How do you create positive locum experiences? **44**

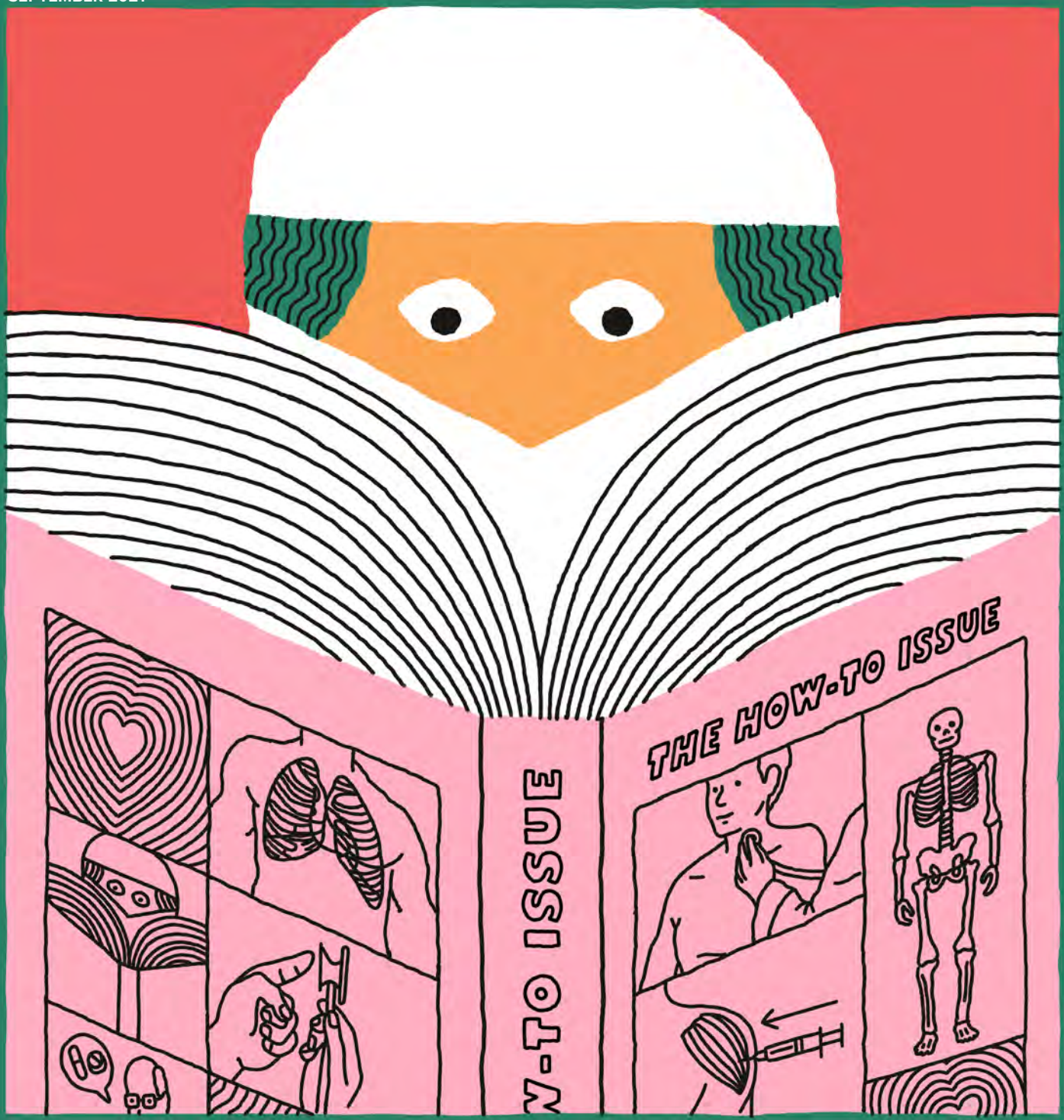
5 tips on managing anticoagulation for patients with AF **48**

