC. In 1985, the Health Planning Council and the various other committees that advised the Board on issues of public health were organized into the Council on Health Promotion (COHP).

Efforts to reach and connect with people in the community were a priority for the BCMA, and one such initiative was *Doctor, Doctor*, a weekly medical information TV show that the association underwrote from 1986 to 1989. Hosted by Dr Art Hister and Ms Barbara Constantine, the show invited BC doctors to advise about a wide range of health issues.

Also essential to advocacy was the MD/MLA program. A doctor from each riding was connected to every MLA in the province. Among other duties, each year they would travel to Victoria and meet with their MLA over a meal and discuss public health issues. The program kept MLAs



Mr Jim Gilmore, 1976.



BCMA logo created under Mr Jim Gilmore.



engaged, and the BCMA enhanced its ability to advocate for the public in government policy.

In addition, each city or town's local medical society had a communications officer who received media training and was familiarized with BCMA's action program—the list of each year's priorities as set by the Board. These doctors developed excellent relationships with their local press, which further helped them connect with their communities.

Having put together an excellent communication and public advocacy structure, the BCMA launched a series of successful campaigns to influence the public and government.

1977—The mandatory use of seat belts

The first public health issue that the BCMA decided to tackle was seat belt use. The Social Credit government in the mid-1970s was dead set against making the use of seat belts mandatory because it believed that such laws intruded unnecessarily into people's lives. The BCMA organized a petition, which was signed by tens of thousands of British Columbians, which, along with

lobbying efforts of local doctors through the MD/MLA program, prompted the government to change its policy. In 1977 the government passed legislation to make using seat belts mandatory for everyone over the age of 16.

1979—A moratorium on uranium mining

The BCMA's newfound willingness to take a stance on controversial issues, coupled with strong relationships between doctors and their communities, led to a landmark public health win.

In 1979, a subsidiary of Denison Mines applied for a licence to mine uranium near Clearwater. The local community and Indigenous bands were against the mine and turned to local family physician Dr Bob Woollard for help. He took the issue to the BCMA's Environmental Health Committee (EHC) and Board of Directors. In response to pressure from the community and the association, the government appointed a Royal Commission, headed by Dr David Bates, Dean of the Faculty of Medicine at UBC. Based on the scientific evidence presented, the Commission recommended a moratorium on uranium mining in BC, which remains in place today.



Drs Bill Jory and Bill Ibbott present Health Minister Bob McClelland with a BCMA "Buckle Up & Live" bumper sticker, 1977.

1979—The Sedro-Woolley nuclear reactor

Soon after the successful campaign against uranium mining, the BCMA's EHC became aware that Puget Sound Power and Light had applied to the US Nuclear Regulatory Commission (NRC) to build a nuclear reactor in Sedro-Woolley, about 110 km southeast of Vancouver. The proposed reactor site was on a major seismic fault line. The BCMA Board was concerned about the public health implications and had the EHC work with scientists from the University of Victoria on plume dynamic atmospheric accident scenarios.

During the public hearings in Seattle, Dr Woollard, on behalf of the BCMA, was able to show that, in the event of a Chernobyl- or Fukushima-type accident, large areas on the Pacific Northwest would become uninhabitable for decades. Depending on the wind direction, Vancouver and Seattle or eastern Washington, Idaho, and Montana would become wasteland. The BCMA's presentation, which was strictly based on science and not on ideology or fear, turned the tide against the application, and the NRC refused to grant the licence.



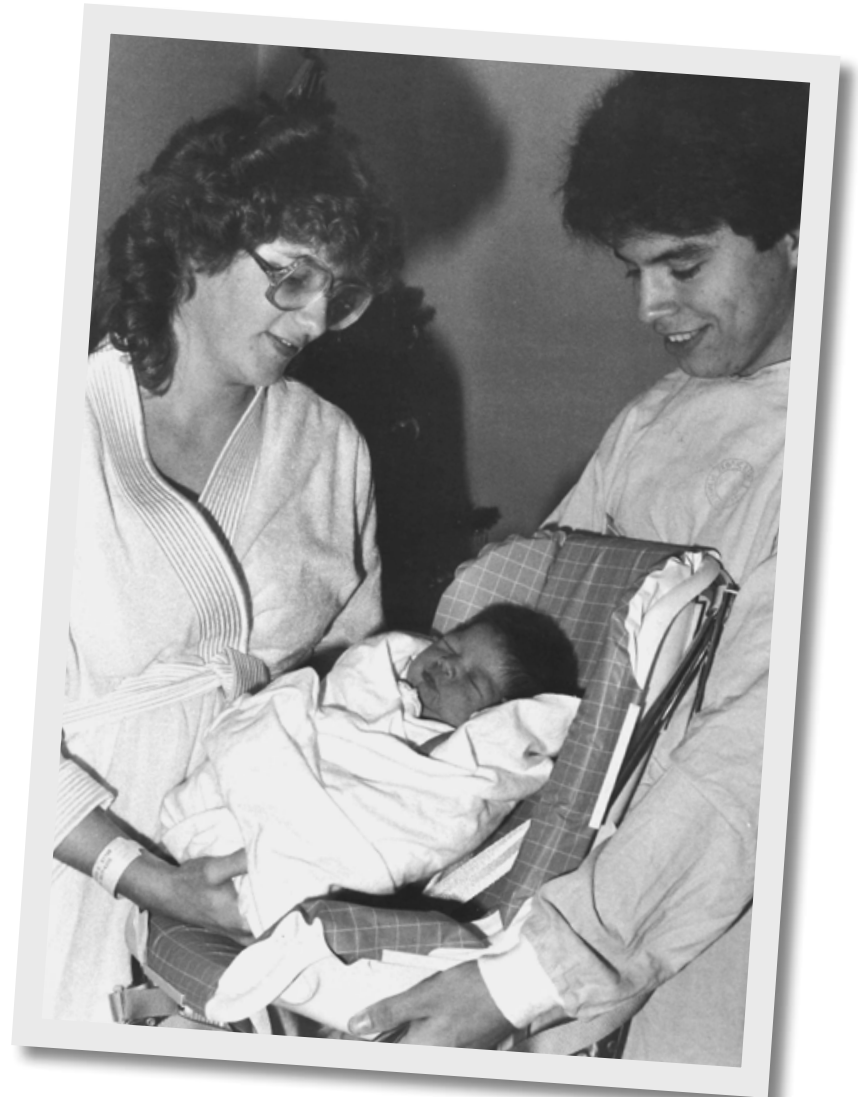
Dr Bob Woollard at his presentation to the US Nuclear Regulatory Commission.

1985—Infant car seats and child car seat restraints

The 1977 legislation making seat belt use mandatory applied only to people over the age of 16 and did not cover infants, toddlers, or children. The BCMA began a campaign to correct this oversight, although it faced resistance from the Socred government, which considered mandatory car seats an unnecessary restriction of the public's freedom.

The BCMA highlighted the use of car seats by donating one to the first baby born each year in every hospital in the province, a program that always generated a picture of a local doctor with the new parents. In addition to putting pressure on the government to make use of child restraints mandatory, these pictures encouraged parents to safely restrain their children.

The BCMA collected 104,000 signatures on a petition that was placed in doctors' offices. When the government refused to take delivery, the boxes containing the petitions were left on the front steps of the legislature by a crowd of BCMA members—a move that was carefully documented by the press. The government capitulated and made infant and child restraints mandatory in 1985.



A car seat being presented to new parents, c. 1977. Photo by Jim Gilmore.

Editorial cartoon in the Vancouver Province during the debate about child restraint legislation. By Bob Krieger. Reproduced with permission.





1980s–1990s—A ban on smoking in public places

Although tobacco advertising on radio and television had been banned in BC since 1971, smoking in public was still legal. Spurred on by committees in COHP, the BCMA organized several anti-tobacco campaigns during the mid-1980s. First, the association distributed decals to restaurants to advertise that they had non-smoking sections. Next, the association organized “Cold Turkey Day” to encourage people to quit smoking. Finally, in-office petitions were signed by close to 100,000 people and presented to the government. In keeping with growing anti-tobacco sentiment in other jurisdictions in North America, BC passed a series of laws in the late 1980s through to the mid-1990s that outlawed all forms of tobacco advertising, forbade the sale of tobacco products to minors, and eventually banned indoor smoking in all public places.

Dr Fred Bass accepting an award for the BCMA Stop Smoking Project from George Lawson of Ciba-Geigy, 1992.



A bicycle helmet success story

Members of the BCMA's Sports Medicine Committee are waving their bike helmets and hoisting their water bottles in celebration of recently-announced provincial legislation.

As of September 1996, all cyclists in British Columbia will be required to wear helmets, and the committee can take a large measure of the credit for bringing this about.

In 1987, the committee, chaired by Dr. Bill Mackie, put forward a resolution calling for legislation requiring cyclists to wear protective headgear. This was followed by an extensive public awareness campaign, sponsored by the BCMA's Communications Committee and in collaboration with the Registered Nurses' Association of BC, the Insurance Corporation of BC, the Cycling Association of BC, and the BC Home and School Federation.

The campaign's highlight was the "Protect Your Melon" poster, in which a crushed watermelon appeared as a

graphic example of what can happen to an unhelmeted head. The poster and other informational material received wide distribution through the province's schools, community centres, and recreational facilities, and is still in great demand during the spring and summer cycling seasons.

The committee, while pleased with the education campaign, recognized that more was needed if bicycle-related head injuries and deaths were to decrease. So members began serious lobbying efforts, supported by the Emergency Medical Services Committee's 1991 resolution issuing another formal call for helmet legislation.

Going beyond the usual letters to government ministers, the committee took every opportunity to get the helmet message out to the public, through newspapers, radio talk shows, and television appearances.

When organizers of a mass cycling fundraising event in Vancouver balked at requiring



Dr. Bill Mackie, chair of the Sports Medicine Committee, accepts congratulations from Dr. Tom Perry, MLA for Vancouver-Little Mountain, at government's announcement of bicycle helmet legislation

helmets for participants, the committee questioned how an insurance company could sponsor an unsafe ride. This led to a showdown, when medical personnel withdrew their support, only to be replaced by ski patrollers. The following year, ride participants wore helmets.

The years of such sustained effort paid off in the spring of 1995, when Jackie Pement, BC's Minister of Transportation and Highways, announced helmet legislation. This will be combined with a strong educational component; Mackie represents the BCMA on the campaign's advisory committee.

Mackie would like to see this education campaign carried

to the community level through the support of BCMA members. "We can talk to our patients about the importance of bike helmets," he says, "and encourage them to think in terms of safety. A few positive words from a doctor will go a long way toward reinforcing the message."

In acknowledging his colleagues' work in achieving the legislation, Mackie said, "It was an effort of the whole committee. Everyone worked hard to make this happen." The Sports Medicine Committee can indeed congratulate themselves on a job well done.

Copies of the BCMA's bicycle posters, including "Protect Your Melon," are available through the COHP office, (604) 736-5551. ▲



1995—Bicycle helmets

As bicycle use in BC increased over the years, so did the number of cycling-related head injuries treated in emergency rooms and doctors' offices. Having heard from the membership about the often-devastating effects of these injuries, the association mounted a campaign in the early 1990s to push the government to legislate mandatory helmets while riding a bicycle. Once again, the use of petitions figured prominently in the campaign, but by far the most effective tool were ads on billboards and in print that showed a watermelon being squashed by an elephant's foot or a watermelon in a helmet being protected. It did not take long for the public to get behind the campaign, and the government passed bicycle helmet legislation in 1995.

