The Kindly Country Quack

The Wit and Wisdom of a Small Town Doctor

Dr. John Wyatt Crosby, M.D.

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Dedications

I dedicate this book to my wife Jill. To my three sons; Andrew, Stephen & James. To my daughter-in-law Kristy. And to my mother and father; Jack & Doris Crosby

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36 reasons why I still love medicine after 45 years

I have been lucky and made my own luck too. I have worked hard and relentlessly to make my life as a family doctor wonderful.

1. Good hours. I start at 8 a.m. doing paper and computer work, go to my two nursing homes then have one and a half hours off for lunch then am done by 4 p.m.

2. Good pay.

3. I am valuable to my patients. I save the odd life, prevent a lot of bad diseases like strokes and MIs. I prevent horrible infectious diseases like polio, meningitis, diphtheria, tetanus, measles and mumps. Google them and look at the pictures. I have prevented suicides with good treatment of depression.

4. I have nice patients. Even the difficult ones have a reason to be like that and I have learned how to manage them (and they me).

5. I have the world's best staff. My secretary is great as are the nurses at the nursing homes. I now share the practice with a terrific nurse practitioner. I pay them well, treat them well, teach them well and they treat me well.

6. I take medical students and family practice residents but only for a month or two. I then have time off to recharge my batteries. Their enthusiasm is contagious and they teach me a lot too. We keep in touch by email. I am having lunch with one that I taught years ago. She is bringing her new baby.

7. I am off the fee-for-service hamster wheel. I am in a family health organization which pays a set amount per patient per month. Heaven!

8. I am in a good group of 18 family doctors and we get along amazingly well and have for 10 years. We let everyone be independent. I am a solo GP but have a group backing me so I have the best of both worlds.

9. We have a good hospital, Cambridge Memorial Hospital. I go out to lunch with the CEO every year and tell him what is happening with my patients and in the community. He listens.

10. We have wonderful specialists in Cambridge, Ont. and I can phone them for help anytime.

11. My work is interesting. No patient is the same and lots of really complicated problems are seen daily because I have two nursing homes and 70% seniors in my practice. I just had a guy come in with a cardiomyopathy yesterday.

12. I really help people, even if it is just to reassure them.

13. I get lots of paid, good vacations at my cottage and travel world wide.

14. I live in Canada, the best country in the world. I never have to ask if the patient can afford my diagnostic tests or treatment.

15. We have good new technology like the quinolone's, biologicals, laparoscopic surgery, MRI and CT. I am old (71) enough to remember the bad old days without them.

16. I work with good paraprofessionals like physiotherapists, social workers, home care staff, chiropractors, dentists and podiatrists.

17. I never have to collect money from patients unlike every other professional.

18. I don't sweat the stuff I can't change like naturopaths asking for lab work or lawyers wanting MRIs on whiplash patients. I just use Choosing Wisely algorithms.

19. I don't envy dentists. They have to inflict pain on every patient and there are too many of them. Their overhead is massive. Veterinarian's patients bite them, although my babies pee on me. I love babies and they love my exam table paper.

20. I don't envy anyone.

21. I don't fight about time off with patients. I just describe the medical problem and the boss can worry about it. Work is therapy.

22. I don’t use narcotics with chronic pain patients because they don’t work and they give the patient a second problem. I try everything but.

23. I chart well and easily using Telus PS Suite EMR and templates for good patient care and to keep the college happy.

24. I take the afternoon off when working evening clinics, which are only once a month.

25. I am always home for supper with the family

26. I never take work or worries home.

27. I turn off my dumb phone at 5 p.m. and on weekends and holidays.

28. I take a one-week holiday every three months. I sign out to another family doctor and reciprocate.

29. I am in a rostered practice and get paid vacations, study and sick leave. See #7.

30. I complain to my secretary, wife and colleagues when I am stressed then I let it go.

31. I haven’t been on call since I was 65 (I invented our super call system 25 years ago because I am a lazy, call weasel).

32. I change it up all the time. I have been an emergency physician, university professor, hospitalist, surgical retractor jockey, chief of staff, chief or ER and chief of surgery. I have been an urgent care doctor too. I have been a ministry of health consultant for paramedics. I am a GP, private consultant for doctor efficiency, lecturer and writer. I am a College of Physicians and Surgeons of Ontario supervisor for two doctors.

33. I have worked in London, Ont., Warwick, England, Hazelton, Northern British Columbia, Cambridge, Kitchener, Oakville, Toronto, Hamilton and Montego Bay, Jamaica mon.

34. I have trained paramedics.

35. I love paperwork because I do it daily.

36. I love my nursing homes because I go three times a week.

But most of all I always ERO every sticky situation. Event plus my Reaction equals Outcome.

Talking with the new Canadian Medical Association chief of physician wellness

I recently interviewed Dr. Caroline Gerin-Lajoie by phone. She is the new doctor in charge of physician health and wellness for the Canadian Medical Association (CMA). I think it is great to have an individual leading this initiative at the CMA, as it is the number-one issue for Canada's doctors.

What is your job?

My official title is vice-president, physician health and wellness. With the help of my team, my goal is to create and implement CMA's roadmap to address issues affecting physician health and wellness.

How did you get the job?

I was a psychiatrist in Ottawa, specializing in psycho-social oncology. In the area of physician wellness, I was working as medical director in physician health and wellness at the Ottawa Hospital, and as director of the faculty wellness office at the faculty of medicine, University of Ottawa. My colleagues encouraged me to apply and I was also head-hunted. So I decided to take the plunge and applied for the job. Following a comprehensive interview process, I was delighted to learn that I was the candidate selected for this new position at the CMA.

What surprised you about your new job?

How huge Canada is! This is a great, large country with many silos, unfortunately. There are many great initiatives led by passionate people from coast to coast to coast that we can learn from but we need to bring them together, share this information about what worked and what didn't, so we can ultimately apply it to the benefit of the profession.

What is the future?

It's become clear to me that we need a national strategy to address issues affecting health and wellness of our physicians and trainees.

With a national plan, we can then start putting the right resources in the right areas, and have impact. Since starting this new role, I've had the opportunity to listen to the experience of physicians and trainees from across the country during CMA's regional member forums. Overall, doctors love what they do, but the changes affecting their work are implemented at a pace that is challenging—at best—to keep up with. While the number of patients and work demands keep increasing significantly, compensation and overall work structure and support are decreasing, which create a widening discrepancy.

How do you balance your own life?

I'm fortunate enough to still be connected directly to my profession with continued clinical work. I have also remained as medical director of physician health and wellness at the Ottawa Hospital, which allows me to connect the front line and organizational perspective with the broader CMA perspective. I strongly believe that these roles complement each other and allow me to better understand this complex issue.

Vision

What I heard recently at the CMA regional member forums is clear: We need a concerted effort to address the individual, systemic and cultural factors affecting physician wellness. Physician health is a shared responsibility, and we need to engage all stakeholders to help find solutions and break down barriers.

Are pharmacists eating doctors' lunches?

It's 10 p.m. on a Friday night. A patient starts to pee steam. Oh no, a bladder infection.

Their family doctor is off, after putting in a 60-hour week of seeing 35 patients per day, plus on call and computer/paperwork.

The patient turns to Google and finds that all the nearby walk-in clinics are closed. All that is left is the ER. Wait times there are six hours, and they include crying babies, cursing drunks and people coughing pestilence hither and yon. Plus, this conscientious patient doesn't want to tie up the ER with a non-emergency.

How about driving up to the local pharmacy? Park for free, tell the pharmacist the problem (they are on duty until midnight, or maybe even 24 hours a day).

The pharmacist gives the patient an antibiotic; the patient is in bed by 11 p.m., on the mend.

This is what the Ontario government is planning within the next year. There are already courses in the diagnosis and treatment of minor medical programs.

I think this a great idea, but many doctors don't.

Advantages include fast care for longer hours, especially after hours.

My dad and grandfather were pharmacists. I grew up in Sarnia, Ont., as a delivery boy, shop clerk and bookkeeper for Crosby Pharmacy. I get along great with all the pharmacists in Cambridge, Ont., where I have been a family doctors for 27 years and before that an emergency physician for 20 years. I relate well to pharmacists in the hospital and in long-term care settings.

I think the Canadian healthcare system is wonderful but it is a monopoly and needs competition to improve efficiency and access.

We also need nurse practitioners and physician assistants to help us improve access. I work with a nurse practitioner and have worked with physician assistants; I have also trained them. There is more than enough work for all of us. It will increase as the population increases, and as Canadians age and become more in need of medical care.

Here are the common things Ontario pharmacists will be diagnosing and treating:

Acne vulgaris
Allergic rhinitis
Aphthous ulcers
Atopic dermatitis
Calluses and corns
Candidal stomatitis
Cough and sore throat
Diaper dermatitis
Diarrhea (non-infectious)
Dry eye, red eye and minor eye infections
Dysmenorrhea
Emergency contraception
Fungal skin infections
GERD and dyspepsia
Hemorrhoids
Herpes simplex
Impetigo
Insomnia
Mild headache
Musculoskeletal pain
Nausea and vomiting
Patient assessment and triage
Seborrheic dermatitis
Threadworms and pinworms
Urinary tract infection
Urticaria (insect bites and stings)
Vaginal candidiasis
Warts

A few warnings:

Cough and sore throat in a patient with COPD can quickly turn into pneumonia and kill them.

Eye infections can be iritis or glaucoma.

Mild headache could be a subarachnoid bleed or meningitis.

GERD could be a myocardial infarction.

There doesn't seem to be any MDs on the list of faculty for the training courses. This is a serious oversight medically and politically, and from a public relations viewpoint.

Also, how will pharmacists be paid, and how much? Family physicians in Ontario get $33 and ERs get $300 per visit.

How will pharmacists communicate their charts back to the FP? We already don't get walk-in notes.

What about Choosing Wisely? Won't a pharmacist be tempted to prescribe an antibiotic for a virus since he or she is selling the antibiotic? Isn't this a conflict of interest?

What about fee-for-service FPs? They lose money on difficult patients and make it up with these little cases.

I, like half the FPs in Ontario, am in a captitated system of payment, so having pharmacists treat "minor ailments" actually helps me. I get paid the same no matter who sees my patients, except with walk-ins: I pay for the walk-in physician's fee out of my office income.

Insomnia: 10 tips to help patients (and you) sleep

I have a handout for insomniacs (see below). I put my handout on my computer screen and then go over it line by line with the patient. I ask them when they go to sleep, when they wake up and what they are thinking about when their brains are churning in the middle of the night. I also refer them to a sleep clinic to rule out sleep apnea.

1. No caffeine, ever. (Cola, chocolate, coffee, tea, Red Bull, power drinks, wake-up drops, etc.)

2. Sleep in a cool room: 15 degrees Celsius

3. Use a source of white noise (fan) — but not blowing on your face and drying your eyes out. Try ear plugs made of soft wax; ask your pharmacist.

4. No napping, ever. Go for a walk.

5. Spend money on a good bed. You spend 33% of your life it.

6. Go to bed at the same time each night.

7. Write down your worries if you wake up and your brain is churning.

8. If you can’t sleep after 10 minutes, get up and read a boring book and drink warm milk. Have a warm bath.

9. Get rid of your alarm clock.

10. Avoid the computer, smart phone, iPad, TV or any screen two hours before bed; read a printed book or magazine. Turn off your smart phone at 5 p.m. Your brain doesn’t have a shutoff switch like your screen.

Also:

Google “CBT Insomnia Harvard” for self-help programs on the Internet for insomnia.

Google: “4-7-8 breathing exercises” for sleep technique

That is the science of treating insomnia; what about the art?

The art is in talking to patients about changing their habits. Sleep is a habit just like putting on a seatbelt when you get in the car or brushing your teeth in the morning.

I always get pushback on the caffeine angle. Every Canadian loves their Timmies or Starbucks. I tell them no caffeine ever, not even a little cup at 6 a.m. They often have to wean themselves off slowly by trying half-caf for two weeks, then decaf. I also tell them that tea contains caffeine, which is a surprise to many.

The cool room is easy, as most Canadians have at least a window unit air conditioner for summer (which can cost as low as $200), and of course we have winter. Boy, do we have winter. It lasts longer than the final minute of a basketball game.

The white noise is news to many. A cheap solution is a fan in the corner (avoid it drying out your eyes) or an app on your smart phone for nice wave noises or gentle breezes.

Napping is very hard to stop because the patient is so tired after a sleepless night. Tell them to take a walk instead. This is the biggest cause of insomnia in seniors and for those patients in long-term care. Activities have to be planned to avoid napping.

Same time each night—this is a biggie for teenagers and shift workers. I was a shift worker in the ER for 20 years. I always had a nap before night shifts and never drank anything after 4 a.m. so I didn’t have to get up to pee a lot the next day. I had soft wax earplugs form the drugstore to keep out day noise and a sleep mask to keep out the light.

I got a day job as a family physician when one of my kids opened my eye and said, “Daddy, are you in there?” while I was sleeping after a night shift.

Write down what is worrying you. Everything is worse at 3 a.m. so if your mind is churning, get up, go to another room and write down everything you are thinking about. Read a boring book and have a warm milk and a hot bath. You can’t just lie there looking at the clock.

If a partner is snoring, go to another room or get them treated.

Get rid of your alarm clock. Go to bed eight hours before you have to get up so you don't ned one. It is very upsetting and stressful to be jolted out of a deep sleep by these unnatural devices.

Everyone is addicted to their devices, especially screenagers. Your brain thinks it is still daylight when the screens are on so you don't get the nice slide into sleep just before turning out the lights.

Internists have the highest risk of burnout

As a former emergency physician for 20 years, I got to see most specialists working the 24-hour-clock. I think internists have the toughest job because they are left with the sickest patients in the ER and ICU at all hours of the day.

A young, female Canadian internist (who wished to remain anonymous) wrote to me with her thoughts on the matter:

Remember that the first sign of burnout is anger, not depression, and the three symptoms to recognize early are emotional exhaustion, cynicism and feeling ineffective. Be proactive about caring for yourself first and foremost. Address chronic stress by insisting on control over parts of your schedule, minimizing interpersonal conflict, avoiding political subterfuge, managing patients' expectations, lowering office overhead and learning how to create efficiencies within your EHR.

Create an identity outside of medicine and, if need be, have an exit plan (i.e., how to pay off your debts early, another career, financial independence by having varied income streams and retire early).

If you want to survive residency, consider the following:

1. Take time to go to loved ones' weddings, birthdays, funerals and other special events. Missing out on these moments detracts more from your life than you realize and in a few years you'll wake up not remembering what it feels like to have a support system because you were never there for other people.

2. Don't lose sight of what makes you you. Continue to play an instrument or sport, dance, go to concerts, plays, travel, etc. Often this is what grounds you and allows you to connect with patients, as these things make you relatable.

3. Manage expectations. You are your own worst enemy and critic. Forgive yourself for not knowing all the different ways multiple myeloma can cause renal failure or the criteria for CRT implantation. You are in training and the knowledge will come. Forgive yourself for

not remembering something: It’s called sleep deprivation.

4. Figure out what type of learner you are (kinaesthetic, musical) and optimize retention of knowledge by remembering that perhaps hands-on experience or the order of words, not just the content, matters.

To build resiliency and achieve longevity in your career as staff, consider that most people don’t have any idea what it’s like to manage your cognitive load. Therefore, reduce the extraneous decision-making to a minimum:

5. Have your groceries delivered to you as pre-portioned meals and have your partner meal plan. Recycle the same outfits from a two-week wardrobe so you don’t have to pick out something in the morning. I try to wear indestructible black jeans or variant, a tank top and a blazer. I will also leave a blazer or cardigan in the office so I can switch that out. Have your dry-cleaning delivered to you.

Most of the stressors in the workplace stem from interpersonal conflict, so create boundaries and stand firm in the face of pressure.

6. Remind patients and their families that you have both an office and a clinic practice, and that you will reassure, update, etc., when you have new information to convey.

7. Say no to hospital commitments if they are not in your contract and only participate on the committees where you feel you can make a difference (however long it may take).

8. Figure out at what point you develop compassion fatigue in your office. How many patients can you see in a day before losing this ability? What kind of patients are you more likely to have compassion for and therefore are willing to be their go-to internist?

9. Remember the law of diminishing returns: perfect is the enemy of good. How many times can I edit this list, for example?

10. Don’t let your medical office assistant over-schedule you. I round in the morning and do clinic from noon to 5 p.m. only 10 days a month so I have time to manage paperwork and not develop compassion fatigue. I don’t ask my MOA to fill cancellations and I do not see someone urgently if they don’t need to be seen urgently, which can be ascertained by triaging your referrals.

11. Stand your ground. Having conviction and not allowing administrators, colleagues, etc., to undermine your decision-making when you feel you are ethically or clinically justified is important to your mental health and resiliency, as there is always pressure to conform to someone else's standard.

Learn how to be good to yourself and what "self-care" means to you. I have learned to:

12. Start the day by having a good breakfast with a cup of strong coffee, and to not rush through it. Don't look at your phone. Once you've had a moment of peace and have had an executive meeting with yourself, then tackle the task you have been putting off and dread the most.

13. Take sleep vacations. I tend to do this once a year and will book a luxurious hotel room for two or three nights. Go without the kids or even your partner and just sleep in, order room service, watch a movie and go back to sleep to try to make up for that sleep deficit.

14. Try to schedule regular exercise and know how long it takes for you to achieve a calm and worry-free state. For me, it's a brisk walk in the forest with my dogs; after an hour and a half I am ready to tackle the anxieties of the day.

15. Practise good sleep hygiene. Ear plugs, a cool, dark room, no lights whatsoever, minimize moving things in the bed, etc.

Finally, in terms of your office:

16. Try to negotiate an office lease based on weekly use (since we are not there half the time due to in-hospital duties), and share your office to lower your overhead. Work smarter, not harder.

17. Work in an office with colleagues who are mindful of containing costs and who listen to you during your office meetings. Don't work with bullies or personalities that really grate on you.

18. Use macros, templates and get your MOA to add the allergies into the EHR.

In praise of solo practitioners

I have been a solo GP for 26 years. Before that I worked in a big family practice clinic and then did emergency medicine for 20 years. All the young medical students and family practice residents that I train are all brainwashed into thinking that a clinic is best because that is all they see.

I have the best of both worlds. It is just me and my secretary and my wife does the billing. We have a cleaning lady too. It is like the way medicine was since time began. I get wonderful little old lady baking and booze from my patients, plus Tim Hortons' treats.

Patients love us. They complain that their friends and families that go to big clinics can't get through on the phone lines and have to drive to the clinic and line up at 8 a.m. for a 9 a.m. opening. This is just like people did before the phone was invented. They always want me to be their doctor. Then they can't get an appointment for weeks. Then they see someone they don't know. The secretaries at big clinics don't know them either.

My patients can get through on the phone lines and talk to my secretary who knows them all and their families too, all four generations with some.

We see them the same day, on time, whereas clinics have them see a strange doctor who when sends them back to the real doctor the next day.

At 5 p.m. I sign out to my 18-doctor family health organization and we all take turns running an after-hours clinic where the patients are seen immediately from 5 p.m. to 8 p.m weekdays. They are also seen stat from 9 am to noon Saturdays. There is a nurse on call for free with interpretation services from 5 p.m. overnight until 9 a.m. the next day and also weekends and holidays 24/7/365.

We fax each other our chart notes instantly.

This nurse is backed up by phone by one of us doctors.

We also had three social workers working for our group and they are

free and see patients within a few weeks. They even work evenings.

I have all the benefits of individual service and none of the drawbacks of big groups like meetings and staff absenteeism and conflict.

My overhead is also lower.

For vacations I sign out to another family doctor and my nurse practitioner. If I am sick or going to a conference on sunburn treatment in Mexico they back me up so my patients always have same day care on weekdays.

I don’t return to a mound of paper or computer work either so I am happy.

The business aspect of running an office is easy and handled by my secretary and our accountant.

So you young doctors out there, give solo practice a try, you will love it and so will your patients and staff.

9 reasons surgeons are under all time massive stress

Dr. John Crosby recently interviewed by phone the chief of surgery of Oakville Trafalgar Memorial Hospital, Dr. Duncan Rozario, about what the causes of burnout are among surgeons. Here's what Dr. Rozario said:

We recruit talented young women and men, and train them to be the best surgeons possible. Then the institution of healthcare puts numerous barriers in the way of them providing timely, quality care, and that is the fundamental issue causing surgeons to experience the symptoms of burnout. Many things are under our control, however and we need to address those. At the same time we need to get involved in administration at all levels to produce systemic changes. Here's my nine reasons surgeons are under all-time massive stress:

1. **Work hours and night work:** Many surgeons work too many hours a week and too many nights, weekends, and holidays. To a large extent this should be under their control.

2. **Inability to delay financial gratification, high debt load and poor employment prospects:** I find that many of the younger surgeons want an expensive lifestyle immediately which results in significant debt, or the inability to pay off student debt. We had 51 surgeons apply for our last orthopaedic surgery position. The universities are training far too many surgeons, and surgeons are not retiring when they should. Young surgeons are having a significant problem getting a job.

3. **Higher stress specialties:** Neuro, trauma and cardiac surgery have particularly high burnout rates.

4. **Medico-legal concerns, greater government regulation including regulatory bodies:** Patients are under the belief that surgery should be complication free 100% of the time. This is not realistic and not possible. Society has become more litigious, and our colleges of physicians and surgeons are not seen as supportive of doctors.

5. **Poor work-life balance and lack of hobbies:** Surgeons need to operate less, and spend more time with their families and realize that their identity and self worth is not directly related to the job. We need hobbies, and we need to get back to the interests we had before going through residency.

6. **Increasing patient and societal expectations including Dr. Google looking over our shoulders:** Patients come to us with stacks of printouts from the Internet ready to tell us how we should operate on them.

7. **Lack of attention paid to resilience, personal health, healthy eating and living:** Surgeons do not place a priority on learning how to deal with challenges of surgical practice, nor do they attend to having healthy lifestyles at times. This leads to lots of bad habits such as alcohol abuse.

8. **Inefficient work practices and inadequate access to operative resources:** Society expects everything immediately, if you want a book Amazon should deliver it tomorrow morning, if you want your hernia repaired any competent surgeon should be able to do it within 24 hours. This is unrealistic and these type of expectations create additional stress. Surgeons need to learn how to schedule surgery appropriately and optimize their access to the operating room. Surgeons need to learn how to run an efficient office, use a website for their practice, have a good electronic medical record and pay a fabulous secretary well.

9. **Lower number of colleagues:** In my hospital when I started 22 years ago we had five general surgeons. When I became chief of surgery one year ago we had six general surgeons. I pushed hard and now we hired four general surgeons (including 3 for an acute care surgery service) in the last 14 months to get to a much more reasonable number. Surgeons need to realize that when you increase the number of surgeons that the entire pie grows bigger with more elective cases and a greater referral base. I have been pushing my colleagues to hire, we are hiring five more surgeons in other specialties this year, and I am already making plans for another five surgeons next year. Of course the additional surgeons need to be provided with new resources which requires capacity at the hospital, innovative scheduling, and funding from the Ministry. Work is not the only thing in life and respecting that will significantly reduce surgeon

burnout.

Lastly, the profession has certainly improved with more women in surgery. Unfortunately society does not help women, and expects them to maintain everything at home at the same time so this can be a cause of burnout for some women surgeons.

What's your Maslach Burnout inventory score?

Are you burned out? It comes, as the things that inspire passion and enthusiasm are stripped away and tedious or unpleasant things crowd in. Try this self-test (Maslach Burnout score) to see if you are burned out: (Score 1 point for a, 2 for b, 3 for c, 4 for d, 5 for e)

1) I feel rundown and drained of physical or emotional energy.
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

2) I have negative thoughts about my job.
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

3) I am harder and less sympathetic with people than perhaps they deserve.
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

4) I am easily irritated by small problems or by my coworkers and teams.
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

5) I feel misunderstood or unappreciated by my coworkers.
a. Not at all

b. Rarely
c. Sometimes
d. Often
e. Very often

6) I feel that I have no one to talk to.
a. Not at all
b. Rarely
c. Sometimes d
d. Often
e. Very often

7) I feel that I am achieving less than I should.
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

8) I feel under an unpleasant level of pressure to succeed
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

9) I feel I am not getting what I want out of my job.
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

10) I feel that I am in the wrong organization or the wrong profession.
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

11) I am frustrated with parts of my job.
a. Not at all

b. Rarely
c. Sometimes
d. Often
e. Very often

12) I feel that organizational politics frustrate my ability to do a good job.
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

13) I feel there is more work to do than I practically have the ability to do.
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

14) I feel that I do not have time to do many of the things that are important to do a good quality job
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

15) I find that I do not have as much time to plan as much as I would like to.
a. Not at all
b. Rarely
c. Sometimes
d. Often
e. Very often

<u>Score interpretation:</u>

Score 15 – 18: no sign of burnout here.

Score 19 – 32: little sign of burnout here unless some factors are particularly severe.

Score 33 – 49: Be careful – you may be at risk of burnout, particularly if several scores are high.

Score 50 – 59: You are at severe risk of burnout – do something about this urgently!

Score 60 – 75: You are at very severe risk of burnout – do something about this urgently! If it is severe, see your family doctor stat and get help and counselling. a

Email me for my free ebook ‘A Prescription to Avoid Physician Burnout’ drjohncrosby@rogers.com.

Doctors are the golden retrievers of humanity

Doctors want to please everyone and be loved by all. That's a very high bar to live up to. That's why they burn out so much. I recently met Dr. Mabel Hsin at the Family Medicine Forum in Toronto in November of 2018. She was leading a workshop on avoiding physician burnout. It was a great talk, very practical and she had the whole audience doing mindfulness exercises. I interviewed her by phone later.

Q: What is your background?

I graduated from the University of Toronto as an undergrad and doctor of medicine too. I moved to Bradford just north of Toronto and have been a family physician there for almost 30 years.

To help patients combat burnout I run an eight week, two-and-a-half hour program as a mindfulness stress reduction instructor. Separately, I collaborate with professionals at Altitude HCM in sharing the benefits of mindfulness to corporations interested developing mindful executives. The executives are a lot like doctors, with a lot of stress and hard work that never ends. They, like doctors, sometimes try to cope with maladaptive behaviours like drinking too much alcohol and eating poorly. They get isolated. It's lonely at the top.

Q: Why is there so much burnout everywhere including medicine?

Everyone is overloaded with too much work and too much smart phone and computer time. There is less face time. On the subway and buses everyone is looking at their phones and not at each other. A table full of kids are all looking at their phones and not interacting with each other. They are screenagers.

We need balance in our lives. We need to detox from our phones. (Dr. Crosby note: Dr. Hsin emails her patients with lab and imaging results to cut phone time

Q: How do you avoid boundary issues with your patients?

I have a no reply on my emails.

Q: What do you do personally?

I practice what I preach. I have lots of friends and family to talk things out with. I exercise regularly about five times a week, doing a variety of things including running, swimming, and martial arts I practice mindfulness daily. This includes up to a half hour of formal meditation which I try to do daily. I aim to bring awareness during my day, of simple things like the taste of good coffee, It doesn't always happen when life gets insanely busy, but I make an effort.

Q: Are you a Pollyanna?

No, I get down and irritable like anyone else. Just ask my husband. But I always think about how tough my grandmother's life was. She was a child bride at age 4 and managed to get out and she made enough money to buy herself back in her twenties. Later, she worked three jobs to support her five children and husband who was not working. So, I don't feel too sorry for myself.

Q: What about medical students? How can we help prevent them from burning out?

I have had students through ROMP (Rural Ontario Medical Program). They are wonderful and enthusiastic. They have this beginner's mind that is really refreshing. Mindfulness programs are offered through many medical schools to their students, which I feel is very important.

Q: What else causes physician burnout?

Some of us have learned helplessness. We blame the government and the system for all our ills. We can never be happy if we don't fix ourselves. Even though the system is presently the prevailing cause, we have very little control over it. But the one thing we have control over is our reaction and response to it. Stress is a story we tell ourselves.

Q: What is the cure?

Number one is to recognize if we are burned out. Rx: walk instead of

drinking wine when you come home from work stressed out.

Find an outside passion which is not medical—anything, be it a sport, a cause, or a hobby.

Get help. Consider taking a mindfulness based stress reduction course.

Develop social connections with people whose company you enjoy—with the demise of the doctor's lounge, we need to find other sources

A happy Canadian doctor

I recently met Dr. Allison Dysart at the Family Medicine Forum in Toronto. He is a family doctor in Sackville, New Brunswick and he is happy.

Q: Why?
Well, I live in a small town of 5,000 people, 40 minutes from Moncton on the border with Nova Scotia. I have great colleagues. We have Mount Allison University here too which makes the town really interesting. I mix up family practice with ER. I like my patients and enjoy talking to them, diagnosing and treating them. I don't even mind paperwork (when I'm in a good mood!) as it helps the patients.

Q: Why do you think doctors are burning out more than in the past?
I think the biggest reason for physician burnout is that the doctor-patient interaction is unsatisfactory for many patients and for most physicians. No matter how many holidays we take, we will still come back to a job that feels off-kilter unless our interactions with patients are, for the most part, satisfying and rewarding. The sad thing, to me, is that most of us feel like our interactions with patients are sort of "fated," for lack of a better word, to either go well or go poorly, almost like there's not much we can do about it. . . . And when they go poorly, not only does it cause us to feel badly and to lead to burnout, but we tend not to recognize that there are solutions to the problem. We think that we need to take more time off, or develop outside hobbies or whatever, but in fact what we need to do is to "lean in" (to borrow an expression). We need to recognize that our interactions with patients are likely the greatest single factor in avoiding burnout. So we need to work on that. And you can't change the patients that you see; some are easy and fun, some are really difficult, angry, resentful, projecting their baggage onto you, etc. You can't do too much about that, but you *can* do something about the other half of the equation, and that's us. By that, I mean how we attend to our patients, how we talk to/with them, how we structure the interview, how much time and attention and presence we can offer, how we deal with subtle insults or attacks or whatever without losing equanimity (a particular challenge for me!). And even if we aren't naturally good at those things (like me), the good news is that there are solutions out there that can help us to turn around our patient interactions so that we begin to feel

rejuvenated rather than exhausted, excited about work rather than dismayed, hopeful about our careers rather than discouraged. From my perspective, that is the true solution to burnout. In my own case, I was lucky to find a mentor who helped me to identify the source of dissatisfaction in my practice, and he put me onto a path which has led to addressing some of my shortcomings in interacting with patients. That was Dr. John Meagher, a retired ER doctor in Moncton, who has published a book on avoiding medical errors through a better way of attending to patients. I am still not very good at it, but I am better than I was, and I am a lot happier for it

Q: What about new doctors?

Part of the difficulty for students is that they are forced to make their minds up too early in their training about what specialty they will pursue.. They are already thinking of specialities in second year. We used to have a rotating internship and had lots of time to really see what each type of medicine was like, warts and all. In allowing the system to have been altered the way it has been, and to the degree that we were complicit with those changes, we have failed our youngest and most vulnerable colleagues.

Q: What is a week like in your life?

I do one or two shifts per week in the ER, which covers call for the 10 FPs in town (8 do ER). Daytime ER shifts are 8 a.m. to 6 p.m., and I might see 20 to 30 patients per shift. Nights are 6 p.m. to 8 a.m. overnight but we rarely get up after 1 a.m. We see 16,000 patients per year. We get paid a $400 stipend, plus fee for service, after midnight.

Q: What else do you like about small towns?

In a small town ER you might not get to see a lot of trauma (our ER is bypassed for most trauma cases because we are not technically considered a trauma centre), for example, but what you do get is a ton of feedback about the patients you have seen, which is a fantastic learning tool if you are willing to use it as such. *(Dr. Crosby notes: Dr. Dysart takes off the afternoon before and the morning after a night shift.)*

Q: What about your family practice?

I work Monday to Friday except when I am in the ER. From 8 to 9 a.m. I am in the hospital seeing inpatients, From 9:30 a.m. to noon I am my office. From noon to 2 p.m. I have lunch and from 2 p.m. to 5 p.m.

I do my office

Q: Do you take a half day off? What about weekends and holidays?
I don't work weekends or holidays unless I have a shift in the ER scheduled during that time. And I do not take a scheduled half day off each week except for just before and just after night shifts in the ER.

Q: How old are you?
55.

Q: How long are you going to do nights?
We are looking at working with the excellent Moncton emergency physicians and having them help us more so I can do less nights. Patients from Moncton drive to our ER as theirs are so crowded. So far I am managing, but it's tiring for sure.

Q: Are there any orphan patients in Sackville?
Only a few but Moncton has a lot, I am guessing 10,000 for a city of over 140,000.

Q: Why are you so happy?
I like my life more than I did 10 years ago as I have taught myself to reframe and change the things I don't like.

Q: Is there anything wrong with your medical life?
Not really. I dislike the stupidity of the bureaucracy that runs our healthcare system, but it's tough to change that. It's more fun to focus on what I can do myself to get better. The less I think about the failings of the system, the happier I get!

Q: Anything else you want to say? What about hobbies, family, etc.?

I had to give up running when I developed subtalar arthritis a few years ago, and I really miss that, but I am trying to do more cycling and cross-country skiing. And I read far too much, to the point where I can be antisocial. I have a wonderful wife, Lise, and three bright teenaged daughters, a fluffy dog and two stupid cats. I have a great job and wonderful colleagues. What more could anyone want?

30 tips for educating medical students one on one in your family practice

I have had hundreds of medical students work with me over my 45 years in emergency and family medicine. Here are some things I have learned. My current, excellent third-year student from Western, Kishor Johnson, helped me write this.

Medical students today are under much more pressure than doctors in the past. There is so much more to learn in every specialty and there are more than 6,000 drugs (I had to deal with a few hundred).

Many have horrific debt. Tuition for me was $700 and now is north of $30,000 per year. They have delayed gratification for years and homes cost $1 million for a dog house in Vancouver or Toronto. It is much harder to get into med school now. I had a 74 average in grade 13, 56 in first year university and 80 in fourth year. Now you need a 90 average and to have built a school in Borneo. I would be a teacher now (with an indexed pension at age 55 and perks galore).

Here are my tips for educating medical students in your practice:

1. Make first contact by email. Tell them where you are going to meet them. Tell them about parking and if they will be in a hospital take them to get their identity badge and parking pass. Ask them to bring a laptop, white lab coat, name badge and stethoscope.

2. Give them your cell phone number.

3. Tell them where the washrooms are.

4. Tell them about how to get meals.

5. Take a one month break between students to recharge your own batteries.

6. Show them how you do your paper and computer work and forms. This is the reality of medicine. Don’t shelter them.

7. Let them shadow you the first day then let them see patients with you in the room then let them see patients alone and present to you.

8. Let them see the toughest patients while you keep on time by seeing patients with little problems.

9. Let them have as much time as they want and then tell them to come to you with their differential diagnosis and plan of action.

10. Be honest with feedback. Use the McMaster fecal sandwich method©. "You are very keen" (one slice of bread), "but you should give the chief complaint in one word" (feces). "Hey, the patients and staff love you" (other slice of bread).

11. Let them do procedures. See one, do one, teach one.

12. Take them out to lunch.

13. Invite them to speakers' dinners, grand rounds and continuing medical education events. Take them to your admin meetings and committees = real life.