A doctor's 1900s warning on residential schools **52**

# The Medical Post

*The Independent Voice For Canada's Doctors since 1965*

SEPTEMBER 2021




EnsembleIQ

# Contents

VOLUME 57 NO. 4



### Creating the magazine


**Josephine Woertman** recently joined the *Medical Post*'s creative team, responsible for designing all inside editorial pages of the publication. Working out of Toronto, she reads each article first, and then starts to conceptualize visuals and how they will either enhance or create interest to draw the reader into the story. Next, she creates the page layouts of the magazine. We asked her what topics in the *Medical Post* she finds most interesting. "Oh, that is a hard one as I find all the articles interesting! Since I started with the magazine I have been avidly reading the articles on COVID-19 because they are informative, well-written, up-to-date and I always come away with knowledge that I did not have before. For example, I was surprised and fascinated to read in our June issue Back Pages column that in 1918-19, society acted like the Spanish flu had not happened! I also like that I can find the most current COVID-19 info in various spots of Canada on the CanadianHealthcareNetwork website (the only home of the *Medical Post*). It's very helpful and reassuring as a lot of my family and friends live in the West."

### Next Issue:

**The Anti-Racism Issue:** The next issue of the magazine will be out in mid-October. Here's what's in it:

- Columns: Dr. Ferrukh Faruqui on racism in medicine and a Dr. Melissa Yuan-Innes item titled: "Racist I have been."
- Welcoming: How do doctors offices show they are welcoming to marginalized groups?
- Making a difference: Mini-profiles of physicians across the country who are seeking better care for racialized and disadvantaged patients.
- Practice management: If you run your own little clinic, how can you provide diversity training for colleagues and staff?
- Issues: We're aiming to look at the challenging issue of patients' micro-aggressions.

EDITORIAL

# The How-To Issue

## For young or experienced doctors, this issue is about the skills you don't learn in school

**COLIN LESLIE** EDITOR-IN-CHIEF

**In 2004, I flew** from Toronto's summer to Paraguay's winter in South America (most days it was about 25° C but then an Antarctic front would come and it would drop to 15° C and all the Paraguayans would shiver and wear jackets and hats). I was there as a journalist for the *Medical Post* to cover "Canada Week" with Orbis' Flying Eye Hospital. Orbis is an NGO that works to prevent and treat blindness, and during "Canada Week" it was Canadian ophthalmologists doing the surgeries on a DC-10 the charity had converted into a flying surgery suite.

Over the week, I spent a lot of time talking to Ottawa ophthalmologist Dr. Brian Leonard (he's one of Orbis' "heroes" and has done more than 70 Orbis programs). I've always remembered something he said about the importance of a doctor's clinical skills. When he was just starting out he was observing a surgery and saw the surgeon fumbling with tying knots. He never wanted that to happen to him, so he tied strings to the headboard of his bed and would reach up at night and practise so that he could tie a knot without looking.

Your core clinical skills are going to vary by what type of doctor you are, so in this issue, we focused on the common questions that all doctors face—the kinds of things you can't truly learn in medical school and only really get once you're in practice: how to handle difficult patients, how to keep staff happy, how to call out racism, sexism and homophobia, and much more. That coverage runs from pages 14 to 26. (Thanks to our physician advisory board for help coming up with the topics for this feature!)

There's a sub-theme to this issue: young doctors. So you'll see plenty of coverage that, though it applies to all doctors, has a focus on learners and new-to-practice clinicians. The "Wisdom of Youth" feature on page 30 has mid-career or older physicians talking about what they have learned from resident and medical students.

Lastly, I can't not use this opportunity to restate the importance of the biggest "how-to" we all face: Ensuring that everyone in the world who wants to be vaccinated against the coronavirus can be. Whether that is via COVAX or through rich countries like Canada donating vaccines to poor nations, we should all be encouraging our political leaders to make this happen.