The campaign for bicycle helmets was the last major effort by the BCMA to publicly influence public health policy. By the start of the 21st century, the focus of the association and the government had shifted to joint efforts to improve the health care system in BC, with an increasing interest in the economics of medical practice. Although the BCMA put forward many laudable projects, such as a paper on

childhood obesity,³ public campaigns to influence the government did not back up these efforts.

Although many of the BCMA's activities have focused on supporting doctors in negotiations with the government, in these many campaigns, the association has also provided a platform for the political and advocacy arms of the profession to come together to influence public policy, showing the power of organized medicine to contribute to public debate while taking a strong moral stance based on scientific evidence.

1 Mackie, B. COHP: 47 years at the forefront of change. *BCMJ* 2005;47:16.

2 Unpublished interview with Mr Jim Gilmore by Dr Brad Fritz, March 16, 2015.

3 British Columbia Medical Association Council on Health Promotion. Child and youth growth index: BCMA feasibility study. Vancouver, BC: BC Medical Association; September 2006. https://www.doctorsofbc.ca/sites/default/files/bcma_cygi_feasibility_study.pdf.

CHAPTER 6

1974–2010—Benefits

After the NDP was elected in 1972, Mr Dennis Cocke was appointed Minister of Health. He developed a good working relationship with the doctors, but because the government was running large budget deficits, he had a mandate not to exceed a certain fixed-percentage increase in fees—one that wasn't enough to entice the association to a settlement.

Minister Cocke asked the BCMA in early 1974 if the doctors might be interested in additional benefits in lieu of a larger fee increase. The two sides agreed to create Continuing Medical Education (CME) and Physicians' Disability Insurance (PDI) funds, pending membership approval. The CME Fund was to be organized by a Joint Committee and would accumulate an amount equivalent to approximately 1% of the physicians' gross payments.

Some members of the Executive moved to use the CME Fund to set up a CME division at the UBC Faculty of Medicine. The ordinary members, who felt that the fund had been developed to cover the costs of individual doctors' continuing medical education, did not like this



Health Minister Dennis Cocke worked with the BCMA to establish its first benefits program.



proposal, and the first referendum on the CME Fund was defeated. After the proposal was reworked to ensure that all monies went to individual doctors, the membership approved the creation of the CME Fund in late 1974. The PDI Fund, which gives physicians a source of monthly income if injury or sickness prevents them from working, cost roughly the same as the CME Fund and was created in 1975.

Unfortunately the government contributions to the two funds were not indexed to future fee increases, so the amount each member received for CME stayed the same, even as the cost of education increased dramatically, especially for specialists. Only the low rate of use by members kept the PDI benefits from being cut. From an economic standpoint, putting the money into fees and having it compound with fee increases may well have served the members better.

Having benefited from these two funds, many members wanted the BCMA to negotiate similar programs, such as for retirement. The government was not interested in expanding the benefits until 1987, when the Canadian Medical Protective Association (CMPA) reimbursement plan was negotiated.

During the mid-1980s, two factors led to rapidly escalating costs of CMPA coverage to members. First, court awards in that decade increased dramatically, and the CMPA, as a mutual defence organization, had to increase the premiums to maintain reserves for future awards. Second, whereas the premiums for all doctors had been the same for decades, the ballooning costs of awards to certain specialties (obstetrics and gynaecology, neurosurgery, and orthopaedics, among others) forced the CMPA to move to a differential fee schedule, where specialties with higher costs were charged larger amounts. Many doctors who did not work in those areas found their fees increasing despite their own specialties' "good experience" (using the parlance of insurers), and they were actively looking for insurance elsewhere. By 1987, the highest rates approached \$30,000 a year.

In that year's negotiations the BCMA was not prepared to settle for anything less than funding for CMPA increases beyond the amounts paid in the base year of 1987. The government capitulated, and the CMPA Fund was ratified, with all excess costs reimbursed to individual members.

In 1991, the BCMA and the Social Credit government negotiated a pension plan for members at an initial cost of



\$25 million. Both parties ratified the agreement, and the Professional Retirement Savings Plan was established on March 31, 1992. In the meantime, however, Social Credit lost the 1991 election to the NDP, which refused to fund the plan.

Like almost 900 other doctors, in the run-up to the election I attended a meeting at the Hotel Georgia in Vancouver, where Mr Glen Clark promised that the NDP, if elected, would honour the agreement. However, NDP Premier Mike Harcourt's government passed legislation in July 1992—Bill 14—breaking that promise. Once passed, the Professional Retirement Savings Plan Agreement Extinguishment Act eliminated all mention of the pension agreement from the public record and effectively rewrote history. The act read: "The Professional Retirement Savings Plan referred to in article 2.1 of the agreement shall be deemed not to have been established."

The members were livid at the betrayal and demanded some sort of retirement funding. There was increased pressure for the members to opt out of the MSP en masse. During the negotiations of 1993, the government agreed to match contributions to a member's RRSP contributions up to a certain limit, but at the price of co-management. To the members, the Contributory Professional Retirement

Savings Plan program was a huge success, and in 2010 a length-of-service bonus was instituted.

▶ [SEE 1992—PROS AND CONS OF UNIONIZATION](#)

In 1998, the BCMA negotiated the Rural Education Action Plan, which provides extra funding for doctors in the more remote areas of the province to access CME.

The last benefit program established was the Parental Leave Program. Originally negotiated as a Maternal Leave Program, members requested a change to the plan in 2010, providing benefits for members of both sexes who take time away from practice to raise children.

BCMA members have been largely in favour of these six benefit programs, but some members have expressed misgivings about benefit programs for three reasons: First, the Canada Revenue Agency might interpret these benefits as evidence that doctors are employees of the province, rather than independent contractors. Second, these programs may erode the profession's independence, in that relying on the benefits may make members less likely to be willing to take action in a dispute with the government. Third, some members feel it would be better to have all the funding that has gone into these programs added to the MSP Payment Schedule.



CHAPTER 7

1979–1981—A united front, balance billing, and a successful negotiation

By 1979, after a fractious decade, the Reform and Establishment parties had grudgingly declared a truce, recognizing that while they were fighting, the earning potential for an individual doctor had fallen compared with inflation.

In the hope of forcing a settlement to close the gap, the BMCA tried to persuade members that its next negotiations would require unified action and decided to use balance billing as its main weapon.

▶ [SEE 1968-1979—A DECADE OF TURMOIL](#)

When the BCMA entered the BC Medical Plan in 1965, the association’s leaders had Premier WAC Bennett agree to the concepts of “extra billing” and “balance billing” in the negotiations. Extra billing, which had never been used, allowed a doctor with special expertise in a particular

area to bill a patient in addition to the medicare payment, without opting out of the BC Medical Plan. This option was meant to be used only by those with a particular enhanced skill set and not by the average member.

The balance billing option, however, was available to all BCMA members and allowed doctors to bill patients the difference between the BCMA schedule of fees and the rate the MSP paid for a fee item as set out in the MSP Payment Schedule. To start balance billing, doctors had to give notice to the MSP. Mr Ben Trevino warned the Board

that if doctors used balance billing, there was a good chance the government would outlaw it. In his opinion, threatening to use balance billing was far more powerful than using it. ▶ [SEE 1972-1980—A PROFESSIONAL NEGOTIATOR](#)

The BCMA entered into negotiations and warned the government that, if an agreement acceptable to the membership couldn't be reached, the doctors would start billing the difference between the two sets of fees to the patients as of April 1, 1981. Negotiations started and stopped several times, with the BCMA asking for a 41% increase in fees. The government responded with an offer of just over 15%, and the Board sent this to the membership as a referendum. The membership voted 94% to reject the offer and, at the same time, voted 86% in favour to start balance billing April 1.

In response, the MSP sent every doctor in the province a printed Payment Schedule. The members sent them back to the association office on West 10th Avenue, and they were returned by truck, unopened, to the Ministry of Health.

Also in response to the threat, Minister of Health Jim Nielsen tabled Bill 16 to outlaw balance billing. If this bill became law, it would break the existing agreement—and force doctors wishing to bill patients directly to opt out of the MSP.



BCMA Negotiating Committee members Drs Brad Fritz, GG "Bud" Lott, and Murray Kliman.



Drs Brad Fritz and Bud Lott in a strategy session, c. 1980.



BCMA staff member Ms Tanyss Nofle with returned MSP Payment Schedules, 1981.



As negotiations continued, the Board extended the deadline to start balance billing. As the new date drew near, negotiations broke down, as neither side would budge. At the request of the minister, the BCMA's President, Dr Alex Mandeville, met with Minister Nielsen, and they agreed to send the negotiating committees back to the table for three days in early May to see if an agreement could be reached.



Mr Jack Paul and Drs Jack Hamilton, F Norman Rigby, Brad Fritz, and Bud Lott congratulating Mr Ben Trevino at the Penticton annual meeting, 1981.

Days one and two resulted in movement, but the two sides were still far apart when negotiations ceased for the night. On the third morning of bargaining, the government team came to the table with a new member, Mr Charles “Chuck” Conaghan—someone the BCMA's negotiators knew was close to Premier Bill Bennett. Mr Trevino opined that Mr Conaghan was there to make sure the two sides would reach an agreement that day, and, as he surmised, the government negotiators—spurred on by Mr Conaghan—reluctantly agreed to a 40% fee increase to be implemented over the next two years.

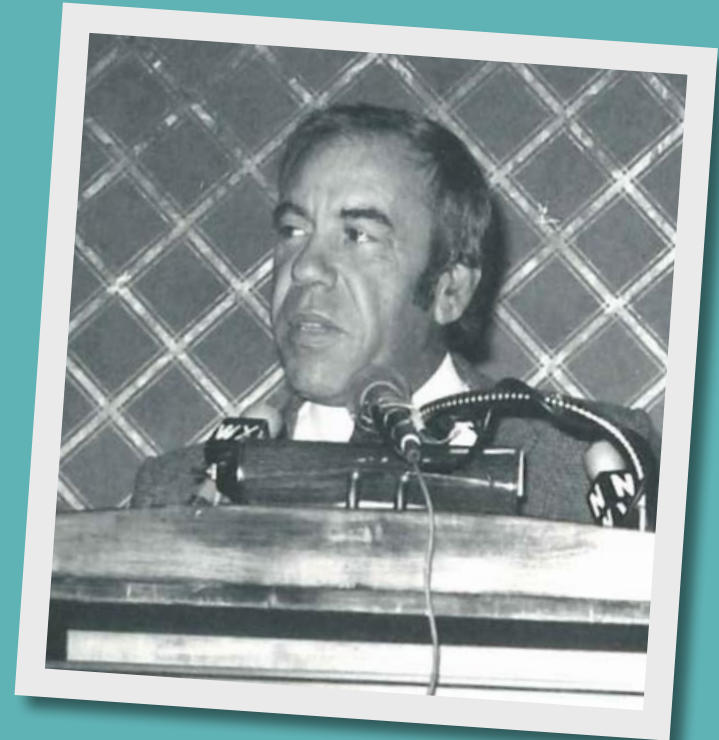
In those days before email and conference calls, there was no easy way for the Board to meet quickly to discuss the proposed settlement. The Board scheduled a meeting for one week hence, but because no details of the agreement could be released in the meantime, some Reformers in several communities started to balance bill patients.