14. Introduce them to your town's doctor recruiter. They will get a free meal and you may get a new doctor.

15. Keep in touch by email after they leave.

16. Shut up and don't answer your own questions (this is the hardest for me).

17. Have fun, show them the joy of medicine.

18. Show them how to bill and get your secretary to show them how she runs your office and you.

19. Tell them how you cope with stress.

20. Enjoy their enthusiasm—it is a huge cure for your own burnout.

21. Get them to do a small project. I had one student poll every patient after we saw them to see whether they had consulted Dr. Google and she wrote it up and had it published in the New England Journal Of Medicine. Actually it was in Dr. Crosby's blog.

22. Get them to read about one interesting case of their choice a day and present it to you the next day. Put this in your smart phone calendar so you don’t forget.

23. Let them do all your needles and flu shots while you goof off reading late-night jokes on the Internet.

24. Take them to family meetings.

25. Get them to type for you.They are really fast; it is like having your own private secretary/dicta-typist and they feel useful.

26. Remember what it was like when you were a medical student. You were nervous and wanted to do everything and not be third in line behind residents and more senior students.

28. Send them to other doctors if you are away. I send my students to a methadone clinic, a homeless shelter medical clinic, hospitalist service, infectious disease service and, a young female FP.

29. Use colloquial language with students, rather than being overly formal all the time. From a medical student’s perspective, this helps foster a better mentor-student relationship.

30. Sit them down in your office and be real about medicine. There are ups and downs in the career, and it’s better that students are aware of both the most gratifying and least gratifying parts of the job early on, rather than when they’re first thrown into practice.

How to keep a medical office administrator: your best ally for an efficient office

I am lucky: I inherited the best medical secretary ever, Michelle Chinn. She shields me from a lot of stress and the patients love her. The pharmacies always tell me how she gets back to them with refills stat.

I have received one complaint against her in 26 years (a crack addict wanted to see me when I was away). She has missed two days of work in all that time.

Your medical office administrator is the face of your practice. I delegate all the non-doctor tasks to mine, including paperwork demographics and timelines. For example, with a work form she can fill in everything except the medical part. This is why I love paperwork.

Remember, all this costs 50% as it is a tax deductible business expense. I am using the female gender below to avoid repetition but a few are males. Here are my tips:

1. Pay her well. I pay mine $31 per hour.

2. Full hours = 40 per week.

3. Give her lunch off. Put the phones onto voice mail from noon until 1:30 p.m. If a patient has an emergency they should be calling 911, everything else can wait an hour and a half.

4. Give her 8 weeks of paid holidays off a year.

5. Give her a Christmas and birthday bonus of $1,000.

6. Take her out to lunch at a nice restaurant every three months.

7. Be nice to her.

8. Praise her if she does something good.

9. Don’t dump a lot of work at once. If she is on the phone, write out

the message or put it on the lab slip. For example “return to clinic one week” or “repeat sugar in 3 months.”

10. Do not bother her after hours with work items.

11. Clean up after yourself. For example after a pelvic exam put the disposable speculum directly into the garbage. After a needle is used I put it into the sharps container.

12. Warn her early if you are running out of supplies.

13. Pull up a new paper exam table sheet if you are going into a room and this hasn’t been done.

14. Give her one day a week to catch up. I give my secretary every Friday with the phones switched to another doctor so she can get caught up on her paper and computer work without being interrupted.

15 Give her an employee membership at Costco.

16. Walk her to her car after an evening clinic for safely.

17. Back her up over posted policies like missed appointments, prescription renewals and cost of forms.

18. Be specific when you delegate. For example, “Send patient to diabetic day care and start diabetic diet 1,500 calories and see me in 1 month.”

19. I always feed back to her in a positive way if I am overbooked and the two of us try to problem solve how to smooth out the schedule if one day is heavy and one light.20. Also on any committees or advisory boards I am on I always remind everyone to include input from

secretaries as they run our offices.

What the Medical Post editor thinks about Canada's doctors

I recently interviewed Colin Leslie, editor-in-chief of the *Medical Post*, by email, phone and in person. I first met him 10 years ago at a conference in Toronto and we have lunch every year. He has published more than 200 of my blogs and 10 articles in the *Medical Post*. I really like him (can I have a raise?) and he has tremendous insight about doctors, as he has been writing and thinking about us for decades.

Q: I would like to know how you got here?

On an air ship! Actually I grew up in Victoria and moved to Toronto when I was 20 to seek my fame and fortune. I thought I'd be a pop music star or a television or fiction writer (I'm not joking). I worked hard at those things (a friend and I were in an unsuccessful synth duo and I wrote TV scripts and short stories, which all got rejected), so at about 25 years old I realized: "Wait, I'm a waiter who goes out to nightclubs four nights a week! Hmm, I know what I should do: Go to university!"

It was either political science or journalism but when I was accepted to Ryerson University's School of Journalism (I think they were getting about 1,000 applications and accepted 100 students per year at that time) I started to get excited about that. Maybe because I was a bit older than the other undergrads or maybe I was good at it, but even though newspapers were having a hard time (early 1990s), I got summer internships at big newspapers (the O*ttawa Citizen* and the *Toronto Star*) and thought I might get a full-time job at the *Toronto Star* but that didn't happen.

I was freelance writing when I saw an ad in the paper for a job at the *Medical Pos*t and have worked here ever since 1996 in a number of different roles: associate editor, features editor, news editor and then I became editor/editor-in-chief in the winter of 2008/09.

Q: What you really think about doctors?

I think doctors are amazing! Look, I've spent all of my professional life working with physician authors, talking, meeting and thinking about

doctors. Physicians are a super smart and motivated group and I really like how they think through issues. I feel like their dedication is holding the Canadian health system together. I super appreciate that I ended up with Canadian physicians as the audience for the magazine I work for: I find the topics we cover interesting.

Q: What is a day like in your life?

I live on the 18th floor of an apartment building in downtown Toronto so I'll either take the subway or my bike up to the Yonge/Eglinton area, arriving between 8 a.m. and 9 a.m. The first thing I'll do is look at the "heat map" from the daily newsletter we sent out that morning (it shows us which stories readers clicked on). My day is made up of bits of editing other people's items, writing and some management-y things. I'll leave work usually around 5 p.m. but I will write work articles on the weekend sometimes.

Q: How do you cope with stress?

Getting better? I started yoga a few years ago and I think that helps. I exercise and eat regularly. I sort of meditate sometimes. I've always been a bit prone to insomnia and I will still often wake up around 5 a.m. thinking or worrying about something related to the *Medical Post* but I am getting faster at letting that go and falling back to sleep.

Q: What question have you never been asked?

Some kinds of journalists don't get asked questions in a professional sense very often and you're the first person who has asked to interview me for a long time! The things I get asked all the time are about process: "Is this cover working or not?" So there are tons and tons of things I haven't been asked professionally—in my personal life I think I've been asked every possible question!

Q: What is your take on the future of Canadian healthcare?

I have to be an optimist. On the face of it, there are a number of markers that look grim in terms of costs, expectations and governments' abilities to keep taking care of the health of Canadians. I feel like it is the dedication of Canadian healthcare workers that is holding together a system that is really struggling right now. and I don't think the public realizes how much it is struggling. But I'm a big believer in the abilities of the Western liberal democracies—Canada

and countries like ours—to solve problems. We've seen lots of examples where change and solutions can come up faster than we expect and suddenly a big problem that looked intractable is with human effort getting better . . . and we'll move on to worrying about some other problem.

Q: What do you like/hate about Canadian doctors?

Didn't you already ask me this? *(Dr. Crosby's note: "No, I asked what you thought about us. I have always wanted to do this.")* I like that doctors are both caring people and scientific people; that this is a group of people who responds well to discussions using logic.

I think doctors, to be good doctors, are usually smart, independent thinkers who aren't afraid to tell you what they think. But those very characteristics probably make leading physician associations challenging. That is great as a journalist—there's always something happening in medical politics and someone is more than happy to tell you about it—but I think that is a challenge when doctors hope to advocate collectively on an issue. So that isn't a "hate" but I think there is something innate in doctors that makes it a challenge for your professional organizations to be cohesive.

Q: What do you love/hate about your job?

Hate? Journalists burn out more than they used to and the reason they cite is the grind of the 24-hour news cycle. That isn't exactly a problem for the *Medical Post* but I do feel like it is necessary to stay immersed in the online comments our readers are making and the discussions doctors are having on social media about the things we cover at the *Medical Post*. I do think there can be something to those who see a connection between time spent on social media and dissatisfaction. And I just feel like I can't say, "Oh, I'm sick of what people are saying on Twitter and I'm not going to read it for two weeks." I have to keep reading it.

Love? I do love that I think really important discussions about the future of being a doctor in Canada and the health system in general are happening right now and that we at the *Medical Post* are playing an important role both in our print magazine and our daily newsletter in helping that happen. I love the look of the magazine when I think an issue really worked well. I love the newsletter when I think the topics are really good. I love my co-workers and the amazing

connections I’ve had and have with so many really interesting physicians because of my job.

Q: Are you ever bored?

Never. My job is a great blend of science, art, humanities and the stakes are the highest in the world: human life and happiness and health.

Q: What is the biggest change in Canadian medicine in your time?

Technology, such as electronic medical records, Dr. Google, smart phones and social media.

Q: Do you think Ontario premier Doug Ford or Quebec Premier François Legault will go rogue and split from the feds on medicare and allow a private second tier?

No. Canadians love medicare and fear the U.S. system. It would be political suicide. The feds still contribute 25% I think, so that is billions of dollars.

‘Doctor, I need an antibiotic for my cold’

How I cut my inappropriate antibiotic prescribing to zero
The biggest problem, as you know, is that patients think antibiotics will cure their colds and flu.

It is far easier and less stressful for family docs, paediatricians, physician assistants, nurse practitioners, walk-in doctors or emergency physicians to write a prescription than to take the time to explain the reason why they don’t work. I have done it for decades but now thanks to Choosing Wisely I have found religion and have cut my inappropriate antibiotic prescribing to zero.

The secret is to convince the patient that not getting antibiotics is a good thing.

My script after a history and physical exam is, “Wow, are you ever lucky!”

When the patient asks why I say, “because you have a virus causing your cold or flu. And as you know, viruses are not curable by antibiotics.”

I then wait a beat or two. If there is no pushback I talk about rest, fluids, Advil or Tylenol, and advise not going to work and infecting others.

If they push back—”I have always gotten antibiotics”—I say, “This is new and the experts have found that antibiotics don’t work and can cause superbugs, diarrhea, mouth ulcers, fatal allergic reactions and, if you are female, vaginal yeast infections.”

If the patient says, “But we are going to Disneyland/world tomorrow …” I respond with, “You don’t want to have diarrhea on the car drive or flight do you?”

If the patient is still pushing back I bring out my medical nuclear weapon—the rapid strep or throat culture. “We will do this test and call you and send out antibiotics if it is positive.”

We have to watch out for patients with pneumonia, immune deficiency or chronic lungers who are at high risk.

I have found that in my 45 years as an ER, walk-in and family doc that the wrong patients always push themselves to the front of the line. The COPD patient in whom a cold can kill feels guilty because the have smoked. Also the elderly at most risk come from a stoical, non-complaining generation. Unlike me and my fellow boomers.

Why are female physicians burning out more than men?

Recently the Canadian Medical Association released a survey of 2,547 Canadian doctors and 400 residents and 25% said they were burned out. More women than men felt that way. I emailed some female physicians I know to see why this is so.

A female family physician age 50 said:

"Women have much harder time with staff. Female employees take better direction from male bosses. (Also) no one likes to treat fibromyalgia, chronic pain, emotional issues and do Pap tests, etc., but they fall disproportionally on female doctors, in my opinion.

"When men are competitive and ambitious and aggressive, they are looked upon more favourably than when women are. They are seen as positive traits in men as leadership. Even other doctors expect women doctors not to show such traits."

A new female FP said:

"Hey Dr. C! Cool article. As you know I'm having a tough time right now and I think you hit the nail on the head. . . . I feel guilty working because my son is only seven months old and needs his mum. I'm stressed while at work that I'm missing one of his 'firsts.' But on the flip side I worry that if I don't work, that the work will be offered to someone else. I'm also tired because as the primary caregiver I'm the one that my son calls for at night.

"I also agree that female physicians are expected to be more empathetic and consequently patients tend to unload their baggage on us and that weighs heavily on you day in and day out.

"Finally there is still a lot of chauvinism both among physicians and the general public. For example even though I introduce myself as doctor, patients still think I am a nurse. Because of this I feel like I'm always having to prove myself as a physician. . . . I can never make a mistake and always have to be on my capital 'A' game, which causes extreme mental fatigue.

"For sure it is harder when we are physicians, wives and mothers. We have to be whole-hearted in our work providing the best care we can for our patients and at the same time making sure our families are OK and our kids are well taken care of. Sometimes we feel we are like machines giving everything all the time and no time for ourselves. It is physically and emotionally difficult."

The husband of a middle-aged doctor emailed me:

"First of all, in my wife's situation, I do all the housework, we don't have any kids, and I also help her with lots of her 'busy work' and paperwork related to her job, so those areas do not apply to her. I do know that those issues do affect other women who are active mothers."

"In a general sense (this is backed up by some studies I have read about women in the workforce) and specifically for my wife, recognition is just as important as monetary compensation. Here in Canada, the College of Physicians and Surgeons of Ontario (CPSO) has truly had a very negative impact on her self image as a human being as well as her self image as a medical professional.

"This has been done in many ways.

"A. One way they do it is through the language they use in dealing with complaints and evaluations. I am sure you are already familiar with it. The words and phrases they use bring into serious question a doctor's ability to function in a professional and ethical manner, insinuating that the doctor really should not be a doctor.

"B. Another way the CPSO has a negative impact on her self image and causes her to not feel recognized is that when there is a complaint, such as the assessment she went through, the CPSO gave absolutely no evidence that they spent even one minute reviewing her responses to the accusations made by the peer assessor who reviewed her charts. The CPSO also gave absolutely no evidence that they spent even one minute looking at the assessment done by a neutral third party doctor who reviewed the exact same patient charts the peer assessor reviewed so negatively.

"My wife and the third party assessing doctor very thoroughly and convincingly refuted approximately 80% of the negative observations made by the peer assessor. The 20% remaining observations were

ones of very minor consequence, primarily indicating that my wife needed to take more time with her charting. The peer assessor never took even a single minute to speak to my wife on the phone or via email to ask questions for clarification. At least one of the peer assessor's most negative findings was regarding a patient visit that very clearly was done by another doctor, a doctor, who by the way, is also a CPSO assessor. My wife had not even seen that patient on the occasion in question. The other doctor's ID was clearly present in the chart as the physician of record for that visit. When this huge mistake was pointed out, the CPSO did nothing to recognize the error.

"In other complaints, most of which have been relatively frivolous in nature, the CPSO has been overbearing in their 'punishments.' The demeanour and words they use typically make my wife feel like a criminal. At the end of one of her complaints about not calling a patient immediately with a slightly out-of-range cholesterol test result, my wife had to appear before a board of three examiners up in their offices in Toronto in person. She had to stand in front of them for about 10 minutes while they criticized her without even a hint of compassion.

C. In the name of 'transparency,' my wife's CPSO complaints are publicly posted on the CPSO website—essentially a one-sided accusation with no way for the doctor to give their side of the story.

"D. The OMA seems to only give lip service to representing the position of the doctors, and so my wife feels like she has absolutely no voice in spite of the fact that she has a lot to offer if given the chance.

"2. Difficult patients

"The CPSO makes in nearly impossible to 'fire' a patient who is extremely difficult to get along with, and who manipulates my wife by threatening to complain to the CPSO. My wife has often called in sick on days when these very nasty and toxic patients were scheduled for a visit. Granted, there are some doctors who are very good at dealing with difficult patients because they don't take anything personally and they are low-stress individuals.

"This has contributed to my wife feeling like the CPSO and the Canadian government only recognize the rights of the patients and have no consideration for the rights or the mental health of the doctors who must interface with them.

"3. Difficult employees

"Employment laws have made it extremely difficult and expensive for my wife to dismiss employees who are not performing satisfactorily. When the doctor must be responsible for the mistakes made by her employees, and at the same time it is very difficult to fire an employee without being sued for violating their 'human rights,' it all adds up and contributes to burn-out."

One middle-aged female surgeon told me:

"Women doctors need a wife. My husband and I hired a nanny and we both avoid burnout by coming home to kids well looked after, a clean home, dinner on the table and laundry done. The arsenic hour (5 to 6 p.m.) is now the white wine hour."

A 70-year-old recently retired family physician said:

"In all cases women put in more time for all their roles not just in medicine. Medicine is very demanding of time. The expectations of work require a thick skin as do the expectations of being a mother and wife. You have to weather a lot of not being able to do it all feelings and that can be hard."

I personally think some causes are that it is because women still tend to do more housework than men on top of their medical work, the so-called second shift. They tend to do more caregiving for kids and parents who are living longer and are frailer. They are expected to be more empathetic by patients.

New College of Physicians and Surgeons of Ontario head promises a kinder future

I recently interviewed the new registrar, as of June, of the College of Physicians and Surgeons of Ontario Dr. Nancy Whitmore by phone. She's been an ob/gyn in Stratford and St. Thomas, Ont. and most recently was CEO of St. Thomas Elgin General Hospital.

Q: Where were you born?
Brandon, Manitoba.

Q: Where did you go to medical school and do your residency?
Medical school at University of Manitoba and residency at Western University.

Q: Why did you want to do this job?
I wanted to make system-wide impact in healthcare delivery at the provincial and national level. I wanted to improve the process. The vast majority of doctors are doing a very good job. I want to help the few who are struggling to improve. I want to change the culture of fear of the college.

I want to change the process of complaints by making resolution faster and more appropriate. My goal is to connect the complainant with the college in two business days. It used to be one to three months. This shows we are taking it seriously. I want to prevent complaints through stakeholder engagement, education and ongoing quality assurance programs.

I know that patients and doctors alike are under huge stress due to the length of time it takes to process a complaint to everyone's satisfaction.
We are starting an alternate dispute mechanism (if approved by the patient and doctor) for lower risk complaints. It will have a 60-day goal for resolution.

(We are) instituting a "Right Touch" resolution of complaints as all complaints are not of the same severity. It is not light touch or heavy handed. It's about applying the right resolution based on the issue. For

example, a family physician had a complaint about him for not getting a patient into an orthopaedic surgeon for six months. This was beyond the doctor's control and would be dealt with quickly without stressing out the doctor.

We at the CPSO are also hiring a Chief Medical Advisor who will manage the medical advisors. This role will be a major asset in complaint resolution and influencing policy here at the college. We are not hiring more staff at the moment. We are focused on hiring the Chief Medical Advisor at this point.

The college will also be re-evaluating the former random peer-assessment program and looking at self-assessment and coaching especially for opioid prescribing and electronic medical record use. The college is looking to develop a quality assurance program through self-assessment and potentially peer coaching. We are developing a quality improvement program in early 2019.

(She said she will continue her well received short emails being very sensitive to the huge amount of paperwork and emails we all get. The college will be launching a new website in the spring of 2019 which will offer a more positive user experience for both physicians and the public. She is going to continue one on one chats with doctors to see what is happening on the front lines.)

Q: What do you love about the job?
It was a huge honour to be chosen

Q: What do you hate about it?
Well I wouldn't say I hate anything but I do find I like any job where there are challenges—I am used to that from my past jobs.

Q: Why are there more college complaints?
1) Patients and doctors are more stressed and frustrated with wait times.
2) There are more patients.
3) There are more older and sicker patients.
4) Public expectations are rising. They want everything now.
5) It is easier to complain. Just Google 'doctor complaints' and the CPSO website will appear. A patient can complain on their smart phone sitting in the physician's waiting room. It used to take a letter and stamp and you had to find the Toronto address of the college.
6) There is more episodic care with patients not bonding as much with

one family doctor.

Q: Why is there more physician burnout? Is the college responsible for some of it?
Yes, and we are trying to cut this back as I explained above with faster resolution and being proactive.

(I told her I was acting as a college supervisor for two physicians and they were made to feel like they were bad people by the college. She is going to try to change this culture with the above new ways of doing things, she replied.)

Q: How do you personally avoid burnout?
I have a condo in downtown Toronto and can walk to work. I go to my country home on weekends. I do yoga.

Q: Why not have a compliments and complaints section on the CPSO website?
Our new website will have both—which will launch this spring!

How to get seniors to accept help

I have been medical director of two long-term care homes (LTC) for 25 years. Half of my family practice is seniors. My mom lived to be 98 and my mother-in-law is 97 so I have lots of experience as a provider and consumer of geriatric healthcare.

Dealing with seniors can be one of the most rewarding parts of medicine, but. . . . What makes them good makes them bad.

Seniors born in the Roaring Twenties or Dirty Thirties are different from us. They have lived through the Great Depression and the Second World War. During the depression there was 50% unemployment and many had to move back in with their parents. There was starvation but doctors signed the death certificate as pneumonia to avoid stigma.

This has made them the survivors we see today. They tend to be very self reliant, frugal and stubborn. The ones that weren't didn't make it. We are seeing the toughest who had few vaccinations or antibiotics. Very few went to the doctor for blood pressure, cholesterol or sugar checks. Smoking rates were 40% (now 17%).

When trouble starts

As family doctors we see them start to fail as they start coming into our offices more and more. They end up going to the ER and walk-in clinics and being admitted to hospital. They start to wobble and then the wheels fall off.

We often see their spouses and kids coming in with stress or caregiver burnout too.

Many refuse all help. They don't want to bother anyone. They are in denial.

They often try to cut their own grass and shovel their own snow or get the kids or neighbours to do it for free. They are often alone watching daytime TV and living on tea and toast.

How do you convince them to get yard help, home care or plan for a

retirement or nursing home?

I make sure a caregiver comes in with them and brings in all their meds. I ask them what they want and then I sit back and shut up (hard for me).

They usually say they want to die in their own homes and not be a burden. They don't want to go to a nursing home. They want to leave their money to their kids.

I tell them that the best way to accomplish this is to get home care. I tell them it is free and they have paid for it with a lifetime of taxes. The entire government system wants to support them in their homes but as they age they often need more help.

I say a home care nurse will come out and check their place with their permission to see if they need help and how to safety proof their homes. Stuff like getting rid of scatter mats that can cause a trip and fall and broken bones. Better lighting, handrails, raised toilets and grab bars in the bathrooms. Help with baths can avoid a fall which can send them to LTC. A stair chair lift can keep them in a two-level home.

I have a handout (attached) for them to read and ask them back in a week to go over it with them so they don't just chuck it.

Often they will ignore me for years but I just keep gently reminding them. I can be as stubborn as they are.

If they flinch at paying for help I give them a session on finances. LTC homes in Ontario cost $1,900 a month for a shared room and $2,400 per month for a private. I show them the $22,800 to $28,200 yearly cost on my iPhone calculator screen and write it down for them. I tell them this can buy them a lot of support.

I tell them that home care is on a tight budget so they have to be the squeaky wheel that gets the grease to keep the help coming or increasing it as they decline.

Caregiver burnout

I make an appointment for the caregiver alone away from the patient even if they are not my patient. I tell them that like on an airplane if the cabin depressurizes and the oxygen masks fall out of the overhead

they are supposed to put on their mask before their child's. This means they are of no help to anyone if they lack oxygen. They have to set boundaries with their loved one. Often the patient's needs slowly build and neither notices that the caregiver is doing more and spending more time. It is like putting a live frog in a pot of water on the stove. When will it hop out as you turn up the heat?

They need to take scheduled time off for themselves, for exercise and for vacations.

They need to book a week off with respite care looking after the patient every three months. Respite care can be booked by home care.

I have a family meeting and even include the "come from away" family by speaker phone. I tell them in plain English the patient's diagnoses and prognoses with the patient's consent. We talk about resuscitation, home care, seniors apartments, retirement homes and long-term care.

Luckily in Cambridge, Ont. we have a free house-call service by MDs for shut-ins.

Retirement homes are for higher functioning patients and are often more expensive as they are not government subsidized. You pay more for more care. They can even go up to $7,000 per month or $84,000 per year. There goes the life savings and kid's inheritances. LTC is cheaper but just like free lunches cause line ups, the wait times for LTC can be years.

I tell patients and their families to start touring them now.

I get them to set up a schedule for sharing care. All families have one or two kids who do more than their share and can start to resent the kids that don't. I tell families to link up by email after any one visits.

I remind the patients that if they wind up in hospital they are often asked to leave in a few days as the hospitals are jammed too.

Sometimes when LTC is a must due to frailty or dementia and they are not safe at home I act the heavy and say, "As your family doctor I advise you to go into a nursing home." This takes the guilt from the caregivers.

Like with union negotiation I start low and try to get my foot in the

door, because the senior may agree to everything at the meeting then refuse to budge when they get home.

I end the meeting by saying, “What are you going to do in the next week?” and then set up an appointment for followup. We usually agree to ask home care to do an assessment.

22 excuses for not working out

I recently met Toronto fourth-year medical student Khash Farzam, who is studying at the University of New England in Maine. Throughout his years of competitive powerlifting, track and field (sprinting), personal training and coaching, he continues to be amazed at how creative people are when it comes to dodging exercise. Here are some of the excuses his clients have given him:

1. "I don't have time." No doubt this is by far the most common excuse. Personally, I found this excuse somewhat bothersome since I have balanced intense academia and competitive athletics for years. The best remedy for this excuse is simple: make time.

2. "I'm sore." This one would make sense, except there are numerous exercise modalities to select one. Sore from weight lifting? Do cardio.

3. "I already worked out yesterday." If you're using this excuse, you clearly need a better routine.

4. "I'm tired." Caffeine exists to provide energy during times of fatigue and it's at the core of every pre-workout supplement.

5. "I don't want to be seen at the gym." Fear out of being seen out of shape isn't very legitimate when everyone is working toward getting in better shape.

6. "I'll get back into it soon." Usually seen in the gym once every two months.

7. "I didn't eat enough." Justified if you're a powerlifter or bodybuilder. Otherwise, you're better off training fasted anyway.

8. "I've been standing all day." Only two types of exercise this justifies skipping is lower body strength training and running. Everything else is fair game, even if you did a five-hour open AAA surgical repair earlier.

9. "I didn't sleep well." No one gets hurt after one night of poor sleep.

10. "Long day at work." Mental fatigue shouldn't ever be a barrier to exercising.

11. "It's just so hard." As is any meaningful goal in life.

12. "It's expensive." Not all gyms are expensive and nonetheless it's an investment in one's health.

13. "Training partner wasn't available." Working out solo shouldn't be an issue. Most people at the gym have no problem giving a spot.

14. Female: "I don't want to get bulky." One of the biggest myths in the fitness industry. Female participation in Powerlifting has approached 50% and very few look anything close to bulky.

15. "The gym was closed." What's wrong with body weight exercises?

16. "It's boring." Time for a better workout routine that focuses on incremental improvements.

17. "My back hurts." Probably due to a sedentary lifestyle.

18. "I'm already skinny." Weight loss is just one of the goals of exercise. Plus, being skinny doesn't guarantee a healthy lipid profile.

19. "My car broke down." Fine, you get a pass.

20. "I had a personal emergency." Pass.

21. "I stubbed my toe really badly." Good excuse for an arm day rather than a missed day.

22. "The AC at the gym broke." Personally guilty.

Some tips I have for my patients include:

10. Use the stairs, not elevators.
11. Schedule your exercise time into your smart phone calendar. For example, on weekdays I have "7 a.m. to 8 a.m. swim at the Y" in my iPhone calendar for weekdays.
12. Park far away and walk.

Exercise on a stationary bicycle while watching TV for a half hour.

Time management in long-term care

How I deal with the mounting pressures we face in long-term care
I have been the medical director of two long-term care homes for 26 years. One has 55 beds, the other 190. Two other doctors and a nurse practitioner help me at the larger one. I also have a family practice of 1,200 patients, about 60% of whom are seniors.

Long-term care has changed a lot in 26 years. It used to be quite easy since the seniors were relatively well, and despite how (or perhaps because) they live longer they have become sicker. Mass immunization against influenza, better antibiotics for urinary tract and respiratory infections, better wound care and pressure sore prevention have kept more people alive. We have better teams for behaviour problems, wound management and nutrition and better medications and diagnostics. We have X-ray and lab available the same day on weekdays.

But access is becoming a problem. Among the younger patients are those with head injuries facing 20-year waits (because the turnover isn't as high as it is at long-term care homes). Down Syndrome residents are also living longer (one of mine is 75) due to heart surgery advances. We have more psychiatric patients due to the closing of the large psych hospitals. Increasing numbers of homeless mental patients are living past 65.

Residents and their families are also becoming much more informed due to Dr. Google and are much more demanding (though we still have a 100% death rate).

We are all doing a better job, but that makes for a more intense job. LTC has become more like a chronic hospital rather than a resident's home (which it should be), and hospitals have had their beds cut in half so patients are coming back sicker and quicker. This means more complex patients like those with tube feeds, dialysis, ventilators and palliative younger cancer patients.

In other words, a perfect storm has developed in LTC.

How I cope

I found 20 years ago I could not manage with rounding once a week. I was getting phone calls from the nurses and pharmacists all the time. I was seeing huge numbers and no one was happy. I changed. Now, I go four times a week.

Patients love it. I think I am giving better care. I have had only one college complaint that was trivial (a son couldn't reach me due to the clerk forgetting to notify me, it was dismissed over the phone).

I found 20 years ago I could not manage with rounding once a week. I changed. Now, I go four times a week.
Our transfers to ER are the lowest in Canada, having dropped from 15 to 5 per month at the big home and from five to one per month at the 55-bed home. We have low drug usage, seven per resident versus the provincial average of 12 because I have time to talk to the substitute decision makers about de-prescribing.
I break up my day so I don't end up in the office listening to people complain for eight hours. I am at the homes every morning and my office every afternoon.
Staff love it. They don't have to phone me, they know I will be there in 24 hours if it can wait.
The substitute decision makers (SDM) love it. Especially with palliative patients because we can tell them an MD or nurse practitioner will round in every weekday. It gives me time to get to family meetings. I am on for 10 minutes and then leave.
I love it. It takes me less time because I am ahead of the problem. A cough is prevented from becoming pneumonia. I am never faced with a ton of patients to see. If I am off on a long weekend I catch up on the Tuesday.
Small bites, not a huge indigestible chunk of food.

Downsides

You always have one or two patients perching at their doorways wanting to see me every time I come. I handle this by telling them they have to go through the nurse, just like I do when I see my doctor.

In winter you end up putting on and taking off your gloves, boots and coats a lot. There is also more driving. I talked to our CEO at the big home into giving us a 24-hour reserved doctor parking spot.

The nurses still try to dump everything on me on Monday so I have to

triage the patients. For example, if they want two physicals on Monday I write "I will see Tuesday" on one of them to spread out the work

As medical director, I have house doctors sign a contract saying they will round at a specific time twice a week, not during meal times. For example, I go Monday, Tuesday and Thursday at 10 a.m. and the other house docs go Wednesday and Friday so we have an MD in-house daily. We see each other's urgent patients. My nurse practitioner goes Friday and covers my holiday and educational leave.

Our on-call is one in 30 because all the FPs in town in one giant call group. I did this by combining all the little call groups 25 years ago. They get paid $600 per night plus visit billing. This money is pooled from the on call money from eight homes.

After 11 p.m. they are not called due to protocols for blood sugar and INRs. Pronouncement of death is by the RN. The house doctor signs the death certificate at 7 a.m. For obvious transfers to the ER, for example lacerations or fractures, the on-call MD is not woken up as they would have nothing to contribute and would delay care.

Tips for learning to love paperwork:

13. Do it at a scheduled time every weekday morning like 8 to 9 a.m. or noon if you have young kids or like to sleep in. Avoid after 5 p.m. or weekends so you can be off totally.
14. Charge your provincial medical association administrative fees for private paper work like lawyer's letters and the disability tax credit forms.
15. Delegate some parts (demographics) to the nurse or physio or your secretary and make sure it is correct.
16. Come back early from vacations to get caught up.
17. Start a Fun Fund and contribute money for travel or something you want like a concert, sporting event, live theatre, book, or fancy restaurant. If not, you can give it to your favourite charity.

Reduction of antipsychotics.

We went from 40% to 20% by having a scheduled meeting. It is on Thursday at 11 a.m. when I have caught up on ward work for the week. I meet twice a year with the nurse and pharmacist. We lock the door because when anyone sees us they have work for us. We discuss

each patient on antipsychotics and plan how to wean off as many as are feasible. With some we fail but with many we get off them. Its like spring-cleaning.

Time managed meetings

As medical directors we are paid an honorarium, which is modest but mounts over the year. Think of it when you are in a boring meeting. Put it in your fun fund. Ask for meetings to be scheduled to not infringe on your office time such as 8 a.m. or lunchtime. Ask for an agenda and stick to it. Start on time and end early. Do phone meetings to avoid travel time. Ask: “Do we need this meeting?”

In summary if you do the above you can render better care and have a better life.

How many of your patients are consulting Dr. Google?

I recently had fourth-year medical student Pree Takhar working with me in my family practice. She is from Cambridge, Ont., and is studying in Ireland. She asked my patients if they had consulted Dr. Google prior to coming to their appointment. What she found is revealed in her study, below.

Doctor Google

In the ever-growing age of technology, access to all sorts of information has become increasingly simple. With a quick Google search, information ranging from what car to buy to the cause of a stomach ache is literally at our fingertips. The world of healthcare has not gone untouched by this phenomenon. Although the public has placed its doubts in Google searching symptoms knowing that it can often be misleading, it's undeniably tempting.

A recent Pew study showed that more than 80% of Americans between the ages of 25 and 35 had looked up healthcare-related information online compared with only 15.4% of people age 65 years or older. This information, along with the ever-growing simplicity of accessing healthcare information, led to this study.

In the setting of one family practice it was hypothesized that:

• younger patients would look up their symptoms online prior to coming to see the doctor much more than elderly patients, and

• the rate at which patients Google their symptoms would be directly correlated with their age.

This study was conducted over a period of two weeks and involved asking every patient if they had looked up their symptoms online prior to coming into the clinic. They were given an option to say yes, no or prefer not to answer. The patient's age, gender and patient number were all also documented.

Patients were divided into four different age groups in order to more

accurately review the results: 0-25 years, 25-50 years, 50-75 years and 75+.

As this family practice was largely geriatric, the majority of the patients fell into the last age group.

The results of the study were largely in keeping with the hypothesis, in that the youngest age groups had the highest percentage of patients who looked up symptoms online prior to their doctor appointment, with 57% of the 0-25 years category answering yes, and 50% of the 25-50 years category answering yes.

The 59-75 and 75+ age groups were found to have a “yes” percentage of 0% and 15%, respectively. This result was surprising, as it was hypothesized that the oldest age group would have the lowest yes percentage.

It is important to note, however, that as the practice was largely geriatric, almost half of the patients fell into the 75+ age category, thus giving these results some margin of error.

Other things to note in this study were that the cause of the visit was not documented, so the cause for the results may be due to more elderly patients coming in for routine physicals or blood results and younger patients coming in for acute conditions that would provide them with symptoms to look up online. In future studies of this nature it would be best to take into account the cause of the visit to the doctor.

Additionally, to make this study more accurate, a larger population size would be greatly beneficial. This study was conducted on 56 patients over a period of two weeks; doing the same study over a year would provide more patients and a better picture of the correlation between age and using the Internet to look up symptoms.