Pandemics end, but this one hasn't yet. Not quickly stopping COVID-19 from spreading in poor countries through vaccination is wrong from a humanitarian perspective. It also prolongs the risk that more variants will arise—potentially one that our vaccines will not work against. **MP**




The Medical Post

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# Feedback

## Article didn't adequately acknowledge clinical concerns with flibanserin


*And now it's women's turn (June)*

**Dr. Joel Lexchin**, an emergency physician at the University Health Network in Toronto, wrote a letter to the editor noting that this article overstated the effectiveness for flibanserin and testosterone and didn't adequately acknowledge clinical concerns. The article "calls flibanserin 'a game changer' but in fact it is a drug of little to no value. According to Woloshin and Schwartz (*JAMA Internal Medicine 2016;176:439-442*) premenopausal and postmenopausal women taking the approved dose—compared with placebo—experienced 0.5 more satisfying sexual encounters a month and scored 0.3 points higher on a five-point sexual desire scale. At the same time, flibanserin increased somnolence, sedation, or fatigue compared with placebo," he wrote.

"Combining flibanserin with alcohol can cause dangerous hypotension and syncope—problems so serious that the FDA put a black box warning, its most serious safety alert, on the label. Finally, unlike sildenafil (Viagra), which only needs to be taken at the time of intercourse, flibanserin needs to be taken continuously."

Further, wrote Dr. Lexchin, the assertion in the article that testosterone therapy can be prescribed for low sexual desire had no source. "The Global Consensus Position Statement on the Use of Testosterone Therapy for Women concluded that: 'There are insufficient data to make any recommendations regarding the use of testosterone in premenopausal women for treatment of sexual function or any other outcome.' For postmenopausal women, the conclusion was that the only evidence-based indication for the use of testosterone in women is for the treatment of postmenopausal women who have been diagnosed as having HSDD (hypoactive sexual desire disorder/dysfunction) after formal biopsychosocial assessment.

"Finally, the article mentions that the injectable bremelanotide (Vylessi) has been approved in the United States for low sexual desire, again without any mention of any evidence. An article about this drug in the *Annals of Pharmacotherapy* (2020;54(7):684-690) concluded that: 'Although the trials met statistical significance for change in sexual desire elements and distress related to sexual desire, the clinical benefit may only be modest.'"

*Ontario launches new billing audit scheme (June)*

Online commenters discussed Ontario's new billing audit plan and the nature of the OMA's input to it. **Dr. Ferrukh Faruqui** of Ottawa added: "Yes, those who are scamming the system should be held accountable, but why are any claims allowed to be stale-dated and not paid? There is no rationale for this rule and it means that the service we offered was done for free. Why doesn't the OMA take this issue up? No one tells us how to bill. We just have to learn on our own and I know many of us, or probably most of us, have left dollars of billings on the table because we were unaware of how to bill. OHIP doesn't care if we are underpaid by virtue of not being able to navigate the complicated billing system. (It is) an inefficient, overly complex maze that results in underbilling, some inadvertent overbilling or some skimming off the top. The whole thing should be overhauled and rejigged." **MP**

**(It is) an inefficient, overly complex maze that results in underbilling, some inadvertent overbilling or some skimming off the top.**

VITALS

# Canada's health system lags other rich nations

BY COLIN LESLIE

**The "Mirror, Mirror 2021" report** from the Commonwealth Fund came out in August and shows the performance of Canada's health system trailing other high-income countries. Canada performed poorly in three areas:

- **Access:** The access category is split into two subcategories: affordability and timeliness. Canada scored poorly on affordability because of its lack of universal coverage for dental care and drugs. On timeliness, Canada was hurt by long waits to see specialists, undergo elective surgery and receive care in the emergency room.
- **Equity:** Patients in other nations have quicker regular access to a doctor. As well, patients skipping care (dental, prescription drugs) because of cost impacted Canadian performance.
- **Healthcare outcomes:** Canada performed poorly relative to its peers on health outcomes. Canada's infant-mortality rate of 4.8 deaths for every 1,000 live births was second only to the United States. As well, 16% of Canadians reported having at least two of five common chronic conditions, again, second only to the U.S. at 21%.