At this point, the fragile truce within the BCMA broke down, with the Reformers suggesting that there was more money to be had by rejecting the offer and the Establishment wanting to send it to referendum.

The Board decided to send the 40% offer to the members, giving them a five-week window to vote. During that time, the BCMA had its annual meeting, and Minister Nielsen attended. In response to the outbreak of balance billing, he reiterated his plan to pass Bill 16, which would put an end to both extra and balance billing.

In mid-June, the ballots were counted, and the members voted 71% in favour of the settlement. On June 26, the legislature passed Bill 16, prohibiting any form of billing to patients above the agreed-to MSP Payment Schedule for insured services by an opted-in doctor.

The 1981 negotiations showed that once the warring factions within the BCMA reached a (temporary) truce, the united profession was prepared to act together and to take the government on. Having recognized that balance billing was a potent threat in negotiations, the BCMA was able to achieve the highest settlement in the history of Canadian medicare. Once discipline broke down and some members started balance billing before the Board could meet to decide on next steps, the government—which always has the power of the legislature to pass laws—was



Health Minister Jim Nielsen announcing the outlawing of balance billing, 1981.

given a public relations tool to rally public opinion in favour of Bill 16, and any form of billing above the MSP Payment Schedule was outlawed.



CHAPTER 8

1983—Protecting the base: The gift to the Crown

In the 50 years since the BCMA signed its first medicare agreement with Premier WAC Bennett in 1965, the association has had to think on its feet in negotiations with the government on a number of occasions. If the BCMA negotiators could not expect to make gains, their priority was at least to protect the base.

What do I mean by protecting the base? One of the BCMA's core beliefs in negotiations over the years has been never to let the government reduce fees across the board. Where the fees are set in a given year creates a new base, and any increase over successive negotiations has a multiplier effect. For instance, if the base was 100 in year 1 and there was a 5% fee increase the next year, then the new base would be 105 in year 2. If the next increase was 2.5%, the new base would be increased to $105 \times 1.025 = 107.625$ in year 3. The next year's increase of, say, 3% would result in a base of $107.625 \times 1.03 = 110.85$ in year 4.

Let us suppose that in year 2, the government rolled back fees by 5% instead. The base in year 4 would be $100 \times 0.95 \times 1.025 \times 1.03 = 100.3$, meaning that the members would have lost 10% in earning potential not only that year but in every subsequent year.

After the BCMA negotiated a 40% increase in fees in 1981, the early 1980s were a time of financial difficulties for BC and Canada, with high inflation and poor growth in the economy, resulting in little or no increase in government revenues. Faced with significant increases in the cost of providing medical services because of the two-year deal



Labour Minister Bob McClelland and BCMA Executive Director Dr F Norman Rigby sign the Gift to the Crown document, 1983.





signed with the doctors in 1981, the government spent the next two negotiations trying to persuade the association to accept a rollback in fees. The BCMA refused and signed two one-year agreements for no increase in either year.

When the US market for new homes collapsed in 1983, resulting in markedly reduced royalties for the province from the forest industry, Health Minister Jim Nielsen told the BCMA that he would unilaterally move to cut the payment schedule by 10%.

BCMA President Dr Bill Jory came up with the idea that, since the minister had presented the forestry issue as a temporary problem, perhaps there was a temporary solution that would protect the base. He suggested to Premier Bill Bennett (without having consulted the Board) that the doctors would respond to the government's plight with a \$30 million "gift to the Crown." Once this idea became public knowledge, Premier Bennett could not refuse the offer. If he instead imposed a permanent reduction of 10%, he would have faced a great backlash from the association, the press, and the public.

Dr Jory and Executive Director Dr F Norman Rigby met with Premier Bennett and Minister Nielsen.

Dr Rigby suggested that the gift would have to be coupled with a fee increase of 4% to cover the overhead cost increases for doctors' offices. Without getting input from Minister Nielsen, Premier Bennett agreed. The members voted 53% in favour of the gift, which was paid to the government by way of reductions in each MSP payment over several months. Each doctor received a tax receipt for a charitable donation for his or her own contribution.

Let's do the math again:

Base for the government proposal in year 2: $100 - 10 = 90$

Base for the BCMA proposal in year 2: $100 \times 1.04 = 104$,
a difference of 15.6%

There is another side to this story: After the Board received the vote on the gift, Dr Jory, a Reformer, released the result to the press before being told he could do so by the Establishment-dominated Board, which responded by passing a motion to censure him.

After the BCMA's gift to the Crown, the government passed legislation outlawing this approach. The association would have to come up with other ideas for future negotiations.



CHAPTER 9

1985—A new building: Bigger and definitely better

The BCMA in 1965, with fewer than 10 employees, was headquartered in the western wing of the Academy of Medicine building on the northwest corner of Burrard Street and West 10th Avenue in Vancouver.

The eastern part of the building housed the College of Physicians and Surgeons of BC. A common reception area that faced West 10th Avenue joined the two wings. The BCMA wing consisted of a three-storey building of about 10,000 square feet. There was only one meeting room, furnished by and named after Dr Wallace Wilson, a former President of the association. The meeting room was too small for the Board of Directors to meet in, so Board meetings were held in the basement of the College wing.

When Dr Tim McCoy retired in 1975, Dr F Norman Rigby was appointed the new Executive Director. Dr Rigby

identified early in his tenure that the BCMA would soon outgrow the space, as serving the needs of the steadily growing membership and the increasingly fractious relationship with the government required more and more staff. Dr Rigby therefore presented to the Board the idea of establishing a “contingency fund” to allow the BCMA to move to bigger premises. Working with the Director of Economics, Mr Jack Paul, and the Finance Committee chaired by Dr Don Rix, Dr Rigby was able to gradually grow the fund to \$5.1 million by 1984. By then the number of employees had doubled from 1965 levels.



Lunch in the College basement at a BCMA Board meeting, with Drs Walter Rebeyka, Mark Schonfeld, John Anderson, and Hedy Fry.





Dr Don Rix, Chair of the Finance Committee, at an annual meeting.

In those days before email, much of the BCMA’s business was done in person at the BCMA building. Understanding the need for accessibility, Dr Rigby identified two areas where a new building would allow the far-flung membership to access the headquarters with ease. He felt that headquartering downtown was too far from the airport, but he understood that being close to the College was important. He started to look on the “Broadway corridor” between Oak and Burrard Streets for a suitable space.

Dr Rigby learned that Manulife Financial had decided to sell many of its properties because of a change in corporate investment strategy. One of these properties was a six-storey building at 1665 West Broadway, which, as Dr Rigby discovered, Manulife was prepared to sell for \$7 million.

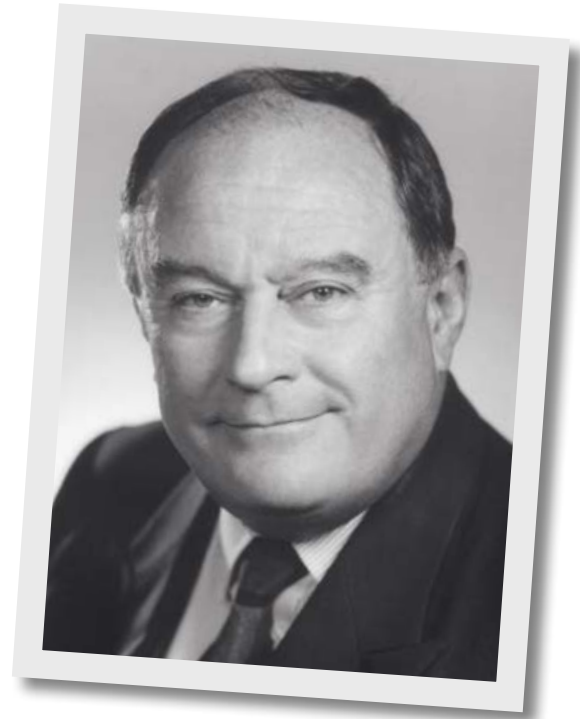
Dr Rigby presented this possible sale to the Board of Directors, who walked the three blocks from the Academy of Medicine to tour the empty building. Board members were impressed with the location and size of the building. Their one quibble was that the floors weren’t level!

The Board met to decide if the BCMA should proceed with a formal offer. Some Board members wanted the money in the building fund returned to the membership, but most of the Board was in favour of the purchase. The cost, including renovations and moving expenses, totalled \$8 million and was financed by the building fund, the sale of the West 10th property, and a small mortgage, which was paid off over the next few years.

In 1985, the BCMA moved to 1665 West Broadway, initially occupying three of the floors. A Building Management Committee was established, responsible for renting out the rest of the space. A new boardroom was built on the fourth floor, several meeting rooms were constructed, and a large kitchen and staff room were added.

Financially, the building has provided two important rewards. First, it has allowed the BCMA to maintain an operating line of credit such that the association could continue to function for six to nine months in a time of financial crisis. Second, and more important, the building is an asset that could be sold for emergency funds in

the event of a complete breakdown of the association's relationship with the government. The value of the property has appreciated over the years to many times the original cost.



Dr F Norman Rigby, who saw the need for the BCMA to move to a new building.



1665 West Broadway, Vancouver—home of the BCMA (now Doctors of BC) since 1985. Photo by Ariana Flynn.

Over time, the association’s space needs increased as the BCMA took over administering joint programs with the government, such as the General Practice Services Committee (GPSC), the Specialist Services Committee (SSC), the Shared Care Committee, and the Physician Information Technology Office (PITO). These needs have been met within the almost 50,000 square feet of the building, and income lost from other leases has been offset by the funds for managing the joint programs, so the building continues to have a positive cash flow. With

the most recent Master Agreement mandating even greater administration by the association, there are now more than 200 employees and, 31 years after the move, the building is again bursting at the seams. Between 2014 and 2016, extensive renovations to the entire building were completed, and the staff is even better able to look after the affairs of the BCMA. ▶ [SEE 2002—THE GENERAL PRACTICE SERVICES COMMITTEE](#)



Mr Jack Paul, Director of Economics, one of the driving forces behind the fund for a new building, here likely at a Negotiating Committee meeting, c. 1980.



CHAPTER 10

1985—Billing number restrictions

By the late 1970s, the provincial government had become increasingly concerned about both the number of doctors practising in BC and the relative mismatch in distribution geographically, with family doctors in particular being concentrated in areas around Vancouver, Victoria, and the Okanagan.

Spurred by reports from economists such as Robert Evans,¹ in 1978 the government appointed the six-member Advisory Committee on Medical Manpower, chaired by Mr Wesley Black, to examine physician supply in the province.²

The commission made several recommendations, but the most controversial was that billing numbers should be restricted.³ Because a physician needs a billing number to receive payment from the Medical Services Plan, billing number restrictions would effectively limit the number of doctors that could practise. The government did not take action on billing numbers at that time but did work with the BCMA to create the Northern and Isolation Allowance program, which offered doctors financial incentives to work in underserved areas.