In conclusion, it does seem that there is a correlation between age and looking up symptoms online prior to coming to the doctor. The hypothesis was proved mostly correct, in that the youngest patients used the Internet to look up symptoms the most and there was a correlation between increasing age and less use of Google to search symptoms.

There are many factors that come into play when considering the

reasons as to why this conclusion was found. At least three patients in the oldest age group said the reason they had not looked up their symptoms was because they did not have a computer at home. This may have been true for many of the elderly patients and should be considered in future studies. These results may also stem from a change in doctor-patient relationships and trust in the younger age group, making them more likely to want a second opinion rather than trusting their doctor's judgment.

In a study such as this one, many factors come into play and the exact reason as to why people tend to turn to the Internet more and more for healthcare-related problems remains a multi-faceted question with no one single answer. With technology expanding and more and more information becoming ever-available, it will surely be interesting to see how "Dr. Google" impacts doctor-patient relationships.

What it’s like to be under supervision by the college

Everything you wanted to know about Ontario's college supervision program
Recently, I was a supervisor at the College of Physicians and Surgeons of Ontario (CPSO) for two physicians who had a lot of patient complaints. There were gaps in the patients’ care, but I could see the potential for both of them to becoming better family doctors.

I would meet with each doctor once every week from 8 – 9 a.m. on a weekday in their clinic. I met their staff and did random chart reviews right on computers. I couriered in all the charts reviewed with an overall comment on the practice to the college contact person each month.

Their main issue was charting. Eventually, using the Canadian guidelines for blood pressure, cholesterol, diabetes, chronic pain, antenatal forms, depression scales and the Rourke Baby scale helped ensure they were up to standard, or even exceeding them. Choosing Wisely was a huge help for antibiotic usage, labs and imaging. They began to screen all opioid recipients for abuse potential and monitored them carefully with drug screens. They started getting their patients to sign opioid contracts.

As supervisor, I felt like my job was part psychotherapy too as both physicians were devastated by having to hire a supervisor in the first place. Both were spread too thinly (just like me when I was young and foolish) and had to learn to refocus on patient care. I’m pleased to say they have both done an outstanding job and I am learning from them. Being a supervisor was not easy, but it was the most rewarding thing I have ever done—short only of being a physician.

CPSO Supervisor: Dr. John Crosby

Dr: X

Case ID number: (EMR patient number)

Date of Appointment:

Date of Review:

Patient initials: **Gender:** **Date of birth:**

Reason for visit:

Appropriate/Appropriate with recommendations/concerns/N/A

History/Physical Assessment:

CPP (Cumulative patient profile)

Overall:

Problems addressed

Problems solved

Signed

John Crosby MD, CPSO Supervisor

This is my self-made form that I filled out for every chart review.

I interviewed advisory physician Dr. Michael Szul from the College of Physicians and Surgeons of Ontario by email and asked him all the questions I had about the supervision program, including what happens when a doctor doesn't meet expectations.

How do doctors end up in the supervision program?

The CPSO may require a physician's practice to be supervised for a variety of reasons. In some cases, a physician may be missing the usual qualifications for full registration, and thus undergo supervision pending assessment as part of the process to independent practice; some physicians change their scope of practice or re-enter practice, and some undergo supervision as a result of areas of practice identified for improvement through an investigation or a quality

assurance process.

How are supervisors chosen?

While the college ultimately approves the supervisor, supervised physicians are generally required to locate potential supervisors. Supervisors must have a minimum of five current and consecutive years of experience in the scope of practice to be supervised and have adequate knowledge of the area in which they supervise. There are additional supervision requirements, including acceptable investigative and assessment history with the CPSO, sufficient time and resources necessary to carry out the supervision, as well as no real or perceived conflict of interest with the supervised physician.

There are similar guidelines for the selection of a practice or health monitor for each of the roles available online:

- Guidelines for College-directed Clinical Supervision
- Guidelines for College-directed Practice Monitoring
- Guidelines for College-directed Health Monitoring

Each proposed clinical supervisor, practice monitor and health monitor has to be approved by the CPSO and submit a signed undertaking detailing the CPSO's specific expectations as part of the approval process.

How are they paid?

Supervised physicians assume the responsibility for the payment of all fees, costs, charges and expenses arising from the supervision arrangement. It's important to remember that supervisors may need to take time away from their practices. In some circumstances, though, it may be a minimal investment of time and the supervisor will not charge any fees because they view the process as part of their professional or collegial responsibility. The college does not act as an intermediary and does not participate in any financial arrangements between the supervisor and the supervised physician. Although there may be a financial arrangement between the supervisor and supervised physician, the supervisor's ultimate responsibility is to the college, i.e. supervision reports must be completely objective, fair, and impartial.

What are their duties?

The specific role for a supervisor will vary based on the unique terms of the supervisory agreement.

While each supervisory relationship has its own unique requirements, it generally, involves the following:

18. Reviewing care and documentation;
19. Providing feedback with discussion about the care provided and records, noting concerns if any, and making recommendations for practice improvement and professional development;
20. Being available to respond to questions or to discuss challenging situations;
21. Submitting regular written reports to the CPSO;
22. Facilitating the educational program recommended by the college; and
23. In some instances, conducting direct observation of patient encounters and/or interviewing colleagues/staff of the supervised physician.

Practice monitors are responsible for observing that a physician follows the terms and restrictions imposed by the CPSO and provide reports back to the college. Their role is to monitor a physician's status and to report any significant health concerns that may pose a risk to patient safety.

Health monitors focus on treating the physician for particular health issue(s) which may potentially affect their practice. Generally, the health monitor is a physician, but can be another regulated health professional.

What happens if the doctor doesn't meet the supervisor's expectations?

The supervisor's expectations will be set out in undertaking with the college and the supervisor would provide feedback to the physician they're supervising about changes they should be making to ensure safe and effective practice. Generally, this undertaking would include the requirement that issues of significant concern or risk would be reported back to the college immediately. Based on the unique circumstances, the relevant committee would determine how best to proceed. In instances where there is no risk but other issues are identified, the supervisor can make recommendations and report them

back to the College.

Who is in charge of the program at the college?

Supervision is ordered and directed by particular college committees (Registration, Inquiries, Complaints and Reports, Quality Assurance), and any issues, outcomes or reports are reviewed by the Committee that ordered the supervision.

How many supervisors are there at present?

In 2017, there were 880 physicians with active supervision (excluding health monitors).

How much time do supervisors have to commit to?

The time commitment required depends on the supervisory arrangement. This will often include reviewing background material to prepare for the supervision, chart reviews, discussions with the physician and college staff, report writing, and travel time.

The length of the supervision is typically between 3 months to 24 months. The frequency of visits may also vary (e.g., bi-monthly, monthly) and can increase or decrease as outlined in the undertaking or as required during the process.

Doctors are burning out more now than in the past

I have been a doctor for 45 years and I have never heard more about burnout than now. It affects half of us. If doctors had sick pay there would be a national crisis.

Maybe in the olden days doctors didn't talk about it or maybe they were more stoical; I don't know and it's hard to find out. Perhaps our more seasoned readers could enlighten us.

I think unrealistic patient expectations are really causing doctors more stress. In the good old days if someone really old died, it was "nature's way." Now the family wants to know why and often think their loved one should have lived forever.

We doctors are victims of our own success. People who would have died 20 years ago are still alive thanks to modern medicine but are frail and taking many medications; they require more and more care.

Patient volumes are higher. We used to see 20 patients a day and now we see 40.

We do four times as much paper and computer work. Fifty years ago the physician I replaced had patient records on recipe card records featuring a diagnosis and any medications. I have a $47,000 computer system and type the equivalent of the Manhattan phone directory on each patient.

Way back when you varied your day by going to the hospital, covering the ER, delivering babies and doing house calls. Now we sit in our offices all day listening to people whine about trivial First-World problems.

Doctors had a harder job in the good old days but it was much more varied, interesting and rewarding. You could actually fix someone by realigning a shoulder dislocation using your big toe. You didn't just chat about cholesterol.

When I first started general practice in the 1970s, my neighbour, Dr.

John Whilaw, had been a GP since the late 1930s. I asked him how he coped. He said his wife took the phone calls after 5 p.m. and he was rarely called. If he was called, it was for something very important and he didn't mind seeing the patient in his office or at the hospital. In July he covered another GP's practice and in August that GP covered Dr. Whilaw. He said people tried home remedies before they bothered the doctor, especially in the nighttime. It cost money to see the doctor and cost more for after-hours care and/or a house call.

Thankfully very few patients are seriously ill anymore and I haven't seen a really sick child in years, which is wonderful. This is due to vaccines and better safety equipment, such as bicycle helmets.

Children now have behaviour problems, which are more challenging but less gratifying than saving a life by treating pneumonia with penicillin.

Old timey docs did not have to compete with Dr. Google or helplessly see themselves disrespected on Rate MD. They didn't have patients take a phone call during a consultation.

Today we are blamed for under-treating chronic pain or getting patients hooked on narcotics.

I don't recall any narcotic problems in the past. As an intern at the Wellesley Hospital in 1973 in downtown Toronto I never saw one narcotic problem; I never treated a victim of a shooting or a stabbing. Even as an emergency doctor from 1979 to 1992, I saw only one shooting and one stabbing.

There were only a few medications then; now we have more than 6,000 and many have two names—generic and brand.

Doctors can do a great job with six million emergency patients per year but you only hear about the one that didn't do well. It's the same for cases of maternal mortality or damaged babies. I have never had a baby in my practice suffer anoxic brain injury but the media only grouses about high C-section rates.

Another stress buster in earlier days was the doctors' lounge. Family doctors seldom go now except in the smaller towns. In the doctors' lounge we could meet our peers and get to know the specialists. We could complain about the government and have group therapy. We

could help each other with difficult cases. Sharing is a great way to avoid burnout. Now we do it online; for example, with this blog.

I am lucky because my practice is made up of 60% seniors practice so I still get lots of respect and thanks. I even get paid in chickens, tomatoes, cakes and vodka.

At age 71 I am a wise enough old geezer to know that we see the past without its warts, but I do think we have more doctor burnout today.

What it was like to be president of the Ontario Medical Association

I recently had lunch with former president of the OMA, Dr. Shawn Whatley. Shawn is a family doctor in Newmarket, just north of Toronto. He was born in Thunder Bay, Ont., and is 48 years old. He went to Lakehead University and graduated with a BSc in biology and chemistry. He got his MD in Ottawa and was an ENT resident at the University of Toronto. He had more fun off-service and didn't like getting up at 5:30 in the morning to round pre-op.

Shawn said he wanted to see sick people but didn't want to "own" them like surgeons have to post-op, so (like I did) he became an emergency room physician and worked in Orangeville then York County in Newmarket from 2000 to 2014.

Why can't doctors strike like teachers?

When teachers strike the whole province shuts down because there is no free child care for the kids.

We can't strike because it would harm people.

Can doctors work to rule, such as not doing forms?

It depends on the form.

There are many things that we can do, but we cannot withhold medical care.

So there is no reason for a government to ever honour our demands?

That's why we now have binding arbitration. (Note, with the new Ontario PC government negotiations are being reopened).

Why don't doctors have pensions?

We are small-business people. You have to be an employee to get a pension, but the laws are changing. There may be an opportunity to

get something like a pension soon.

Do you know what the Canada Pension Plan pays?

No.

(Authors note: As a senior age 71, I get $1,000 per month from the Canada Pension Plan and my old age security of $600 per month is clawed back.)

Why don't we have perks such as dental, prescription coverage, physio, vision or disability insurance?

We are considered independent contractors by the Canada Revenue Agency. If we were to get a full benefits package like a regular employee, the CRA might start to treat us as employees.

What was a typical day like as president of the OMA?

I got up at 6 a.m. and a car and driver took me to downtown Toronto, which takes and hour and a half to an hour and forty-five minutes in normal traffic, longer in heavy traffic—but still faster than when I drive. I handled telephone calls and booked teleconferences to coincide with the drive. I also used the time to get email and computer work done. I got to the OMA offices at 8:30 a.m. and had meetings, calls and correspondence to handle. But no day was the same.

I was usually done at 5:30 or 6 p.m. and got back home by 7:30 or 8 p.m.

I got involved with everything from communications to politics, to legal threats and meeting agendas. There was no end to work. But I got through it with help from a large team.

How many times were you out at night?

During the binding arbitration roadshow and the fall 2017 President's tour roadshow, I was out four to six evenings per week. Other times of the year it was, on average, two evenings per week. But it came in clusters. Even when I was not out, I could not remember an evening that didn't have at least two or more phone calls.

How did your wife and kids feel about this?

I could never have done it without their support. They were happy for me, but happier to see it come to an end, I think.

How did you deal with the stresses of the job?

I had a solid team around me who shared the stress. Family, friends and community helped, too.

What would you like the new president to do?

I hope she keeps doing more of the same. Nadia (Dr. Nadia Alam) is doing great. She listens. She's smart. She is not arrogant.

What are your plans for the future?

I have a few things brewing. I'll let you know when I've finalized the details.

Does the staff at the OMA get perks and pensions?

Human resources was not in my mandate. I believe they get salaries and benefits like any other organization.

What was the best thing about the job?

The opportunity to work with great people who are passionate about making change.

The worst thing?

Being criticized for things I never did and being slandered without the chance to respond.

How did you handle the press?

I got formal media training. With practice, I could usually get our messages out, if I had a fair journalist. Again, I had a great team helping me.

What were you most proud of?

I am most proud of serving during such a crucial time of crisis and transformation at the OMA, and being able to see renewal and stability returned to our association.

What are you passionate about now?

I continue to be passionate about improving our healthcare system.

Why did you become president?

It was an incredibly chaotic time. Doctors wanted change. A number of people asked me to serve. My vision of what needed to be done seemed to dovetail with what most of council wanted to see, so I stepped forward.

* * *

Shawn seems like a very nice man who really cares about healthcare for Canadians. While he was president he always got back to me (one of his 34,000 doctors) by email within a day. He was very open in his blogging with the Medical Post and was very accessible.

A day in the life of a super-busy, full-service rural doctor

I recently spoke to Dr. Michael Ackermann about what it is like to be a full-service family doctor. I was one 45 years ago.

Dr. Ackermann was born in Ottawa in 1958, went to Acadia University in Wolfville, N.S., and graduated from Dalhousie University medical school in 1988. He joined the military and was stationed in Germany in 1989, and also did a surgical residency for one year. He was a military doctor in Lahr, Germany; in Cyprus; and Shilo, Man.

Dr. Ackermann has been a family physician since 1995 in the District of St. Mary's, 60 km south of Antigonish, N.S., which is 217 km from Halifax, just east of Cape Breton. There are about 5,000 residents in summer, which last year was July 14 (a little Ontario humour here), and 3,500 in winter.

A typical day

Dr. Ackermann awakes at 7:30 a.m. and does chores on his farm. He then does hospital rounds and checks out the ER for holdover patients from the night before.

He has a family practice clinic at St. Mary's Memorial Hospital, with appointments from 9 a.m. until 4 p.m. He uses lunch to catch up with slotted-in patients, and to do paperwork. He sees about 20 patients through the clinic, as well as whoever shows up at ER or in hospital.

In the late afternoon, he does paperwork. He has read my time management book, which says do your paperwork at a scheduled time every weekday.

He is home by 5 p.m. or 7 p.m., depending on patient volume.

He is on call one in two with another doctor. A night on call is followed by a full workday. Dr. Ackermann has been on call every day for two long stretches: once for a year and a half, and another time for three years. (Author's note: I can't stand being on call ever, so I set up a huge call group in Cambridge, Ont., 25 years ago.)

Being on call is definitely hard on his family, he says. “There are many activities that I must either miss or be interrupted in the middle of. I jokingly say there are four ways I can guarantee the phone will ring: Sit down on the toilet, get in the tub, sit down to a meal, or get involved in a fun family activity.”

How does he cope? He has powerful firewalls set up: No practising medicine via the Internet or Facebook. He never brings paperwork home. The nurses (the hospital has two) screen patients well and he only comes into the ER for serious problems such as heart attacks.

Since he practices in a rural area, I asked whether any patients ever knock on his door or call him at home. Not any more, he says.

“Word got out real fast back in 1995 that I would have none of that. I just told the first one that tried it that my home is where I go to get away from my job and that I was not willing to bring my job into my home. I told them they could call the office for an appointment and I would be very pleased to see them there. Of course, this does not include true emergencies. If someone needed emergency aid I would respond regardless of where we are.”

He has great hobbies such as riding horses, target shooting and fitness, punching bag, saber, general calisthenics and hiking.

He also takes on medical students in two- to four-week stints, and they love working with him as he takes them riding and shooting. The students stay for free at the hospital and eat home-cooked meals there too.

What gives Dr. Ackermann absolute joy in rural medicine?

He says you have to remain confident about everything. He had to put in a chest tube for a patient with a tension hemothorax once in 23 years. He stays up to date with Advanced Cardiac and Trauma Life Support courses, Paediatric Advanced Life Support training, as well as online continuing professional development.

His biggest satisfaction? Looking after the babies of the babies in his practice. The intimate relationship with patients over 22 years is very rewarding. For example, he has a bipolar patient who sometime goes off his meds. Dr. Ackermann can call him up and get him to come into the hospital because the patient trusts him.

The down side

Dr. Ackermann once had a two-year-old patient choke to death on a nut, which was very heart-wrenching.

Bureaucrats plan with urban goals in mind, and don't have a clue about rural medicine. For example, the ambulance paramedics used to work 48-hour shifts, which allowed them to commute and sleep. But some Halifax bureaucrat changed the shifts to 12 hours. The paramedics' job satisfaction tanked, as they must now commute up to two hours every day on top of their 12-hour shifts.

The socialist monopoly of the Canadian health system is also an issue for Dr. Ackermann. There is no competition to force evolution. For example, a private ambulance company would be faster. Patients are seen as a source of expense, not revenue.

There are too many administrators and too few front-line workers. Administrators are growing at a rate two times faster than the front-line workers and consume 50% of the healthcare budget. Taiwan spends 2% of its health budget on administrators, with better outcomes than Canada, he says. (His wife had a knee problem in Taiwan and it cost $25 to be seen by an orthopod in 15 minutes: self referral.)

What about backup?

Dr. Ackermann says he rarely needs locums but when he does, he finds them via the grapevine. He says the best are ex-military and current military doctors, as they are accustomed to prolonged periods of semi-isolated duty.

As for obstetrics, pregnant women are transferred to St. Martha's antenatal care service in Antigonish (60 km away) at eight months' gestation or earlier if they wish, or if there are any complications or high-risk issues. The local hospital had one rush delivery in 23 years—thankfully and serendipitously delivered by a locum with a lot of obstetrics experience—and hasn't delivered a baby since 1993.

Michael seems to be really happy and loves his job. He hopes to continue working as long as he can, noting that in a relatively high-risk profession like medicine, he likely won't have a long retirement. As a result, he says he does the things he really wants to do while he is still

healthy enough to do them. “That means that I will not accumulate a huge investment portfolio, but so what? I can’t take it with me and my kids won’t be needing it, having developed heir own earning potential.”

Talking to patients about their weight

I used to be skinny. When I was 16 in 1963 I went to my dad's drugstore in Sarnia, Ont., and bought "Wate On", a hideous glop of high-calorie chalky drink to help me gain weight. Now I can't even look at a Big Mac without wearing my expandable track pants. My washboard stomach is now a front loader. The only things without calories are vinegar, water and lemons. Oh, the cruel irony.

One of the toughest things about being a family doctor is helping patients with their weight.

This is a huge problem worldwide and half the population is struggling and spending hundreds of billions of dollars on diets, foods, books, exercise and medications. Celebrities tout dropping 50 pounds in minutes. They flaunt their after-baby bodies in the tabloids, conveniently omitting the fact they have round-the-clock nannies, private chefs and personal trainers. And we all see stick-figured models in magazines.

Because a visit to one of us Canadian family doctors is free, our patients value our advice that much. I have patients who go to commercial weight-loss centres and drop 40 pounds in three months because they are paying a lot of money. At 3 a.m. when they are hungry they think twice about raiding the fridge. But they can't maintain that rapid weight loss and yoyo back up to a higher weight.

Even if you are overweight you are still hungry every every hours. It's not like giving up booze, drugs or smokes: You can't abstain from food.

Broaching the subject

When I am doing a physical or the patient is suffering a weight-related medical problem such as diabetes, hypertension or arthritis, I start by saying, "You seem to be struggling with your weight." This is neutral and non-judgemental.

The patients usually agree.

I add, “I know it’s hard and 50% of Canadians are like you. Would you like some help?”

Often patients say yes, and I ask them what they have tried for weight loss. I then pull up my “11 reasons people are overweight” in the computer, print it out and go through it with them.

11 Reasons People are Overweight

by Dr. John Crosby
(feel free to use or modify or hand out to your patients)

1. They don’t practise portion control. Eat less = weigh less

2. They skip meals. You should never skip.

3. They drink pop, smoothies, fruit juices and triple-triple coffees, which all have tons of calories.

4. Too many desserts. Have dessert only on Sunday.

5. They eat the bread served at restaurants. Send it back before it hits the table.

6. Eating at fast-food restaurants: Try choosing kids’ meals (you also get a toy).

7. They don’t exercise. It rarely causes significant weight loss but it is good for your health.

8. Not knowing calorie content. Bagels, yogurt and whole-wheat bread have lots of calories.

9. Snack foods: Remove them from your house.

10. Sampling: Don’t taste food while cooking and don’t eat off the children’s plates.

11. Alcohol: It has a huge number of calories. If you can’t stop drinking completely, try to drink moderately (e.g., only on weekends and holidays).

Suggested menu:

Breakfast:
• Kellogg's Breakfast Anytime drink
• Small decaf coffee or tea with maximum one milk and one (fake) sugar

10 a.m. break: A banana. No snacks, muffins or donuts

Lunch:
• A meat or cheese or peanut butter sandwich.
• Milk or water or diet pop.

3 p.m. snack: An apple or carrots or celery. No snack foods.

Dinner:
• Meat with salad or veggies.
• No potatoes or rice or pasta or bread or buns.
• Milk or diet pop or water.

9 p.m.: Carrots or celery or an apple.

If you are trying to lose weight, weigh yourself daily when you first get up, without any clothes on. If you lose one pound a month that's 12 pounds per year, which you can then keep off. Rapid weight loss never stays off.

Why people fail at weight loss

The most common reasons people fail at weight loss is the amount of food they are eating (too much), skipping meals and thinking foods such as whole-wheat bread are magically free of calories.

Like all Canadians, we want things in seconds with no effort, pain or hunger, and this includes weight loss. Unfortunately, we have inherited an ability from our caveman ancestors to try to conserve every calorie. Humans have evolved over millions of years of eating roots, berries and mice. Our ancestors had to work for every scrap of food. For the past 50 years we in the First World can buy lots food in stores and restaurants fairly cheaply and with little effort. We can even have it delivered by ordering it online. Uber eats. Skip the Dishes. I am getting hungry just typing.

Here are more reasons people fail at losing weight:

When you shop at big-box stores, you can't buy small.

With every coffee and/or hamburger you buy at a fast-food joint, the clerk tries to up-sell you to a bigger portion. Want fries with that? Biggie fries = biggie MIs.

Deals at the supermarket are only available if you buy big. You can't buy two hot dog buns.

When you buy beer, increasingly it is only available in tall-boy size.

When you crash into bed at night and flick on the TV, there are commercials about food.

When you think you are being good by eating salads, there are croutons, bacon bits and creamy dressings to make you gain weight.

Vegetarians feel so self-righteous that they magically think vegetables have no calories. Baked potato, anyone?

Patients come in to see me, mystified about their weight gain and want me to check their thyroid. "Doctor, do I have a glandular problem?" Yeah—salivary glands.

We all love to kid ourselves and the food and advertising industry is happy to help us. We can stand on second base in a slow-pitch game then reward our "exercise" with wings and fries and a pitcher of beer afterward in the pub.

We see "no cholesterol" and "no trans fats" on the potato chip bag and dig in. You can't eat just one.

I advise people to lose one pound a month because I know they will lose more. I low-ball them and they high-ball me, just like union negotiations.

Does anyone out there have a long-term solution? I sure don't. Food is the only fun left at my age of 71 (except for my grandson, age 3: "Give me some chocolate ice cream poppa, I won't tell mommy."

Top 12 causes of physician burnout and how to cure them

The April 2018 print *Medical Post* featured a poll of 500 Canadian doctors and here are the causes of burnout which affects 50% of us:

Causes
1. Paperwork.
2. Less control over workload.
3. Physician voices are ignored.
4. Government can't manage the system
5. Rising patient entitlement.
6. Health ministry rules
7. Fear of college complaints and lawsuits.
8. Less prestige
9. Lack of a unified voice.
10. Electronic medical records
11. Low collegiality between doctors.
12. Bullying from colleagues.

Treatment

1. Paperwork. I love it because I do it from 8 a.m. to 9 a.m. and 1 p.m. to 1:30 p.m. every weekday. It is in my smartphone calendar. I charge the going provincial medical association rate for private paperwork and forms. I have a good computer system, Telus PS Suite, with which I can hit the print button and it does most of my work automatically. My secretary brings in patients with big forms and we fill them out together.
This is part of our job. Quit whining and "get 'er done."

2. Less control over workload. This is different for different specialities. Emergency physicians (I was one for 20 years) have no control whereas some specialists can cherry pick. Like orthopods who don't see sore backs (I envy them). You do have control over hours worked so set them up to get lots of breaks. Take the day off after being on call. Take lots of vacations. This costs money so work longer at the end like me at age 70 and lovin' it. Retirement is boring.

3. Physician voices are ignored. This has always been true for the 45 years I have been a doctor. You have to be persistent and put in time on committees. You have to keep advocating for your patients. You can't expect to walk into a meeting and get your way. This is tough for us who have to make snap life or death decisions frequently all day long.

4. Government can't manage the system. I agree. Run for office or quityerbellyachin. A free lunch monopoly has worked no where in the world.

5. Rising patient entitlement. This is a biggy. I am very frank with my entitled patients of which I have many. I tell them to complain to the minister of health and premier of Ontario. Free postage. I never apologize for the system unless I am to blame for a problem. Wait times are not my fault.

6. Health ministry rules. I don't like them either but that's what you get living in a civilized society. You can go to a third world country with no rules.

7. Fear of college complaints. Read my ebook (email me and I'll send it to you). Pages 80 to 111 (one half hour). Be nice to everyone, take lots of breaks so you are not crabby. Chart well. Have a chaperone prn.

8. Less prestige. I haven't noticed, not that I cared anyway. Don't let your plumber know you are a doctor or he will charge double.

9. Lack of a unified voice. Join the teacher's union. We are all small business people. 10 doctors have 11 opinions. I have no idea how to fix this. Hire a cat herder?

10. Electronic medical records. EMRs are a tool. Get a good tool like Telus PS Suite, it cuts my stress.

11. Low collegiality among doctors. Go to conferences and create your own collegiality.

12. Bullying from colleagues. The only way to beat a bully is with a bigger bully. Get help from your chief of service or staff or clinic director.

See, you are in control of your life. You don’t have to be burned out. I still love my job as a GP after 45 years.

There is no zero when it comes to chronic pain

I recently spoke by phone with friend and classmate Dr. Dwight Moulin. He is a professor in the departments of Clinical Neurological Sciences and Oncology at Western University, and he is also the Earl Russell Chair of the Western Pain Program. He has published extensively on the role of opioid analgesics in the management of chronic pain and recently has led a series of observational studies on the long-term outcome of the management of neuropathic pain. He chaired the Neuropathic Pain Special Interest Group of the Canadian Pain Society from 2005 to 2014, and led the Consensus Statement on the Pharmacological Management of Chronic Neuropathic Pain, initially published in 2007 and updated in 2014. In May 2012, he was the recipient of the Distinguished Career Award from the Canadian Pain Society.

Dwight is now focusing on chronic pain and has some tips for those of us labouring in the salt mines.

1. Validate the chronic pain patient's pain. Even if all tests are negative, it is real to the patient. Dr. Moulin sees very few malingerers. They have what they say they have, recognizing that anxiety and depression can magnify pain and disability enormously.

2. Set realistic expectations for the patient. They will never get to zero pain.

3. The opioid epidemic is driven in part by the goal of no pain—patients have higher expectations of pain relief than they did previously.

4. There is limited government money for psychologists, physiotherapists or pain clinics. It is easy and free to write a script for narcotics (with government drug plans and private insurers who together cover more than 90% of Canadians). Academic pain clinics in Ontario are now funded by government for allied healthcare workers; this is a start and hopefully will be extended everywhere in Canada.

5. Doctors fear the College of Physicians and Surgeons of their

province or territory. They don’t have to if they chart well and follow opioid guidelines for screening and prescribing.

6. Some doctors are too compassionate and have trouble saying no. They are people pleasers. Guidelines are extremely important for these doctors. They can print them off for the patients and tell them that this is the plan.

7. Anxiety and depression amplify chronic pain and need to be treated aggressively with counselling and antidepressants.

8. You have to change the mindset of the patient. Healthcare is not passive for chronic diseases. They have to exercise and lose weight even at the expense of mild to moderate discomfort. Just as we treat diabetics, pain patients have to take control of their chronic disease with active participation in their care, with physicians as advisers.

9. Encourage them to be as active as possible: keeping busy helps to distract from the pain. Patients need to engage in hobbies, and pool therapy is good. They should improve their sleep hygiene and avoid naps during the day.

In the past decade opioid use has gone up 242% in our country. Canada is now the number one country in the world, and Ontario the number one province in Canada, in per capita usage of opioids. The United Kingdom has far less usage. Dwight says this is due to their stiff upper lips—the different mindset of patients and doctors.

What’s behind the rise in college complaints?

The Canadian Medical Protective Association recently sent every doctor in Canada a bulletin stating that complaints are up. They told us how to communicate better with our patients, their friends and their families.

I think there are a lot of other causes besides physician-patient communication that are contributing to this trend. Here are my thoughts:

1. The internet. When I started practising 45 years ago, the public had no access to medical literature except via ponderous encyclopedias, which were expensive and hard to access. Now they can Google headache in the doctor’s office and get a whole range of diagnoses and treatments. This raises expectations that we have to meet. I always ask every patient if they have consulted Dr. Google and in a non-threatening way I explore their concerns and try to address them all.

2. Electronic medical records: Mine is wonderful and makes my care better and me faster. It is Telus PS Suite—but if you are looking at the computer and not the patient, they will get mad.

I always go into the room, wash my hands, introduce myself, shake hands with everyone in the room, then wash my hands again. I make small talk to relax the patient and I look at them and do a history and physical examination. I then say, “Please excuse me as I type up this visit.” I wind up by looking at them and asking them if we have covered everything, and what do they think is going on? I ask if they are worried about anything and have I helped them solve all their problems.

3. Increased number of patients. I have seen a trend over the past 45 years of more patients with more trivial problems who they have Googled their issues and fear the worst. If you Google “headache” it will say “brain tumour” but I have seen only one in 45 years and 500,000 patient encounters. I have seen thousands of tension headaches. The brain-tumour patient presented with a seizure and no

headaches.

4. More paperwork and computer work. Even I, the only doctor on planet Earth who loves paperwork, have seen it explode. Every employer wants us to police their absenteeism problems so doctors become the bad guys. I counter by explaining to the patient that I will describe the problem but it is not my decision about time off. Ditto for insurance and disability forms. If they are rejected I go over the form with the patient. For example, if they are rejected for the disability tax credit because they say they can't walk a block, I go over how I assessed the patient. I offer them a second opinion with another doctor, so I am not blamed.

A recent complaint in Ontario involved a doctor refusing to give charts to a patient. Always call the CMPA for advice. If it is not going to harm the patient or someone else, I just hit the print button and give them a copy in seconds. It costs $1 for paper.

5. Sexual assault. Even though in my office it is only me and my secretary, she chaperones all intimate exams. I use a paper poncho with a hole for the patient's head and a paper sheet for the lower body so the patient is covered but I have access. I explain what I am doing —e.g., checking for breast lumps—and I show them the vaginal speculum and brush for pap smears. I let them feel how soft the brush is. I tell them this brush helps rule out cancer at the mouth of the uterus, while my gloved fingers are feeling for enlarged ovaries and the uterus.

6. Angry patients. We all run into people who might be in pain, are worried, on meds or depressed, or are just plain ornery. I take a deep breath and give them empathy and understanding, and I try not to not snap back at them like an untrained person might. If you are getting into fights with patients, get a second opinion.

7. Family conflict: If there is family tension on how to treat a child or senior with chronic serious diseases such as dementia, I convene a family meeting and include people from away by speaker phone. They might feel guilty about not being there and take it out on you.

8. Narcotics: This is a huge minefield and is the topic for a fat book. I am very upfront with why I can or can't prescribe them and use the Canadian Chronic Pain guidelines. I document thoroughly.

A lot of doctors get into trouble with the college because they don't chart thoroughly. You can't just have one page for 10 opioid repeat prescriptions without bringing in the patient to do a targeted history and physical, and documenting it. Have a narcotics contract and use addiction screening tools.

9. Physician burnout. I think a lot of doctors (50%) are burnt out, which makes them look uncaring to the patients. The well is dry for empathy. The cure for this is proper stress management, as outlined in my free ebook. Take a holiday every three months. Take the day off after being on call (or the morning). You can get crabby with patients when you are tired.

10. Wait times. These are not the fault of doctors. They are the fault of gutless, weasely politicians promising a free lunch to everyone. They are very frustrating to patients who become angry as they suffer waiting for tests and specialists, and in the ER. When they finally meet a doctor they are in a bad mood so a fight may erupt due to no one's fault. The cure for this eludes me. Any ideas out there?

Spring cleaning: decluttering your office, home and life

I am a thrower-outer. Unfortunately the rest of my family members aren't.

The worst words I can hear are: "Honey, have you seen my ––––– ?" I am always guilty.

Now I have figured out a way to keep us all happy. I put everything into big clear, labelled, plastic boxes and stack them neatly in the attic, garage (which has not seen a car in 40 years) and basement.

In the spring I book a five-minute appointment with my wife on a Sunday at 3 p.m. and have all the contents of the entire garage laid out on our driveway. I ask her to point out (like a queen gesturing to her serfs) what I can toss.

I pay my three sons $20 per hour to help me declutter the attic every spring and I buy them beer and pizza and let them blast their hideous music during the ordeal.

Why declutter?

24. It makes you feel "light."
25. You will find stuff you forgot you had.
26. You can donate junk to your friends, family and charities. One man's treasure . . .
27. You can prevent fires.
28. You can prevent vermin.
29. You can free up space for new junk.
30. It will make you more efficient because you won't have to waste time looking for stuff.

How to get started in your office

The biggest hurdle to decluttering is making time for it. You and your staff never have time, as you are medical professionals and people get sick and injured 24/7/365.

Email your staff today that on a Sunday two weeks from now you want

them to come in at 9 a.m. until noon at double pay. Hire their kids and yours at $20 per hour. Turn off all your phones and email and beepers and texts and assign each person to a room.

Wear your grubby clothes and take everything out of one room at a time. To the bare walls. Now that most doctors have electronic charts, the biggest clutter—paper charts—are not as much of a problem.

Vacuum the room and wipe it down and dust it so it is clean, then put everything into three piles: toss/shred, keep, or sell or donate.