**All 11 nations were ranked best (1) to worst (11) on each of the five categories.**

| Rank | Nation | Access to care | Care process | Admin. efficiency | Equity | Health outcomes |
|---|---|---|---|---|---|---|
| 1 | Norway | 2 | 8 | 1 | 8 | 2 |
| 2 | Netherlands | 1 | 3 | 8 | 5 | 4 |
| 3 | Australia | 8 | 6 | 2 | 1 | 1 |
| 4 | U.K. | 4 | 5 | 4 | 4 | 9 |
| 5 | Germany | 3 | 9 | 9 | 2 | 7 |
| 6 | New Zealand | 5 | 1 | 3 | 9 | 8 |
| 7 | Sweden | 6 | 11 | 5 | 6 | 5 |
| 8 | France | 7 | 10 | 6 | 7 | 6 |
| 9 | Switzerland | 10 | 7 | 10 | 3 | 3 |
| 10 | Canada | 9 | 4 | 7 | 10 | 10 |
| 11 | U.S. | 11 | 2 | 11 | 11 | 11 |

SAME CARE

# No vax no visit is a no go

**Even as Canada** continues to make great strides in its goal of immunizing everyone against COVID-19, physicians across the country are worried about their unvaccinated patients. In particular, many were unsure about in-person appointments with those who have not rolled up their sleeves for the jab.

In an online poll posted in July by the *Medical Post*, more than a third of respondents said they would treat unvaccinated patients only by video, phone or email.

It's no surprise that the Canadian Medical Protective Association has been fielding more calls from physicians asking what they should—and can—do about vaccine-hesitant patients.

The guidance from the country's medical professional regulators has been unequivocal: Unvaccinated patients are entitled to the same access to care as vaccinated patients. The College of Physicians and Surgeons of British Columbia said it would be ethically "indefensible" for doctors to require documented proof of vaccination before allowing a patient into their clinic.

In Ontario, the college reminded physicians that in-person care can be provided safely "even in the absence of a negative test result or vaccination—by taking appropriate precautions, including screening patients and using necessary PPE."

Marie Carniello, president at Systemic Healthcare Solutions—a healthcare consulting firm in Niagara Falls, Ont.—offered suggestions for managing unvaxxed patients in a clinical practice. These include dedicating blocks of time on the appointment calendar for them, seeing patients in their cars, and booking fewer appointments while increasing the level of over-the-phone triage.

By mid-August, Canada had become the global leader in COVID-19 vaccinations, with more than 70% of all Canadians immunized with a first dose, and close to 62% fully vaccinated. That still leaves a few million Canadians unvaccinated, for reasons that range from lack of trust in the vaccine to medical conditions incompatible with getting immunized from COVID-19. **—MARJO JOHNE**

## AUSCULTATIONS

**"Tone deaf CFPC fails its members, embarrasses itself."**

**—Dr. Sohail Gandhi,** a former OMA president, arguing that an editorial published in *Canadian Family Physician* and titled "Family medicine is not a business," was a "hit piece" against FPs. The editorial's writer said he'd anecdotally heard about FPs abandoning patients with high medical needs and "charging excessive fees" for services not covered by health insurance.

**"I was almost 80 years old . . . and I never did anything to satisfy any sexual desire."**

**—Dr. Stephan A. Jacobson,** in his defence, after the Montreal doctor performed bare-handed vaginal exams (there were other issues as well). The disciplinary council of the Collège des médecins du Québec took his licence away (he had also recently retired).

**"(One approach is) penalties if a family doctor does not take charge of a minimum number of patients."**

**—Quebec Premier François Legault** saying his government is going to "work very hard" this fall to do something about the number of patients who can't find an FP. He said the plan is to move toward more capitation, but mandatory numbers of patients is another option.

**Source:** All from CanadianHealthcareNetwork, the online home of the *Medical Post*

Photo of François Legault: The Canadian Press/Graham Hughes

CPSO POLICY

# Doctors and 'appropriate' social

**The College of Physicians** and Surgeons of Ontario (CPSO) is reviewing its statement on physicians' use of social media and replacing it with a policy that sets out robust professional expectations. Public consultation of the new draft policy closed on Aug. 27. The policy will be used by the CPSO "when considering physician practice or conduct," meaning violations could launch professional misconduct investigations.

It's a reasonable list of dos and don'ts, for example: Conduct yourselves in a respectful and professional manner; don't be abusive, don't share confidential information without full documented consent.