Unfortunately, these efforts to influence the distribution of doctors led the government to bring in financial disincentives for doctors wanting to practise in overserved areas. Over several years in the mid-1980s, the government unilaterally introduced a series of bills designed to limit access to billing numbers through the MSP. The first of these was Bill 24, which was tabled in 1983. Interestingly, the universities minister, Dr Pat McGeer, announced at the same time that the medical school at UBC would double the number of positions for admissions!⁴

The BCMA began a fierce lobbying campaign and soon found itself involved in redrafting the bill. Under pressure from the association, the government withdrew the

provision allowing it to dictate where a new doctor could practise. The government then switched tactics and tried to tie billing numbers to hospital privileges. The hospitals in the overserviced areas were asked to refuse billing numbers to new applicants.

Having been involved in reworking the proposed legislation, the BCMA vacillated about whether to oppose the new restrictions. During Board debates that I attended, some doctors in established practices felt that restricting billing numbers would reduce competition and hence were a good idea. Other members felt that restrictions on the younger colleagues were manifestly unfair and should be opposed. The profession was divided. From the introduction of the bill until the issue was resolved nearly six years later, billing number approvals by MSP dropped by two-thirds.

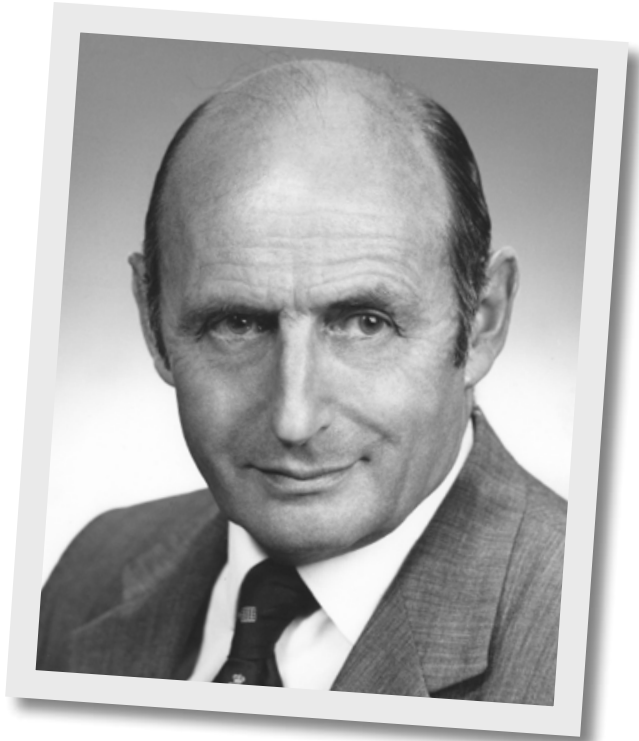
Both the Professional Association of Residents and Interns (PARI) and the Canadian Association of Interns and Residents (CAIR) vehemently opposed the legislation and were preparing to take the government to court, urging the BCMA at its annual meeting to join them.

The BCMA's decision not to be party to the court action at that time left members of PARI and CAIR feeling betrayed,



Minister of Universities Dr Pat McGeer announced that UBC would double admissions to its medical school at the same time as billing numbers were being restricted.

with CAIR warning in a June 1984 letter that “The BCMA’s implicit acceptance of this government policy allows other arbitrary intervention into our profession such as the discrimination against our senior colleagues, or removal of MSP numbers for political reasons.” Echoes of that resentment persist to this day.



Dr John O'Brien-Bell's reading from the Hall Commission report of 1964 galvanized the Board to appeal Bill 41.

The issue did not go away, and the Board eventually joined PARI and CAIR in the legal challenge, using the case of Dr Raziya Mia—who was refused a billing number to practise family medicine in Kamloops—as a test in court. The three associations won the case in March 1985. In his judgment, Chief Justice Allan McEachern was scathing about the government, calling the restrictions “Orwellian” and

“so patently unfair and unjust that it cannot be allowed to stand.”⁵

Health Minister Jim Nielsen interpreted the judgment to mean that the province had no legal authority to limit billing numbers under current law, and he responded by immediately tabling Bill 50 to give the government that authority, both proactively and retroactively. Essentially, rather than complying with the thrust of the decision, Minister Nielsen hoped to limit billing numbers based on a technicality. There was a huge outcry in the press, and even Prime Minister Brian Mulroney and federal Liberal leader John Turner criticized the provincial government.⁶ Justice McEachern said, “I wish the government would obey the law. I can’t put it any stronger than that.”⁷

Bill 50 never passed, but Minister Nielsen then introduced Bill 41, which still allowed the MSP to restrict or attach conditions to billing numbers. As a concession to those doctors already in practice, the retroactivity clause was removed. The bill became law on May 24, 1985.

Separate legal challenges to Bill 41 were started in the fall of 1985 by PARI and the BCMA. In January 1987, some 18 months later, the Supreme Court of BC upheld the law.



(Meanwhile, billing number restrictions had continued.) PARI and CAIR immediately announced that they would appeal the decision. Unfortunately, PARI made a number of suggestions publicly about how to deal with the issues—for instance, PARI suggested capping the health budget—that were contrary to BCMA policies. This schism between the associations, coupled with many BCMA members' opinion that the restrictions were not a bad idea for those already in practice, led to a heated debate at the Board over whether the BCMA should appeal as well. At the Board meeting, Dr John O'Brien-Bell read an excerpt from the original report of the Hall Commission of 1964. According to the meeting minutes, "The President asked the Board to keep in mind the expressions from the Hall report: 'the highest possible health-care,' 'freedom of choice' and 'free and self-governing profession.'"⁸

The Board voted to appeal Bill 41.

The Court of Appeal overturned the Supreme Court ruling in August 1988. The government's appeal to the Supreme Court of Canada was dismissed.

After six years of court battles, the medical profession had won.

When the BCMA and some of its members put their self-interest ahead of their younger colleagues—medical students, residents, and fellows—they abandoned the future champions of health care. Unfortunately, many of those colleagues who suffered as a result of restricted billing numbers during those years still harbour ill feelings toward the association.

- 1 Evans RG. Supplier-induced demand: Some empirical evidence and implications in the economics of health and medical care (proceedings of a conference held by the International Economic Association at Tokyo). In: Perlman M, editor. *The economics of health and medical care*. New York: Halsted Press; 1974. p. 162-173.
- 2 Taylor MG, Maslove A. Health insurance and Canadian public policy: The seven decisions that created the health insurance system and their outcomes. McGill-Queen's University Press; April 1, 2009.
- 3 Ibid.
- 4 Farough, D. Professional autonomy and resistance: Medical politics in British Columbia, 1964-1993. PhD diss., University of British Columbia, 1996. p. 165.
- 5 *Mia v. Medical Services Commission of British Columbia*, 1985 CanLII 148 (BC SC). <http://canlii.ca/t/1p6p4>. Accessed October 17, 2016.
- 6 Farough, D. Professional autonomy and resistance. p. 176.
- 7 LeBourdais E. Doctors win latest round in BC billing-number dispute. *CMAJ* 1988;139: 654-655.
- 8 BCMA Board of Directors' meeting minutes, January 31, 1987. p. 9.



CHAPTER 11

1987–1989—Income disparities and societies

In the early 1980s, every time the membership ratified a settlement, the Board of Directors would decide how to distribute the proceeds.

Specialists grew concerned that the GP-dominated Board would not give them their fair share. Over the decade, frictions between the GPs and specialists escalated.

Each medical specialty has its own section to represent the interests of those doctors who share a common type of practice within the organization. For instance, there is a Section of General Practice, a Section of Psychiatry, a Section of Paediatrics, and so on. The number of sections has grown from about 20 in 1965 to almost 40 today, owing to subspecialization.

In those days, the main interface between the sections was the Intersectional Council, a body initially composed of one representative from each section. For any motion

from the Council to be sent to the Board of Directors for action, it needed to be proposed, seconded, and passed by a majority. By the middle of the 1980s, relations between the Section of General Practice and the specialist sections had deteriorated to where no specialist would second any motion by the sole GP representative. The Board finally dealt with this problem by appointing two GP reps to the Council so that motions could at least be moved and seconded for debate.

There had been various attempts to address disparities in earnings among the sections over the previous 15 years. One of the reports came from a committee headed by Dr Cam Coady in 1976, which proposed that the income of GPs on average should be 77–80% of the income of

the specialists, recognizing that the earning life of a GP was longer and the training of a specialist took longer.¹ The report did not comment on the relative complexity of specialist versus general practice. Essentially, the committee concluded that the lifetime earning potential of a doctor should be the same, regardless of discipline.

By the mid-1980s, the average income of a family doctor had fallen to 60% of that of specialists, with the GPs arguing that this disparity was due to their fees being too low and the specialists arguing that they worked harder and longer hours than their generalist colleagues. The Section of General Practice threatened to leave the BCMA and negotiate separately.

In 1986, the Economics Committee (the predecessor of the Tariff Committee) compared the cataract fees in BC and Ontario and decided to reduce this province's fee by about 20%. Despite the protests of the Section of Ophthalmology, the Board of Directors approved the reduction. Although the money stayed within the Section of Ophthalmology's control, the specialists became concerned that other fees may be reduced and became unsettled.



Dr Norman Finlayson, Executive Director (1986-1998), proposed that each group should have its own society to appoint representatives to the Negotiating Committee and the Executive.

The acrimony reached a boiling point in 1987, when a number of specialists decided that their only course of action was to create a new organization, the First Association of Specialist Physicians (FASP). FASP argued that GPs, by virtue of their majority on the Board of



Annual meeting in Penticton at which the BCMA approved the formation of the societies, 1989.

Directors, controlled the BCMA and denied specialists their share of negotiated funds. The specialists also threatened separate negotiations with the government.

The membership was polled about separate negotiations. Knowing that in Quebec, the government played the two groups against each other in separate negotiations, resulting in the worst fee schedule in Canada, the

membership voted 78% in favour of unified negotiations. Only 66% of specialists supported this idea, however, and the leadership of the BCMA would have to mollify them to keep them from fracturing the profession.

Over the next year and a half, the leadership adopted an idea proposed by Executive Director Dr Norman Finlayson that each group should have its own society that would be able to appoint representatives directly to the Negotiating Committee and the Executive. The GPs and the specialists endorsed this plan, and the Society of General Practitioners and the Society of Specialist Physicians and Surgeons—which effectively replaced FASP—were created in 1989 at the BCMA’s annual meeting in Penticton.

This new process, although it solved some problems, led to an impasse in negotiations in 2002. ▶ [SEE 2002-2003—THE BONITA THOMPSON REPORT AND A CHANGE IN THE SOCIETY APPOINTMENTS](#) Meanwhile, disparities remained, a problem the Relative Value Guide Committee tried once more to tackle in the mid-1990s. ▶ [SEE 1994—FEE DISPARITIES AND THE RELATIVE VALUE GUIDE](#)

1 Coady C, chair. Report from Ad Hoc Committee to investigate differential earning potential between general practitioners and specialists, 1976.



CHAPTER 12

1992—Pros and cons of unionization

Until 1972, the BCMA had never contemplated becoming a union, a move that the Board and the members were concerned might be considered unprofessional by the public and, perhaps more importantly, by government negotiators.

Even Dr Euan Horniman, whose ideas about a Negotiating Committee and a referendum had transformed the association into a first-class collective-bargaining unit, did not want the BCMA to be a union that could call on its members to strike. ► [SEE 1968-1972—REFORM GROUP-ESTABLISHMENT CONFLICT, REFERENDA, AND A NEGOTIATING COMMITTEE](#)

In the early 1970s the government introduced a bill that established a labour union for all civil servants, including the 200 or so doctors who were employed directly by the province. These doctors, who wanted to continue to be represented by the BCMA through the Section of Salaried Physicians, were required by law to join the newly formed union called the Professional Employees Association (PEA).