Go through the keep pile a second time and ask yourself, did I use this in the past year? If not, why do you need it? The biggest reason is sentimental (heavy on the mental). Take a picture of it or make a memory box.

Get someone else to go through the keep pile with you who can offer an outsider's view.

Get rid of old textbooks; everything is on the Internet now. Donate reading books to nursing homes or the hospital. What, are you going to read them again? Chuck your journals. Be brutal; you forgot you had them anyway.

At noon have the beer and pizza and celebrate your wonderful work. You have freed yourself from possession oppression. This can cause depression.

If you just can't do it, hire a professional organizer. Google one.

If you have a ton of stuff that you can't get to the dump, hire a Got Junk? company. Google one. They will even come right in and carry out everything.

Fighting back against RateMDs

I recently got a fax from GlowingMDs which said they could help me with my RateMDs online reviews.

I phoned up the owner, Ryan Forman, who has been involved in the medical communications industry for the past five years and he told me he recently started this company to help doctors combat negative ratings on RateMDs. The business came about after a number of doctors approached him who were frustrated that disgruntled patients or ex-employees were posting negative and libellous reviews and hiding behind anonymity, with no way for the doctor to respond to the accusations.

The service costs $189 per month and is 50% tax deductible as a business expense. He has 50 doctors using it so far including GPs, rheumatologists, orthopaedic surgeons and an ophthalmologist. The ophthalmologist was loved by everyone except one patient whom he had fired, who started posting terrible comments on RateMDs. He wanted to have a lawyer sue RateMDs for libel. Besides the high cost to hire a lawyer he was advised that he would be fighting a losing battle.

Ryan says bad reviews are very upsetting psychologically for doctors even if there are just a few.

How it works

GlowingMDs sends the participating doctor a template which the secretary types onto the doctor's stationary. It is handed to all patients in the waiting room and they fill it out and hand it back to the secretary while waiting for their appointment. She then faxes it or scans and emails it to GlowingMDs.

GlowingMDs then submits it to RateMDs from a unique IP address as RateMDs filters out mass emails from one location. GlowingMDs also flags libellous ratings and sends them to RateMDs.

Ryan told me that 100% of his customers liked his service. He advertises through mass faxing, the Medical Post, the Canadian Medical Associating Journal and word of mouth. For example one

doctor in a group will tell the whole group.

Personally I find RateMDs annoying. Most of my ratings are great, but a few are from disgruntled patients that I have refused narcotics to, because they were at high risk for addiction. Others I have tried to get back to work, as work is therapy. I think RateMDs could help you improve care if you had a large number of people complaining about the same thing. Such as you are late a lot, or your staff is rude.

How I time manage the top 12 family practice diagnoses

A few years ago, when I was giving a time management lecture to 200 family physicians at the Family Medicine Forum in Toronto, a young resident at the back of the room commented: "Dr. Crosby, you have told us all about being more efficient about everything except when you are in the exam room with the patient."

I have been thinking about that comment ever since, so here is my belated answer.

Time-managing the top 12 diagnoses

1. High blood pressure. I have a template in the computer that has all the patient's history and physical in a SOAP: Subjective Objective Assessment and Plan. I ask the patient how they are doing and if they have any ankle swelling, shortness of breath or chest pain. I ask about lightheadedness or headaches. I then take their blood pressure, listen to their chest and heart, and check peripheral pulses and ankles for edema. If all is normal, I remind them why we do blood pressure (to prevent stroke and heart attacks) and that they can't feel it when it is high. I see them in six months and give them a handout (printed from my computer) to reinforce my teachings. I print a lab slip on my secretary's computer (exit strategy) and type on it "back in six months" so I don't have to interrupt her.

2. Arthritis: For any patient with a painful joint, I get a history and examine the area. I do an X-ray if I suspect osteoarthritis and wait until the patient returns a week later to review the X-ray with them and then advise them regarding medications, physio, bracing and ice. I have a handout and I refer to physio with the "consult letter function" on my EMR. It includes my history, physical and the X-ray results. I refer to an orthopod early if it looks surgical.

3. Upper respiratory infection: I use a computer template that asks how long the patient has had the infection, if they have a cough, sputum, ear pain or an above-normal temperature. I then examine their ears, nose and throat, palpate their neck for lymph node enlargement, take their temperature and listen to their chest. If it is

viral I explain that antibiotics are not only useless but also harmful, as they may cause allergies, diarrhea or superbugs.

I have a handout in the computer ready for printing that outlines why they patient is not getting an antibiotic. If they need an antibiotic, I have a prescription function on my computer for that.

Also, there is an off-work letter-writer on the computer.

4. Abdominal pain: I have a template that prompts me to ask what caused the pain, where the pain is, its quality and duration, what helps it or makes it worse, and what the patient has tried as a home remedy.

I then take the patient's temperature, check ears nose and throat, listen to their lungs and palpate and auscultate their chest and abdomen. I do a rectal if needed.

I can order imaging by computer. If they need stat help I can write a consult letter to the emergency physician.

5. Depression: I have a stamp in my computer that prompts me to ask about the nine symptoms: Are you tired? Do you wake up in the middle of the night? Are you crying? Do you blame yourself and feel guilty? Do you lack concentration? Do you lack joy in things you used to love? Has your weight gone up or down unintentionally? Are you faster or slower than others? Are you suicidal?

If the patient is suicidal, I get immediate help. Otherwise, I give them my handout on depression and ask them to read it and set them up for counselling. I have them back in a week to go over the handout.

6. Prenatal care: I use the Ontario prenatal forms and get my secretary (delegate) to fill out as much as she can, then review it with the patient for accuracy. I do the physical on the next visit. I tell the patient to read the book, *What to Expect When You are Expecting*. I leave the pelvic exam for the obstetrician or midwife to avoid double discomfort.

7. Well-baby care: I use the Rourke Baby Scale in my computer for every visit. It is really good and helps you remember all the milestones and tips.

I always talk to the parents before examining the baby to avoid having to shout over the crying. I always compliment the parents and tell them to never hesitate to call for advice, which we have 24/7/365 through our Ontario Telehealth service and my office.

8. Diabetes: My secretary gives them a lab slip signed by me to do blood sugars, HbA1C, creatinine, urine for protein, lytes, CK, liver profile and lipids one week before each visit. I use a stamp and check feet and eyes. The patient has their shoes and socks off before a see them and must bring their list of sugars since the last appointment. We go over their lab and how they are doing, then I examine their heart, lungs, peripheral pulses, skin and blood pressure. I weigh them as I am talking to them.

If stable I bring them back every six months.

I send them to Diabetic Day Care with their spouse to learn about diet and exercise and how to handle their disease.

9. Urinary tract infection: I use a stamp that asks how long they have had symptoms, whether they have frequency and burning, or any temperature or flank pain. I examine their abdomen and take their temperature. If it is a simple UTI, I do a urinalysis routine and micro and culture and sensitivity. If the results can't be back in a reasonable time, I start an antibiotic.

10. COPD: I ask about sputum change and shortness of breath. I inquire regarding smoking and encourage them to stop; I try medications to help with this. I examine their chest and ENT. I refer them to the COPD clinic and give them an antibiotic to take if they get a URI. I encourage them to get a flu and pneumonia shot.

11. Physicals: I do one every three years on healthy, symptomless patients. I give them my Ocean Wave.ca tablet, which does the functional enquiry wirelessly. I can see other patients while they are filling it out. It is more thorough than I am and the patients will answer more truthfully.

I weigh the patient and do their height and blood pressure. With women I bring my secretary in to chaperone breast and pelvic exams.

I do labs for complete blood count, lytes, blood sugar, cholesterol and stool for occult blood. In women ages 50+ I do a mammogram

every three years and bone density every three years.

12. Hypercholesterolemia: I have a stamp for this too, and go over the patient's labs and meds. I do their BP and examine their heart, lungs and peripheral pulses. I ask about muscle aches and, if they are stable, I see them in six months for a lipid profile, creatinine, BS, lytes, CK and liver profile.

The last patient is usually at 4 p.m. Hey I'm 70; I am tired by then. I deserve to go home early.

I go home and visit with my wife from 5 p.m. to 6 p.m. and unwind from the day by reading the mail. I complain for 10 minutes then move on to non-medical, fun stuff. We eat at 6 p.m. then read until 8 p.m., then watch trash TV (e.g., Modern Family; no news—it is always bad and stressful) until 10 p.m. then go to sleep so I get eight great hours. This is how old people party!

I also take all of March off and drive to Florida and rent a condo. The kids come down for March break but we have three weeks to read and swim and walk on the beach, which helps us unwind and recharge our batteries. My nurse practitioner covers me 100% in my office and at my top nursing homes. I have 1,200 patients, 70% seniors. They rarely go to walk-ins or the ER.

What it’s like to be a doctor for a homeless shelter

I recently tagged along with fellow Cambridge, Ont., family doctor Craig Albrecht on his Thursday-morning clinic at our local homeless shelter. I have driven by it for years and have seen the poor, unfortunate people outside shivering in the dark. I have always felt so sorry for them and have wondered how they ended up in this place of last resort.

As with everything in life there are many different causes for each person. They may have had mental health issues and/or addictions. They may have had physical problems with work, been mentally, physically or sexually abused, or have been born into poverty. Often it is more than one problem.

The shelter was clean and new—and jammed. It has a huge sleep room for 80 men and a separate one for 20 women. Residents have nice clean beds and their own lockable lockers. There are clean private showers and bathrooms. They can do their laundry for a $1.

There is counselling available on site but the clients are not pushed into it. They have a breakfast of sausages, eggs, toast, peanut butter, coffee, tea, milk or juice. The shelter inhabitants have a nutritious supper, too. Lunch is available at local churches on a rotating basis.

The homeless people have to leave the shelter at 11 a.m. and can come back at 1 p.m., so many roam the downtown area looking for a warm place, such as the library or a mall. When the temperature is cold they can stay in the shelter 24 hours a day.

There are 700 volunteers and the police are there proactively as a positive force to help them if they have had a theft or have been assaulted.

The medical clinic

At the clinic Craig sees patients with a variety of problems. He has a nurse and social worker with him and they all sit in together with the

patient.

Many patients do not have any identification, health cards or drug cards, so staff help them register for these services. Patients can also get help with looking for a job, assistance with welfare applications and help with housing.

Craig works every Thursday from 8:30 a.m. until noon. Most patients are drop-ins but they can also book an appointment.

Craig works in a local Community Health Centre (CHC) called Langs Farm the rest of the week and they pay him a salary for the shelter work. CHCs provide primary healthcare, social programs, and health promotion services with an emphasis on populations that face barriers accessing healthcare services. He connects remotely to the CHC's EMR vis his laptop.

The patients that I saw Craig treat on my recent visit included the following cases:

A burns victim who had fallen into a campfire; he was living in a tent. There were third-degree burns to the patient's legs and back, and the patient was getting dressing changes from a home care nurse who makes house calls to the shelter. With concurrent addictions and no adequate housing, the burns continued to reinfect.

Another man had insomnia but Craig could not give him any controlled drugs. This is a policy at the shelter, as so many people abuse narcotics and tranquilizers. They often come in for one appointment only, so can't be monitored. Craig referred him to a social worker and a nearby clinic run by a nurse practitioner who can prescribe and monitor controlled drugs if natural treatment for insomnia failed.

The workers in the clinic try to hook everyone up with a family doctor who is taking new patients. They drive patients to appointments with specialists, as well as for lab tests and imaging.

A third patient had a swollen left foot. She was an information technology specialist who had lost everything due to alcohol abuse. Craig was getting a bone scan because her X-ray was normal, but from the rundown condition of footwear (sneakers in the winter) she probably had a chronic sprain. She was very nice and very well-spoken.

My thoughts

I was an emergency room doctor for 20 years so I have have a lot of experience with homeless patients. We were their family doctors, for the most part. However, that was 25 years ago and now the problem is much worse. I even worked in downtown Toronto and it wasn't nearly as bad as it is today. I think this is because the psychiatric hospitals have closed and dumped the patients out onto the streets. They are not getting their regular meds, clinical monitoring, meals and/or shelter.

Access to psychiatrists for all my patients took nine months a year ago and is now down to three months but these people can't wait for help. Their need is now.

Another big cause is the high cost of housing. People get $600 monthly on welfare and apartments go for $600. Not much wiggle room.

There is more opioid abuse now than years ago because of us, and the availability of drugs on the streets. Ontario has just been declared the number-one place in the world for narcotics prescribing by doctors; Canada is the number-one country for narcotics prescribing. This is a gold medal we don't want.

I was so impressed by the staff and volunteers at the shelter. Everyone was happy and in a good mood, and staff were not burned out. They had a very "can do" spirit.

Talking physician health with CMA president-elect candidate Dr. Mamta Gautam

I spoke with Ottawa psychiatrist Dr. Mamta Gautam about why she wants to be president of the Canadian Medical Association. Dr. Gautam is an assistant professor in the department of psychiatry at the University of Ottawa, a certified coach, and president and CEO of PEAK MD. She is a pioneer in the area of physician health and well-being, and an expert in the field of physician leadership.

Her motto is: **No health without doctor health**

Dr. Gautam has looked after doctors, medical students and their families for 27 years. She knows what is bothering them and how to fix it. She says it is a system-wide problem.

She wants to help build a healthcare workplace across Canada that will support medical doctors, not make their lives more difficult. This involves first listening to them to see what their problems are.

She wants to see a national policy on physician health, which would involve hospital accreditation and a way to track and measure it. She would fight for funding to accomplish this goal.

She would set up national focus groups looking at the big stressors we have, such as electronic health records, and bringing back the doctors' lounge (at least virtually).

She wants to ty to attract family doctors back into the hospitals.

How would you interact with the provinces that are responsible for most healthcare and its funding?

Dr. G said she sees the CMA as setting up national principles for the provinces to filter down to the health regions and local regions.

What about wait times?

Dr. G said that for psychiatry she would study the success of the

cancer system to see if it could work elsewhere. For example, Hamilton has one-month waits for psychiatry because they have a team-based system wherein a psychiatrist is assigned to a group of family physicians for shared care. A lot of psychiatrist hang on to a small group of patients across the country who could be sent back to the family doctor.

The family doctor would be guaranteed quick access to the psychiatrist if any problems arose much like we do with cardiologists today.

She would look into government funding for psychologists and social workers to help cut wait times.

She would also have a task force look at why psychiatrists are not filling the residency slots. This is mainly due to poor funding, with many medical students coming out of training $300,000 in debt.

She would also like to see the funding of psychiatric day hospitals in general hospitals, something that worked well years ago but fell victim to global budget cutbacks.

What would you do about national pharmacare?

Dr. G said she would support it vigorously because it would save a lot of lives and taxpayer dollars, as many patients have to skip meds due to cost and as a result wind up sicker.

What would you do about teaching time management in medical school?

Finally an honest politician! Mamta knows this is my hobby horse but she very insightfully said that at that stage students are focusing on medicine so we should wait until they are out in practice.

You can read Dr. Gautam's presidential platform in depth here.

Dr. Gautam can be reached at mgautam@rogers.com.

The case for general practitioners

When I was five years old I met Paul Mann. His dad was our family GP. Paul is a malpractice lawyer in Cambridge, Ont., where I practise. The article below was written by him.

* * *

General practitioners no longer make hospital visits or house calls, nor do they work evening hours. I would like to deal with some of the reasons behind this.

The common assumption among specialists is that general practitioners are basically referral sources. Nothing could be further from the truth. General practitioners are first-line doctors. They see flus, they see coughs, they see paediatrics, oncology cases, and patients with a variety of problems. They are hard-working individuals who know their medicine and are more than a referral source. They are the first people any patient with a problem sees.

The huge mistake of general practitioners and the reason why so many of their patients go to the ER when the doctor is not available or it is outside the GP's hours of practice, is that these doctors have a recording on a machine saying, "If you are an urgent case, please go to an urgent care clinic or your local emergency room." That is exactly the reason why emergency care in a hospital has eight-hour and 10-hour wait times, and why when a doctor finally sees the patient it is for a period of about 12 minutes, and the patient is thereafter either labelled a "drug seeker" or told to "follow up with family doctor."

Why don't GPs have privileges at hospitals?

Generally speaking, general practitioners do not have privileges at hospitals, and do not make rounds as they did back in the 1950s and '60s because they are not paid by the government to do so. In addition, they are now charged parking fees by hospitals: For every visit they make, they're going to be charged about $9 to $20 or more, depending on how long they're doing rounds. If that type of a "penalty" was taken off, you would find more general practitioners doing rounds at hospitals, speaking with their patients (who are more comfortable with them than a strange doctor such as a specialist, who

comes in once a day or once a week). The general practitioner has known the patient for 10, 15 or 20 years, has treated their whole family on an ongoing basis, knows about their situational awareness, what's going on in the family, what's going on with the kids, who's a complainer, who's not a complainer, etc.

General practitioners in hospitals would serve their patients and the community well, and would alleviate problems in emergency rooms to a great degree. Why GPs are therefore not paid extra for rounds or for house calls after working hours is merely that they are not getting compensated in any manner whatsoever by the government (e.g., OHIP in Ontario). General practitioners know their patients. Specialists in hospitals don't know the patient and are relying on information given by the patient to the triage nurse and then the emergency doctor, and then the patient goes on to whatever ward they put them on and the doctor ends up being a complete stranger. Completely inadequate.

The failure of patients and specialists to communicate is a measure of the level of treatment the patient is going to be receiving in a hospital where the GP is effectively shut out of the process, except for receiving copies of consultation notes, which do no one any good but look mighty fine on paper.

General practitioners should be paid extra for doing rounds and house calls; then you wouldn't find that GPs who are near the end of their career are taking on nursing homes as clients and doing Workers' Compensation cases for extra money.

This is nothing more than doctors being underpaid and looking for a secondary source of income.

General practitioners should not be considered "visitors" to the hospital. GPs could be granted privileges, and could fill in charts, bring up-to-date information as to why the patient is there, their medical history, etc. Rarely is a GP ever communicating with a specialist about a patient's background, the nature of their problem, whether or not the patient has complained in the past and continues to complain.

Communication is a key source of proper and adequate medical treatment. Failure of a patient to communicate the problem to a GP is often caught by the GP in the next visit.

Failure of a patient to communicate with a specialist is never caught because the specialist may be on his or her fifth day of practice at the hospital, at which time the patient will either go to a resident, an intern, a medical student or somebody else—another complete other stranger—as the original treating specialist is at home or on call.

Problems with hospitals

The old adage of "do not get sick on a weekend" is completely a viable source of concern.

If, for instance, a patient has suffered a stroke on a Thursday, is taken for a CT scan or an MRI on a Friday, and remains in the hospital, it is highly unlikely that an experienced specialist will be there to treat them or to operate on them over the weekend.

What can a GP do? A GP can call the specialist, a GP can make notes in a chart, advise of the urgency of their patient's situation and communicate with a specialist.

In the current system, the GP is not even allowed in the hospital to see the patient.

The problem with all of this is that GPs are at the low end of the totem pole, whereas 40 years ago GPs were the whole totem pole.

The bottom line

Governments have to smarten up. You don't need hospitalists; you need GPs. Hospitalists are for "orphaned patients" (i.e., those without a doctor). Hospitalists should be debunked as "specialists" and GPs should be taking their place on a routine basis. There is no need for a hospitalist who has no authority to order anything other than a blood test.

I am writing this article in the hopes that somebody out there will understand the nature and consequences of the way the OHIP system is set up, the way hospitals work, the way hospitalists work and that failure of communication is the bottom line.

One final thought: A GP with a computer who sees their patients from 45-degree angle while typing out notes often misses the nuances in dealing with the patient directly instead of worrying about making

typos.

Computers are good for some things (e.g., googling the middle name of the Prime Minister of Canada), but are of little use for listening to and communicating with a patient. I may be an old-school guy, but the old school was one damned good school.

It is time for the medical profession to understand the utility of a GP, to correct the misunderstanding of the role of a GP in treating patients, and the waste of a GPs' practice and understanding.

All of which is respectfully submitted herein,
Paul Mann

* * *

We had 55 medical beds in our local hospital in the year 2000. We had 55 GPs admitting to those beds so we brought in hospitalists. They are there eight hours a day and have time to talk to family, the nurses, social workers, pharmacists, occupational therapists and physiotherapists, plus home-care coordinators.

Also, when I started 45 years ago we had 35 GPs covering emerge. We now have full-time emergency physicians on site 24/7/365.

My visit to the methadone clinic

I recently had lunch with Dr. Andrew Worster and asked what it was like to practise addiction medicine (read the blog here). I then visited his clinic to have a look at the inner workings.

Dr. Worster's clinic is in downtown Cambridge, Ont., in a government building with a small sign outside that says OATC (Ontario Addiction Treatment Centres). The waiting room is large, clean and modern.

Andrew was in an office with two computer monitors: on one was an electronic medical record and the other was a telemedicine hookup. He treats patients with opioid use disorder by prescribing opioid agonists: methadone and suboxone. He treats patients from Cambridge on site and those in northern Ontario by telemedicine.

When I visited he was speaking to patients in a northern OATC clinic 1,700 km away. The video resolution was really good and you could see the patients just like they were in the office with us. You could see their skin and diagnose rashes, the resolution was so good.

The staff at the northern clinics dispenses the patients' medications and observes the patients ingesting it to minimize diversion. Like all opioids, suboxone and methadone have a street value. Methadone diversion is a particularly dangerous problem because the prolonged half-life of the drug can be fatally toxic to those who are opioid-naïve, especially children.

The staff at the remote clinic also monitors urine collection to minimize tampering, and checks the urine temperature to confirm the sample is fresh. They test the patients' urine samples for proof of compliance with methadone or suboxone and the presence of illicit opioids, cocaine, benzodiazepines and amphetamines mostly.

As part of his assessment, Andrew first reviews the urine drug screen results and then the medication dosing history. He asks the patients if they've missed any (methadone or suboxone) doses, how long their dose lasts, if they want or need to change their daily dose, if they've used drugs or alcohol and how much. Patients who have evidence of illicit drugs in their urine results are further questioned about amounts and triggers for drug use. He discusses the dangers of overdose and

infections in those who continue to use drugs and encourages access to naloxone kits for overdose reversal.

Those patients who are "stable"—i.e., show insight into their addiction and no signs of illicit drug use—are granted daily take-home doses, known as carries. These must be kept secure in a locked box to prevent unintentional and potentially fatal ingestion by others.

Andrew also asks patients general questions about their well-being such as stressors, recent illnesses and medication changes.
He counsels them if they have any stress or refers them to local counselling. He then writes a prescription and books their next appointment online.

The cost of opioid agonist therapy (OAT) is approximately $6 per day and is covered by government programs and most private drug plans, although most working patients pay out of pocket.

Andrew says the most stressful part of the job is trying to find appropriate mental health support for patients in need, especially those in remote areas. He says rarely do patients get angry or threaten him. In fact, that's much more common in the ER than in the clinic.

I was struck by the normalcy of it all. The patients were very nice and had real social stresses.

Help me treat this patient who is driving me crazy!

I have a delightful 78-year-old patient with whom I have struck out trying to treat her insomnia.

She has been my patient for 26 years and I really like her but I got mad at her a month ago when she refused everything I suggested to treat her insomnia. I apologized a week later and we are friends now.

She is on no meds and has had perfect health. I did a full physical and lab, checking TSH, CBC, Lytes, BS and creatinine, and also did a urinalysis. All were normal.

Her husband died of throat cancer 14 years ago and she has never gotten over it. I think she is depressed and I have tried to refer her to a social worker and a psychiatrist but she has refused all help. She says they are just talk therapists, which I said was good as her brain got her into this and can get her out of it. I told her that if she had heart disease I would refer her to a cardiologist if I couldn't handle it, and said that psychiatrists are experts on medications.

I started my patient on an antidepressant and have slowly doubled the dose every month to no avail. I tried Imovane (zopiclone) 7.5 mg and gave her my handout on insomnia and the one on depression, which we reviewed in my office.

Download Dr. Crosby's patient handout on insomnia.

Download Dr. Crosby's patient handout on depression.

She bought a new mattress and has white noise for sleeping (a fan in the corner of the bedroom that does not blow on her eyes and dry them out).

She doesn't nap.

I referred her to a sleep clinic and they felt her insomnia was due to depression and told us to do what we were already doing.

She drinks no caffeine (coffee, tea, cola or chocolate), and she exercises in the daytime. I have told her to try a volunteer job but she refuses.

She says she goes to bed at 10 p.m. then awakens at 4 a.m. and just lies there with her mind churning. I advised that she get up and go to another room and write down all her thoughts. I advised her to drink warm milk and read a boring book and not watch the news, which talks about the few people out of seven billion who have had trouble that day.

I really feel bad for her and she is really driving me crazy. I am losing sleep over her. What would you do? Comment below or email me at drjohncrosby@rogers.com.

What it’s like being a methadone doctor

I recently had lunch with Dr. Andrew Worster, an old friend from my emergency days 25 years ago. He works at an opioid addiction clinic in Cambridge, Ont., and still does ER shifts at Hamilton General Hospital. He works in the ER one or two eight- to 10-hour shifts per week but doesn’t do night shifts any more so he enjoys the two jobs. He has been practising for 26 years and also runs a non-profit corporation called BEEM—Best Evidence in Emergency Medicine—which conducts evidence-based emergency medicine courses for emergency doctors worldwide.

Andrew works in the addiction clinic on Monday morning and all day Wednesday. It is a private business and they help patients get healthcare cards. He says that 70% of the patients are functioning, with jobs and families.

Many patients start with chronic pain and about 50% work at physically demanding jobs, hence, they use opioids to get through the day’s work as their bodies are wearing out on the job. They start small and gradually require higher and higher doses for relief.

Andrew said he feels opioids are sometimes appropriate for short-term severe pain but not for non-cancer chronic pain.

Andrew noted that doctors and the patients have to accept that in life there will be pain. In the ER, he often gets patients who tell him that their GP has done nothing for their back pain. For ER patients with severe, debilitating pain, he sometimes uses ketamine (15 mg I.V. over 15 minutes) to break the cycle of pain and spasm but does not prescribe opioids upon discharge.

In the methadone clinic Dr. Worster spends 20 to 30 minutes with the patient on the first visit, then five to 10 minutes per followup appointment. The clinic staff dispense one dose of methadone per day on the doctor’s prescription, and watch them swallow the liquid methadone or take the crushed suboxone sublingual tablet. As patients continue to demonstrate abstention from drugs, they gradually earn take-home doses at a rate of one per week each month. These are

removed if the patient relapses.

Once or twice each week, patients must leave a urine sample for drug testing: males do it on video and females are watched by a female nurse to make sure they don't substitute urine from someone else. The urine is tested for methadone or suboxone to make sure patients are taking it (not selling it), and is screened for benzodizapines, opioids, cocaine and other drugs of abuse. Positive test results are discussed with the patient to determine the cause(s) of the relapse and the associated risk of recurrence.

What about marijuana? Andrew said that because so many patients routinely use cannabinoids, they do not test for it but he does counsel patients on its adverse effects.

Andrew said he treats addiction, not pain, and more than 90% of his patients are self-referred. Although some don't want their family doctor to know, this attitude is discouraged and the patients are advised that they need the family doctor to be in the loop.

Dr. Worster said some patients report that their family doctors have abruptly discontinued their opioid prescriptions and won't treat their chronic pain when they find out they have been to the methadone clinic. Although he doesn't treat chronic pain, Andrew recommends Tylenol, NSAIDs, physio and a pain specialist referral as non-opioid strategies for chronic pain. I told him as a GP that the patients often can't afford physio or counselling and wait lists for pain specialists are brutal.

Highly motivated patients do well and many own their own businesses, Andrew added.

In terms of methadone use while driving and operating heavy machinery, he said his patients have all been doing this while taking varying doses of opioids for many years and that if there is no perceived increased risk, patients are not reported to the ministry of transportation. However, they do counsel patients about these safety issues. Andrew said if the clinic reported patients to the ministry, very few would agree to start treatment.

What drives the patients to seek methadone treatment? Some are seeing their businesses or jobs suffer, some are told by their spouses that they will leave them if they don't get help. Some are just tired of

the lifestyle of having to seek drugs to ward off withdrawal.

What about the socially disadvantaged? Andrew said he concentrates on harm reduction for all addicted patients, such as getting them off needles, which can cause cellulitis, abscesses, hepatitis or HIV.

About 10% of patients are hard-core addicts with no stable housing, and are often living in shelters or couch surfing with friends and/or family.

The most common mental health diagnosis Andrew sees is anxiety.

Andrew advises doctors interested in this type of work to never work harder than the patient—good advice for a lot of treatments.

Cost

Methadone costs approximately $6 per day and is covered by government welfare and private drug plans but many working patients pay out of pocket because it's still cheaper than street opioids.

The Ontario visit fees are the same as for family medicine office visits ($33); although, the overhead is quite high as the clinic is open seven days each week, urine testing and monitoring equipment is needed, as well as medication dispensing and support staff.

What is the cure rate?

When I asked, Dr. Worster answered, "What is the cure rate of diabetes, hypertension or hypercholesterolemia?" We treat these as chronic, incurable diseases that we try to control to avoid harm to the body. He says that once people accept that addiction is a disease with its own signs and symptoms, it becomes much easier to help patients and to deal with some of the difficult behaviours. He added that seeing people overcome the challenges of addiction and take control of their health and their lives is extremely rewarding.

How doctors end up prescribing narcotics for chronic pain

I have been a family doctor in Cambridge, Ont., Canada for 25 years. Before that I was an emergency physician for 20 years. I have had more than 500,000 patient encounters over those 45 years. The toughest cases that I have had to handle were those of people with chronic pain.

Sample case

A 45-year-old construction labourer presented with low back pain for two months. His examination was normal, with spasm in the lumbar spine. There were no red flags such as night pain, pain radiating into legs, bowel or bladder control problems.

X-ray, CT and MRI scans were normal. (Choosing Wisely says to do none of these things.) He smoked a pack a day and drank a case of beer every weekend. His liver exam and lab function were normal.

He showed me an opioid pill that a co-worker gave him; it really helped him and wanted me to prescribe more.

I advised him that I feel he has a potential addiction problem and I wanted to avoid narcotics. I advised him to try two Tylenol (500 mg) every four hours to a maximum of eight tablets a day, and to taper his beer drinking to avoid liver damage from the Tylenol. I referred him for physiotherapy and told him to alternate cold and hot packs, and to buy a good, firm mattress.

He returned a week later and was no better. Physio has prescribed exercises that have not helped him.

I suggested Advil, two tabs every four hours to a maximum of eight per day.

He returned in a week no better and the Advil upset his stomach. I prescribed Losec, a drug to protect his stomach.

He wanted time off work but I told him work is good to keep the back

functioning and to help take his mind off the pain.

I referred him to a physiatrist with a six-month wait. Orthopaedic surgeons and rheumatologists don't consult on mechanical back pain.

I referred him to our pain clinic, which has a three-month wait.

His wife came in the next week and they were both angry with me, even though I have been their family doctor for 25 years.

I explained that 80% of Canadians get back pain and it is really hard to treat. I shared that I have had it twice in my life for a month each time and know how frustrating it is to suffer with pain and not sleep, and to try to go to work with it.

The next week the patient was no better and had tried chiropractic, acupuncture, Voltaren cream and A-535 liniment.

Another week and he was no better and he has tried Aspirin, Aleve, Celebrex and Naprosyn.

I started him on Effexor 75 mg daily to treat depression, which is part of chronic pain. I doubled it every month up to 300 mg daily.

The pain clinic gave him a steroid/xylocaine (freezing) shots in his back and the physiatrist had no new suggestions. His boss wanted him off work and on long-term disability, and the physiotherapist thought he should be off, too.

Let's pause for a moment here. What would you do if you were me? Because this is our life as Canadian family doctors.

If I cave in and give him a narcotic, I am a dope pusher causing Canada to have the second-highest narcotic prescription rate in the world. If I don't, I am cruel and don't care about my patient and am a bad doctor and a bad human.

Luckily the patient got better—probably in spite of the back pain industry, of which I am a charter member. Now four years later he is pain-free, working at his same job and not addicted to opioids.

This type of problem is encountered daily across Canada, with thousands of cases. It also happens to specialists, nurse practitioners,

dentists, emergency and urgent care physicians.

My five-year sort-of retirement plan

I just turned 70 this month and have notched 45 years on my stethoscope. My wife is quite happy for me to work until I die, as I would be annoying around the house trying to organize her kitchen.

A lot of my friends are retiring and I am always pumping them about whether they are bored or not. Most are quite happy to be retired and are enjoying the freedom. Dr. John Birss, friend and fellow Cambridge, Ont., GP, has been retired for two years. He says every day he wakes up he loves the choice of not doing anything or doing everything. He is single so he is rich and goes to Florida for three months in the winter and is building a year-round house in the ruins of his family summer cottage in Muskoka, 166 km north of Toronto.

A general surgeon friend retired at age 70 last November and loved assisting at surgery. No paperwork, no responsibility, no talking to anyone and no on call. He has just signed on for a maternity leave locum for a surgeon from now until spring, so we will see what it is like for him to be back in the saddle.

A lawyer friend retired six months ago and loves being able to read as much as he wants and not law stuff. He is travelling a lot and loves the freedom.

Every weekday morning at the YMCA I see a urologist who retired four years ago; he is assisting at surgery and loves his life. He is able to travel with his wife to see family all over the globe and doesn’t have to rush back to a jam-packed office and pay for the sin of being on vacation.

Another local family doctor, age 65, retired last spring and is volunteering for Habitat for Humanity, building houses in Haiti.

Cambridge family doctor Jay Baker gave away his general practice two years ago and just does mornings in his two nursing homes, plus the occasional locum, and really is happy.

My plans

I personally am not on call anymore (wonderful) and take Wednesday afternoon off and all day Friday. I spend the month of March in Florida with my wife. The kids come down with my three-year-old grandson and we really enjoy their visit, as well as being alone for the other three weeks. It's a nice balance of chaos and serenity.

I work with a nurse practitioner and she covers me so I am not drowned by work and disgruntled patients on return ("Doctor, how could you be off when I was sick???"). The patients and nursing home staff where I work like it, as they always have coverage.

I plan to work another five years and have my NP do more and more and me do less and less. If I feel OK at 75, I will try to do just my two nursing homes until age 80—or until I need a room in one of them.

Everyone advises me to get a hobby. I hate hobbies and have never done them. I hate golf; as Churchill said, it is a good walk spoiled. I like reading and I like chocolate but both get tiresome in great quantity. I could volunteer and would like to read to people in nursing homes who don't get any visitors; there is so much loneliness there. I like travel but hate all the bull feces, like lining up to park and lining up to check in and lining up for luggage and lining up for customs. Whoops, trip is over.

I like Florida in March. I like reading the New York Times about Trump all morning and walking with my wife on the beach and swimming in the afternoon. We have the early bird special at 4:30 p.m. and are asleep by 7 p.m. Just kidding; we watch Andy of Mayberry reruns until 9 p.m.

I am useless in the workshop but I do love my Lionel trains and playing with them with my grandson, who is more intelligent than many people I meet in a day.

Are doctors responsible for the opioid epidemic?

I recently talked to an old friend, Dr. Sol Stern, by phone about his role on the committee that developed the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain. He has been a family doctor in Oakville, Ont., for 34 years and I knew him well when I was the chief of ER there. He was chief of staff at Oakville Hospital for five years and he has always been a highly regarded doctor.