Refinements to an early version leave Ontario doctors with a draft policy more comprehensive than other Canadian medical regulators' positions on social media conduct. In this time of rampant misinformation, the policy dictates that any health information posted by physicians must be verifiable and supported by evidence. Doctors must be open about their qualifications and the limits to their knowledge. Professionalism is defined and includes demonstrating cultural humility and safety.

Still, the new policy may prompt worries. It states physicians must consider the profession's reputation, but does that leave room for critiquing remuneration or management? The concern is not unfounded: The Saskatchewan Registered Nurses Association fined Carolyn Strom $26,000 for unprofessional conduct when she complained about her grandfather's care in a long-term care home on a 2015 Facebook post. She only got her case overturned by the Saskatchewan Court of Appeal in October 2020.

The CPSO recommends physicians have separate professional and personal accounts. Yet on social media, the personal and the professional can blend: Professional accounts have photos of docs on docks and pictures of pandemic puppies. Sharing personal stories helps physicians feel connected. Whittling down physicians to just their white coats could limit their role as health advocates; without the personal touches, they could appear less authentic and their message less compelling. With this new policy, Ontario doctors will need to pause and think before sharing their views on social media. **—KYLIE TAGGART**

# HOW TO DO EVERY THING BETTER

We looked for doctors' most common 'how to' questions and asked colleagues and advisers to help answer them

BY ABIGAIL CUKIER, LOUISE LEGER AND KYLIE TAGGERT

HOW TO . . .

# Keep staff happy

IT may not be the first thing you think of when you set up a practice, but keeping the team happy and avoiding the revolving door of ever-changing staff can go a long way to guarding your reputation and saving you money and stress.

In talking with HR experts and experienced physicians, keeping staff happy seems to come down to three Cs: Communication, Compensation and Culture. That means paying fairly, understanding and building office culture, and creating an atmosphere of open, two-way communications.

## Compensation

Dermatologist Dr. Benjamin Barankin is the medical director and founder at Toronto Dermatology Centre, which has a staff of 40. At times in the past, he admits, the clinic has had trouble retaining staff, who tend to compare salaries and benefits with others across the sector.

"Number one for keeping the staff happy is paying top-of-scale," he said. "We've had staff being poached by other clinics and had to raise our wages to slow down the revolving door."

Marilyn Lawrie, a healthcare human resources consultant at BizShrink in Vancouver, agreed.

"If you're not compensating people on par with what the industry says, you're going to lose them and you're going to have constant turnover, and that costs a lot of money," she said. "We work on a business model in healthcare that's really dysfunctional, especially in public healthcare. So, doctors are dealing with the reality that profit margins aren't huge. But the other thing that helps (is to) look at giving people a number of personal days they can take a year for their personal health and wellbeing."

## Communication

Dr. Paul Johnson is a family physician at Synergy Medical Clinic in Sherwood Park, Alta., which has 30 full-time-equivalent family physicians and 50 staff.

Managing such a large team successfully, he said, means, "keeping open communication with staff and holding regular meetings. I try to have an open-door policy where employees are free to mention any concerns," he said.

Lawrie fully endorses this approach. "This is the number-one place people go wrong: not communicating with their employees, not giving employees the feeling that it's emotionally safe for them to disclose the things that aren't going right for them," she said. "If you don't, underground communication starts, resentment builds (and) you've got a whole group of people who are negative and unhappy, and then that's a big problem to fix."

Dr. Barankin agreed. "You have to take the pulse of the office, know how people are feeling. If equipment is getting slow or freezing up, you want to know and replace it ASAP. But often staff won't complain about such things unless you ask them."

Noted Lawrie: "Talk to them. 'How are you feeling? How are you doing? What would you like? What do we need to do as a team?' Physicians often give everything to the patients and they forget that their staff need attention too."

## Culture

Building a positive culture doesn't have to mean giving gold stars and taking the team bowling—but it can.

"These days, everybody is looking at environments where inclusion is key," said Lawrie, "and not just racial, sexual, and age inclusion, but inclusion as a team, as a group of people who are working toward a common goal."