Pressured by the BCMA, Health Minister Dennis Cocke ignored the law and allowed the salaried doctors to be represented by the BCMA instead of PEA, which then charged the government with unfair labour practices. When Minister Cocke announced that he would introduce amendments to the legislation that would allow the BCMA to represent the doctors, the Public Service Commission infuriated the PEA by ceasing negotiations in the meantime.

Coupled with ongoing issues relating to the Workers' Compensation Board's unwillingness to provide services to any group not covered under the Labour Relations Code,¹ the salaried doctor-PEA conflict stimulated a debate within the association of whether it should apply for union status.



Many doctors felt there were advantages to unionization. First, the Rand formula, which would require workers covered by collective bargaining contracts to pay dues, would apply, meaning that membership would be automatic for any doctor licensed in BC. Second, given the deteriorating relations with the government and the hard-nosed bargaining atmosphere of the day, being a union seemed more appropriate than the genteel discussions of previous years. Third, if the doctors formed a union separate from the association, the BCMA could focus on medical concerns and not on economic issues. The escalating costs of bargaining would be the responsibility of the union. The only downside was the spectre of deprofessionalizing the doctors.

Minister Cocke's legislation that excluded doctors, lawyers, and justices of the peace was passed in June 1975. PEA filed a breach-of-contract action against Minister Cocke and the BCMA. The government and the BCMA settled the suit by paying an undisclosed sum to PEA.

Few members of the Board supported unionization at that time and, because the vast majority of members were not government employees, the movement to unionize disappeared, only to reappear almost 20 years later.

Late in its last mandate before losing the 1992 election to the NDP, the Social Credit government of Premier Bill Vander Zalm had established a royal commission under Justice Peter Seaton to examine health care in BC. The Commission report, released after the election, called for capping doctors' total billing to the MSP.

Finance Minister Glen Clark introduced Bill 13 in 1992, which imposed a hard cap on MSP expenditures and a cap on individual doctors' earnings. Despite having promised in a pre-election meeting with 900 doctors to uphold the recently negotiated pension plan for fee-for-service doctors, Minister Clark introduced Bill 14 to "extinguish" the plan. ► [SEE 1974-2010—BENEFITS](#)

In support of this legislation, Premier Harcourt stated that the medical profession, because it was not a union, had no rights to negotiate with the government.

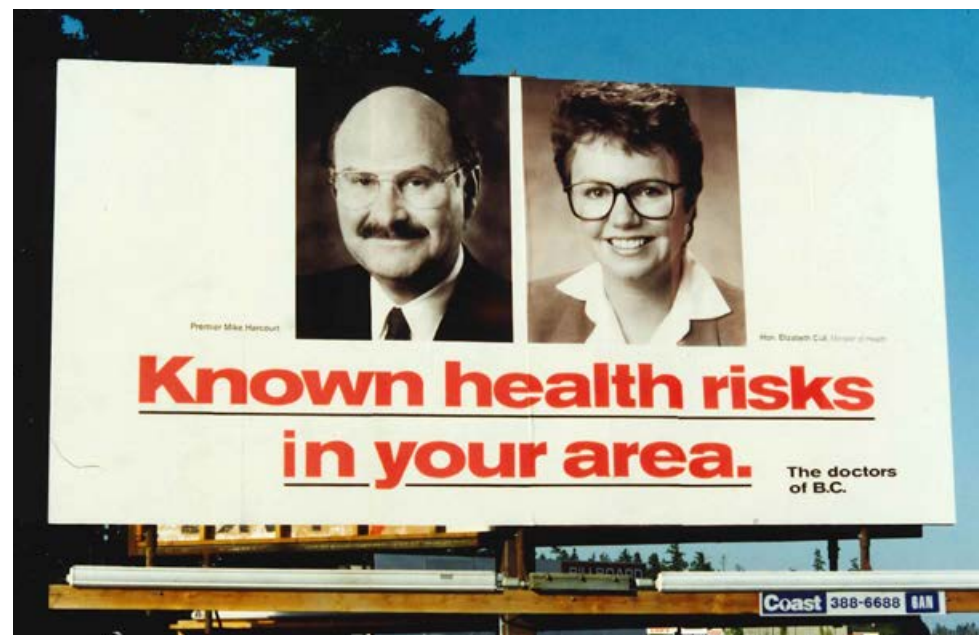
The BCMA launched a fervent response, which included a \$3 million ad campaign that emphasized fairness and the right to negotiate legally binding contracts through open and honest discussions. The association highlighted what it felt was the hypocrisy of a left-leaning government

violating bargaining rights. The ads quoted Health Minister Elizabeth Cull's own words, written when her party was in opposition in the legislature:

Doctors, together with other health care professionals, workers, and consumers, bear the brunt of the government's mismanagement of our health care system. New Democrats are committed to redressing this situation. This can only be done through honest negotiations with physicians directed towards a settlement which both the physicians and the government, on behalf of the public, recognize as fair.²

The BCMA's message was that doctors were the only group that would stand up for a patient's right to accessible and timely care.

The campaign was effective. The NDP withdrew Bill 13 and introduced Bill 71, which did not cap individual doctors' incomes. The global hard cap remained in the proposed legislation, however, and the government refused to consider increases in the budget for anything other than population growth. New provisions included the formation of a Medical Services Commission with nine

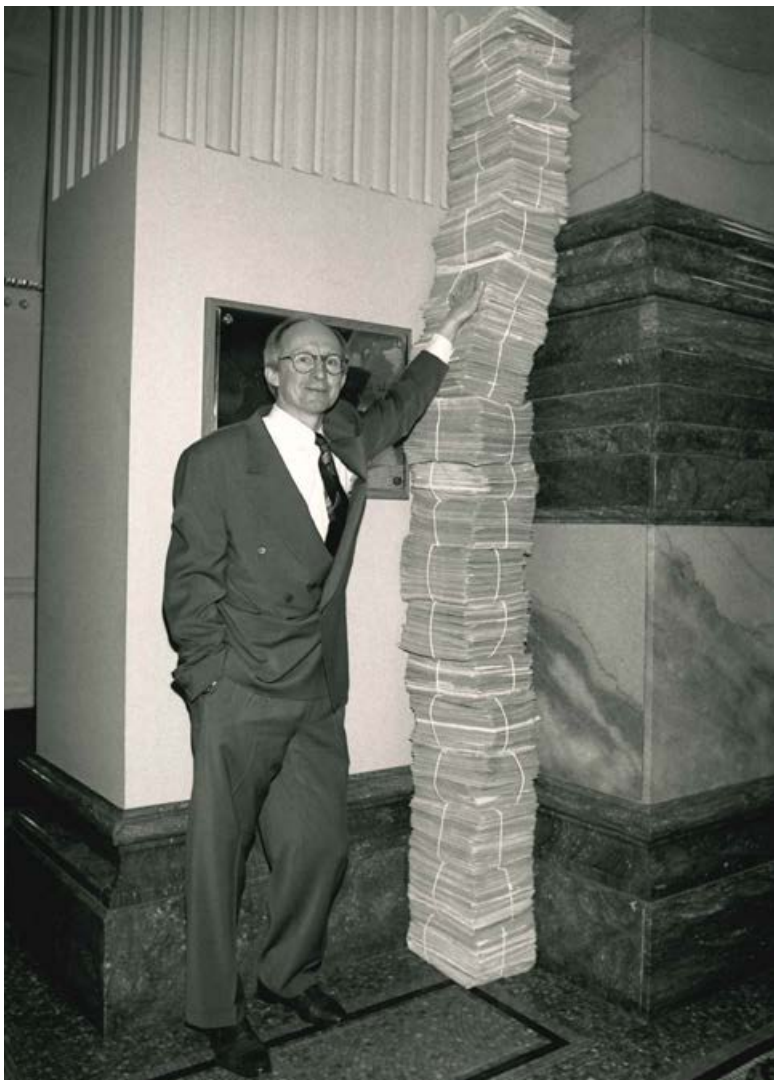


BCMA campaign billboards on the Island Highway near Victoria, 1992.

members to oversee the health care budget: three would be doctors, three would represent the government, and three would represent the public but would be chosen by the government. Under the bill, the Medical Services Commission could impose a settlement on the doctors if negotiations failed, and the BCMA was concerned the government-appointed members of the public would vote with the government members.



Dr Steve Hardwicke presents petitions signed by British Columbians to Premier Mike Harcourt and Health Minister Elizabeth Cull, 1992.



Dr Steve Hardwicke with petitions signed by British Columbians protesting the government's actions, 1992.

The bill passed in July 1992. The battle was joined.

Over the next year, doctors staged walkouts and resigned from committees, physicians in some communities opted out of the MSP, and the association initiated a petition, which attracted almost 400,000 signatures from the public. The BCMA demanded arbitration as the only meaningful dispute-resolution mechanism and maintained that any budget must include increases not only for population but also for utilization. While the government offered 1-2% a year to the BCMA, Minister Clark negotiated 12-15% increases for the nurses and other health care workers. ▶ [SEE 2002—BILL 9 AND ARBITRATION](#)

In response, the BCMA withdrew from negotiations in early 1993 and struck a committee to examine unionization as an option once again.

The committee looked at the experiences of the British Medical Association (BMA), which had unionized in 1971; PARI, which had unionized in the early 1970s; the Fédération des Médecins Omnipraticiens and Fédération des Médecins Spécialistes in Quebec; and unionized residents and salaried doctors in the United States. Some felt that under the new provisions of the Labour Relations



Drs Steven Hardwicke and Derryck Smith announcing that the BCMA is looking into becoming a union.

Code, the BCMA met the criteria of a union, lacking only certification by the Labour Relations Board (LRB).

The doctors did not intend to give up professional privileges for trade union rights but wanted to add the force of labour legislation to their professional privileges. The committee identified the same list of pros and cons of unionization that had been raised 20 years earlier and also noted that a physicians' union could establish

affiliations with other unions in the health care sector. The BMA had found that unionization did not harm doctors' professional image but enhanced it, by promoting high professional and ethical standards. Unionization and professionalism were not inherently contradictory but could be complementary, strengthening the profession's public image while giving the BCMA access to remedies through the LRB, such as binding arbitration.

The BCMA Unionization Committee's report clearly supported seeking certification by the LRB. Despite this, two-thirds of the members rejected the idea in a referendum. Many felt that the tactics of unions such as the Teamsters and the Hospital Employees' Union, which threatened or carried out strikes at the expense of the public good, were so distasteful that they voted against the idea. This rejection doomed the association's last look at unionization.

1 Farough, D. Professional autonomy and resistance: Medical politics in British Columbia, 1964-1993. PhD diss., University of British Columbia, 1996:141.

2 BCMA ad campaign, 1992.



CHAPTER 13

1993—Utilization and co-management

The BCMA made a major miscalculation when it agreed to co-manage the MSP budget in 1993—an arrangement that saw the government control the purse strings while members became responsible for controlling increased costs—following a long and tumultuous period of confrontations with the newly elected government headed by Premier Mike Harcourt, Health Minister Elizabeth Cull, and Finance Minister Glen Clark. The basic issue was utilization.

