Mistaken

I often log on to my EMR remotely to check results on days I'm not in the office. At one point, I saw a patient in the office and diagnosed him with a minor illness requiring no treatment. Later, I checked my EMR and there in front of me was the sickening truth that I had made a mistake. He had presented to emergency the night before with a life-threatening illness. Much to my relief the patient didn't die, but he could have. I immediately felt guilt, remorse, shame, and self-doubt accompanied by a chest pain and a sinking feeling in my abdomen. I was flooded with negativity. How could I have been so careless? I'm a terrible physician! Why didn't I take the time to listen and make the correct diagnosis? Maybe I should tell all of my patients to find a physician worthy of them? The visceral malaise and cognitive despair was overwhelming. There was no escape from it in the days that followed—it was there when I closed my eyes at night, in the morning when I woke, and all the time in between. It is a struggle to deal with all the emotions associated with such a blunder while carrying on seeing patients.

The experience got me thinking about how physicians deal with mistakes. Doctors are human and, therefore, fated to make errors during their careers. Fortunately, my mistake didn't lead to mortality or significant morbidity, but it could have. My heart goes out to physicians whose misdiagnoses led to significant adverse patient outcomes. I can't imagine the mental and physical stress involved (there by the grace of God go I). I confess that this isn't the first mistake I've made, and I'm sure it won't be my last. However, enough time has passed that I've now reflected on the process I went through and thought I would share it in case it might help someone else.

First, I talked to my wife and colleagues, discussing my error and sharing my feelings. My wife, as always, supported me and reminded me of the many patients who would vouch for my care as a physician. My colleagues listened and shared their stories of medical woe, making me feel less alone. I carefully looked back at my encounter with the patient and thought about where things went wrong and what I could have done differently. What factors were involved, including mine, the patient's, and those of our therapeutic relationship? I was able to identify and take ownership of my part of the interaction, which led to my misdiagnosis. I then took the difficult step of phoning the patient and apologizing for letting him down. This was not a pleasant process. He was justifiably angry, but I believe this step was necessary for me to move on and continue to be an effective physician. As a result, with the passage of time, I have been able to put this experience in its proper place as an unpleasant memory, but one I have learned from.

The patient has come back to see me in the office, which I'm sure was a big step for him. He related that much of his disappointment and anger was tied up in the thought that he might not be around for his daughters. This was a sobering reminder to me of the lives that can be affected when we make errors in our profession. The challenge is to accept this reality without letting it paralyze us while we do our jobs and hopefully learn from our infrequent mistakes.

—DRR

Priorities in health politics and policy making

Observing the current federal and provincial political scenes makes one wonder why anyone would become a politician. The same question may be more valid when considering medical politics which, as Dr Pat McGeer implies, is more demanding and less well paid than the real thing.[1] Many of us have tried, without achieving the level of satisfactory outcomes that we hoped for.

Major themes that our national and provincial medical organizations have focused on include physician health and burnout, and increased funding for seniors care and Pharmacare. However, when it comes to policy determinations, we have not followed the usual axioms in medicine, that prevention is better than cure, and that diagnosis and causation should usually precede treatment.

Forty years ago, physician health problems and burnout were not so prevalent. I suggest that this is in large part because, despite often working exhaustive hours, we were extremely happy with our work. We did not experience the frustrations of extreme rationing or the access issues of today. Physicians had an important and respected role in determining health policy.

Who can argue against additional funding for seniors care? Well, as a senior, I can. I received a Gold Care Card from the BC government that afforded me greater health benefits *based on age*. Since two-thirds of Canadians' wealth is held by those over 65, what sense does that make? Why should poor young families subsidize richer seniors? As Canada's population doubled between 1961 and 2017, per capita spending on health rose sixtyfold. Wealthy baby boomers will receive $4000 more care than their lifetime tax contributions fund. Millennials and iGens will pay $18 000 to $27 000 more in taxes than benefits received. We are imposing long-term debt on our youth.[2] The emphasis on seniors is misguided. Low-income groups *of all ages* need adequate care and, as happened previously with family allowances, a means test is needed.

Government Pharmacare is another ill-advised initiative. Private insurers (such as not-for-profit Blue Cross) already provide drug coverage for 70% of Canadians. A new costly bureaucracy will mean further rationing of existing services, and perhaps long lineups to see a pharmacist. If Pharmacare (and dentistry, physiotherapy, etc.) are to be added as benefits (and they should be), it should not be through an expanded bureaucracy but through funding or subsidizing premiums for those who lack coverage.

Governments are inefficient at providing services. Stats Canada data show the poor and underprivileged covered by government plans suffer the worst health access and outcomes. Indigenous health services are a prime example.