Kindly Country Quack: Why were you picked to work on the guidelines?

Dr. Stern: I am really not sure. There were so many clinicians who could have been appropriately asked. I guess I had a lot of experience on the front lines with managing chronic pain and was also willing to put in the time.

What was the time commitment?

I spent at least 100 hours on this project, mostly on the clinical guidance and best practice parts of the guideline document. None of the panel members, including myself, were remunerated for our time and that was fine with me.

How was it structured ?

I went to an initial meeting with 70 to 80 people in 2015, then we met in smaller groups. We communicated a lot by email (90%) and teleconferences.

Dr. Stern said the whole process was very well-organized. He was joined by other FPs on the clinical expert committee and the voting panel, and he tried as much as possible to represent the views and opinions of the clinical experts.

There was 100% consensus on the voting of the 10 recommendations in the guidelines.

What are some tips for our readers who are family doctors, walk-in doctors, nurse practitioners and physician assistants?

Tapering narcotics in legacy patients (those already on >90 MED). Get patient buy-in. Go slow and do 5% to 10% dose reduction every one to three months; pause and take a breather if the patient's function or pain are adversely affected. Try other things such as Cymbalta and physiotherapy, reminders regarding lifestyle changes, stress reduction, etc., when doing the taper.

What if the patient can't afford physio?

We are trying to get Health Canada to encourage the provincial governments to help out as part of the opioid crisis. Recommendation #10 indicates there is good evidence that multidisciplinary pain clinics are beneficial for treating chronic pain, especially if a legacy patient is being tapering down or off the opioids.

Are doctors responsible for getting patient hooked on narcotics?

Dr. Stern says he is seeing much better (safer) prescribing by doctors in the last two years with all the media attention on opioids. He would like to see more education in medical schools and a more balanced approach by regulators, media and MDs in the use of opioids for chronic non-cancer pain.

He suggests every patient on long-term opioid therapy sign a treatment agreement with his MD. This is a kind of informed consent and a document both patient and physician can refer to if something goes wrong in the treatment (e.g., finding cocaine in a urine drug screen). If there is push-back from the patient when asked to sign the agreement, this should be a red flag. Below is an example:

My Opioid Medication Treatment Agreement

I understand that I am receiving opioid medication from Dr. Crosby to treat my pain condition. I agree to the following:

1. I will not seek opioid medications from another physician. Only Dr. Crosby will prescribe opioids for me.

2. I will not take opioid medications in larger amounts or more frequently than is prescribed by Dr. Crosby.

3. I will not give or sell my medication to anyone else, including family members; nor will I accept any opioid medication from anyone else.

4. I will not use over-the-counter opioid medications such as 222s (Aspirin, caffeine, codeine).

5. I understand that if my prescription runs out early for any reason (for example, if I lose the medication or take more than prescribed), Dr. Crosby will not prescribe extra medication for me; I will have to wait until the next prescription is due.

6. I will fill my prescriptions at one pharmacy of my choice; pharmacy name: _____

7. I will store my medication in a secured location.

I understand that if I break these conditions, Dr. Crosby may choose to cease writing opioid prescriptions for me.

Sign: _____
Date: _____

What is the number one substance abused by patients?

Dr. Stern says that in his opinion it is alcohol. Recommendation #3 of the guidelines strongly recommends a physician not to prescribe opioids if there is the presence of an active substance use disorder, such as alcohol abuse. He also talks to family members with permission from the patient to see if the patient is abusing any substances. He will often do a serum GGT to check liver function.

What about the Colleges of Physicians and Surgeons?

Dr. Stern has acted as a clinical supervisor for physicians that the college has had concerns about. In his opinion, record-keeping and adhering to the 2017 Canadian opioid guidelines are critical. He says he believes the Ontario college will be using these guidelines as standard of care.

Consider this sample patient:

Back pain for six months caused by lifting, no night pain or radiation, has tried ASA and Tylenol with no help. Bladder and bowels OK. Intensity is 7 out of 10. Patient has a low risk for substance abuse, and no present of past psychiatric history. On exam: normal range of motion, normal reflexes, spasm in lumbar area.

Assessment: mechanical back pain

Plan: Weight loss, increase exercise, physio, said if indicated, Tylenol 500 mg one every 4 hours prn x 30, maximum 3-4 g per day. Side-effects of meds explained.

What if the patient says NSAIDs upset their stomach and Tylenol is of no help?

Try non-pharmacological treatment and other options before prescribing opioids.

What if they say they can’t afford physio?

Suggest visiting YouTube for exercise videos for the particular condition they have.

What if they live in the 90% of Canada that has limited access to a multidisciplinary pain clinic?

Do the best you can for every individual patient. Pick the things they can afford and have the most likely chance of adhering to. Don’t just turn to the opioids at the outset just because most of them are covered by the provincial formularies.

Physician retires in frustration at age 58

Dr. Perry Tibbo, a fellow family physician in Cambridge, Ont., has retired due to his frustration with the Ontario provincial government, including the second round of clawbacks that he has experienced in his 32 years of practice, as well as the passing of Bill 41, the Patients First Act, 2016, which he believes will lead to increased bureaucratic control of physicians and more funding directed at administration rather than frontline medicine.

As well, he believes the Ontario Medical Association has been unable to effectively advocate for the profession.

Dr. Tibbo was a respected physician in the community. He enjoyed 32 years in medicine, including 20 years in Cambridge where he also acted as coroner for the past several years. While the coroner position was interesting, call was onerous as there were only two other coroners in the community, so he has decided to resign from that duty as well.

Once the decision was made to retire, the search for a replacement physician began; fortunately, an excellent new graduate assumed the practice. During this process it became apparent that new physicians were trained to work in groups and did not have much experience with the administrative side of medicine. Some were concerned about working as a solo physician in a family health organization (a group of physicians with rostered patients who cover for each other, including in after-hours clinics).

His replacement enthusiastically accepted some advice from Dr. Tibbo’s wife, who did the administrative work for his practice. The new physician consulted her own professionals and forged ahead with her practice of approximately 2,000 rostered and 300 unrostered patients.

Perry will miss his patients. Most were very gracious, and he received many lovely notes and gifts. A couple of them who were upset complained to his receptionist (who was also a little apprehensive).

Perry was born in Burgeo, N.L., and grew up in Corner Brook. His

parents later moved to Gander, where they assisted stranded airline passengers during 9/11. He completed his bachelor of science and doctor of medicine degrees at Memorial University in St. John's. He completed a one-year internship in 1985 and then completed a three-year return of service for the Canadian Armed Forces in Shilo, Man., and Trenton, Ont., as the Forces had financed his medical degree.

During his time in Shilo, he fondly remembers receiving veterinary supplies because he worked for the Third Royal Canadian Horse Artillery, and laughs when recalling how he could use them as props in his medical practice to lighten some situations.

Upon leaving the military in 1988, Perry spent eight years working as a GP in Trenton, and then moved to Cambridge in 1996 to join a group practice in order to help reduce office overhead. Financing a medical practice was difficult during the clawbacks imposed during the Rae Days.

He has enjoyed his time practising in Cambridge, a mid-sized city of 150,000, which afforded the opportunity of less call and a little more anonymity.

Last year his wife encouraged him to pursue retirement because he was tired of the political situation and public perception that physicians are wealthy. He believes his family has lived frugally and saved well. For instance, his last car, a Buick, was purchased eight years ago. The family has contributed to RRSPs, as well as invested through his medical professional corporation, which was established in 2005. They transferred their investments from MD Management to a self-directed discount brokerage accounts to save investment fees and they ensured they were debt-free before retirement.

Both of Perry's children had their education partially financed through his professional corporation. His son, 31, works as an engineer, and his daughter, 29, is completing a PhD in physics. He currently is unsure how the proposed federal tax changes will impact his financial plan.

It is Perry's understanding that the changes, if they occur, will be on a "go forward" basis from 2017, and current investments and earnings from them will not be impacted; however, the ability to income split with his wife is uncertain. Given her contribution to the practice over the years, this seems grossly unfair. His plan is to live off the proceeds of investments. Unlike most of his immediate family who were

teachers, he has no pension plan. He also realizes there are no guarantees, unlike those who are fortunate to have pensions funded by government.

What is it like to be free? Well, Perry has lost 10 pounds and works out daily. He has a big smile on his face and feels contented. He and his wife just got back from a five-week road trip down East and are going to Europe on a river cruise and to visit the battlefields of Normandy, France, next week. Later he may do some locum work and surgical assisting.

Perry and his wife plan to travel a lot and see their granddaughter as much as possible. Perry says he would have had grandchildren before children if he had known they were so much fun!

It’s so hard for doctors to say no

I am like a lot of doctors and find it really hard to say no. Many of us are people pleasers and were trained to trust everyone and try to fix everything. Sometimes you have to say no and people don’t like it and things can get very uncomfortable. My approach is to always put saying “no” as being in the patient’s best interest.

Narcotics are a huge problem for specialists, family doctors, emergency physicians and dentists. We want to treat pain adequately but not get patients hooked. I recently had a mom very mad at me because I wouldn’t give her 23-year-old son narcotics for his chronic mechanical back pain. I got his permission to talk to her and explained that narcotics would not help him and would give him a new problem of addiction. We tried physio and exercises and he is doing much better.

I say to the patient, “You are going to not like me but you will thank me years from now.” I now have five out of 1,400 patients on long-term opioids.

Tapering opioids: I see patients who have been prescribed opioids by other doctors. If they have seen a surgeon and had surgery and want more narcotics, I tell them I will give half of the drugs and substitute the rest with Tylenol. Then we gradually taper the patient’s opioid use to zero over the next month.

If they have been started on a fentanyl patch, I take them off over two years gently but firmly, using physio, NSAIDs, Tylenol and pain blocks as necessary.

Off-work notes: I tell patients that it is in their best interest to get back to work to avoid sitting around all day thinking about their problem. Plus, work affords you a paycheque and social interaction. I had a patient who wanted three months off after her mom, age 87, died. I said I would give her two weeks and get her grief counselling; three months would not help her get back on her feet emotionally.

I have had to tell patients to get another doctor if they requested help getting time off work too often. I had a young welder booking off monthly with various trivial problems. I finally confronted her and said

she should get a new job and that I wouldn't be giving her medical leave in the future except for serious problems. She took a week off when her dog died so I told her to get a new doctor, as I felt this was harming her health.

Refusing tests: Now, with Dr. Google, lawyers, friends and family pushing for PET scans for hangnails, I ask the patient why they feel they need the test. I explain, using Choosing Wisely, whether experts recommend the test or not—for example, an MRI for chronic neck or back pain with no red flags.

Happy doctors give good care

Fellow blogger, the great writer H. Jaye Goldstein, found my article on why I love medicine did not sound like his life. He is a family doctor in Toronto and I practise in Cambridge, Ont. (population 150,000), so maybe it is easier in small cities. I don't run into as many patients who consult Dr. Google or herbalists. Also, I am off the fee-for-service treadmill that Dr. Goldstein is on.

I have lots of things that annoy me but I don't dwell on them and I try to fix them. When I came here 45 years ago as a medical student from the University of Western Ontario to do my family practice rotation at Grandview Medical Centre, I loved the place. I returned as a family physician and tried to fix the things that made my life unhappy.

For example:

As an intern (to you young punkers, that was the white-clad, first-year rotating residency spot you needed to do family practice), I was at the wonderful, tiny, now defunct Wellesley Hospital in Toronto. We were paid $7,000 a year (my new car was $3,000)—a drop of $500 from the year before—and were on call one in every two nights. One crusty old surgeon's line was that the only problem with one-in-two call was that you missed half the cases.

In protest, we stopped doing on call for a week and the consultants took our call and we won the job action. We got one-in-three call and $14,000 for all the residents following us. Instead of complaining we changed the system. Maybe the Ontario Medical Association should hire us.

When I got to Cambridge a year later (1974), we had 50 family doctors and 80,000 people. There were no emergency physicians and we took call from outside the hospital. Not a good system for the patient, nurse or doctor. So I became the first one to stay at the hospital and not try to cover my office at the same time. Win-win-win.

We all did obstetrics, but sharing the duties meant individually we didn't have a lot of deliveries to keep up our skills. I remember delivering a baby with shoulder dystocia at 3 a.m. The anesthesiologist and obstetrician had to race in to save us but luckily I

solved the problem in time and there was no damage except to my gastric mucosa. They refused to bill. The addition of midwives, more obstetricians and a few family docs who specialized in OB fixed this situation.

Ironically, we have a whole new group of family docs wanting to do OB again. So much for these lazy, new, uneducated MDs.

I remember my new wife (she is still my wife) saying to me on my first night on call, as I was getting ready to sleep beside the rotary phone in the guest room, "Honey, I am a doctor's wife. We will go together through life with me supporting you 24/7." After the fourth call she planted her cold, tiny feet into my lumbar spine and growled for me to get the hell out of there.

Because I hated being on call and couldn't sleep, I copied the Oakville, Ont., model of every family doctor in one call group. It is still going 24 years later and gives better care because the doctors aren't exhausted and grumpy and trying to weasel out of answering. This took me two years to do but instead of bitching I changed the system to improve my life and that of patients and staff.

We also had 50 family doctors doing rounds on 55 internal medicine patients. It drove the nurses crazy, so I joined with a group of internists and family doctors and we brought hospitalists into the system while leaving the option for a few family doctors who wanted to, to see their own patients. A nice hybrid. Also it was a better system for all. Instead of family doctors spending eight minutes, the hospitalists were there for eight hours, with the entire team to look after the in-patients.

I also helped develop a system of family doctors assisting at surgery.

I initially was bored by family practice so I became an emergency physician for 20 years and loved it. I wanted paramedics so went to Hamilton to be the doctor in charge and then to Toronto to be medical consultant for the provincial ambulance services. We brought in paramedic services and established trauma and sexual assault centres across the province. I didn't whine, I helped change the system.

I came back to family medicine 25 years ago and love it because I am much more mature and realize it is half psychiatry.

At our hospital I helped set up a fracture clinic with appointments. This sounds Mickey Mouse but they used to have a first-come, first-served mob at 8 a.m. sitting around all day.

I brought a family physician speaker to Cambridge to talk about rostered care and helped persuade 60% of the family doctors into adopting it. The other 40% were already doing it. This is a huge plus for our patients as we now have everyone with a family doctor in town (there were 30,000 orphans 10 years ago), and we offer after hours clinics with quick service and MDs get paid vacations at no cost to the taxpayer. I think Dr. Goldstein would have found this much better than fee-for-service.

I helped bring three free social workers into our group instead of complaining about the nine-month wait for shrinks. That took me two years of meetings.

I took over two nursing homes and found it tough to see the residents once a week. I changed the system and now go three times a week. Less stress for me, better care and it takes less time.

I helped establish house doctors coming to my two nursing homes every weekday, which has helped cut ER transfers to four per month from 19.

I have worked with a physician assistant and trained PA students. I work with a nurse practitioner sharing my office and nursing home practice.

I have supported pharmacists doing more, such as immunizations and advice, and believe the only way to improve a monopoly is competition. Air Canada (us), meet West Jet.

I have mentored hundreds of medical students, residents and graduate physicians but make sure I don’t burn out by having breaks between them when I am on my own, which helps recharge my batteries.

Now I am trying to get doctors to be on time and cut stress and malpractice risk with my ebook (email me for a free copy) and lectures worldwide, and with this blog.

Aren’t I wonderful? No, I am quite lazy and wanted to create a great system for my patients, staff, the taxpayers, administration and my

fellow doctors.

I have failed at a number of endeavours. I tried to get internists to work 24-hour shifts on site in non-teaching hospitals. I saw them trying to cover ER and ICU from their offices, like we family doctors did 40 years ago with the ER. Lose-lose-lose. I failed probably because I am not one of them.

I have failed to get ERs to have better flow because the payment systems don't reward this.

I have failed to get walk-ins in Cambridge to open on the 12 stat holidays and take the load off the ER because the payment system rewards bankers' hours. Bankers used to work 9 a.m. to 3 p.m. weekdays, before instant tellers and online banking.

So I am not a Pollyanna (a person with a child-like, positive, innocent view of the world); I am a pragmatist who believes that happy, well-rested, well-paid, well-respected doctors give good care and everyone benefits.

Pet peeves about referrals by family doctors and specialists

When it comes to the referral process, there are a few problems from both sides—family physicians and specialists—as well as from their staff members.

As an emergency physician then family doctor for 44 years, I have had 99% of my interaction with specialists turn out very well. Specialists are brilliant, hard-working, and really have helped my patients and me.

But there are a few who can improve. I feed this back to them face to face and they reciprocate. One orthopaedic surgeon kept sending back my referrals asking for more information, which I really appreciated as it helped me improve too.

Cherry-picking referrals

I have had a lot of complaints by family physicians about specialists sitting on referrals if they are not suitably challenging. This drives family doctors and their staff nuts because the patients keep calling the FP to find out when their appointment is with the specialist.

No one wants to see back pain or chronic pain, or patients with a personality disorder. Boy, do I wish that I, as a family doctor, could tell my secretary to screen out patients with problems I don't like. I am on the front lines and take everyone. As an emergency physician we couldn't even fire a patient if they were violent, which is the way it should be. Every one needs healthcare.

FPs even look after dental problems because a lot of patients can't afford the upfront fees demanded by dentists. My dentist gets $200 to rollerblade past my open mouth, while I would get $33 if he infarcted in front of me. He goes to Florida every other week in the winter, I shuffle off to Buffalo for the weekend. Do I sound bitter?

Not enough information by the family doctor

When I was a medical student on an exchange visit to England in 1972, a patient's referral came to the ER with a note from the GP "Query back?" The ER doctor wrote back, "Back Confirmed."

Specialists want to know what question you want answered. They want all the information, including what didn't work in the past. They want nice legible (should be typed) notes and an up-to-date, accurate drug list, a working health card number and demographics. They want all the relevant labs, imaging and other consults.

"I lost the fax." We get that a lot from specialists' staff. We are piloting email referrals (or referrals) now in Cambridge, which ensures the specialist gets the consult and confirms it immediately. The specialist can ask for more information and the family physician and their staff

can see the wait times for all the specialists.

What it is like being a family doctor in Canada

The Lancet featured a series on physician experiences around the world. Here is what I submitted (though they decided not to publish it).

I have been a family doctor for 24 years in Cambridge, Ont., Canada, a city of 150,000 people 100 km to the west of Toronto. Before that I was an emergency physician for 20 years. Imax was discovered here. The telephone was discovered 20 km south of us and the smart phone (Blackberry), 20 km north of us. We have a big Toyota plant. We are an old Scottish mill town (200 years; I know you British consider that paediatric).

I love my life here. I have 1,400 patients, including two nursing homes of 165 patients.

I have not had to be on call since I turned 65, which was five years ago. Before that I was on call one day a month. Very civilized.

My day is like this: I get up at 6 a.m. and go swimming at the YMCA. I then do my paperwork and lab and imaging report reviews on the computer. I have a fully functional electronic medical record and use little paper. The only things that are still paper are letters from consultants. These are scanned into the computer chart and shredded. Our EMR was designed by a family doctor in our town and is the biggest system in Canada, used by more than 4,000 doctors.

I go to my nursing homes and do rounds Monday, Tuesday and Thursday mornings from 9 a.m. to noon and have 1.5 hours off for lunch.

Hospital work is optional, as is obstetrics and ER. We have hospitalists at our 150-bed facility. ER visits are 55,000 per year (as many as the biggest hospitals in Toronto, Montreal and Vancouver). Emergency physicians cover the patients here.

Hospital visits are free to patients, as are doctor visits. There is no co-pay or deductible, and no private medicine. The only thing patients

pay for is cosmetic plastic surgery, circumcisions and wart (other than plantar) removal.

I have been sued once and was exonerated. We have a terrific malpractice association that gives us great support. We are not at all like the Americans south of us, in this respect.

I do my office practice from 1:30 p.m. to 5 p.m. and get home on time. I spend about 10 minutes per patient, longer for counselling and physicals. We have three free social workers attached to our group of 28,000 patients. It takes nine months to get an appointment a psychiatrist.

On Wednesdays I work in my office from 9 a.m. until noon, and take Wednesday afternoons and all day Friday off. Heaven. Younger doctors with mortgages work 4.5 days a week. I get eight weeks of paid vacation and study leave per year. We get all 12 paid statutory holidays (such as Christmas and Boxing Day, and Canada Day) and every weekend off. We get 90 days paid sick leave per year.

Drugs are $2 for seniors and welfare patients, and most other patients have coverage under private insurance plans. Dentistry is private. There are long waits for nursing homes and in the ER.

I am a solo GP in a group of 17. I have a secretary and my wife does the billing (two hours a week). As a solo GP am a dying breed. New doctors want to work in clinics. (I think they are nuts; more meetings and bureaucracy and everyone slowing down to the slowest person's pace.)

We do after-hours clinics for each other from 5 p.m. to 8 p.m. Monday through Thursday, and Saturday mornings 9 a.m. to noon. We work one night a month and one weekend every 17. We have a nurse on call 24/7/365 to give advice to our patients in all the hundreds of languages from around the world that are spoken in Canada.

I (like half of Ontario's 12,000 GPs) am paid on a roster system and if my patients go to a walk-in clinic I have to pay their doctor full price, so this keeps us from getting too lazy. Fee-for-service physicians are paid by the government, $33 for an office visit and no bad debts. Every patient has a government health card, including homeless people.

Every person in Cambridge has a family doctor, but five years ago 30,000 did not, and relied on walk-in clinics and the ER.

Specialists do no primary care at all.

We have midwives who do obstetrics work and home deliveries. A few family physicians do ob-gyn and it is making a comeback with the younger crowd. I have medical students and residents (registrars) work with me from five different medical schools, including Irish ones (a lot of Canadians go abroad).

All the GPs know the specialists and we get along very well.

I am very happy being a doctor in Canada and recommend it to anyone. The hours are great, the pay first-class and we get lots of respect and satisfaction. The only bad thing is long waits for specialists but patients are very understanding and love getting everything for free.

I love my job and find it very easy to do and don't plan on retiring until my mid-70s, health permitting. Family physicians have no pension or benefits plans, though in my case I do get benefits coverage from my nursing home (this is rare).

The bad part

In Canada there is no charge to see a family doctor or a specialist, and no private medicine, so the waits for specialists can be brutal. If you have an emergency you might be seen right away, but for elective problems it can take months.

Waits for MRI scans are two months, same for CTs. There is no private imaging, except in Quebec, our French-speaking province.

On a personal note, my grandparents came form Bristol, England in 1912. The Titanic was too expensive so that is why I am here now. I spent the summer at the hospital in Warwick, England as a second-year medical student in 1971.

My wife and I go to Florida for a month in March, and we have a cottage on Lake Huron (one of the Great Lakes) that we visit in the summer. The water is so pure we can drink it.

Winters can be really cold and snowy in Canada, with temps to -20 C but summer days can reach +30 C. We average one murder a year in our city of Cambridge, and have strict gun laws (thank you U.K.).

We downhill and cross country ski, snowshoe, swim, boat, sail and skin dive, and love baseball, basketball (invented by a Canadian) and hockey.

If I had it to do all over again I would not change a thing.

My biggest stressor? Wait lists for specialists

As a family physician, my biggest stressor is wait times for specialists.

On the plus side, waits for CT and MRI have shrunk to acceptable times but for specialists they have risen to the highest in my 45 years of being an emergency and family physician.

This is the experience in Cambridge, Ont., a city of 150,000, 100 km west of Toronto and within an hours drive of Kitchener, London and Hamilton. So if we are in trouble it must be far worse in the rest of Canada.

Rheumatology: The wait time is 14 months, as an aging rheumatologist in the area just retired and the only other one moved away. Now senior patients have to drive a long way to be seen. Luckily the freeways are all jammed around the clock so there is no danger of a high-speed crash.

Gastroenterology: Wait time is 14 months. I recently had a patient with constipation wait a long time and he turned out to have cancer of the bowel. His daughter blamed me for not calling the gastroenterologist and begging for an earlier appointment. If I did that for everyone I would be seen as crying wolf, not to mention that I can’t do it for my 1,400 patients.

Neurology and ENT: six months.

Ophthalmology is very fast. The trick here is to send the patient to an optometrist if you are worried about a red eye or acute glaucoma. The optometrist can measure the patient’s eye pressure, use a slit lamp and get the patient in to an ophthalmologist stat.

Psychiatry: nine months. I could have a baby faster. They add insult to injury by sending us a letter at six months asking if we still want to refer. I want to write back, “No, the patient suicided” but my secretary won’t let me. So guess who has to look after the patients due to the wait and who is blamed for it? Yep, the guy I shaved this morning.

Urology: six months. Our two area urologists brought in a third and shared operating room time with her and cut waits to a month but now this is being reversed. So the specialists are getting innovative to help the patients.

Dermatology is only a few months' wait because we have a 70-year-old dermatologist who works like a maniac to keep up. But talk about putting all your eggs in one basket.

Internal medicine is good with a two-month wait. The paediatricians are fabulous and you can call the on-call and get a child seen in minutes.

Plastics is fast, and it only takes two weeks to see a gynaecologist.

The ER has 12-hour waits sometimes and the patients complain to me endlessly. I tell them to write to the premier and minister of health. I did not cause this problem.

Doctoring the very old

I have a delightful 96-year-old patient who tells me jokes: "Doc, if I had have known I would live this long I would have taken better care of myself" or "When I wake up, if I am not in the obits I know it is going to be a good day."

The secret to caring for the very old is to do as little as possible. Remember, all the protocols and guidelines we follow were invented for the mythical 40-year-old 70 kg man. So if you try to lower blood pressure to target, you might make your very old patient fall and break a hip. If you aim for an HbA1C of 6.0, they might go too low and slip into a coma. Low can kill you in seconds, high in decades.

Seniors in my practice

I have been a family doctor for 25 years, and before that an emergency doctor for 20. My practice of 1,400 is 60% seniors and I look after two nursing homes. My mom died at age 97 and my mother in law is 96.

I have looked after hundreds of 90-year-olds and about 10 centenarians (auto correct says centurions but they are not that old). My oldest was a woman of 108, who had a picture of herself on the wall driving a motorcycle at age 93. One 95-year-old still roars around in a little red sports car that I covet, and passes her driver's tests with ease.

Most over-90s are women because more men smoked back then. My dad told me that the tobacco companies sent free cigarettes to Canadian soldiers who were serving overseas during the Second World War. How patriotic.

Also, most patients didn't get their cholesterol, blood pressure or blood sugar checked in the old days. Doctors were too busy treating sick and injured patients to do much prevention.

Medications had severe side-effects too, so blood pressure pills made you feel bad even though they were treating an asymptomatic disease. U.S. President Franklin Delano Roosevelt died of a cerebral hemorrhage weeks before the Second World War ended. His blood

pressure was sky high. He was often seen with his jaunty cigarette in a holder. The Americans thought he died due to three, four-year terms as president. They felt his death was due to stress, so they limited future presidential terms to two.

People in their 90s also tend to have good arteries. The ones with bad ones have died. I always tease them and say, "Why did all the men die early; did they have a harder life than you?" They stare at me over their glasses and say, "You young whippersnapper (I love this), we are tough because we worked harder than you."

Very old patients are often tiny women on few meds. They are at high risk for malnutrition (tea and toast diets) and osteoporosis. They are usually widows who eat alone. Eating is a social activity, and they tend to not do as much and become frail.

I try to get them set up with friendly visitor programs and meals on wheels. I ask them what their goals are and then sit back and shut up. Most tell you they want to die in their house and avoid a nursing home. I tell them how to do this by suggesting they get a home care assessment, which is free—they have paid for it with their 70 years of taxes.

Don't just do something, stand there

The biggest piece of advice I can give you is to try to not do anything. Just keep your very old patients healthy and happy and socially connected. Loneliness is their biggest risk factor. Avoid meds, and if you have to use them, adjust for kidney and liver problems, and your patient's probable tiny size and lack of muscle mass.

Avoid benzodiazepines that can make elderly patients fall. They usually have insomnia due to daytime napping and osteoarthritic pain, so a Tylenol at bedtime can help.

What are your tips for treating these wonderful people? Comment below or email me at drjohncrosby@rogers.com

P.S.: If you are thinking of taking on super-seniors as patients, I highly recommend it. They don't Google, they respect doctors, they are not trying to bag work and they are living history unfiltered by writers, historians or politicians. They don't talk on their dumb phones while

you are seeing them, either.

Doctor, Why aren't you exchanging emails with your patients?

That is what I heard recently from a patient. I replied (in my mind) that the last thing I wanted to do after a busy day seeing 40 patients and doing mountains of paper and computer work was to open my smartphone and have to deal with 1,400 patients emailing me. Also, I am not paid to do this nor can I cope with emergencies online. "Dr. Crosby, I am having chest pain into my left arm and it is 3 a.m.; what should I do?"

So I called up Doug Kavanagh, a young family doctor in Toronto whom I know from when he was growing up in Cambridge. Doug has a computer company that makes a patient engagement system called Ocean. Using Ocean he can send and receive secure emails from his patients.

Kindly Country Quack: Doug, how many patients do you have?

Doug: 850.

KCQ: AHA, one of those young, Toronto, lazy family doctors with a boutique practice, eh?

Doug: Ha! Well I'm part of a great team of family doctors and we cross-cover for each other. I fill up the remainder of the 60-hour week with development work for my software company :)

KCQ: Sorry, I need to get to my month-long vacation in Florida. Hell, I am pushing 70 and deserve it. How many emails do you get daily from patients?

Doug: From one to six. 90% of my patients are involved, including seniors in their 80s if they are tech-savvy.

KCQ: So I would get double that with my practice of 1,400? When do you answer them?

Doug: Pretty much any time of the day when I have the time and

energy. I avoid checking email during family time, to keep my marriage healthy. When patients email me, they get this response:

For patients using email to communicate with me:

31. *Please call reception for appointment booking and other administrative tasks instead of emailing me directly.*
32. *Never rely on e-mail if communication is urgent or sensitive; use the phone or go to the emergency department.*
33. *Please note that email-based care is an uninsured service under OHIP. Regular users are asked to contribute via the annual subscription.*

This e-mail, including any attachments sent with it, is confidential, and for the original recipient only. If you receive it by mistake, it remains confidential; please notify me of the error as soon as possible.

I have them sign a consent form such as the one approved by the Canadian Medical Protective Association.

It reminds patients that this is not an emergency service. My staff has the patient fill out their demographics and email address on the Ocean Tablet when they are enrolling and it includes a consent to use their email.

Having their email is a huge timesaver. I can tell them their tests are normal with one click. I can email them their test results and tell them simple things such as, "Come in and get your blood pressure done." I also send pre-visit questionnaires for physicals, well babies, pre-ops, and so on.

We also send out blasts to big groups of patients about things such as flu shots, pap reminders, fecal occult blood tests, office alerts, etc.

When I am on vacation their emails just bounce back, so I'm not drowned by them when I return.

Patients love it. I also avoid a lot of unnecessary appointments. I am in a family health organization so I'm paid monthly, more or less the same whether I see them or not.

KCQ: What about filthy lucre?

Doug: This is included in our block fee of $120 per year and there's a

pay-as-you-go option. We waive the fee for patients who can't afford it, but that's uncommon in north Toronto.

KCQ: Would this work for fee-for-service doctors?

Doug: For sure, but only if a barrier is in place to ensure patients pay for the service. Otherwise a lot of emails and time are spent in charity. Uninsured service provider companies can help to collect and ensure fair payment.

KCQ: What are some typical emails that you see?

Doug: A recent patient emailed me that their muscles were sore on a statin so I told them to cut the dose in half and email me in two weeks with what happened. This is a huge timesaver for me, my staff and especially the patient. They also avoid coming in to my office and catching a cold from sick people in the waiting room. They can avoid voice jail on the phones, too.

KCQ: Do you use your own smartphone and email?

Doug: I usually use my Android phone and my laptop to check on the emails. I have a separate account dedicated to patient emails.

KCQ: How do you keep confidentiality and avoid hacking?

Doug: First we ensure we have email consent, because hacking is always a risk no matter what you do. However, simple measures keep the risk low and keep you out of trouble in the worst case. I start with the basics: I use unique, long, random passwords and I change them frequently (a password manager app is a huge help here). I use secure encrypted email instead of regular email when possible. I don't share my password with anyone (especially lazy people who write them on yellow stickies in the office). Cyber insurance is important these days as well.

KCQ: Doug told me than another bonus was with time management. For example, if the patients start getting into a lot of detail in an office visit he tells them to email him what is happening and he can read it at his leisure in a quiet time. For example, if they are having stress issues he can read about in their detailed email it and link them to resources such as counselling services , etc., to help support them.

OK Doug, this sounds all rainbows and lollipops, what is the downside? Every tool has a negative effect. You can use a hammer to build a house or to hit your thumb with it.

Doug: Not everyone uses email appropriately at first, so there is some extra time spent "training" patients. The occasional inappropriate email will cause headaches. I had to deactivate it for about five to 10 patients who repeatedly sent me single sentences like, "My headache is excruciating and I am dying." Others send novels, but I don't mind this because it's quicker to read than to listen.

You also need to have a certain comfort with the uncertainty of it, since you only know what they tell you. The key is to err on the side of caution by either calling them, advising them to come in or to go to the ER if they have any doubt.

In summary, Doug estimates there are about 15% of Canadian doctors using email or online messaging with patients. He likes it because he has limited hours and it helps avoid "outside usage" by patients (outside use is a penalty that family doctors have to pay when patients visit walk-ins or see other family doctors).
Here is a good CMPA overview on using email with patients. Doctor, why are you or are you not exchanging emails with your patients? Comment below or email me at drjohncrosby@rogers.com.

How to avoid college complaints for your nursing home work

I have looked after two nursing homes in Cambridge with 155 residents for 25 years. I have had only one college complaint and it was trivial. A resident's son couldn't get me to call him back because the ward clerk never gave me the message. The College of Physicians and Surgeons of Ontario said to just call up the patient's sone and there would be no black mark on my file. We instituted a patient list for me to check every day that I am in the homes and this problem has not been repeated.

A college complaint can be brutal. It can take years to process, and your name will be in the media and/or the monthly college magazine that everyone reads with dread and morbid curiosity.

Here are my top 10 ways to avoid complaints in the nursing home:

1. Talk to the patient and/or their substitute decision maker about any major changes.
2. See 1
3. Ditto
4. as above
5. like 4
6. as in 5
7. encore
8. You get the picture
9. ” ”
10. See 1 again

I know you think I am being annoying but this is so key. Lack of communication is a huge cause of complaints. I go three times a week to my homes and it takes me less time than going once a week because I am ahead of the curve. This gives me lots of time to talk to patients and their substitute decision-makers.

I once had a 92-year-old man with myasthenia gravis on steroids. He bruised really easily and fell all the time due to weak muscles and dementia. His daughter was worried he was being abused by the staff so I called her once a week for five years to go over what was

happening. It only took a minute and saved us all grief.

Tranquilizers

A huge cause of complaints is when a confused patient is put on a tranquilizer and then falls and gets hurt or is drowsy when the kids come to visit.

I phone the substitute decision-makers and tell them this: "Your dad has dementia and is hitting our staff when they try to give him a bath. That is why he is here. You couldn't handle him at home with the help of home care and the hospital couldn't handle him. You have been replaced by 10 people. We will try to redirect him to do other activities like music or hobbies but we may have to give him a tranquilizer.