Every year since 1965, the BC government's expenditures for doctors' services have risen faster than the growth in population, for a number of reasons: improved technology, an aging population, and escalating use of medical services. Together, the year-over-year increase in expenditures due to these three factors is known as

"utilization." As a result, by the early 1990s, health care expenditures had increased to one-third of the provincial budget. (Utilization continues apace—in 2015, health care costs had increased to more than 40% of government expenditures in BC.)



Protest at the legislature, 1993.





In the early 1980s, after the 40% fee increase for doctors in the negotiation of 1981, the provincial government's position in the next several negotiations was to make doctors responsible for utilization. The government seemed to put little effort in persuading the population to reduce their use of the system, perhaps fearing that such efforts would cost the party votes in the next election. At that time, the BCMA refused to enter into any agreements that saddled the members with responsibility for utilization. ► [SEE 1979-1981—A UNITED FRONT, BALANCE BILLING, AND A SUCCESSFUL NEGOTIATION](#)

By the early 1990s, utilization continued to be a major thorn in the government's side. Between 1991 and 1993, negotiations dragged on between the province and the BCMA for some 18 months, and the government tabled legislation that would have placed a hard cap on MSP expenditures, with the profession being responsible for all increases in expenditures year over year. The BCMA responded with an advertising campaign and a petition for patients to sign, and groups of doctors in several communities opted out of the MSP and started billing patients privately. At the same time, the government negotiated large increases with the health care unions,

and eventually the editorials in the press started to roundly criticize the government.¹

Finally, negotiations resumed, and a settlement was reached. The government agreed to the Contributory Professional Retirement Savings Plan, a 6.5% increase in fees to be phased in over five years, and funds to maintain the other benefits. In return, the BCMA agreed to co-manage the budget, with the members being responsible for half of the increases in expenditures year over year, excluding any population increases, and the Medical Services Commission retained the right to unilaterally set the next year's budget with no input from the BCMA. If the budget was exceeded, the MSP could recover the portion attributable to the doctors by prorationing future payments. By taking on some responsibility for utilization while assuming no control of the budget, the BCMA put itself in an unfavourable position that would take several negotiations—and job action—to correct.

► [SEE 1974-2010—BENEFITS](#)

► [SEE 1993-1998—REDUCED ACTIVITY DAYS AND THE END OF PRORATIONING](#)

¹ Farough, D. Professional autonomy and resistance: Medical politics in British Columbia, 1964-1993. PhD diss., University of British Columbia, 1996:162.



CHAPTER 14

1993–1998—Reduced activity days and the end of prorationing

As far back as 1935, members of the BCMA were concerned that a government-run medical care program could result in fee prorationing, where the government would withhold a portion of doctors' billings if physicians' services looked as though they would exceed a fixed budget.

The government of Premier Duff Pattullo had passed a bill that would have created a commission with the right to determine the scope and standards of insured medical services and would have had a great deal of control over physicians' incomes. The commission would have been given a fixed budget regardless of the true cost of providing care for the people covered. Although the bill passed, it never received royal assent because of the furious lobbying by the BCMA.

In response to public pressure after the Second World War, the BC government established the Social Assistance Medical Services (SAMS) fund in 1949.¹ Before this, most employed BC residents were covered by the Medical Services Association (MSA) and Medical Services Incorporated (MSI) plans established by the BCMA in 1940 and 1954, respectively. People who did not work outside the home were not covered (including individuals with disabilities). SAMS was created to



cover these people and was funded by the government but administered by the BCMA. Over time, however, the funding from the government did not increase, and when SAMS was integrated into the BC Medical Plan in 1965, bills were being paid at 30% of the posted BCMA schedule of fees. (Once the BC Medical Plan came into effect, SAMS, like MSA and MSI, disappeared, and all fees were paid at 100% of the negotiated rates.) Thus, the concerns of the doctors in the 1930s about prorating came to pass in the middle of the century before rearing its head again at the end of the century.

Concerns about prorating arose from the Master Agreement of 1993 in which the association agreed to co-manage, with the government, the budget for the MSP. As part of that agreement, the BCMA agreed to a hard cap on physician expenditures in a given year and, if the cap was exceeded, the government could recover the excess by reducing future payments from MSP to the doctors.

▶ [SEE 1993—UTILIZATION AND CO-MANAGEMENT](#)

In return, the association would recommend three appointees to the new Medical Services Commission,

had a say in influencing the public on utilization, and achieved the right to have future disputes between the parties resolved through binding arbitration. For its part, the government was to actively work to reduce utilization pressures by educating the public. The government retained the right to unilaterally determine the “available amount” for physician services—the budgeted hard cap.

▶ [SEE 1993—UTILIZATION AND CO-MANAGEMENT](#)

▶ [SEE 2002—BILL 9 AND ARBITRATION](#)

This agreement did not work out well for the members. As soon as the government had the power to prorate, it lost all appetite to persuade the public to use the medical system less. It wasn't long before the available amount was exceeded and the government imposed prorating on the payments to doctors. Each month, the MSP would assess the overrun and tell the doctors how much their cheques would be reduced on a percentage basis.

Needless to say, the members felt they were paying for unlimited access to medical care. As prorating continued, member unhappiness grew. By 1997, the Board recommended to the members that, if the government



Billboard in BCMA's "Putting Patients First" campaign, in response to prorationing.

Health care reform must put patients first

Doctors do...every day.

BRITISH COLUMBIA MEDICAL ASSOCIATION

SEABOARD



would in effect pay only for a certain amount of medical care through a capped budget, then the doctors would provide only that amount of care. Because the MSP informed the BCMA about the amount of prorating that would occur in the next month, the association could identify how much needed to be saved. The Board recommended that members start closing their offices and operating rooms on “reduced activity days,” which came to be known as RADs. The number of RADs in a month was calculated to “save” the required amount for the MSP. The number per month gradually increased and, by the time the government stopped prorating, there were as many as five RADs in one month. (The doctors always made emergency services and on-call services available.)

RADs were controversial with the membership and were not initially supported by all. They were largely successful because family doctors closed their offices and anaesthesiologists refused to work on the RADs, effectively closing the operating rooms, forcing surgeons to not work as well.

In the negotiations of 1998, the Board charged the Negotiating Committee to bring back an agreement only if it ended prorating. As more and more days of closed offices and operating rooms accumulated, public pressure on the government grew. The two sides eventually reached a deal with the provision that the government had to give a full year’s notice before they could prorate payments in the future, which essentially ended prorating. In a successive Master Agreement, the wording allowing prorating was eliminated.

1 Shillington CH. *The road to medicare in Canada*. Toronto, ON: Del Graphics; 1972. p. 72.



CHAPTER 15

1994—Fee disparities and the Relative Value Guide

No other issue has bedevilled the BCMA after the start of medicare as much as disparities in earning potential between doctors in different disciplines.

The perceptions of inequality have led to heated debates, threats to the unity of the association, and multiple attempts to address the problem.

The concerns were not only between family doctors and specialists but also between different specialties, especially where technical advances led to new ways to examine or treat patients or faster ways to perform surgery. The introduction of simplified cataract surgery, the advent of endoscopic examinations for diagnosis and treatment, and the development of cardiac stenting in the 30 years after 1965 are examples of advances that increased the earning potential of some doctors. Very few fees were cut during that time, so disparities were largely due to increases in income for some groups relative to others.

My discussions with doctors who practised before the introduction of the BC Medical Plan have led me to conclude that disparities were not an issue prior to 1965. Not long after the start of medicare in 1965, however, concerns arose among the membership that the members of different sections were falling further and further behind in their earning potential. This problem was made worse when Premier WAC Bennett published the Blue Book, listing the gross incomes from MSP for each doctor. For the first time, members found out what their colleagues earned. Jealousy reared its ugly head.

By 1970, the issue had already become of enough concern that the Board appointed a committee to report to the annual meeting in Penticton in 1972 about potential

solutions. The Disparities Committee met and developed an approach that would correct inequities, primarily by cutting fees to the higher-paid sections. When the membership learned about this proposal, many members planned to attend the meeting, one group even chartering a plane to fly them to the Okanagan from Vancouver and back.

With many of the sections facing a cut to their fees, the proposal was voted down after a long and raucous debate.



Dr Cam Coady, head of a 1976 committee to study income disparities, at an annual meeting.

But the issue continued to fester and arose again in the late 1980s with the creation of FASP and, subsequently, two societies. ▶ [SEE 1987-1989—INCOME DISPARITIES AND SOCIETIES](#)

This problem of disparities was not a BC-only phenomenon. In the United States, Professor William Hsiao of Harvard University and colleagues addressed the issue in a report in the late 1980s.¹ This report has been used for Medicare and Medicaid payments to various groups of US specialists for over two decades. Around the same time, Mr Darrell Thomson prepared the “Visit Grid Adjustment” proposal for the Saskatchewan Medical Association² that was brought into effect with general approval of all sections there. These two approaches, which are still in use, have successfully tackled disparities by allocating larger increases to underpaid groups of doctors rather than by cutting the fees of higher-paid groups.

The BCMA recruited Mr Thomson to become Director of Economics in the late 1980s. The next attempt to lance the boil of disparities came under his direction when the Tariff Committee tried to adjust disparate consult fees set by the specialty sections to pay consultants equally for equal work done. This effort met great resistance from a number of sections and was abandoned.

By the 1990s, the Ontario Medical Association (OMA) was embroiled in a similar controversy. It had started work on its Resource-Based Relative Value Schedule (RBRVS) in 1997 and developed a methodology that had the support of both the Section of General Practice and the Specialist Coalition of Ontario. After following the methodology over a number of years, the RBRVS report went to the council of the OMA and recommended correcting the disparities by both reducing fees to some sections and increasing fees to others. The council rejected the recommendations primarily because the higher-paid sections that faced cuts were adamantly opposed to any reduction in their incomes. The methodology was reworked, but the final report was never implemented because some of the fees proposed did not seem to make sense to the council—for instance, although many felt that radiology was a high-paid section, the report suggested that imaging fees be increased. The entire process was dropped after a decade of work and great expenditure of members' money.

At the start of the 1990s, pressure grew within the BCMA to deal with the issue. The section heads met and recommended that the BCMA undertake a Relative Value Guide (RVG) process similar to what Dr Hsiao had done in the United States. The Board of Directors approved the

idea, and the RVG Committee was struck with Dr Wally Unger as Chair. An independent economist was appointed to perform all of the calculations, and the committee approached the process as a zero-sum game—that is, there would be no overall increase in MSP expenditures as a result. The work involved a very time-consuming and complicated series of meetings between sections that were designed to result in fee relativity based on time and complexity. From the outset, it was clear that the process had the buy-in of almost all sections.³



Dr Wally Unger, Chair of the RVG Committee, addresses the Board meeting with the section heads, 1994.



Meeting between the Board of Directors and section heads about the RVG, 1994.





During the work, the Committee recommended to the Board of Directors that there be a bylaw amendment to ensure adoption of the final report and its recommendations by a fixed date. The proposed bylaw was approved by more than a 75% margin in a mail vote of the membership. Because of the complexity of the work, however, some sections felt the RVG results presented at deadline had been rushed, and others felt that some of the fees recommended in the final report were counterintuitive, as had been the case in Ontario. There were growing concerns that the Society of Specialist Physicians and Surgeons and some of the specialty sections would block implementation, even though it was now part of the BCMA's Constitution and Bylaws. The final report recommended cutting some fees of high-paying sections while increasing others. The adjustments would be done at one time, resulting in a major shift in the MSP Payment Schedule.