Doctors are blamed for systemic weaknesses that governments have built into a rationing-based system. Provincial medical associations are hampered when it comes to confrontation with their health ministry employers, with whom they negotiate their own reimbursement. Collaboration may become a harmful synonym for appeasement. However, in policy making, our national association should not fear confrontation when collaboration fails.

Governments like to assign blame for cost overruns to "overpaid" physicians. I recently paid $576 for a 30-minute house call to unblock a sewer drain. That's 6 or 7 times the fee for an equivalent family doctor visit; perhaps we need to consider teaching doctors to clear drains. An entity called Choosing Wisely often focuses on inappropriate actions of doctors as a factor in escalating costs. There are good aspects to their work, but in championing it the CMA must protect the rights of patients and physicians. The group bases protocols on expert opinions and peer-reviewed studies, many of which are without merit.[3] Experts opine on inappropriate investigations or procedures, and I am aware that they sometimes base their recommendations on inaccurate analyses. Like Feynman, I believe "Science is the belief in the ignorance of experts."[4] Clearly, not everyone with a headache needs an MRI. But ask a patient whose symptoms did not fit a protocol but who benefited from an early diagnosis that saved their life if their so-called inappropriate test was worthwhile. If I spend 45 minutes doing a complete physical and find a rectal tumor, was I not choosing wisely when I examined areas that were normal? Negative clinical exams—and yes negative findings on laboratory and imaging studies—are

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an empirically important and relevant part of practising good medicine. Physicians cannot be blamed for accessing what they consider appropriate and available diagnostic tools. Choosing wisely must not violate the rights of patients to override the societal directive or protocol and choose for themselves when their own health is involved.

Finally, I am disappointed that the CMA, as the main sponsor of a recent Economic Club of Canada event titled "Is It Time to Revisit the Canada Health Act?" agreed to the assignment of our president as a moderator while three nonphysicians (some of whom blame physicians for our system's failings) espouse their opinions and recommendations. Our talented CMA president, Dr Gigi Osler, should have been front and centre as the main speaker at that event. Our professional bodies should not deviate from the principle that physicians should lead, rather than moderate, important discussions on the future of our health system. **—BD**

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Improving access to team-based primary care in Burnaby

Three primary-care networks (PCNs) and the new Burnaby Urgent and Primary Care Centre (UPCC) are coming to Burnaby in May 2019. The PCNs and UPCC will recruit approximately 68 new health care providers over the next 3 years, including 10 general practitioners, 10 nurse practitioners, 3 clinical pharmacists, and 45 nursing and allied health care professionals.

The three networks will be the Brentwood/Hastings PCN, Edmonds PCN, and Metrotown PCN. A fourth PCN located in the Lougheed region will be developed in the future.

Currently, Burnaby has 45 primary care clinics participating in the PCN and 133 general practitioners. The networks will partner new and existing health care professionals with the health authority and community organizations as part of a networked, team-based approach to providing care.

The Burnaby Urgent and Primary Care Centre, located in the Edmonds PCN, is the sixth centre to be announced in BC. The centre will open in two phases. The first phase offers extended hours evenings and weekends and will increase access to team-based care for a range of primary-care needs. In the second phase, the centre will host an incubator clinic to support experienced family physicians in mentoring new family physicians, consolidate nursing and allied health resources, and work to attach people in need of regular primary care.

In addition, once fully developed, the Metrotown PCN will also form a Centre for Healthy Communities that will support an incubator clinic. Centres for Healthy Communities are hubs for co-location of practitioner, health authority, and community services and resources. They will serve as the focal points in the PCN to anchor, integrate, and support services and providers to serve the entire neighborhood.

The three PCNs will focus on the specific needs of the community and improve health services identified as high priority for each community, including:

- Enhanced access to regular, extended, and after-hours services for comprehensive primary care.
- Improved access to primary-care services for priority populations including seniors and immigrants.
- Team-based resources to better meet the needs of low- to moderate-complexity patients requiring specialized services including for frail seniors and mental health and addictions.

The PCNs will operate in close partnership and collaboration with the Division of Family Practice and Fraser Health primary care networks being implemented in Fraser Northwest communities.

The Ministry of Health will provide approximately $12 million in annual operating funding to the Burnaby networks and UPCC by the third year, as new positions are added and patients are attached. To learn more about the province's primary health care strategy, visit https://news.gov.bc.ca/releases/2018PREM0034-001010. To learn more about the Fraser Northwest primary care networks, visit https://news.gov.bc.ca/releases/2019HLTH0036-000266.

The Victoria Combined Peripheral Nerve and Spasticity Clinic

The Victoria General Hospital Clinic is offering novel, ground-breaking collaborative innovations. After witnessing impressive neuro-orthopedic

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