"We will start out with the lowest dose and move up slowly, monitoring him carefully but he may fall or get drowsy. There is no way to guarantee any human will not fall but we will try to prevent it."

I then shut up and let them talk and ask questions. There is no good answer for these types of problems and we have to keep talking to the families. They often feel guilty about putting a loved one in a nursing home and can take it out on the doctor and or staff.

Family meetings

I and the appropriate staff meet with the families if there is a problem, and we have any out-of-town children on speaker phone.

I recently had a patient with dementia whose one child was a family doctor and the other a forensic psychiatrist. They had a lot of questions about the choice of meds and were very happy to have input into dad's care.

I also had a daughter from out of town who was a clinical psychologist whose dad had dementia. She wanted Beri Beri ruled out. She wrote me a three-page letter with 21 causes of dementia listed. I phoned her with the nurse listening in on speaker phone and went through every cause. It took a long time but she was happy and never bothered me again.

Switch doctors

I once was giving a tour of the nursing home on my own time to the minister of health when a patient's wife came up to me to ask about her husband. I told her I was doing a tour and another doctor was on call for me. She got angry and fired me and now has another doctor in the home looking after her husband. No one can please everyone, so from time to time it is good to get a new doctor taking over care if you aren't getting along with a patient or their family.

Do your labs and imaging every weekday to avoid missing or delaying treatment of critical results.

Encourage your staff to tell you if any next of kin are unhappy. Thank them for telling you. Call the unhappy person and talk it through.

Avoiding polypharmacy

I hate when the doctor's duty list says "call daughter of Mr. Jones." It is rarely to praise me or tell me I have won the lottery. In fact, in 25 years it has been uniformly bad news. I get the nurse to find out what it is about and then have her on speakerphone beside me with the chart so we can answer all the questions when we call.

If you are going to discontinue a drug, tell the substitute decision-maker why. They get printouts monthly of all the drugs the patient is on.

We stopped all proton pump inhibitors and the residents had no ill effects. We told the substitute decision-makers that these drugs are not usually needed, as the food is blander and the drug may cause C. difficile diarrhea.

How to reach you

I tell every family that I can be reached by having the nurse write on my daily list to call substitute decision-maker at their cell phone number. I tell them not to call me at my family practice office, as I don't have the chart or the nurse who knows them or their med list, labs and imaging. I tell them I will get in touch within 24 hours.

I tell them about my philosophy of medicine, which is to avoid too many drugs and the ER.

My script is this: “There is a pill for every ill and an ill for every pill. We will try to cut out as many drugs as we can and will tell you why we are doing it to avoid side-effects.”

For the ER I say, if dad has a cut or fracture we will transfer but if he gets pneumonia we recommend treating him here. We will call you for the final decision but ERs can be confusing to patients with dementia and they can catch a superbug there.

I don’t recommend CPR, as it rarely works and result in the resident having broken ribs and prolonged suffering. I ask the substitute decision-maker, “What would your mom want if she wasn’t confused?” I tell them that I wouldn’t do it for my mom or myself.

Have good after-hours coverage. In Cambridge, Ont., we have all the family doctors in one call group, so you are only on once a month. This helps avoid being tired and making a bad call at 3 a.m. You can take the day off afterward. You have the time to go in and see the patient and not just do a phone consult.

Listen to the nurse; she knows the patient.

In summary, the best way to avoid a college complaint is good old communication and a good system. Patients and their families get angry if they feel ignored or not heard. Nature gave you two ears and one mouth to make sure you listen more than you speak.

Teaching medicine is an art. Why are so many doctors terrible at it?

I hate to say it but only 1% of the thousands of medical lectures I have attended over 50 years have been good.

The vast majority are a doctor mumbling in front of Powerpoint slides featuring tiny type.

Most doctors have never been taught how to teach. At the most recent Family Medicine Forum in Vancouver, I attended a great talk by Dr. Jon Davine, a McMaster University psychiatrist, who taught us how he teaches. Here are a few tips to help you become a "Ted Talk-er."

Preparation: find out who your audience is and what they want to learn. A lot of specialists give too much detail if speaking to family doctors.

Get there early (at least one hour) to avoid traffic and equipment malfunction. Bring a backup to your flash drive and bring a paper backup to your Powerpoint presentation.

Arrange the audience in a U shape and avoid barriers such as tables and lecterns. Work the crowd like a gospel preacher; walk to the back and talk to everyone in the audience.

Your powerpoint slides can be a picture, but if they are text-based keep them to less than 10 words. This will help keep you on track and avoid the audience reading over your shoulder. Don't use short forms or initials.

Give out handouts after your talk so the class isn't reading them during your presentation.

Dr. Davine also had some great ideas on how to get shy audience members engaged:

Buzz groups: After a 45-minute lecture, break the audience into random groups of five, have them elect a leader and solve a case in five minutes. The leader then presents the case to the big group.

One to one: Have everyone introduce themselves to the person beside them and then argue for and then against a topic for five minutes.

Stand up and be counted: Present a case and have the audience line up under five signs taped to the wall: 1. disagree strongly 2. disagree 3. neutral 4. agree 5. agree strongly. Then pick people out of each group to justify their choice.

Some students can end up hogging the entire session by answering all the questions. Dr. Davine's approach to these overly enthusiastic students is to hold up his hand like a stop sign and then redirect the question to a shy audience member.

Medical assistance in dying: a hospital's step-by-step protocol

If your patient asks you for help in dying, here's what you here's what you can expect before, during and after.
I recently talked with Dr. Kunuk Rhee, chief of staff at my hospital, the Cambridge Memorial. Cambridge is 100 km west of Toronto, just south of Kitchener-Waterloo and has a population of 150,000. The hospital has 143 beds.

Dr. Rhee came to our family practice meeting last year and told us to phone the hospital and have him paged so he could refer any of our patients asking for medical assistance in dying (MAID) to the appropriate physician.

The hospital has had six requests to date.

A year ago Cambridge Memorial Hospital formed an internal resource group and looked at MAID protocols from around the world. The group also evaluates referrals that are rejected and reviews all completed MAID services.

The protocol

1. The patient asks family doctor for MAID.

2. The family doctor (if he or she has active privileges at the hospital) calls the chief of staff personally, doctor to doctor.

3. The family doctor types the usual consult letter to the appropriate specialist (e.g., an oncologist for cancer) with medical history, cumulative patient profile and past relevant chart entries.

4. The patient has a consult with two doctors at the hospital, 14 days apart. The patient does not have to wait a long time to be seen. Average wait is less than three weeks.

5. The patient has to be mentally competent and have good pain control and not be depressed.

What happens at the hospital

Only staff and physicians who are not conscientious objectors will assist in and provide MAID.

6. The patient is admitted to a private hospital room and is allowed any visitors he or she wants to be there to say goodbye. Anyone who wants to stay for the entire process can stay, as per patient and visitor wishes.

7. An intravenous of normal saline is started by a nurse.

8. A doctor (a specialist depending on the disease, e.g., an oncologist for a cancer patient) injects medications prepared by a pharmacist into the I.V.

What medications are used?

Physicians with experience or some training in MAID will ensure that the medications are given with the right process, that organ donation requests are honoured, and that backup medications are available.

9. Midazolam 10 mg (a benzodiazepine) is injected into the I.V. first.

10. This is followed with Lidocaine (a local anesthetic) 40 mg, also I.V.

11. Then Propofol 1000 mg (a general anesthetic) is given intravenously and the patient falls into a coma.

12. Rocuronium 200mg (a drug that paralyses respiration) is given intravenously.

13. The coroner is called to pronounce death and fill out the death certificate.

14. The funeral home is called to remove the body.

The death certificate reads cause of death as the initial disease, for example, cancer of kidney with widespread metastases, but this is at the discretion of the coroner.

This policy took one year to develop and went through the medical advisory committee (all the chiefs of service, e.g., chief or surgery,

medicine, chief executive officer, vice-president of nursing, etc). It also went through ethics and administration committees. All hospitals in our region, except the faith-based hospitals, will provide the same level of compassionate service.

Dr. Rhee did not have any answers about the issue of a patient's life insurance, as some policies are voided by suicide. He said the issue is under consideration.

My personal feeling on MAID

I have never had a patient ask for this service in my 44 years as an emergency and family physician.

If someone did ask, I would make sure the patient had good pain control and didn't have an untreated depression. I would get them to take their time with this and talk to their loved ones and be really sure.

Then I would call Dr. Rhee. I would volunteer to be there with the patient if they wanted me to, as I have been their family doctor for a long time.

I applaud the role of nurse practitioners

In October, Ontario health minister Dr. Eric Hoskins sent a letter to the College of Nurses of Ontario telling them to "proceed expeditiously" on permitting nurse practitioners to broadly prescribe controlled drugs and substances by the end of March 2017.

I hired a nurse practitioner, Kim Rovers, to work with me three years ago and she is terrific. I am a solo family physician in a family health organization with 1,400 patients. Our group of 18 has 30,000 patients dispersed amongst solo GPs and two-, three- and four-doctor clinics. That means I am paid a fixed amount monthly per patient.

The NP covers my two nursing homes (111 patients) when I am on vacation or study leave. This is great because before her I would sign out to another busy FP and would return to 60 patients who wanted to be seen on my first day back. I would need a vacation from my vacation. It totally ruined my time off and put stress on the patients, their families, the nurses and the other doctor.

The NP also saw my family practice patients, but had to fax over prescriptions for narcotics to the doctor on call to be countersigned by him.

NP Rovers is loved by my patients, my secretary and the nurses and pharmacists. I can really enjoy my time off now as I age (I am a year younger than The Donald). As I slowly semi-retire, she will take over more and more of my work.

Last year nurse practitioners in Ontario got the dubious privilege of being able to take away driver's licences if patients were unable to safely drive. I joke with her that why would anyone want to be involved with this and narcotics control, the two most stressful things about being a family doctor.

Facts about the flu shot to share with patients

I post this on my office bulletin board and on every exam room door, back and front. I also post it in the office washroom and send it out to my two nursing homes. Both of my nursing homes have more than 97% staff and 100% resident immunization rates for the flu shot.

Please feel free to put your name on the top and edit it as you see fit.

By the way, we have “Flu Fridays” in my family practice office where we do nothing but flu shots so patients don’t have to book an appointment. They can just walk in. We encourage them to get the flu shot anywhere, including at pharmacies.

Facts about the Flu Shot by Dr. John Crosby

1. The flu shot cannot give you the flu. It is a dead virus and when people say they got the flu from the flu shot they have actually contracted the common cold, which is prevalent at the same time of year that flu shots are given.

2. “The flu shot has serious side-effects.” False. I have been giving it for 24 years to more than 10,000 people, including myself and my family members, and have never had a serious reaction reported.

3. “The flu shot should not be given to pregnant women.” False. It is recommended for all pregnant women to protect them and the baby.

4. “The flu shot hurts.” Myth. It doesn’t. You can get it in nasal spray if needles worry you.

5. “I never get the flu.” You have been lucky; anyone can get it.

6. “The flu shot is free in Ontario.” True. In the U.S. it can cost $40.

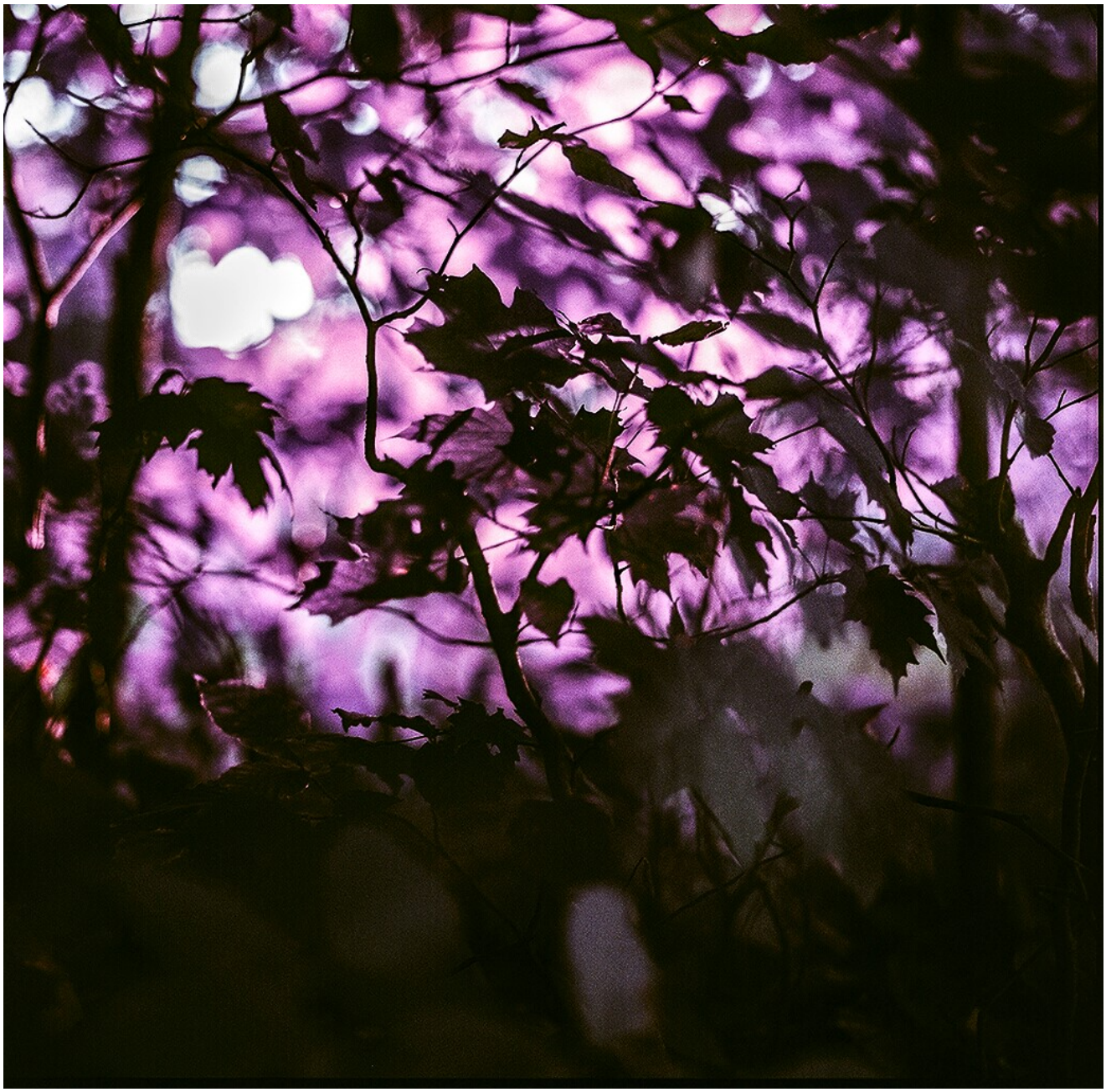
7. “The flu shot is convenient.” True. It takes one minute to receive it.

8. “The flu is just like a cold.” False. Flu is short for influenza, and it is a killer. Many Canadians die of it yearly, especially the old, the very

young and those with health issues such as chronic lung, kidney or liver disease. It strikes hard those who have cancer, diabetes, heart disease or are on cortisone or who have low immunity. It starts with a high fever, severe muscle pain and cough. It can turn into pneumonia, which can be fatal.

The only reason to not get a flu shot is if you are allergic to eggs or

are younger than six months of age.



This one huge change might help keep an ER flowing

I was hired part-time for three years to help improve the flow of a large ER that treats 55,000 patients per year. One of the big bottlenecks, as in every Canadian hospital, is backup from the in-patients.

Discharge planners are supposed to make sure every patient is in the right place at the right time but they are "meetinged" to death and can't get to every patient every day for hands-on bed management. Here is my solution:

A paid nurse bed monitor. She or he is paid at a senior nurse's salary, with benefits.

This nurse goes to no meetings. Read that again: no meetings, with no exceptions.

She comes into her office at 7 a.m. every weekday and checks her computer to see which patients are at their expected discharge date, whether they have been discharged or are overdue for discharge. For example, patients with congestive heart failure have an expected length of stay of five days; for chronic obstructive lung disease it is six days.

This nurse visits every one of these patients (including babies) in the entire hospital, checks the patient's chart and talks to the MRP (most responsible physician) and MRN (most responsible nurse). She may also talk to the involved social worker, physiotherapist, occupational therapist and home care rep to find out why the patient is over their length of stay.

She works with all involved to try to get the right patient to the right place at the right time. She does this until 3 p.m., with time off for lunch and two breaks.

She does this every weekday, even if the patient is in the hospital forever. She reports directly to the chief executive officer of the hospital.

How is this different from current discharge planning?

Discharge planners go to too many meetings. They don't get to the coal face for every patient every day.

If an MRP or MRN were to get a call every day regarding their overdue discharges, the might start to get proactive about discharge planning. Just like when you get a traffic ticket and you start to drive better.

Anticipate huge pushback from everyone because this is a huge change. Doctors will get annoyed when they get 30 calls in 30 days about a patient who is stuck in the hospital.

The paid nurse bed monitor will be accused of being a heartless monster, tossing little old ladies out into the street. Do you know what is heartless? Having little old ladies lying on hard gurney stretchers in ER hallways for days with the lights on and enduring the loud noises of a busy ER. Sharing a toilet with 12 people is not good medicine. I once sat in an emergency department for three days with my 95-year-old mom waiting for a bed; it wasn't fun.

Hospital administrators can't stop meeting people to death. They all came up through the ranks and got spanked when they made solo decisions, so they learned the hard way to rule by consensus. Not bad people, just their way of coping. All hospitals are complicated bureaucracies. They have to be, with 200 patients and 2,000 staff. You need chains of command and job descriptions.

Our nurse bed monitor will be a lonely missionary in a foreign land. But by reporting directly to the hospital CEO, who can tell the chief of staff or chief nursing office to work with the MRP or MRN, will help the nurse bed monitor to avoid the political pressure to back off.

No one has agreed to do this but I think it is a great idea.

24 tips to avoid doctor burnout

More than 50% of doctors are verging on burnout. It is a huge problem for us because our jobs are 24/7/365 and high pressure. Helpguide.org says the symptoms of burnout are: every day is a bad day; caring about your life and job seems like a total waste of time; you are exhausted all the time and you feel like nothing you do makes a difference or is appreciated.

I have been a doctor for 44 years and still look forward to going to work every day. Here is how I have avoided burnout:

1. Have fun. I am always joking with my secretary and the nurses at my two nursing homes . Even though we deal with many sad events, there is humour and warmth in the everyday if you look for it. I Google late-night jokes for a laugh between patients.

2. Take breaks. Plan a vacation every three months so you have something to look forward to. If you can't get a locum, sign out your practice to another doctor and then her or she can cover you. I get two doctors to cover me so as not to burn them out—one for my two nursing homes and one for my office.

3. Exercise daily. Sounds easy but as you well know with patients, the road to hell is paved with good intentions. You have to put it in your calendar. My smart phone reads 7 a.m. to 8 a.m. Monday to Friday: swim at the Y. Or lunch may be a better time for you to exercise, especially if you have young children. Avoid after work or weekends because you are likely to weasel out of it when you are tired.

4. Mix up your day. Sitting and talking to patients who are complaining for eight hours a day would induce me to blow my brains out. I go to my two nursing homes in the morning and have my office in the afternoon. I am never more than two hours from a break.

5. Meditate. Take a course in it or there are good online sites. Try Deepak Chopra's.

6. Do yoga.

7. Turn around difficult patients. I make it a game to get patients who hate me to like me. I had one guy who had chronic back pain and was very angry at me because I slowly but surely weaned him off narcotics over one year. Now he thinks I am great and have saved his life. I was very honest with him and told him we would get this monkey off his back and I spent many hours helping him. I look forward to seeing him, not dreading his name on my list.

8. Delegate your stress. If I can't figure out a patient's problem after a history, physical, lab and imaging, I admit it to them and say, "That's why specialists were invented."

9. Don't take responsibility for the healthcare (non) system. If a patient complains about long waits for CT, MRI or specialist appointments, I tell them to complain to the minister of health. I have no control over these things.

10. Never skip a meal or a bathroom break. Even when I was an emergency physician I always took my breaks. Even in a busy ER 80% of the patients have less-than-urgent problems. In general practice, you can have your staff stop booking patients at 11:30 a.m. and 4:30 p.m. to get your lunch and get home on time. Take from noon to 1:30 p.m. for lunch.

11. Never take your work home, either mentally or physically (paperwork or computer). If you are lying in bed ruminating over a patient interaction, get up and write down all the pros and cons of the situation then deal with them when you get back to work. I forbid my secretary to tell me about anyone coming in or I will worry about them in advance.

12. Turn off you dumb phone when you aren't at work. No emails, texts or phone calls = serenity now.

13. Create a big on-call network. I did in Cambridge, Ont., and it is still going 23 years later with 70 doctors participating. We are on call one day a month—heaven.

14. Cherish your patients. They each have a story to tell, especially the old ones. We are so lucky to be Canadian doctors because we get to treat people from all over the world and learn first-hand about their cultures and backgrounds. I have one old guy who always has a joke for me on every visit. One 92-year-old British lady worked decoding

Nazi secrets at Bletchley Park in England during the Second World War and met Winston Churchill. We trade books about him. Another man is an American civil war buff. Same with hockey, baseball and soccer fans. We have a front-row seat at the banquet of life.

15. If you have a boring case, such as an upper respiratory infection, **change your attitude** to, "Wow, isn't this great. I can see this patient in five minutes."

16. Reward yourself. Take a day off and do whatever you want. Book it now. Email your secretary: "Book me off for the whole day on January 11, 2017 to do anything I want." Buy yourself a good book once a month or get a free audio book from the library and listen as you drive.

17. Get a hobby. I have a great Lionel train set and play with it with my two-year-old grandson. My wife says, "Now you have someone to get your nerd on with." It even includes Thomas the Tank Engine.

18. Take one half-day off every work week. Don't do medicine or get caught up in paper/computer work.

19. Volunteer. I take medical students and family practice residents and they bring back the joy of medicine to me with their keenness. I take a two-month break between them to recharge my batteries. I give them the hardest cases and all the time in the world to handle them while I see the quick cases to keep from getting behind. We keep in touch via email regarding their medical careers. I also mentor graduate physicians on office efficiency.

20. Switch jobs if you are not happy. I have worked as a family doctor, emergency physician, hospitalist, urgent care doctor, surgical assistant and chief of staff, surgery and emergency. I have been a consultant for the ministry of health on emergency health services. I have been a writer and consultant for office efficiency. I have worked in England, Jamaica and Northern B.C.

21. Get home for dinner with your family. My wife made this rule when we got married 41 years ago. She was so right. It is the one time the whole family can get together and share their triumphs and disappointments.

22. Fire patients who annoy you. Check with your college as you

have to do this with a certified letter and give the patient 30 days to find another primary caregiver. I have only had to do this a few times in 44 years but am so glad I did. Sometimes you just have a personality clash with a person and it is better for both of you to part ways. I always put it in the patient's best interest.

23. Go away once a year to a nice place for your CME.

24. Put yourself, your family and friends ahead of medicine. Its a calling, not a religion.

It's also a marathon, not a sprint. Enjoy it; I am.

How to inoculate yourself against medical malpractice

I have been sued once in 44 years as an emergency, nursing home, hospitalist, urgent care and family physician. I was exonerated but I would like to spare your patients and you the grief.

Practise good medicine. Sounds simple but it is hard to be good, day in and day out, and when on call in the middle of the night.

Talk to your patients. You really need to communicate and ask them what you said at the end of every encounter. If they are children or have dementia or trouble with English or French, get help from a translator or their guardians. Give them a handout to reinforce your instructions.

Talk slowly: no jargon, big words or short forms. I usually try to avoid insulting patients by talking with big and little words. For example, "You have diabetes, or high sugar in your blood." Or "You have a fractured or broken arm at the elbow."

Tell them of the major side-effects of a treatment or drugs. No on has time to list everything. A reasonable, prudent and average doctor would say: "Please try some Aspirin for your sore ankle. Aspirin can cause allergies or upset stomach or stomach bleeding. Call us or go to the emergency department if this happens or if you develop black bowel movements or shortness of breath." Document this in your notes, e.g., "Side-effects explained."

Be nice. I have seen so many cases where the patient said, "I love my family doctor so don't sue him, just the other doctors." If you are nasty to patients and things go bad, they may sue you.

If they are unhappy that you can't find anything wrong with them, send them to a specialist.

Apologize. This is a real tough one. You don't have to go overboard; just say I am sorry you had a bad outcome. You don't have to admit you made a mistake. Always talk to your lawyer before you do this. I have heard so many plaintiffs say that if only the doctor had said

he was sorry we wouldn't be here (in court) today.

Have a good system of followup. That means do your lab and imaging reports and review of consult letters every week day, initial them and have your office staff file or action them. Charting is the most important thing the judge looks at that. The judge and plaintiff's lawyers know only too well that doctors see hundreds of people weekly and often can't remember the details.

Try to dictate charts or use an electronic medical record. The standard of care now is typed notes. Make sure you have a history, targeted physical exam, assessment with differential diagnosis and plan. Even if you make an honest mistake, the judge will see that you were trying to be thorough. Always note that the patient was encouraged to call you or return or go the nearest emergency department if worse or no better. Document this, e.g., "Call office or go to ED prn."

Always document followup on every case, e.g., FU/FD prn. One old GP in Oakville said to me: "It took me years to figure out that FU/FD meant followup with family doctor."

Never change the chart. The plaintiff's attorneys can hire a handwriting expert to tell if the ink is older or different, and forensic computer experts can check the hard drive to find out on what date the computer notes were typed.

For my malpractice avoidance advice when treating specific conditions, click here.

In summary, be nice, follow up, apologize and chart, chart, chart.

Why is Canadian medicine soooo sloooow?

Canadian medicine is so slow because it is a monopoly.

Remember the post office before FedEx and email? If you are of such a tender age to not remember, I will tell you. Back in the 1970s, when my hair part was narrow and my tie and bell bottoms were wide, we had one post office in downtown Cambridge, Ont. You lined up from 9 a.m. to 5 p.m. weekdays in a huge queue like Soviet Russia and eventually a surly teller would glare at you from behind bars and often as not crash down his wicket to have an hour-long smoke break just when you got to him. The workers were on strike constantly. Now I can go to my neighbourhood drugstore, park for free, and see my postmistress in seconds, any time from 9 a.m. to 9 p.m., Monday to Saturday, and be greeted cheerfully and efficiently. The difference is competition. In the 1970s there was only one place to go and you could like it or lump it. Sound familiar?

We doctors are Canada Post before FedEx and email.

Few physicians (including me) don't allow online booking, our phones are usually busy and you can't leave a message. They are turned off at lunch and after 5 p.m. If you finally get through you get to beg the frazzled secretary for an appointment before the next millennium. When a patient finally gets to the office, he or she can wait for hours for the equally harried doctor, then wait months for an MRI or CT scan, and years to see a specialist. Seriously, our one, lonely rheumatologist in Cambridge (population 150,000) is booking appointments for 14 months from now. Her office staff underline and bold the appointments so patients will notice the date is August 2017.

ER waits can be brutal, too, everywhere across Canada. Bring *War and Peace* to read while you wait.

Free lunch = lineup

How did we get here? Well, Canadians love their "free" healthcare and will put up with ridiculous waits. Canadian politicians are not stupid enough to alter medicare in any way and never ask about efficiency.

Nor does the media, except for some bright Globe and Mail writers like André Picard, Margaret Wente and Jeffrey Simpson. The Medical Post gets it too. Just borrow more money from our kids and grandkids in the form of debt and kick the can down the road. Only Cuba and North Vietnam have free systems and they have little in the form of medications and technology. I am sure they both have a thriving black market to help with queue-jumping. Cuban doctors get paid $45 per month so I guess I needn't say more (Uber driver anyone?).

Every day my 1,400 patients and the 28,000 in our family health organization whine only about the waits, never about the quality of care.

What is the solution?

When I was young and foolish I thought it was a good idea to have user fees. Now I see how that hurts the poor and sick and elderly, who are our biggest customers. They just wait longer and suffer, and end up costing the system much more to treat their pneumonia (three weeks in hospital at $21,000) than an early upper-respiratory infection ($34).

I don't know the answer. That is the problem about getting older: you start to see too many sides of every argument. I am just here to point out the problems. You, gentle readers are here to fix them.

How about more doctors and nurses and CTs and MRIs? Sounds like a good idea, but the need is infinite and just expands to suck up the resources. I remember when I was head of the Oakville, Ont., ER 30 years ago. We had double the family physicians and specialists and seven times the walk-in clinics as Cambridge did a mere 45 km away. Still, everyone was busy. I guess when your child had a viral cold you just treated it with chicken soup in Cambridge but in Oakville you went to the local walk-in.

How about technology? Dr. Google just makes life busier for us all. Booking appointments online sounds great but I am afraid to approach my secretary with one more stressful new idea. She can hurt me very badly by letting in all our challenging patients prn.

How about emailing patients and vice versa. Doctors don't get paid for that, and when I get home exhausted after seeing 40 people over the past 10 hours the last thing I want to do is check emails from patients.

I am too busy treating my patients from the stress of them being wired into work 24/7 by their ~~dumb~~ smartphones.

What do you think can help make the system move faster? Comment below or email me at drjohncrosby@rogers.com. Your answer must not cost any money and cannot involve politicians in any way, as they are smart enough to never touch the third rail of politics, e.g. our wonderful but slow "free" system.

For a prize you might get a Canadian of the year T-shirt in lieu of Tommy Douglas, who is centrifuging in his grave. When he invented medicare doctor visits were $5, the hospital cost $10 a day and I am

sure none of the Saskatchewan farmers came in with fatigue.

Talking with the boss of Choosing Wisely: Is it about rationing healthcare?

I recently interviewed Dr. Wendy Levinson, chair of Choosing Wisely Canada. Prior to this role Dr. Levinson was the Sir John & Lady Eaton professor and chair of medicine in the department of medicine at the University of Toronto faculty of medicine, and was recently appointed as an officer to the Order of Canada for her contributions to the medical profession.

Dr. Levinson was also the chair of the American Board of Internal Medicine, which launched Choosing Wisely in the United States in 2012.

I asked her how she decided to bring Choosing Wisely to Canada, and she told me that she shared the U.S. campaign's commitment to supporting professionalism and encouraging physician leadership on the overuse of unnecessary tests and treatments that do not add value for patients.

Q: What is Choosing Wisely Canada?

Dr. Levinson: "Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, in order to make the best decisions for high quality care."

Q: What isn't it?

Dr. Levinson: "It is not rationing healthcare. The goal of Choosing Wisely is to improve the quality of care for patients and avoid harm. In all cases the physician and patient should make decisions together about what tests or treatments the patient needs—this is the process of informed decision-making."

Q: Who is doing this in the world?

Dr. Levinson: "Seventeen countries, including England, France, Italy, the Netherlands, Japan, Brazil, Australia, New Zealand and others

already have, or are starting, similar campaigns."

Q: What is your biggest success?

Dr. Levinson: "One is helping to start a Canada-wide medical student movement in support of the campaign Choosing Wisely Canada STARS (Students and Trainees Advocating for Resource Stewardship), and having ongoing media and social media coverage of the campaign for public engagement."

Dr. Levinson added she was really pleased at how doctors all over Canada have embraced the campaign and have applied their creativity to implementing it in many diverse settings. Also 300 people came to their first conference in March and many hoping to attend were turned away.

Q: Who pays you?

The campaign has three full-time and two part-time employees, physicians who contribute a portion of their time as well as students who work with them. Their funding is from the Ontario Ministry of Health and Long-Term Care and in-kind support from a wide range of partners. The organization's key partner, the Canadian Medical Association, has also been central to its successes.

Q:What about internists who order a lot of blood test daily?

Dr. Levinson: "Choosing Wisely is trying to encourage them to think about what tests their patients need rather than having automatic orders for routine testing, and to consider revising order sets based on campaign recommendations."

Q: How are you doing this?

Dr. Levinson told me that North York General Hospital (NYGH) in Toronto is really taking a lead in cutting unnecessary laboratory testing in the emergency department (ED) and in pre-operative tests for low-risk patients. The NYGH ED is one of the biggest in Canada and staff are really putting in an effort to do this through physician leadership, changes in order sets and electronic ordering, and engaging staff to ensure they support the changes.

Q: What is the future?

They group wants to empower Choosing Wisely Canada regional hubs across the country, where local organizations can help to implement recommendations in practice. Alberta, Manitoba and Ontario are leading the way but many other provinces and territories and joining the campaign.

My opinion

I feel that Choosing Wisely is long overdue. I have been advocating this for 44 years and teach my medical students, residents, nurses and graduate physicians to always ask why they are ordering a test or prescribing a treatment.

A lot of what we all do is by reflex. For example, with a heart attack we order ECG, cardiac enzymes and chest X-ray every day for three days when we should be thinking about every test every day.

I have always found annual physicals to be a waste of time for the patient and me, not to mention being horrifically boring.

It’s not hard: Treating erectile dysfunction

I recently interviewed Dr. Ted Jablonski, a family physician from Calgary who is interested in treating erectile dysfunction. People sometimes joke about ED but it a very upsetting condition for more than 50% of Canadian men and their partners, and can be the canary in the coal mine for cardiovascular disease.

Dr. Jablonski gave a wonderful talk at the Family Medicine Forum in Toronto in November 2015, so I called him up to get the inside scoop on ED. Ted was born in Winnipeg and went to medical school at the University of Manitoba. He worked in Fort Frances in northern Ontario for 12 years as a family physician, then moved to Calgary and has practised there for the past 18 years. He has two kids, one of which is also a family physician. Ted works in general practice four days a week and the other day he does sexual medicine and transgender work. He has medical students and residents who rotate with him in his practice.

Sexual medicine

Ted sees patients referred by their family doctors with sexual dysfunctions including ED, low libido, and premature ejaculation. He says most family doctors are really good at treating ED but often only try one type of erectile dysfunction medication (Viagra, Cialis or Levitra), and are sometimes not aggressive enough with dosing.

Some GPs miss the possibility of premature coronary artery disease, especially if the patients are in their 40s.

Most common problems

Can the patient take Viagra after a myocardial infarction? Yes, if he is not on nitrates and can ascend two flights of stairs at a normal pace and not get angina.
Or if he can walk the golf course at a normal pace, pulling a golf bag. (Ted has obviously never seen me play as I use a lot of energy flailing at the ball.)

If the FP is concerned, he or she should refer the patient to a

cardiologist and get a treadmill test.

Ted stresses watching for depression, cigarette smoking and alcoholism/drug abuse in resistant cases, especially if there is low libido.

How was Viagra discovered? It was an anti-anginal drug that wasn't very good but compliance was terrific.

What about the four-hour erection we hear about on TV?

Dr. Jablonski said he has never seen this in his practice, but if it happens he recommends:

• the patient masturbate/ejaculate again,
• put the penis on ice,
• use a nasal decongestant (nasally), and
• if the erection persists, the patient should see a urologist, stat, for a large-bore needle aspiration and/or Phenylephrine injections in the corpus cavernosa (ouch).

Priapism that fails to resolve can result in intractable erectile dysfunction.

A pearl about Raynauds disease: Ted has successfully treated severe Raynauds in women with one 5 mg Cialis tablet a day.