Before implementation, the Board of Directors met with all of the section heads. Many of them vocally opposed any cuts to fees, and some intimated that they would urge their members to resign from the BCMA if the Board enforced the Bylaws and implemented the report. In an attempt to save the process, Dr Unger suggested that the implementation could be done over a number of years,

with no cuts, and that lower-paid sections would only be increased through future fee settlements. Despite this last-minute plea, the Board rejected the final report. The new bylaw was eliminated the next year.

In the next several allocations of negotiated funds, some of the RVG suggestions were implemented for lower-paid sections. Some sections used the report to realign their own fees within their part of the fee schedule. By and large, however, the RVG proposals were never acted upon.

Boards since that time have expressed no interest in revisiting a Relative Value Guide proposal. The RVG report still sits in the Doctors of BC Archives and may never see the light of day again.

Experience has shown that no section will agree to a fee cut for the benefit of another group. Thus, disparities can be addressed only by increasing lower-paid sections through new monies negotiated between the BCMA and the government. Any attempts to cut fees to a section might lead to an exodus of those members from the association.

1 Hsiao WC, Braun P, Becker E, et al. A national study of resource-based relative value scales for physician services: Final report. Boston, MA: Dept. of Health Policy and Management, Harvard School of Public Health; 1988.

2 Unpublished interview with Mr Darrell Thomson by Dr Brad Fritz, September 30, 2014.

3 Unpublished interview with Dr Mark Schonfeld by Dr Brad Fritz, October 29, 2014.



CHAPTER 16

1997—The Northern Doctors' Dispute, the Rural Agreement, and MOCAP

Doctors working in smaller and more rural communities throughout BC received bonus payments for any fee-for-service work they provided, under the Northern and Isolation Allowance that was first negotiated in the 1980s in a response to billing number restrictions.

Like other doctors throughout BC, however, providing on-call services as a requirement of their hospital privileges was not compensated. By 1997, doctors working in small communities in the province's north-east had had enough. The number of doctors prepared to work in the rural communities in BC was dropping.

► [SEE 1985—BILLING NUMBER RESTRICTIONS](#)

In response to this crisis, 23 family physicians in Vanderhoof, Burns Lake, Fraser Lake, Fort St. James, and

Mackenzie formed the Northern Rural Doctors Group (NRDG) with the hope of negotiating an agreement that would provide the financial incentives needed to sustain medical practice in rural BC. They decided to push for payment for on-call coverage at their local hospitals and for extra funding for continuing medical education.

The health authority showed no interest in such a plan, so the NRDG served notice that, on January 31, 1998, all 23 doctors working in those communities would resign their



Members of the Northern Rural Doctors Group.
Seated, left to right: Dr Alan Gow (then Fraser Lake) and wife, Anita; Dr Alex Black (Vanderhoof).
Standing, left to right: Ms Colleen Brennan (BCMA staff), Dr George Magee (Burns Lake), Dr Don Wilson (Mackenzie), Mr Geoff Holter (BCMA Director of Negotiations), Dr Brian Brodie (Burns Lake and Chilliwack), and Mrs Petra Black.

hospital privileges. The government felt this issue should be dealt with at the next provincial negotiation, but the BCMA held fast to this being a local issue and refused to accept it as a part of the existing Working Agreement.

At the end of January, the hospitals in those communities closed their emergency departments, and all inpatients were transferred to Prince George or other facilities. No babies were delivered locally. The doctors did provide life-and-limb coverage, however.

By March, there was no resolution. The doctors offered to accept binding arbitration, but the government refused. Local governments rallied behind their doctors, and the mayors put pressure on Victoria.¹ The province refused to seriously address the issues central to the needs of the NRDG. The BCMA provided advice to the rural doctors but up until that time had not been actively involved. Doctors in other rural communities throughout the province started to withdraw their services so that by the end of March 1998, there were about 80 doctors in 22 communities on the sidelines. The “rural doctors’ dispute” was in full swing.

In late April, the new Minister of Health appointed Ms Lucy Dobbin to study the issue and resolve the dispute. The Dobbin report was delivered at the end of May and made 21 recommendations, including that money be provided for on-call services and for education. The government reluctantly agreed to the recommendations and on June 12, 1998, approved an annual budget of \$6.5 million to



cover 90 rural communities. The doctors returned to their hospital work the next day, having been away for over four months. According to Dr Brian Brodie, one of the doctors involved in the dispute, no lives were lost because of the withdrawal of services during the confrontation.

Having supported their more rural colleagues, the doctors of Prince George organized the Northern Medical Society in late 1999, and there was a short but successful withdrawal of service in 2000 that resulted in an agreement that provided another \$10 million in funding for that area. Williams Lake followed, and a separate agreement was reached there.

Many doctors who would normally go to work in mid-sized rural communities shifted their focus to those communities with extra funding. Doctors and local officials in the now-underserved areas began to agitate for similar treatment. Partial service disruptions broke out in many areas. In each case, the government would address the local community issues by, according to Mr Geoff Holter, Director of Negotiations, “shovelling money off the back of the truck,”² which was then used by doctors in the next place down the line to demand even more compensation.

Under the auspices of the BCMA, an Ad Hoc Rural Negotiation Committee was formed to negotiate a province-wide agreement. When negotiations broke down, third-party mediation resulted in recommendations that provided another \$40 million annually to rural communities. The Rural Agreement—the first of the many subsidiary agreements to the Master Agreement—came out of this process.

Of course, being on-call is a fact of life in urban and metropolitan areas as well, and the members in such areas as Vancouver and the Okanagan demanded similar treatment. The BCMA made providing on-call payments a major proposal in the provincial negotiation that began in 2001, an effort that resulted in the Medical On-Call Availability Program (MOCAP), which affirmed that all doctors providing on-call services for their health authority should be paid to do so, whether they work in a large or small community. The budget for this program was \$126 million.

Thus, 23 determined doctors began a movement that resulted in on-call compensation for all doctors in the province.

1 Black, A. MOCAP: The genesis—The story of how the medical on-call availability program came to be in BC (unpublished memoir).

2 Unpublished interview with Mr Geoff Holter by Dr Brad Fritz, November 26, 2014.



CHAPTER 17

2002—Bill 9 and arbitration

There has been a long-running debate within the BCMA about the value of a binding dispute-resolution process such as arbitration.

Calls from the membership for arbitration to be the method to resolve conflicts between the BCMA and the government date back to 1972. Despite this, neither party had any appetite to discuss arbitration for 20 years.

Generally speaking, binding arbitration works in this way: If the two parties can't reach an agreement, either one can ask for the arbitration process to start at a certain date—usually after a set amount of time for negotiation has elapsed. The existing agreements will usually spell out whether the arbitration will be done by a single person or a panel. The BCMA and the government had agreed to use a panel of three, consisting of a chair and two wingers. The two parties either choose the chair by mutual consent or, failing agreement, the chair is appointed by another entity (in our case, the Chief Justice of BC). Once a chair is in place, each party names a winger. At a time

agreed to by the two parties, the panel hears evidence from witnesses for each side. The panel can either rule the evidence presented as being within its mandate or not, so there is a risk that the position taken by a party cannot be considered by the panel at all, as happened to the BCMA in an arbitration in 2004, where many of the BCMA's proposals were ruled to be beyond the scope of the arbitration panel's mandate. Based upon the evidence presented, the panel deliberates and produces a report that is binding on both parties.

The wingers should be well versed in the issues that each side would like resolved through the arbitration process. Before the arbitration hearings begin, each party briefs its nominated winger extensively about the positions of each side, expecting that the winger for the doctors, for instance, to push their agenda aggressively when



the panel considers its findings. Once the hearings have begun, there is no direct contact allowed between the principals and the wingers.

To complicate matters, there are two different types of arbitration. Interest arbitration involves disputes over what terms or conditions should be included in a new agreement between two parties. In 2000, in the wake of RADs, the BCMA negotiated interest arbitration in the Framework Memorandum with the government. In contrast, rights arbitration involves a dispute over interpretation of an existing agreement. ► [SEE 1993-1998—REDUCED ACTIVITY DAYS AND THE END OF PRORATIONING](#)

The BCMA and the NDP government had agreed to rights arbitration to settle future disputes in 1993. Both sides felt that such a process would prevent the patients of the province from suffering if they were caught between the two opposing parties.

When negotiations in 2000 got bogged down, former Chief Justice Allan McEachern was appointed to head an arbitration panel. During the arbitration, the NDP was

soundly defeated in the election of 2001, and the BC Liberals formed the government. Not long after, Justice McEachern made an interim award that addressed some outstanding issues, such as the amount of an increase to the Section of Anaesthesiology. He directed the two parties to try to resolve the remaining issues but warned that he would reconvene the arbitration panel if progress stalled.

The government studied the initial award and decided that it was too rich for its budget. On March 7, 2002, the government introduced Bill 9, the Medical Services Arbitration Act—extinguishing the award, ending the arbitration, and removing arbitration provisions from the Master Agreement.

The members were incensed. They had hoped that Premier Gordon Campbell would live up to the existing agreement that included binding arbitration as the dispute-resolution mechanism. As BCMA President Dr Heidi Oetter told the *Vancouver Sun*, “There is a high level of anger . . . and people are quite prepared to support job action. We can’t deal productively with a government that

has acted in such bad faith.”¹ Almost all BCMA members supported efforts to end the dispute only on terms equal to or better than those that Justice McEachern had awarded, and they responded to Bill 9 by gradually escalating the withdrawal of services.



Dr Heidi Oetter, BCMA President in 2001.

After months of fighting, the two parties went back to the negotiating table and reached an agreement—one that improved upon Justice McEachern’s initial award² and included significantly increased funding for fee-for-service, sessional, service contract, and salaried doctors; the establishment of the Medical On-Call Availability Program (MOCAP); the initial funding for the General Practice Services Committee, and enhanced benefit funding.

▶ [SEE 1997—THE NORTHERN DOCTORS’](#)

[DISPUTE, THE RURAL AGREEMENT, AND MOCAP](#)

▶ [SEE 2002—THE GENERAL PRACTICE SERVICES COMMITTEE](#)

As part of that agreement, the parties decided on a new dispute-resolution mechanism that gives BCMA members de facto binding arbitration. The government perhaps realized that it risked losing votes if BCMA members took job action—as they did in May 2002—during an election. The association therefore agreed not to organize or condone such job actions while there was an agreement in place. If an agreement couldn’t be reached at the table, either party could ask for mediation and, if need be, for a conciliation panel to be appointed. The panel would receive submissions from the BCMA and the government and present a report. Its findings would be binding on the



members and the BCMA, but the government would have 10 days during which it could refuse to accept the award in its entirety (it could not “cherry-pick” only certain points).

In rejecting an award by a third-party process it had agreed to, the government would leave itself open to criticism from the public and would have to deal with an angry and organized medical profession. Should the government reject the entire award, the association would then be free to organize whatever job actions it felt necessary to force an agreement. In effect, the BCMA has a process that is as close to binding arbitration as one can get without its being called “binding arbitration.”

This process is still in effect, and the association has used the threat of asking for a conciliation panel to great effect on many occasions.

There are pros and cons for both parties in a binding dispute-resolution process. Generally speaking, control of expenditure from the public purse is considered in our parliamentary form of government to be solely the

legislature’s responsibility. Because an arbitration panel can bind the government to pay the award in its report, governments are usually reluctant to agree to arbitration. From the BCMA’s point of view, the advantage of arbitration is that it lessens the need for the members to use job action to put pressure on the government, which would almost certainly compromise access to needed medical services for the people of the province. The risk of arbitration is that the arbitrators may not agree with the BCMA’s position, and the association has no recourse except to accept the decision of the panel.

- 1 Beatty J. Meet our demands, or else: MDs: “You can expect to witness the uncontrolled anger of the doctors.” *Vancouver Sun*, March 20, 2002:A1.
- 2 Fayerman P. Their deal is richer than arbitration: Province will now pay more than if McEachern deal stood, BCMA says. *Vancouver Sun*, June 4, 2002:A6.



CHAPTER 18

2002—The General Practice Services Committee

The demise of the Relative Value Guide fee proposals in the 1990s upset the Society of General Practitioners (SGP), which debated the need for family doctors to have a forum where they could discuss issues related to general practice directly with the government.

In the lead-up to the negotiation of 2001, the SGP proposed to the Board of the BCMA that such a forum be created through the negotiating process and that it would be named the General Practice Services Committee (GPSC). The GPSC would be made up of equal numbers of government and SGP members. The idea was that both sides could work toward agreement on issues that were unique to general practitioners that would result in improved care for patients. The SGP requested \$10 million for projects that were approved by both the SGP and government representatives.

▶ [SEE 1994—FEE DISPARITIES AND THE RELATIVE VALUE GUIDE](#)

The agreement negotiated in 2002, after the job action precipitated by Bill 9, established the GPSC, with funding of \$10 million a year for two years. (The government did not agree to the Specialist Services Committee proposed by the BCMA at that time.) The GPSC's mandate was "to encourage and enhance full-service family practice to benefit patients."¹ ▶ [SEE 2002—BILL 9 AND ARBITRATION](#)

The GPSC could implement programs only if it reached consensus, which it initially found difficult. Sometime in the first year of meetings, however, there was an



Dr Bill Cavers, past GPSC Co-chair, credits the committee with revitalizing family medicine.

“aha” moment when Dr Howard Platt, a member of the government team, pushed the other government members to commit more money to the GPSC, an idea that was highly favourable to family practice, while a member of the SGP team, Dr Hyman Fox, maintained that more money, if not invested to support full-service family physicians providing longitudinal care, would be wasted, an assertion the government found well reasoned. From that moment on, the members of the GPSC have by and large worked harmoniously to establish programs that have met its goals.

In the negotiations of 2006, funding for the GPSC was increased, and the Specialist Services Committee and the Shared Care Committee were established to, respectively, find ways to enhance specialist care and to identify areas where family doctors and specialists could work together to care for patients.

Dr Bill Cavers, past Co-chair of the GPSC, and Dr Fox, one of the original members from the SGP, are among many on record stating that the GPSC has been the saviour of family medicine in BC. Many GPs who were going to



retire in the last decade have stayed in practice because of GPSC programs. These programs, which reward family doctors for looking after people with chronic diseases and complex conditions and encourage GPs to deliver babies, have helped address the disparities that have plagued the BCMA for many decades. The GPSC also established the Divisions of Family Practice, which initiated the “A GP for Me” program to ensure that all British Columbians who want a family doctor can find one.

The budgets for both the GPSC and the Specialist Services Committee have grown to well over \$200 million each, but the funding must be renegotiated in each new contract. Without renewed funding, all of these programs jointly created by the government and the BCMA to enhance care and benefit patients would end.

Collaborative committees such as the GPSC, Specialist Services Committee, Joint Standing Committee on Rural Issues (JSC), and Shared Care Committee bring together

physician and government representatives to make decisions on programs that will benefit patients, the profession, and the health care system. These programs enable physicians to become a profession of influence, with input and a voice in health care change.

1 Society of General Practitioners of BC. Advocacy. <http://sgp.bc.ca/advocacy-join/>. Accessed October 16, 2016.



CHAPTER 19

2002–2003—The Bonita Thompson report and a change in the society appointments

In the aftermath of Bill 9, members were yet again frustrated with the government. In response to the furious public outcry, the government agreed to immediately begin discussions between the Executive Director and the President of the BCMA and, on the government's side, the Premier, Deputy Minister of Health, and the Principal Secretary to the Premier.

These discussions resulted in a memorandum of understanding signed on March 26, 2002, that sent the two parties back to the table to resolve the many outstanding issues after the McEachern arbitration was negated. ► [SEE 2002—BILL 9 AND ARBITRATION](#)

Formal negotiations started on April 18, but the government was newly elected with a large majority and so likely had little motivation to make progress.

In response, job action by various groups of frustrated physicians broke out on May 6. The two parties continued in marathon discussions, but a problem arose within the BCMA Negotiating Committee that prevented them from reaching an agreement at the table.

When they were created in 1989, the two societies of GPs specialists were given the right to appoint one member each to the BCMA Negotiating Committee.



Ms Bonita Thompson, QC, Chair of the Negotiations Review Committee.

During the negotiations after Bill 9, the society appointees would agree to an issue on the table only if their respective Boards allowed them to. At several times in the negotiation, the society appointees would leave the negotiations to telephone their Presidents. As a result, the BCMA Committee became gridlocked and could not reach consensus. In response, in an emergency session, the Board of Directors authorized the BCMA’s Director of Negotiations, Mr Geoff Holter, to meet one on one with the CEO of the Health Employers Association of BC, and the two concluded a memorandum of agreement (MOA) on May 29, 2002, that resolved the outstanding issues. The MOA was ratified in July by the BCMA membership.

▶ [SEE 1987-1989—INCOME DISPARITIES AND SOCIETIES](#)

▶ [SEE 2002—BILL 9 AND ARBITRATION](#)

In light of the impasse within the Negotiating Committee in May, the Board of the BCMA appointed a Negotiations Review Committee to examine all of the BCMA’s negotiating structures and appointments. The Committee was chaired by Ms Bonita Thompson and had three physician members.



The Thompson report was presented to the Board in January 2003 and clearly outlined mistakes by all parties on the BCMA side of the negotiations. The Committee made over 70 recommendations concerning the negotiating committee structures, reporting duties, membership, responsibilities, funding, and conduct of everyone involved in planning and carrying out future negotiations with the provincial government.

After deliberating, the Board implemented the many proposed changes, some of which were incorporated into the Bylaws after a member vote, and the result has served the members well in the more than a decade since the report's release. Among the report's recommendations was the creation of a new body, the Negotiations Forum (NF), and the Board and NF have committed to the following process:

- The NF consists of 16 members appointed by the Board, and they represent the entire membership by geography, payment modality (for example, fee-for-service, salaried, sessional, or service contracts) and

specialty. The Chair of the Negotiating Committee and the Chief Negotiator attend as non-voting members as well. In preparation for the next negotiation, the NF asks for and reviews submissions from all members, sections, societies, and committees of the BCMA. After the review, the NF produces a report for the Board with recommendations for the negotiations, including the Negotiating Committee's core objectives, recommended funding for the negotiation process, specific proposals, and responses to government actions if negotiations stall or in the unlikely event a conciliation report is rejected.

- The Board can make changes to the recommendations and, after deliberating, gives the Negotiating Committee its mandate. The most important part of the mandate is the core objectives. The Committee cannot bring a proposed settlement to the Board unless the proposal meets all core objectives.
- Once the Committee brings a proposal to the Board, the Board can either reject it or send it to referendum



for the members to vote upon. If accepted, the BCMA is bound. If rejected, the Board sends the Committee back to the table with updated instructions.

- Once the members accept a settlement, the NF reviews the negotiation and sends out another call to all interested parties within the BCMA for input about how things went. They then produce a report for the Board of Directors to review, thus concluding the negotiating process.

The Thompson report put forward other important recommendations. The first was that everyone involved in the process owed their allegiance first to the BCMA. The Board now has authority through the Bylaws to remove any member of the Negotiating Committee who does not act in the interests of all members (not just those of their particular specialty or society). Second, the BCMA created a Code of Conduct that all members of the Board, Executive, and Negotiating Committee must sign. Third, the Negotiating Committee must now include a non-fee-for-service doctor. In addition, the Negotiating

Committee must have its terms of reference approved by the Board—something that had never been done before.

After the report, the BCMA changed the Constitution such that the societies could no longer appoint directly to the Negotiating Committee. Rather, they would supply a list of three nominees each to the Board of Directors, who would appoint one of the three to the Negotiating Committee.

CHAPTER 20

2013—Doctors of BC

In the mid-1980s, the BCMA undertook an advertising campaign to raise the profile of doctors with the public so that British Columbians would become more aware of the value of the profession.

The highly effective campaign consisted of billboards and newspaper ads. The messages were sponsored by “Doctors of BC.”

In 2011, Dr Mark Schonfeld retired after 14 years as CEO of the BCMA. The Board hired Mr Allan Seckel to succeed him. Early in his tenure, Mr Seckel interviewed all of the Board members, many of whom told him they felt the association had become disconnected from the members—and that a stronger connection was an absolute priority. At the same time, senior staff met with all of the sections to see if they were interested in pursuing non-monetary issues in negotiations with the government and the health authorities. They found that many sections were enthusiastic about the prospect of fostering stronger relationships and influencing policy at that level.



Mr Allan Seckel, who became CEO in 2011, initiated the association's rebranding efforts.



Dr Mark Schonfeld, Executive Director of the BCMA from 1998 to 2011.



Working with consultants, the BCMA held several focus groups around the province to solicit feedback from members, the public, students, and Board members about the BCMA's direction. One key finding was that the public at large had no idea what the BCMA was, with many people believing it was an arm of the government or conflating it with the MSP.

The Board embarked on a strategic planning exercise to:

- Address the mutual disengagement of the Board, the sections, and the membership
- Strengthen collaboration between members, the public, and other players in the health care system
- Foster public support against any government action felt to be “anti-MD”

As the plan evolved, the Board decided that the association needed a new brand that would resonate with members and the public.

The consultants suggested the best new brand would be “Doctors of BC,” harkening back to the advertising campaign of the 1980s. The name evokes a sense of cooperation between the association's membership and

the public to help improve BC's medical system. At the same time, it carries an undertone that, in negotiations with the government, the doctors would be unified in fighting any attempts to break agreements or backtrack on resourcing the system.



Doctors of BC logo.

The legal name of the association has been and still is “the British Columbia Division of the Canadian Medical Association.” Before the end of 2012, our members knew us as the “British Columbia Medical Association.” As of January 2013, however, the membership, the public, the media, and all branches of government know us as *Doctors of BC*—a name in which the staff of the association has taken great pride, and one that will carry us into the next 100 years with the lessons of the past to guide us into the future. ■



The BCMA, Then and Now:

A Selected History from 1965 to Doctors of BC

“Although the BCMA has a robust archival collection, there is little in the way of a written history about the association, beyond an article Dr Ed McDonnell published in the British Columbia Medical Journal in 1984. I felt it might be worth documenting some of the BCMA’s watershed moments—key decisions or changes that have defined the association’s evolution since 1965.”

—DR BRAD FRITZ