Years ago, wonderful Cambridge hematologist Dr. Jim Gowing (recently retired) was successfully treating a 15-year-old boy with Viagra for pulmonary hypertension. All the GPs in town were stuffing his mailbox at the hospital with samples. I wonder what the secretaries thought.

'Expert' advice

What does Dr. Jablonski do differently than a GP? He is "the expert," so there is a placebo effect with patients. He has more time to spend with them and discuss details.

He can lay down the law about drinking, drugs and smoking.

He normalizes the problem: "I see this problem a lot" and takes away the guilt, blame and shame.

He also recommends the partner be informed. Seeing a couple together takes more time but it can be quite a powerful experience for both, as it is not uncommon for a partner to think, "If I were sexier this would not be happening."

Case study

Mr. L.P. is 55 years old and has been unable to get an erection for six months. He has coronary artery disease and had an MI four years ago, and is on ASA 81 mg daily. He has no chest pain, ankle swelling or shortness of breath. His exam is normal, with BP 132/76, pulse 72 with normal sinus rhythm. Penis and testes are normal.

Ted recommends you help the patient control all risk factors such as blood pressure, cholesterol, sugar, smoking and drinking. (Personal note: When patients complain to me about the $14 cost of Levitra, I tell them to skip the $14 bottle of wine, which is aggravating the problem in the first place.)

Ted says to have the patient try all three drugs—Cialis, Levitra and Viagra—and he maxes them out to the upper dose limit, then doubles the dose (e.g., 200 mg of Viagra) if it isn't working.

He starts with the top recommended dose and if it works, drops it by half if there are side-effects such as headache or flushing. Remember, these drugs open blood vessels everywhere, including the head as well as the penis. That's why they are dangerous with nitrates, as the blood pressure can drop. (Of course, always refer to the product monograph.)

If all else fails, try one a day 5 mg Cialis. This is good for vacations, too, when spontaneity is important.

In my own practice a few years ago I had a delightful 90-year-old man come in with his new girlfriend, age 80, asking for Viagra. I joked that his kids would sue me if he died. He said, "Doc, I will die happy and they hate me anyway and want my money, so all would be well." He used the Viagra for two years and died happy but not in the saddle, thank goodness.

Choosing Wisely: Why is it so hard?

Doctors, nurses and nurse practitioners are the ones who shoulder the responsibility of ordering tests and treatments for patients. We are the bottom line. When all the regulators, media, lawyers, pundits, bureaucrats and statisticians are nicely tucked into their warm beds, it is us, and us alone, who are making the medical decisions.

It may be over the phone or in person in an emergency room, operating room or a hospital ward. It may be in a walk-in clinic or office, during a house call or a nursing home visit. The patient or their friends and family may be unreasonable and angry, even threatening, when they want a test or treatment they have seen on TV, or read about in a newspaper or on the Internet. These sources are all huge drivers of unnecessary tests and treatments.

'No' is the hardest word to say

It is so easy to say yes and so hard to say no. I have given in—as I am sure every doctor in the history of the world has—out of sheer exhaustion, mentally, physically or spiritually.

Choosing Wisely Canada is now trying to get us to order tests more correctly, to make evidence-based decisions when ordering, and to have conversations about unnecessary care with our patients. I support them and I have changed my practice after 43 years in emergency, hospitalist, walk-in and family medicine.

We should get behind this movement because it is the right thing to do. It is good for patients. Too many tests can cause worry and can lead to bad things, such as damage from a biopsy performed on a meaningless shadow seen on an MRI.

I have a patient who had her bowel perforated during a routine screening colonoscopy. She has a colostomy bag and comes in constantly with pain and misery. I have to deal with her forever—not the specialist or the people who came up with the recommendations.

Antibiotics for viruses can cause fatal allergic reactions, diarrhea and

stomatitis, and can lead to the development of antibiotic-resistant superbugs. Waiting for CAT scan and MRI results can cause the patient with simple back pain to decondition and maybe lose their job, and to develop chronic pain.

Cholesterol medications in the elderly in nursing homes have not been proven to help and can cause harm, such as muscle aches and pain. Plus, they add to the pill burden. It is hard to stop these prescriptions as patients' families often feel guilty about putting their loved one in a nursing home and want everything done for their care. They watch American TV and hear about cholesterol drugs and extrapolate to everyone of every age.

MRIs

How did we ever live without them? I practised for 30 years without them and things were pretty good. Now everyone sees how the Blue Jays get an MRI, stat, for every sprained finger and they want one too. Also the patient's lawyer, physiotherapist, chiropractor, naturopath and cleaning lady think they should get one but the mean old gatekeeper—aka family MD—won't order one.

"Let's complain to the college and scare the wits out of him!" With a college of physicians and surgeons complaint, even if you win you lose, due to the sheer terror that letter generates when it arrives. Not to mention years driving to hearings in the big city, where the college resides, plus the lost sleep, wages and gastric mucosa.

I, at age 68 and a half, with 43 years of medical practice, have changed due to Choosing Wisely. I do physicals now every three years, not every year. Here's what I and my staff say to patients when they call in about this, or if they are in for their physical: "Great news! The experts and the evidence say we need a checkup only every three years if you have no chronic problems. I am doing the same for myself and my family."

If patients push back, I relent. Discretion is the better part of valour.

I no longer order routine ECGs if there is no cardiac problem. I don't order lumbar X-rays for mechanical back pain with no red flags. I explain to the patient that "I am not X-raying your back because it won't change treatment and can expose you to radiation, especially your testes or ovaries."

I am trying to choose wisely, but if it were easy I would have done it before.

Are Family Physicians being squeezed out? How to fight back

I predict that in the next five years, family doctors in Canada will face the threat of massive unemployment.

Nurses, as outlined in this story, will soon be prescribing medications and nurse practitioners already are. The latter are close to getting prescribing rights to narcotics and controlled substances in Ontario, so they will be able to do everything family doctors do.

They just earned the right to pull driver's licences from patients deemed too dangerous to be on the road. Why anyone would want that curse is beyond me. They can have my rights gladly.

Pharmacists are taking blood pressure readings (as are dentists, chiropractors and physiotherapists), giving advice about medications, and administering flu shots. They can also distribute Plan B, the morning-after pill.

California dreamin'

During a visit to Palm Springs, Calif., I went into a pharmacy where you could get your blood pressure, cholesterol levels and blood sugar checked. You could also get any immunizations for children and adults, as well as vaccinations against tropical diseases. Alberta pharmacists are moving in this direction, as is the rest of Canada.

Meanwhile, physician assistants are pouring out of Canadian Universities and seeing patients, too.

I support all this change, as I feel competition is good for patients. We family physicians can compete. I work with a nurse practitioner and I support pharmacists doing as much as they can to help patients. I have worked with physician assistants and have had them as students.

Don't give up

Canadian family physicians are being encroached upon from all sides but it is our own fault if we give up. Half us can't get patients in for

same-day service and many of our phone lines are jammed. Once a patient gets through they often get voice jail and can't leave a message. Very few of us (including me) communicate by email with our patients or book appointments online, like me dentist or my pedicurist does.

Canadian medical school output has doubled since the mid-1990s, and foreign schools are loaded with Canadians. In my city of Cambridge, Ont., we had 30,000 orphan patients five years ago and now we have six family doctors advertising for patients. New grads in Ontario can't get into family health teams unless they replace a retiring doctor, but doctors can't retire as they have no pensions and interest rates on their investments are dropping (and their children can't get jobs).

All this points to a perfect storm of too many family doctors in Canada, where governments are running up big debts.

So, what is the answer?

I feel family doctors are the backbone of the Canadian health system. We look after everyone, with every problem (including dental abscesses if the patient can't afford a dentist), for free. We are there for patients for their entire lives, and are often the only familiar face in the "system." I have proudly been a family physician for 24 years (after 20 years as an emergency physician).

How FPs can be more user-friendly

34. Be on time and offer same-day appointments. For help, read my e-book on time management (click here to download a free copy).
35. Revise your phone system so patients can talk to a real person—stat!—not voicemail.
36. Allow your patients to book appointments online.
37. Allow patients to check their lab tests and imaging results online with a secure patient portal.
38. Offer evening and weekend walk-in clinic service.
39. Offer 24/7/365 advice by phone.

I do all the above, except for the Internet stuff. Aren't I wonderful? No, just a 68-year-old doctor in a good system (Ontario Family Health Organization) that doesn't burn out me or my staff. I take pride in giving good service.

We can compete and win, and our patients will win too.

Private medicine in Canada: a practice in profile

I recently interviewed Dr. Viviane Provost by phone from her Montreal family practice. I had met her in November 2015 at the Family Medicine Forum in Toronto. She has a private family practice wherein her patients pay (mostly by credit card) to see her and she is not involved with the Quebec Ministry of Health (RAMQ) anymore.

Dr. Provost graduated from the University of Montreal medical school in 1985. She worked many years in hospitals, ERs and in an office practice as many as 50 to 70 hours a week in a Montreal suburb. She has a special interest in treating ADHD in kids, teens (mostly college or university students) and adult professionals.

In 2007 she left Quebec and moved to Ontario to work in a community health centre in the Niagara area and loved the concept, the system and the team she was working with. Unfortunately her mother passed away and she decided to move back to Montreal in 2012 to support her father.

Private medicine

Viviane went into private medicine three years ago. She is 54 years old now and loves it. She is working at PrivaMed family practice clinic on the South Shore of Montreal. Most of the advertising for new patients is done through AdWords internet service, and by word of mouth.

She is privileged to be in a very well-organized environment. Clients have access to urgent appointments the same day. They are allowed to make an appointment online. They may choose how long they can see the doctor, which dictates how much they will pay). They can have a 10-minute phone interview with a doctor for $60. A 15-minute appointment with the doctor is $85 and a 20 minutes costs $110. A general annual physical is $160 and takes 30 minutes. Waiting time in the office is 15 minutes.

I don’t know what the rates are for the Quebec public system. (Help me, readers.) I do know that Ontario doctors grumble about not getting paid as much for Quebec patients so it must be below our

numbers of $21.70 for a minor assessment (15 minutes), $33.70 for an intermediate assessment (20 minutes), and $77.20 for a physical.

Internet access

Patients can log onto the clinic website to access their electronic medical record in order to check out their lab and imaging results through a secure, password-protected patient portal. Dr. Provost says the patients don't fuss over lab results that are confusing or slightly abnormal because she leaves a comment about them. If she believes she has to talk with the patient first, she can block access to the test results until the discussion with the patient takes place (within hours or days). If clinical results are clearly abnormal, Dr. Provost calls the patient before they can check their chart.

Clinic structure

There are four other doctors in her clinic (10 in total for the three Privamed clinics), plus two nurses, two office staff and one supervisor. The patients spend 10 to 15 minutes with the nurse before seeing the doctor.

Dr. Provost's hours are 8 a.m. until 5 p.m., with a 30- to 45-minute lunch break, four days a week. She reviews lab and imaging (about one to one and a half hours per day) from home through a secure computer connection. The clinic also offers one evening of walk-in appointments per week, and Saturday mornings as well. She does not do on-call work during off hours.

She finds that she can dedicate more time to each patient compared to when she was in the public system. She takes four to five weeks off per year and makes about as much money as she did in the public system.

How does she like private medicine?

Dr. Provost loves this new phase of her life. She worked for more than 27 years in the public system, putting in sometimes more than 70 hours a week. At age 50 she decided to stop working night shifts and in the ER. Now she considers her job a pleasure and really enjoys giving good service. She is still very dedicated to her patients. There is a lot of room for patient self-awareness about their own health.

Why don’t more doctors do this?

It would have been very difficult for Dr. Provost to switch from her previous patients (who followed her for more than 20 years) to a private system because it would have been a moral conflict for her, as many patients would not have been able to afford it. However, since she had to start fresh when moved back to Quebec from Ontario, it was easier.

Another reason is that many physicians enjoy hospital practice and, as a GP, are not allowed to practise privately and work at a hospital at the same time.

Are private patients more demanding?

Patients are more prepared for their appointment; they usually have searched for ways to solve their problems prior to coming in and are consulting with Dr. Provost. They want her opinion but also they want tools to manage their health challenges themselves. They are ready to be engaged in their part of the healthcare team. Surprisingly, these patients are not rich but are middle-class.

Dr. Provost’s long service in public healthcare allows her to help her patients navigate both systems. She refers patients to the public

system for specialists.

Nine months of New Year's resolutions to put in your calendar right now

I just read that 2016 is the year of no judgment. What a stupid idea! Now that you and I have failed at our previous New Year's resolutions, let's try again but this time put them in our calendars.

If you have a paper calendar or use your smart phone, enter this now: Do one thing at a time.

1. Month one: paperwork. We hate it more than we hate patients with lists. Put it in your calendar: 8 a.m. to 9 a.m. Monday to Friday —"paperwork." This includes emails, lab and imaging, and review of reports and consults. Make the start date next Monday. On the Sunday before, go to your office and tell no one you are there. Get caught up on all your existing paperwork: shred it, delete it, file it, delegate it or action it. No putting it back in the physical or electronic inbox. This may take eight hours so order a pizza.

Start on that glorious Monday with a clean slate and stay ahead of it. If you fall off the wagon—and you will—go in early the next day to get caught up. If you go on vacation, book your travel plans to come back a day early and do all your paperwork before you open your office the next day.

Reward yourself daily with a decaf coffee and newspaper after you do your paperwork. For a bigger reward, try a new book or a movie or a trip to a museum. Go to a sporting event or buy yourself something you love.

After doing this for a month, try introducing a second change, and then a new one every month until you are perfect.

2. Month two: Lose weight and keep it off forever. Never skip a meal. Have a protein shake for breakfast, a sandwich for lunch, and meat and a salad for supper. No pop or fruit juice, no booze except on weekends, and no snacks. Cut back carbs. Lose one pound a month, 12 in a year.

3. It's month three, and now that you are a slender, fabulous healthcare professional, it's time to try regular exercise. Once again, book it in your calendar: 7 a.m. to 8 a.m. weekdays, go to the gym. Pay big money for the deluxe membership so you will feel bad about not going. Do stuff you like and have fun! I love to swim, but you people with hair might not have time to dry it for an hour afterward. Try a Zumba class (whatever the hell that is), dance, run on a treadmill, cycle on a stationary bike or use a rowing machine, accompanied by music, TV or a talking book. If you're working out at home, try hooking your household electrical system to your exercise bike so the power will only be on when you are peddling.

Put the TV remote between your knees and do sit ups.

5. Month four: better charting. Dictate; it is very cheap. If you have an EMR, set up templates, which can make you more thorough as they act as prompts.

6. Month five: Stop all caffeine. It is in coffee, tea, chocolate and cola. It adds to your adrenalin load. Slowly wean yourself off it with half-and-half decaf for a month, and then go down to zero. You will feel much more relaxed.

7. Month six: Better sleep. Sleep is a habit, like brushing your teeth and putting on your seatbelt. Go to bed at the same time each night so your body gets used to it. Don't watch the news; it's all bad. No caffeine and no napping during the daytime. If you are getting sleepy, go for a walk. Buy a great bed.

When it's time to go to bed, make the room dark and cool, with white noise (such as a fan blowing away from you so as not to dry out your corneas). Take the morning off after a night on call (email your office staff about this right now; I will wait). Avoid fluids and exercise four hours pre-sleep.

8. Month seven: Stop using elevators (unless you are a server at the CN Tower restaurant).

9. Month eight: Split up your on call. If you have an entire weekend on call, split it with another doctor at midnight Saturday. Have a wonderful rest of your life.

10. Month nine: Sit down with your significant other and book off

eight weeks of vacation per year, every year, for the rest of your life. Work a few years past age 65—you will be old and there is nothing else to do.

Copy everyone in your life and stick to your plan. No one cares about you except you.

My best Christmas ever

It was 35 degrees—Celsius not Fahrenheit—and Santa was wearing a Speedo. It was 10 years ago and we were in Brisbane Australia. My eldest son, Andrew, was attending teachers' college there and we hadn't seen him for 11 months.

Andrew had left on January 24 (one day before Australia day) of that year. I remember his guitar sticking out over his shoulders as he wound his way through customs at Pearson airport in Toronto. I was out in the parking building afterward with the cold Canadian winter wind cutting through me and I felt so empty.

I looked at his picture every day, longing for him. He had been away at university and camp but never this long and never this far. You can't get any farther away without coming back. The time difference was 14 hours and there was no Skype or email.

Christmas Down Under

My wife Jill and I took our two other sons and flew out on the shortest day of the year in Canada to the longest one in Australia. We flew to L.A. and then got on a jet and flew 18 hours to Sydney. One thing good about that flight is that any other flight feels puny afterward. Flying Toronto to London, England? No problem.

We watched three movies and read two books then when we were really tired we all took a Gravol and awoke in hot, sunny Sydney. We then flew up to Brisbane. Andrew and his girlfriend, Kristy, were waiting for us at the top of an escalator sporting Aussie hats like Crocodile Dundee. They were tanned and relaxed, wearing flip flops. We were dead fish-belly white and exhausted but never felt better. We hugged and cried and piled into his 1989 sun-baked Holden (an Australian car). Every tree, flower, bush and blade of grass was different than in North America.

Australia

Their eggs had orange yolks and were stored on grocery store shelves, not refrigerated like here. There were huge, free-standing awnings in parking lots to shade cars. No need to worry about snow caving them

in.

We got to our condo and they had a decorated Christmas bush with presents under it and served up a feast of Morton Bay crabs (seafood) for us. We stayed up the first day until 10 p.m. to avoid jet lag and slept like the dead that night. It was so great to get my legs up to my heart level. Now I know why everyone has swollen ankles in nursing homes—they sit around all day like plane passengers.

I remember it was so hot that I when I was walking without shoes across the pavement around the condo pool, I had to jump into the water fully clothed to put out the fire in my feet. It didn't matter because I was dry five minutes later.

Christmas morning

It was the most magical Christmas ever. My wife and I got up early and went for a walk on the beach. The lifeguards were wearing Santa hats. Andrew was sitting out on the deck when we got back, having a coffee with Baileys in it. We only had two gifts each but it took four hours to open them as we savoured each one. It wasn't the usual frenzy of tearing open gifts at once and me putting the wrappings into big garbage bags and recycling the gift bags.

At one point I came out wearing a new Speedo and the whole family fell over laughing for five minutes straight.

Everyone in Australia eats Christmas dinner just like we do in Canada, with turkey, mashed potatoes and gravy, cranberries and dressing followed up by plum pudding and a Losec chaser. I had never had turkey in summer before.

The real gift of Christmas that year was seeing those two people who we loved so much after waiting 11 months and flying 25,000 km. We have put a koala bear ornament on our tree in Canada every Christmas since.

Chronic pain: Is it caused by doctors?

Whenever I speak on physician stress worldwide, the number one stressor for doctors is how to manage chronic pain patients. Personal disclosure: I have had severe sciatica twice in the last 12 years for a month at a time. I can't imagine how terrible it would be if it were permanent.

We have all been there. A huge construction worker is standing in your examination room because he can't sit down due to pain.

"Doc, you gotta help me," he pleads. "I pulled my back lifting wood yesterday. I can't sleep. A buddy gave me some narcotic painkiller his doctor gave him and it took the edge off. Can I have more?"

You do a history and there are no red flags, just pain at L5. Physical yields a man grimacing in agony who can't move his back a centimetre. All else is negative. You tell him he has pulled the muscles of his back and that an X-ray won't help with diagnosis or treatment.

You are damned if you give him a narcotic. You are also damned if don't, you heartless bastard

You prescribe physio, an anti-inflammatory pill every four hours while awake, as well as hot packs, and you tell him to keep working and exercising. He limps out thinking you are crazy and cruel.
You have known him since he tipped your baby scales 23 years ago. He loves cigarettes, booze and marijuana. He hates his job.
Next week he comes in no better. Physio is of no help and he recommends time off. Celebrex is useless and has churned up his stomach. Ditto for Advil, ASA, Voltaren p.o. and cream. All the NSAIDs are useless, such as Aleve and Motrin. Tylenol equally useless. The boss sent him home and his wife and parents think you are a turkey. You are a Canadian GP so can't get any specialist help for six months. A pain clinic is as hopeless as a Leafs Stanley Cup.

What do you do?

You are damned if you give him a narcotic. You are a pill-pusher getting Canadians hooked on narcotics. We are number two in the world.

You are also damned if don't, you heartless bastard.

You have to be Goldilocks, and get it just right. You and your patient are standing at the fork in the road of his life. He can go down the dark alley of chronic pain, narcotics addiction, unemployment, divorce, poverty and depression, or the bright shining expressway of pain-free full function, and you, doctor, will be his guide.

What is the answer? If I knew I would be on my yacht in Bermuda, not typing this blog. But here are some tips: I have never, in 43 years of doctoring, seen a farmer with chronic pain. Maybe they are stoical but I am guessing they have to get back to work or the cows will explode. So they keep active and get better; they aren't paid to be sick. I don't know for sure—I am just a kindly country quack.

What I do know is that no one in the world has an answer to curing chronic pain so let's try to prevent it.
Our patient has muscular pain and it will get better by itself. Do not give him time off from work. He will just decondition and sit around focusing on his pain.

Try Losec 20 mg daily to protect his stomach from the NSAIDs.
Tell him, his wife and his boss (with his permission) that you are not being mean but that this is the proven best way to avoid chronic pain.
Avoid long-term use of narcotics. They are hell to get off.

If your patient has chronic pain, he/she and you need to fight it like a war. That means you do everything to win. Call in the army, navy, air force, marines, spies, home front and the media. That means treat pain without narcotics by using physio, chiropractic, NSAIDs, ASA, antidepressants, heat, cold, counselling—everything you have.
In my practice of 1,400 I have eight people on long-term narcotics. We are weaning them off slowly.

If I won the lottery

I just read how $60 million was won in the lottery by a person in Mississauga, Ont. I only buy tickets at Christmas for stocking stuffers for my wife and kids, but if I won I would give each of my immediate family and in-laws $1 million. I have a big family so this would cost $8 million. My grandson, who is one year old, would get $1 million in trust to be given out at $50,000 per year when he turns 18, so he isn't too spoiled. University tuition will probably cost that much that by then. He will need money for beer (I mean books), too.

I would give my secretary $1 million. Maybe a bad move, as she would quit. I would donate $8 million to cancer and heart disease, our two biggest health-related killers. And I would donate $2 million to the Cambridge Hospital to build and staff a fast track in their ER—with strings attached. I would get to consult with the doctors and nurses to make sure they saw patients promptly.

I would still have $40 million left for my wife and I to stick into guaranteed investment certificates, which would probably yield 2.5%, or $1 million per year as long as we lived, leaving the $40 million principal for my heirs to split evenly.

I would get a new young family physician to take over my office practice but still look after my two nursing homes and their 110 patients, just to keep a hand in. I would fully retire at age 75, in seven years' time. I would continue to hire my nurse practitioner to do cover my nursing home duties while I am on vacation.

I would travel every three months for two weeks and take August off and go to the cottage. I would go to Florida or Palm Springs, Calif., every March and have the family visit (one week at a time).

I would take a course on creative writing and, later, woodworking. I am totally useless with my hands but love the smell of wood and glue and varnish.

I would buy a new 16-foot boat, as our old one is 26 years old. I would also get a new Toyota Highlander; my old one is nine years old. I would buy a fire-engine-red Thunderbird convertible, which is better than a testosterone patch. I would buy my wife a Mercedes

convertible.

I would get two Sea-Doos and two Ski-Doos for the cottage.

I would buy $100,000 worth of Lionel train stuff and hire someone to build a train set in our attic, assuming my wife agreed. I would stay in our house, because we love it. I would get a kitchen and attic reno. We have been waiting 36 years to do that.

I would travel to Ireland and Normandy in France to see the Canadian war memorials. I would also travel to Paris and the South of France. I would go to Amsterdam and visit the Van Gogh Museum.

I would go to New York City to see Broadway plays, including "Beautiful" about Carol King. I would visit Greece and Italy as well, for the historical and gastronomical experiences.

I would go back to London and the places in England where they film Doc Martin and Downton Abbey.

I would buy scalper tickets to Toronto Maple Leaf and Blue Jays games, with front-row seats for friends and family. That would kill half a million dollars right there.
I would hire an editor for the new 2015 edition of my book (click here).

It's funny, but in writing this I have realized I don't really need anything more than what I have now.

How I handle cyberchondriacs

A lot of doctors hate it when patients tell them, "I Googled my symptoms." I look on this as a positive, not a negative. This means the patient is concerned about his or her health. You have to take this concern and channel it into a positive force.

If the patient has a chronic disease, they should become experts in their self care. For example, with diabetes they need to know about diet, carb counting, how to monitor their sugars, what to do if they experience nausea and vomiting. If the patient is are married, they need to learn this with their spouse at diabetic day care, and also can learn a lot from good sources such as the Canadian Diabetes Association website. They need to know about foot care and when to call you versus when to go to the ER. They need to know about hypo- and hyperglycaemia. And patients' friends, families and fellow workers need to know how to deal with low blood sugar. Diabetic patients need to know about exercise, as well.

Patients need to be directed to proper websites. I always tell them that there have been snake oil salesmen for a long time: 100 years ago some guy was selling hair restorer out of the back of a covered wagon and now when you Google "bald" on the Internet, people will try to sell you a cure.

My daughter-in-law recently Googled my one-year-old grandson's symptoms and the Internet correctly diagnosed roseola. I laughed when she told me she "e-consulted" his three days of crabbiness, fever and anorexia. On the third day he broke out into a red rash and was back to normal. They still took him to the doctor, just to be sure.

ERO: Event plus your **R**eaction equals **O**utcome. As I have blogged before about physician, nurse practitioner or physician assistant stress, it is your reaction that determines your stress. A lot of little stressors every day can leave you drained by evening. Patients are going to increasingly Google their symptoms and you can't hold back the flood; they will just go underground if you discourage it. I always remain open to Internet consultations with my body language and tone of voice.

If a patient mentions that he or she has checked out their medical

concerns online, here is my usual response:

"I am glad you are so interested in your disease. As you know, anyone can post anything on the Internet and a lot of people are trying to sell you something there. Always use reputable sites."

If they say nothing, I always ask, "What are you worried this might be?" A lot of people are worried about cancer, so I always address it head on. For example, if they have a lump, I will say, "It is unlikely this is cancer but we will have a specialist do a biopsy to make sure."

If the symptom is cough or weight loss, once again I will tell patients, "We are going to make sure it is nothing serious and If I can't make the diagnosis with lab, imaging, history and physical examination, I will send you to a specialist."

I think this has helped me avoid any malpractice suits or college complaints (except one, which was resolved in my favour) in 43 years with more than 400,000 patient interactions.

Good medical websites include:

Med Effect Canada

- FamilyDoctor.org

- MayoClinic.com

- Drugs.com

Diseases I have never (or almost never) had to treat

I have been so lucky to live in Canada. In 43 years as an emergency and family doctor, I have never seen a patient with rheumatic fever and the toll it can take on the heart. This is probably because of the ready availability of primary care, so that few strep throats go untreated.

Ditto for post-streptococcal glomerular nephritis. I have never seen a woman with a septic abortion.

I have never seen polio. It used to scare the liver out of my parents, as they knew people who had died or had became paralyzed by this virus that attacks the motor neurons. Musician Neil Young had it, as did former U.S. President Franklin Delano Roosevelt.

I have only seen red measles twice. Both kids were very sick with a red rash all over, high fever and symptoms of upper respiratory infection. It can kill a child or leave them permanently brain-damaged. I have never seen German measles with its deadly toll on the unborn.

I have only seen pertussis or whooping cough a few times. It makes the poor patient cough for months and is very hard to treat. Much nicer to prevent.

I haven’t seen diphtheria, but a doctor I was working with in the ER saw one case. It was a patient with a grey membrane over the back of his throat. I have never seen tetanus because I have given many, many tetanus shots.

I have never diagnosed mastoiditis, where an ear infection goes into the mastoids behind the ear and can kill or cause brain damage.

I have only seen malaria twice and typhoid once. I lucked into the diagnoses as a fever of unknown origin in patients recently back from a trip to India. So I threw out the diagnostic nets and caught them.

I have only seen two malignant brain tumours and two meningiomas in 400,000 patients—but 10,000 tension headaches diagnosed by Dr.

Google as brain tumours. (That's a joke.) The four real tumour patients all presented with focal seizures or TIAs and the CT revealed the tumours.

I have seen one pheochromocytoma and one hypothyroid coma. The patient with the pheo had flushing and wild blood pressure elevation.

I have see three cases if quinsy (peritonsilar abscess). One was my son. I have seen two epiglottises. Very scary, with their hot-potato voice, physical leaning forward and drooling. Call 9-1-1 and change your underwear.

I have had one status epilepticus patient in my office. Thank goodness I live a block from the ambulance station. He did great but I still have the stain on my rug where he drooled as I turned him on his side to breathe.

In summary . . .

I think this is a tribute to our immunization programs and much maligned system of "free healthcare." I know it isn't free, as we pay lots of taxes for it. But for those broke, young parents or seniors it can make the difference between them getting help early and not worrying about a co-pay, deductible or user fee.

Relishing the seasonal time shift

My wife, Jill, and I joke that when we first hit the cottage we are on "Toronto time." Even though I only lived a year there in 1973 as an intern at the late, great Wellesley Hospital, being on Toronto time means we are all revved up and ready to work.

We are like the wily coyote running off a cliff, who only falls when he looks down. We use this momentum to get all the chores done, such as cutting the grass, sweeping outside and inside (spiders and sand), painting, fixing screens that critters have clawed through, and all the little jobs that need doing that our guests never see.

We have about 24 hours until "Cottage time" makes Toronto time disappear.

Our "wooden tent" is on the beach of southern Georgian Bay near Midland. When people ask where it is you start with a small reference point and keep getting bigger until they nod in recognition or nod off.

For example, we say our cottage is near Christian Island First Nations Reserve, near Penetanguishene, north of Barrie, 90 kilometres north of the Big Smoke, a.k.a. Trawna.

In medical terms, Toronto is like the heart that pumps you up the aorta (Highway 400) to the artery of Horseshoe Valley road to the arteriole of Highway 27 to the capillary of Cedar Point dirt road.

Cottages dissolve Toronto time because there are no streetlights, just the Milky Way galaxy of stars.

There is no traffic. Just an old dog sleeping on the road that you have to drive around.

There is no mail, radio or TV.

Internet is slow and spotty, so I unplug for two weeks: glorious.

There is no alarm clock, no air or water pollution, no time. No patients, office staff, administrators, pharmacists, beepers, buzzers, phones, texts or emails.

You forget what day it is. You can do chores in the morning then hit the beach to read fat books and nap.

We golf on a free course with only five holes so I can break 50 and not get tired.

We motorboat on calm days and sail when it is windy. It feels wonderful to cut the engine in the middle of the bay and dive in. There is a 120-year-old wooden shipwreck nearby for snorkelling. It is perfectly preserved by the cold, fresh water.

We have nachos on the beach at 4 p.m., then have a BBQ with real charcoal at 7 or 8; we tell time by the sun.

Finally, we drop off to sleep after boys-against-girls Euchre or reading.

Toronto time has been successfully mutated into cottage time.

One reason why I love being a family doctor

I had a wonderful interaction with a patient recently. She was in for a tetanus shot to treat a dog bite and told me, “By the way, thank you for treating my depression.”

I have known this patient for 23 years, since she was 20 years old. She was a hard-driving insurance agent, multitasking all the time. One year ago she broke down in my office, sobbing. She was separating from her husband, couldn’t sleep and was crying all the time.

I did a physical and lab. Her thyroid, CBC, electrolytes and sugar where all normal. I diagnosed depression and started counselling. I tried to get her to see a counsellor but she was afraid of the stigma. So, I continued counselling and advised her on diet (omega 3s) and exercise (gradually walking and then swimming).

She was still not any better after two months, so I advised an antidepressant. She Googled all the side-effects—so I had her Google Aspirin and she laughed when she saw all its side-effects.

She finally and reluctantly started the antidepressant and reported that she felt dopey on it and nauseated. I assured her this would get better with time and that it meant the drug was working.

During her recent visit, she said, “Thanks for encouraging me to take the drug. My son was graduating and I made him a bouquet of roses. Why should girls get all the perks?” The “roses” were bacon swirls wrapped in chocolate.

She told me that three months ago she wouldn’t have been able to get out of bed.

It made me feel so good to be her doctor and to have helped her. We are so lucky to be in this profession.

I warned her to never stop taking her pills until she dies happy at the age of 100.

What makes you love being a doctor?

Teaching your office staff to triage

Triage is French for "to sort." It is a really difficult skill. You have to tell over the phone if a patient is seriously ill, whether to send them to the ER or have them come in to the office now or decide if they can wait for a few days. It can be a life-and-death decision. Commercial answering services have spent huge amounts of time and money perfecting algorithms for 911 operators and nurses in telehealth systems. They always cover their backsides by advising you go to the ER if all else fails.

I was an expert in a malpractice case years ago where a woman called in to her local ER for advice on a dirty needle wound in her thigh. The nurse thought she was a drug addict and told her to soak in the tub with salt water. It was actually an adrenalin needle for allergies that had gotten dirty in the bottom of the patient's purse and she died of gas gangrene from the clostridium welchii bacteria. Tough to defend. The nurse should have just told her to come in.

It is hard to judge a patient's severity of illness over the phone. They may be under- or over-exaggerating their symptoms because they are stoical or trying to get seen quickly.

Someone having a heart attack can present with indigestion. A headache can be migraine, tension, or a lethal brain bleed.

The best thing is to always be open to your staff so they won't feel like they are bothering you if they have a question about a patient on the phone.

My medical secretary is very good and has rarely made any mistakes. For patients with colds she always asks if they have a temperature, a sore throat, difficulty swallowing, shortness of breath, a sore ear or coloured sputum. If they have a simple upper respiratory infection with clear sputum, no fever or pain, she advises them to try home remedies and call back or go to the after-hours clinic that we run. This avoids having the patient spread the virus to us or to others, and saves time for everyone.

Headaches: Red flags here are if they are new or sudden, or accompanied by visual problems such as loss of vision or stiff neck or

fever. This could be a bleed or meningitis.

Abdominal pain: Red flags are if it is in a specific place, such as the right lower quadrant (appendicitis), right upper quadrant (gall bladder inflammation or stones) or loin area (renal colic). With kids it can be due to constipation or upper respiratory infection with mesenteric adenitis.

Diarrhea: My secretary advises adults to take nothing but clear fluids, such as Gastrolyte or flat ginger ale if the diarrhea is mild with no blood or dehydration or foreign travel, and she lets me know through our internal e-mail system. She brings in children to see me the same day. She always leaves the door open for them to call back or go to our walk-in or the ER if any problems develop or persist.

Fever in children: This is a tricky one and can be trivial or life-threatening. It is better to see them the same day. Babies in their first six months need a full septic workup.

Physicals: We try to see our patients as problems arise and will do a physical when more complicated problems present that need a full workup. Some asymptomatic patients will have a physical anywhere from every three to five years, which may coincide with well-women pap tests, as an example. We try to book physicals in our quiet time, if possible, which is summertime for us. If you are in a summer resort area, your quiet time may be winter.

‘Pharmacists are taking over doctors’ jobs’

That is what I heard in the doctor’s lounge recently. Here’s why you won’t catch me saying this. I don’t agree. I feel the more allied health professionals do for Canadian patients the better it is for everyone.

One of the biggest problems we have in our healthcare system is lack of competition. We have very good care for free at point of service, but too often patients have to wait in the ER for hours, worrying and in pain.

If the patient has a family doctor they may have trouble getting through on the phone. If they get through they often can’t get an appointment for days.

There is enough work for all of us and we need to give better service to our patients
If they see their family doctor they can’t get an MRI or CT scan for months. They also can’t get in to see a specialist for months.
It’s like having a great restaurant with free food—there will be a lineup. The only thing that can improve this is competition.
Remember Air Canada before WestJet? Remember the post office before FedEx or e-mail?
I was in Palm Springs, Calif., for a wedding last fall and went into a pharmacy. You could immediately get any immunization for children or adults. You could get a flu shot for $35US. I get paid $8 Cdn to give one.
You could get your cholesterol and blood sugar done for a price, too.
I think that pharmacists in Canada should do this too. They already administer flu shots and provide the morning-after pill. They also do blood pressure checks, which are a huge help to me. I get a lot of patients who first discover this silent killer at the drugstore.
I get patients to do their blood pressure checks and call them in to my secretary to avoid having to come into my office and risk catching a bug, or paying $50 to have a 24-hour BP monitor.
Until doctors want to be in their offices the morning after (Sunday, Boxing Day or New Years Day, etc.), they should not complain that pharmacists are eating their lunch.
There is enough work for all of us and we need to give better service

to our patients. That means free parking, good hours and being on time with open phone lines.

My Family Health Organization of 17 doctors and 28,000 patients offers instant walk-in service Monday to Thursday from 5 p.m. to 8 p.m. on top of office appointments from 9 a.m. to 5 p.m. Monday to Friday. We also offer a Saturday morning walk-in from 9 a.m. until noon.

We have a nurse on call for free 24/7/365, with great advice backed up by computer algorithms, while we 17 doctors are sharing on-call. We can do this and not burn out as we are only on one evening a month. I take off the afternoon before the evening walk-in so as not to exhaust my 68-year-old body.

We are on duty for the walk-in clinic Saturday morning and on-call over the weekend to back up the nurse only one weekend in 17, so we don't stress ourselves out.

The nurse can give advice in all Ontario's many languages of the world.

All this is at no cost to the patient, except when they are paying taxes.

What do you think? Should pharmacists be able to do more? What are the pros and cons? Who will pay? How do we co-ordinate this?

My suggestion is that if pharmacists do any of the above they can fax a report and your secretary can scan it into your electronic medical chart for the patient (e.g., cholesterol is this value).

Here’s how to get started on your nursing home strategy

The Local Health Integration Networks (LHINs) in Ontario, which plan and fund all healthcare (except doctor’s payments), are interested in avoiding transfers of nursing home patients to the ER, as it provides more appropriate care for the patient and saves money. (See also my previous blog, here.)

How to get started

Start with a task force of no more than seven people. I recommend a medical director of long-term care, a front-line LTC nurse, a government funding representative, an ER representative, a chief executive officer of a nursing home and an ambulance rep. Other reps, such as lab, X-ray, etc., can be pulled in prn.

If you can scare up the cash, hire a nurse to work full time who can take ownership of the project. Everyone else is too busy and being “meeting-ed to death,”so you need a real missionary to run this.

I am in the Waterloo-Wellington area (Cambridge, Guelph, Kitchener-Waterloo and Fergus, plus rural areas). Our LHIN hired two nurses to do this and they helped us get same-day X-ray to avoid transfers to the ER. Our previous portable X-ray took a week to get, so 60% of our transfers to the ER for X-rays querying fractures were negative.

She also helped train and support the administration of I.V.s in the nursing homes, which can help avoid transfer and also get patients back earlier from hospital. For example, if a patient needs six weeks of I.V. antibiotics for osteomyelitis, you can give it at the nursing home and free up a hospital bed for five weeks. At $1,000 per day this saves taxpayers 5 x 7 x 1,000 = $35,000. Plus, the patient is in their “home,” not a cold, stranger-filled hospital getting bumped from bed to bed and catching superbugs.

This nurse also studies all the transfers, and reviews what the diagnoses were and how to avoid unnecessary trips.

The most important aspect is to get the medical directors and house

doctors of nursing homes on side.

Nursing home doctors should round three times a week

A lot of doctors are used to going to the long-term care home once a week, as that is the way it was always done. If a resident gets sick the day after the doctor was there, the power of attorney is often going to want to send him or her to the ER, where a doctor can see the patient daily if he or she is admitted.

Doctors think if they visit the nursing home three times a week, like I do, they will have to work longer hours and take more time away from their practices. Not true. It saves time, as you are nipping problems in the bud. You get more time for your practice and yourself, and have far less stress as nurses are not bugging you all the time with lab and faxes and phone calls and texts and emails. They know you are coming regularly and save up the day-to-day routine things for your next visit. Families and patients also feel much more confident with the extra care.

After hours the doctor on call may not know the patient and is tired and sending them to the ER solves the problem and avoids blame. The way to get doctors to buy into more frequent visits is to have them meet with other doctors who have done it to ask about scheduling, billing, etc.

Expect pushback from the doctors. I found it hard when I first went form one visit a week to three visits a week 10 years ago. The nurses tried to dump everything on me on Monday and I had to divide up the routine work:

"Dr. Crosby, you have three physicals and three med reviews today."

"No, I will do one each for the next three days."

Doctors will love it. Instead of blowing a Wednesday afternoon at the nursing home they can be golfing or skiing or relaxing, as they can visit the nursing home from 9 a.m. to 10 a.m. three mornings a week, then get to their offices for the rest of the day. This breaks up their day and helps the patient and taxpayer. Win, win win.

My prediction, and you can take this to the bank: Nursing homes will continue to be more like hospitals and hospitals need doctors to do

rounds every weekday.

Another tip is to get the doctor to attend all family meetings to discuss transfer to ER in the future with the patient, family and power of attorney. The doctor can do this because she can be participate for the first 10 minutes, then leave. If she has 100 residents, this is three meetings per week for 33 weeks a year. If she has 50 patients it only takes 16 weeks a year. Very doable.

Getting nurses on board

The next most important aspect is to get buy-in from the nurses. Many nursing homes are short-staffed and want to get rid of the patient to the hospital. Also, the patient, family and their bosses won't blame the hospital if things go bad with the patient.

You have to educate the staff, especially the inexperienced ones (who usually are working nights and weekends), on the benefits of keeping the patients in their home environment. All nurses must communicate with families immediately when there is any change in their loved one's status. Keeping the family informed and reminding them of their medical directive decision—to keep the resident at the nursing home and provide care at the home—will help alleviate the families' anxiety and possible guilt about not having their next of kin sent to ER.

Families need to be reminded that the direct care staff have developed a relationship with the resident and are confident they can provide effective care without causing anxiety and stress that could possibly result from a transfer.

Patient buy-in

Lastly, and most importantly, you have to educate the patients and their families and friends.

This can be done with handouts (see below) on admission to the nursing home, and at family meetings, which we hold two months post-admittance and yearly. Once again, doctors can do this as they can be on for the first 10 minutes then leave.

It has taken me 20 years to get to one nursing home transfer a month to the ER, but you can do it quicker by learning from my situation.

*Transfer to Hospital Handout

Residents older than 70 years, whose hearts stop, almost never have a good recovery and can linger in the intensive-care unit of the hospital for weeks in pain with broken ribs. They can be tied down to keep them from pulling the breathing tube out of their vocal chords. Then the ICU staff may ask you if they can pull the plug on the breathing machine.

We will try to keep your loved one in the nursing home. If they break a bone or have a bad cut, we will naturally send them to the emergency, but if they have a stroke or pneumonia we can often treat them well here without the disruption of going to an unfamiliar, noisy, brightly lit emergency department, which can upset them and where they can catch a super bug.

We will always call you to make the decision as power of attorney if the patient is incapable.

Dr. Crosby will be able to see them every Monday, Tuesday and Thursday, and is available by phone the other times. If you need to talk to him, leave your cell phone number with the nurse and he will call you back on his next visit when he has the chart and nurse at his side.

Should you care what medical tests cost?

A recent family practice resident of mine, Dr. Michael Mohan, gave me a list of the costs of common outpatient investigations in Ontario. Here is a sampling:

- Urinalysis: $2.59
- Blood sugar: $2.59
- Complete blood count: $8.27
- ECG: $11.05
- HbA1C: $11.37
- Vitamin B12 levels: $14.48
- Pap smear: $14.94
- Stool culture: $17.58
- Free testosterone levels: $25.85
- Urine screening for drugs of abuse: $35.16
- L-spine X-rays: $35.84 to $56.80
- Complete abdominal ultrasound: $106.85
- Stress echocardiogram: $255.00

I was surprised at how cheap everything is, especially after reading about costs in the U.S. I think we have a real bargain in Canada. We also get results quickly, right into our computer, so I think we should all thank our local labs for the great service they provide our patients and us. My local labs are new, fast, courteous and have free parking.

I have never thought about this topic in 43 years of practice so I guess I am a real socialist Canadian doctor.

I like to feel that I am very conservative in ordering all tests. I am a taxpayer and every penny is coming out of our pockets or the pockets of our kids and grandkids when we borrow.

I avoid lumbar spine X-rays if there are no red flags. I don’t do ECGs on routine physicals if there are no cardiac signs or symptoms and am doing routine physicals with blood work every five years on healthy patients without symptoms.

I don’t do iron studies or B12 levels if the CBC is normal. I concentrate

on blood pressure (can’t feel it) and smoking cessation. This is where the money is.

Years ago I seem to recall a big hospital in Toronto sending out mock bills to patients to let them know the cost of their stay. It was a big flop, as expected. People don’t care if it isn’t hitting their wallet. Also, one-half of our provincial taxes go toward health, so most Canadians feel entitled to it as do I.

How to reduce avoidable transfers from nursing homes to Emergency Departments

I was an emergency physician for 20 years and for the past 20 years I have been medical director of two nursing homes, so I have been on both sides of the debate when it comes to the growing problem of transfers between the two facilities.

Recently the Ontario Ministry of Health released figures on the number of transfers to the ER by all the nursing homes in the province. The nursing home where I work, Riverbend, in my city of 150,000 people in Cambridge, Ont., sent on average one patient per month to the ER, while some homes in Ontario sent 29. The average for the province is 16.

I can’t speak for the rest of Ontario but here are some of the things we do at Riverbend to avoid needless transfers.

First, why try to avoid the ER?

Some transfers are necessary for such problems as fractures and lacerations. We really appreciate everything the Cambridge ER does for us; they do a wonderful job. However, going to the ER for a confused senior can be very upsetting—going outside into an ambulance, then taking a frightening ride and being unloaded into a brightly lit, noisy, strange place. There is always the threat of contracting MRSA or VRE, and every test has its discomforts and dangers. Most hospitals in Canada are packed, so patients can spend days in the ER if they are admitted. Two years ago I spent three days with my 94-year-old mom in our ER, awaiting admission.

Why Riverbend’s ER transfer numbers are small

1. Riverbend Long Term Care is small, with 55 beds. Some homes have 200 or 300 beds. But even if my home were 300 beds (or six times as large), six transfers per month is not 16 or 29. I think being small helps us get to know our residents and their families better, so they trust us when there is trouble.

2. I am the only doctor there, with a backup doctor for when I am away.

3. I make rounds on Mondays, Tuesdays and Thursdays at 9 a.m. (not during meals) so the patients and their families know I will be there for them. They don't have to be punted to the ER for more medical care. I am available all weekdays by fax or cellphone, and we have a call system for the remaining times.

I am not an old, semiretired doctor; I still have a full practice. (OK, I am old—67). Many homes employ doctors who only come once a week because they have done this for years and don't think they can spare more time. Actually, going three times a week means I save time because I can diagnose diseases early on when they are easier to treat. I also get fewer faxes and phone calls from the nurses because they know I will be in regularly and they can wait for routine things.

Also, since many psychiatric hospitals have closed, we see more mental health patients at nursing homes. We also are seeing more patients with congenital problems, such as residents with Down syndrome who, are living longer due to heart surgery and better medications. We are looking after patients with feeding tubes, dialysis, head injuries and MS. Hospitals are sending people out sicker and quicker as they close beds to meet budget targets.

I think of my long-term care home as a hospital that requires daily rounds.

I know a young doctor working at another nursing home whom I talked into switching from once-a-week to twice-a-week visits, and she loves it.

"But Dr. Crosby, I don't have time to go to my nursing home three times a week."

Oh, but you do, and it will mean better care for your patients, fewer ER transfers and a better lifestyle for you. Win, win, win. Consider this scenario:

Say you were going to your nursing home every Wednesday afternoon from 1 p.m. to 5 p.m. You are in your office from 9 a.m. to noon every weekday and 1:30 p.m. to 5 p.m. Monday, Tuesday, Thursday and Friday. You could take Wednesday afternoon off and instead go to your

nursing home Monday, Tuesday and Thursday from 9 to 10 a.m. and start your office one hour later those days. You could start at 1 p.m. after lunch to pick up the lost hours.

4. We have an excellent head nurse, Tanya Farrow, who is there Monday to Thursday from 7 a.m. to 3 p.m. This is key. I walk in at 9 a.m. and the head nurse has a list of patients for me to see. We then do our charting and review of labs, imaging and paperwork.

The head nurse also talks to the residents' next of kin about whether to transfer to the ER or not. If the nurses are rotating shifts all the time there is no one to be the bottom line for residents and their families. I trust her judgment and we have each other's backs. Nurses are very important—that's why they are called nursing homes.

5. In the Waterloo Wellington area (700,000 people from Kitchener-Waterloo, Guelph and Cambridge), which has the lowest nursing home to ER transfer rates in Ontario, we can get same-day mobile X-rays on weekdays. We just write on the X-ray form: "To avoid ER transfer, please do same day." Before this program we had to wait one week for X-rays so we sent the patient to the ER for faster turnaround. We still can't get labs for a week.

6. I briefly attend all family meetings at Riverbend yearly, and after a resident's first three months in the home. I talk about DNR and hospital transfers every year so the message sinks in. Here's my script:

Regarding DNR or do not resuscitate: We have to ask you what you want if your loved one's heart stops.

If the patient or power of attorney says they want everything done I say,

"I was an emergency physician and trained paramedics, and by doing CPR or cardiopulmonary resuscitation, oxygen is given by face mask and the chest is pressed on. It is almost never successful in seniors in nursing homes. It can leave your loved one with broken ribs and on a ventilator or breathing machine in the hospital's intensive care unit. There is a tube placed down their throat through their vocal cords into their lungs to connect them to the ventilator. They can't talk and might have their hands tied down to prevent them from pulling out the tube. I would never do this for my parents."

Transfer to hospital

We try to keep residents here at the nursing home if we can. This is their home and they know us. If they have a broken bone or bad cut we will call you and transfer to the ER. I am here 3 days a week and instantly available by fax or cell phone. The rest of time we have an on call doctor.

The hospital can be confusing especially to patients with dementia and they can catch a super bug there. They can end up on a hard gurney stretcher, in a noisy corridor with the lights on all the time waiting to be admitted for days. They can be surrounded by strangers looking after them.

Nothing is in stone and the nurse will call you. You can change your mind at any time.

I repeat this every year at the family meeting.

Dying patients. If a patient is dying I tell the family that this is a natural event that we will all go through. I tell them that the hospital can't help them as well as we can and we know them and this is their home. We will keep them pain free and comfortable and I will check them 3 times a week and be instantly available by cell phone the rest of the time. We do not recommend intravenous fluids as the resident may pull it out and have to have restraints. The needle has to be changed daily which is painful. IV just prolongs the inevitable.

A lot of next of kin feel guilty about putting their loved ones in a nursing home and compensate by wanting everything done for them.

I tell them that it takes 10 people (1 doctor, 3 nurses, 3 personal support workers, a cook, janitor and administrator) to replace their care 24/7/365 and they have done a great job looking after the resident until now. There is no need to feel guilty.

When they tell me that their parents never put their grandparents in a home I remind them that Canadians lived to be on average 65 then and now are living to be 95 and women worked inside the home then and had more time to care for their parents.

I summary I feel that nursing homes in Canada can try the above tips to avoid unnecessary transfers to the ER.

What I tell my patients about dementia

I have been medical director of two nursing homes for 20 years and my family practice is half seniors, so I see a lot of dementia. Here is my handout; please feel free to use it.

Click here to download a PDF version of this handout.

About dementia

Dementia means a loss of the brain's ability to think and remember.

What causes it?

Alzheimer's disease is the main cause and no one knows what is behind it. Other more rare or co-existing causes are hardening of the arteries to the brain caused by high blood pressure, smoking, high cholesterol and high sugar (diabetes).

There is a rare form of dementia called Lewy Body dementia, which results in hallucinations (seeing or hearing things that are not there).

Parkinson's disease can be accompanied by dementia in late stages.

Repeated brain injury and some brain tumours (especially at the front part of the brain) can cause dementia.

How do I know if I or a loved one has dementia?

The first signs are loss of memory, confusion and getting lost. This can also happen with normal aging. See your family doctor or nurse practitioner for brain testing. They will also do a full physical, CT scan of your head and full blood work, including complete blood count, blood sugar, thyroid hormone and Vitamin B 12 level.

What is the treatment?

There is no cure as yet for Alzheimer's disease but research is going on daily. There are three prescription drugs that can slow its progress.

Ask your doctor about them.

Treatment of underlying diseases as mentioned above (smoking, high cholesterol, etc.) can help. Prevention of brain injury by wearing helmets and seatbelts also helps.

What can I do as a loved one and/or caregiver?

It can be very stressful living with a dementia patient. It is normal to get angry, especially if the patient continually gets lost or asks the same thing over and over. Do not feel guilty.
Get counselling from your doctor on how to care give. It can be very lonely, too.

Join the Alzheimer's Society (Google it for your city). It helps to share coping tips with others in your situation.

Have a family meeting in person or by phone with the doctor to go over how everyone can help with caregiving, even if they live far away.

What if the patient acts sexually inappropriately?

This can happen due to the lack of control by the higher centres of the brain. It can be controlled by medication. Inform the doctor.

Can I 'catch' Alzheimer's? Is it hereditary?

No.

What do I do if I can no longer care for my loved one?

Get help from your doctor, who can get a home-care case manager in to assess the home situation. The case manager can put in supports for you and the patient, and modify them as the disease progresses. Take breaks and look after your own needs or you will be of no help.

Take a week off every three months by using respite care available through home care.

Get the patient on the list for nursing homes (ask the home-care manager), and visit three homes before you need them in a hurry. It can take up to two years to find a spot in a nursing home in Canada, so plan ahead.

What do you tell your Alzheimer patients and their loved ones?

Cancer vs. chronic heart failure: Why the difference in palliative care?

According to my highly scientific study of five cardiologists and seven palliative care doctors treating 76 patients over 42 years, heart doctors might be worse at giving palliative care than cancer doctors. OK, so this is a purely subjective observation, but I think it should be studied.

I just saw a 73-year-old patient who has had chronic heart failure for two years. He felt terrible, his ankles were swollen out to his shoe tips and he was short of breath at rest. He was pale and depressed. He is on a ton of drugs and his nephrologist wanted him to cut back on water pills while his cardiologist wanted to increase the dose. He came to me as the tie-breaker. Aranesp had not helped his anemia of chronic disease.

I asked the patient what he wanted. He said he wanted his ankles to go down and his energy to go up.

I advised him to visit the health devices store and buy a chair to sleep in. This way he could have his head and feet up, sleeping in a "V" shape. He had tried support hose and found them to be itchy, as well as hard to get on and off, and of no help.

I saw another patient who had walked around for years with a blood pressure of 80/40 mmHg on an ACE inhibitor and felt terrible. I called his cardiologist and pleaded with the specialist to treat this man palliatively. He finally did, and the patient had a very comfortable death a few months later with a well-perfused brain.

I always ask my chronic heart failure patients if their cardiologists have spoken to them about the prognosis of their disease, and they rarely have. For cancer patients, they are always advised on prognosis and have a death plan. Why the difference?

My theory is that even though my patient has just as poor a prognosis as a terminal cancer patient, society accepts that cancer kills but they figure we can cure all heart disease. We hear of daily miracles with

paramedics and defibrillators and transplants. In the obituary sections of newspapers you read of far more people who died “fighting cancer” than battling heart disease.

Also, I find that cardiologists are the most aggressive (like surgeons) of all the internists due to the fact that they perform so many interventional manoeuvres, such as angioplasties and pacemaker installations. They spend a lot of time in the ICU and CCU, where DNRs are rare. Cancer patients are rarely in these types of situations.

One way of coping with terrible disease is to fight it tooth and nail and never give up, whereas sometimes it is better to have a comfortable death.

I don’t know how to fix this other than to get the conversation started now.

The Third Way: An option for Quebec's family physicians

The Quebec government, responding to the citizens whom they represent, is pushing the province's family physicians to follow a minimum of 1,000 patients or they will have their fees reduced by 30%.

Thirty per cent is a huge number and may set a precedent for the rest of Canada. Other ministers of health may start making draconian laws.

See related article: Quebec healthcare reform criticized for 'dehumanizing' family medicine

I always find it is better to use honey instead of vinegar to get doctors to do things. By practising efficient medicine, there can be a third option for the government and family doctors.

A family doctor can look after 1,000 patients by working 20 hours per week if he or she practises good time management. This would help all Quebecers find a family doctor (one million residents don't have one, says the government), and all would be able to see the doctor the same day. It would allow the doctors to have a reasonable lifestyle, as well.

I have offered a time management course, with lectures and workshops, worldwide for 20 years and it looks at the 10 reasons that doctors are late. It helps correct them.

I even have a French version of my free e-book (download in English or French).

Quebec health minister Dr. Gaétan Barrette has said that Quebec GPs should work as hard as Ontario physicians do. Well, here some tips from an old, hard-working, hard-playing Ontario family doctor.

Top 10 time savers for family doctors

1. Too many patients. That's not a problem in this case.

2. Improper delegation. This chapter of my book teaches how to delegate effectively to staff, nurses, pharmacists, paraprofessionals and specialists.

3. Paperwork and emails suck an enormous amount of time away from seeing patients. I teach physicians how to love them and do them daily, and to keep ahead of them. I look at electronic medical records, iPads and iPhones—for example, the doctor can hand a tablet to the patient to do a functional enquiry for a physical, and during that time can go off and see some patients with minor problems.

4. Interruptions: How to deal with the phone and people who are not the patient who interrupt the doctor.

5. Patients with lists: How to keep the patient happy and the doctor's schedule on time.

6. How to deal with seniors who have all the time in the world when the doctor has none.

7. Too many outside jobs: The Quebec Ministry of Health is proposing doctors spend 12 hours per week in the hospital, nursing homes or other public health venues. This may not be a great idea, as it takes the doctors out of their offices. How do you get 2,000 Montreal family doctors working efficiently, with the right skills, in 20 hospitals?

It is better to have doctors working where they want and doing what they are good at. When I started practising in Ontario 42 years ago, we had 40 family doctors working in the ER. Now we have seven well-trained emergency physicians doing a better job more efficiently. The same can be done for hospital patients. A hospitalist can look after 50 medical patients instead of 50 GPs with one patient each, falling all over each other and driving the nurses crazy.

8. No competition: Start rewarding efficiency, not penalizing it.

9. Counselling: Should family doctors be doing psychological counselling for an hour when social workers are better and cheaper? Doctors could see six patients in that time.

10. Never taught to be efficient: I teach efficiency at the Waterloo Campus of McMaster University to final-year family practice residents. This two-hour course could be on every medical school and post-graduate curriculum in the country.

I fear that the Quebec government is fed up with excuses and will mandate these changes for family practice, which will cause hardship for patients and doctors.

Try the third way, *s'il vous plait*.

‘Your dad is going to die’

“Your dad is going to die.” That is what I recently said to a daughter of one of my nursing home patients. Her father is dying of pneumonia, in spite of antibiotics. She was wondering about sending him to the ER.

I really liked this man, even though he had moderate dementia and wasn’t mentally capable of making decisions about his health. He has been my patient for six years. His daughter is delightful, and is always there for him. She decorated a small artificial fir tree in his room to mark each season. She does Easter eggs, firecrackers for Victoria Day, Canadian flags, Thanksgiving turkeys, then Christmas ornaments. I have a picture of every different tree-scape; they are really well done. I take all my family practice residents and medical students in to see the tree as they rotate throughout the year.

Here is my exchange with her, after I examined her dad:

Me: “I am so sorry but your dad is dying of a chest infection. He is not in any pain and is not short of breath. He is comfortable. He is on the strongest antibiotic we have by mouth.”

Patient’s daughter: “What about sending him to the ER?”

Me: “If this were my dad, I would keep him here. The hospital has to do everything when he gets there, including putting a tube the size of a garden hose down his throat, through his vocal cords and into his lungs to attach him to a breathing machine. He won’t be able to talk and will have to be in wrist restraints to keep him from pulling out the breathing tube. You might have to decide to have him taken off the ventilator if he doesn’t recover, which is almost a certainty.

“The hospital is great for young patients with one disease but for the elderly with many diseases it is a confusing place with ever-changing doctors and nurses, bright lights, noise and superbugs.

“We all know him here. This is his home. We can keep him comfortable with oxygen and morphine in small doses to ease his breathing and pain. I come every Monday, Tuesday and Thursday, and we have other doctors on sight every Wednesday and Friday. We have an on-call doctor the rest of the time.

Daughter: "When will he die?

Me: "I don't know but please get your rest and we will call if things look bad. Call the family and tell them."

Daughter: "What if he doesn't die shortly and they have to fly back for a funeral later? "

Me: "I can't tell you how to live your life but if this was me, I would rather see my parent before death."

Daughter: "What about food and water?"

Me: "We don't do I.V.s here, as they have to be changed daily, which is painful and he would pull it out. The body doesn't feel thirst or hunger during the dying process. Feeding him would cause food to go into his lungs and choke him and cause distress. You can help by keeping his mouth moist with ice chips.

She smiled, nodded and thanked me, and agreed to keep her father at the nursing home.

On March 10, his tree had green lights and shamrocks on it.

How do you deal with the dying process as a doctor, a patient, a friend

or as a relative?

Kicking around my bucket list

Here is what I want to do and see before I kick the bucket. Most of this is travel- or medical-related. I have no yen for sports or taking courses (although it would be fun to take a creative writing course). I have no desire to meet anyone famous. Funny how things look when you reach the clubhouse turn of your life. My bucket list is pretty short because I have everything I want now.

1. Take a driving tour of Ireland. I want to rent an MGB sports car convertible (British Racing Green) and drive all around Ireland, staying at bed-and-breakfast places and eating at pubs. Of course, we would have to pull a U-Haul trailer for all my wife's things. It is her only flaw: she overpacks. Weird for a former flight attendant, eh?

2. Tour an aircraft carrier. You can do this in San Diego, Calif., and in New York City. Aircraft carriers have always intrigued me because of their size. The New York one has a submarine beside it and the Concorde jet on it. Triple play.

3. See the Grand Canyon. I would like to go to Las Vegas and take a tour plane flight over the Grand Canyon, with a side trip to drive over the Hoover Dam (or alo**ng the top of it).**

3. See Ringo Starr perform. I have seen Paul McCartney three times and George Harrison once.

4. See the Toronto Maple Leafs win the Stanley Cup before I die at the age of 100. That gives them 33 years to deliver and me time to save up for scalpers' tickets. I did see the Leafs win the cup on television four times in the 1960s. Can you take out a mortgage on tickets?

5. See Canadian healthcare go totally paperless (refer to Leafs timeline above). It would be so nice to have the pharmacies and all specialists and associate medical professionals communicating with us online in a secure manner. Also, having the hospitals and nursing homes totally computerized would be so much more efficient than their paper backup systems (?) that double the work now. We are getting there as my office is paperless and we get lab and imagining digitally now and a few specialists are dictating at the hospital and we

can download it. Collingwood, Ont., has all its pharmacies and physicians linked digitally, so it can be done. Odd that the rest of the world can do this with everything else; why not healthcare?

6. See all family doctors in Canada offer same-day service on weekdays for urgent cases.

7. See wait times for specialists become reasonable—say, one month.

8. Go back to London, England, and spend 14 days in the museums and tourist traps.

9. Go to Amsterdam and see the Van Gogh museum.

10. Go to Paris (again, though my wife has never been), and also visit the First and Second World War memorials in France and Belgium

11. Tour Italy for the food, the history, and the Coliseum.

12. Tour England, especially Bletchley Park, where they cracked the Nazi codes. I have a delightful 90-year-old patient who worked there during the war. She and I have great chats on her visits. I get paid to do this. What a great job. Also while in England, I'd like to tour Port Wenn, the fictional seaside town where Doc Martin works. If you haven't seen the TV show, please do. It is about a nasty London surgeon who develops a phobia about blood and becomes a family doctor in a small English town. Funny and a cathartic. And I would love to tour the estate where Downton Abbey is filmed. This is another wonderfully written, filmed and acted British TV show.

13. Tour Greece. I want to see those white, white homes and the blue, blue sea, plus the Parthenon.

14. I want to take my grandson, Max, to Wolf Park Lodge, a water park in Niagara Falls, Ont., entirely heated by pee. If you are ever in Niagara Falls (I love the falls and have seen them more than 30 times) try the Jet Boat ride. It will curl your hair, if you have any.

Life as a doctor does get better

I remember different phases of my varied career when I really despaired about getting to 42 years as a doctor. I was really discouraged many times but I would like to tell all of you out there who are younger than me (67), that being a doctor gets better. A lot better. I am now truly happy and fulfilled. I feel I am giving good service and care to my patients and I really look forward to going to work every day.

1973: Starting out

When I started family practice 42 years ago, I hated it. It was so boring and the patients really got their hooks into me. I was exhausted by it. I would look out our leaded glass house window, down the snow-covered street lined by old globe street lights, and I couldn't see myself trudging down that road for 10,000 days of work in the same office.

I had been trained at the now defunct Wellesley Hospital in Toronto with no out-patients, just ward work, so I had no preparation for family medicine (I have one of my 1,400 patients in hospital today as I type this).

So I went into emergency medicine, which I loved. It was fast and exciting with no routine and a great team to work and have fun with.

Family practice

Twenty years on I was 45 and getting tired of working night shifts, weekends and holidays, and I had young children who were 9 to 5'ers with weekends off. So I nervously went back into family practice. This time I set boundaries and didn't have to please everyone. I didn't have to fix everything; often just a sympathetic ear is all many patients want. They can rarely change their lives.

But after seven years I was getting itchy feet again. (I inherited this from my mom, who is 96 and has had 26 changes in the last 26 years. Her parents moved from England to Alberta and then to Toronto, and were contemplating Australia at age 85. You have to have people like us or the world would have seven billion people still living in east

Africa.)

Anyway, back to the seven-year itch. I advertised my practice to give it away—and got one bite. The guy wondered if the Toronto subway had a Cambridge stop. It didn't, so I was stuck.

But for the last 10 years I have really grown to love or like or tolerate or handle my 1,400 patients. I have matured and know what it's like to have a mortgage, kids, family stress and caregiver burnout on a personal level.

I think it's because I have had to stick to something, finally, for 22 years that made me have to make something out of it, and not just run after the siren call of the ambulance.

I like the child patients and the oldies. I love the crusty old farmers and tough workers. They have a certain dignity about how they struggle with their lives.

I love writing and lecturing. We are going on a Tahiti cruise in March and I will be talking about time, stress and risk management. I also like mentoring medical students and residents.

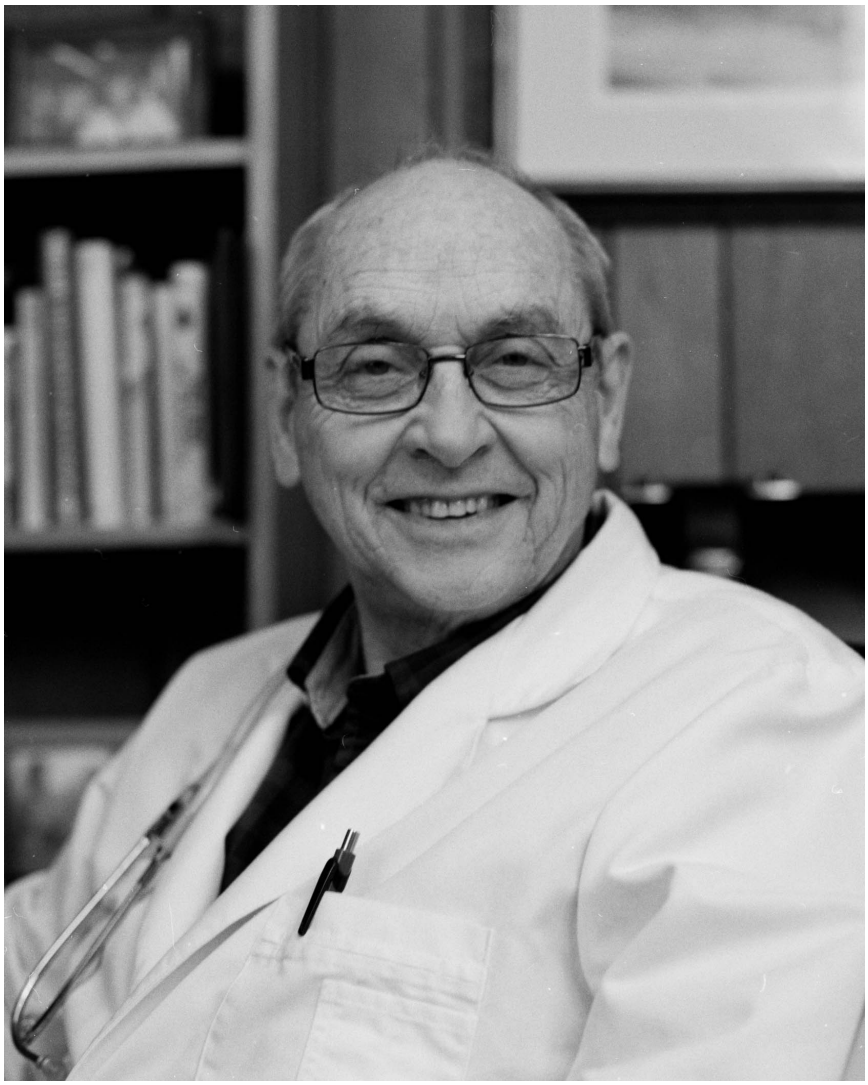
I don't have any call, I can sleep in (but don't) until 9 a.m., and have an hour and a half for lunch.

I am home by 4 p.m., by noon on Wednesday, and am off every Friday year-round. I take eight weeks off every year, too, so my life is very nice.

I am finally content like Elsie the Borden's cow. So take heart: It gets better and easier as you get older.

About the author

Dr. John Crosby was born in Sarnia, Ontario, Canada, in 1947. He attended medical school at Western University in London, Ontario, where he graduated on the Dean's Honour List in 1973.
He received his FRCP (C) (Fellowship of the Royal College of Physicians of Canada) and MCFP (Member of the College of Family Physicians) in Emergency Medicine in 1983.



He was a Medical Consultant for Emergency Medical Services for the Province of Ontario and Director of the Oakville ER and has been a Family Physician in Cambridge, Ontario, for 26 years.

He is married with 3 sons, a daughter-in-law, and a grandson.

He practices what he preaches.