At Synergy Medical Clinic, that means staff social events and regular recognition for a job well done.

"It is important to have regular social nights such as bowling nights and TGIFs in order to keep staff morale high," said Dr. Johnson. "Recognition of the hard work of staff (especially during COVID-19) goes beyond just a regular paycheque."

Lawrie says when it comes to culture, the most important thing is to custom-make the rewards and activities to fit the team. "Even within a company that has multiple locations, you'll find some locations are just really jazzed to hang out with one another (after hours) and others are not at all. It's not a one-size-fits-all kind of a question. Some people really like the social aspect of doing things with their workmates and other people not so much. It really depends on the individual company culture."

## Praise and respect

For Dr. Barankin, praise and respect go a long way to keep staff happy, he said. "Praising them in front of colleagues and patients is always welcome. Talk to them about non-clinic things like their weekend or summer plans, what their kids are up to. Remember their birthdays."

Periodic random acts of kindness are also a good idea, he said, like Starbucks gift cards, movie passes, in-office masseuse for staff, yoga in the park, ice cream and popsicles as an afternoon treat.

Flexibility also helps. "During COVID, some staff had childcare issues," said Dr. Barankin. "We showed our caring and flexibility by allowing them to take as much time off as needed without any pressure, and to allow them to work whichever hours they could, and in some cases doing work from home."

And although it might be tempting for cost savings, Dr. Barankin advised against running your clinic with bare-bones staff. "They need to have some slack, otherwise they will burn out."

Added Dr. Johnson: "Just like most things in life if you are treated well rather than just a number, the favour is usually returned." **—LOUISE LEGER**

HOW TO . . .

# Set boundaries with patients, family members

Medical regulatory authorities have strict rules about professional and personal boundaries, but translating the requirements into everyday life takes discipline.

Dr. Nadya Sankat, a family physician in Brampton, Ont., said that family and friends asking for medical advice is a common occurrence. While they're usually aware that she's not able to treat them, they do use her as a sounding board and resource for trusted information, she said. Dr. Sankat gives them general information, and then directs them to their family doctor.

Dr. Leisha Hawker, a family physician in Halifax, does the same. She provides basic medical information (e.g., "yes, you should get vaccinated") and then steers family and friends to their own family doctor. "I think if you asked my sister and my husband, they would probably tell you that I'm not very helpful," she laughed.

Dr. Jabir Jassam, a family physician in Ottawa, has taken a different route. He said that he himself can separate his personal life from his professional life, but "it is not easy for others to understand and accept it," he said. "I limited my socialization to avoid such conflicts, so I became familiar with lockdown a long time before the COVID-19 era," he said. In a blog for the *Medical Post*, Dr. Jassam wrote about how in other parts of the world, a doctor is expected to treat their families and friends. People from those countries may be confused when strict lines are drawn between professional and personal lives.

**In other parts of the world, a doctor is expected to treat their families and friends. People from those countries may be confused when strict lines are drawn between professional and personal lives.**

## Personal email and cell number

When it comes to patients crossing the line, Dr. Hawker hasn't had any problems. While most physicians don't give their number to patients, Dr. Hawker has shared hers with family members of a patient receiving palliative care. She has never had an issue with them calling her inappropriately or sharing her number. A patient once got her personal email through an administration error, but Dr. Hawker never responded directly, forwarding the message to the receptionist, and the patient contacted the receptionist after that.

Dr. Jassam had to block a patient's email after they kept emailing his personal email. He also changed his personal number after a patient repeatedly called him to ask for an appointment.

Dr. Hawker said that making the rules clear—and sticking to them—is key when it comes to maintaining the confines of the physician-patient relationship. With boundaries, "it is important to be consistent with all your patients so that the expectation is there," she said. **—KYLIE TAGGART**

## How to . . .
## Call out racism, sexism, homophobia

**As a physician,** you meet all kinds of patients. . . including some with closed minds, outdated ideas and hurtful views. How do you call them out on it? The subject came up in a recent "Solve My Problem" feature in the *Medical Post*.

Dr. Sarah Giles, a remote and rural family/emergency doctor, says you *don't* call them out. You call them "in."

"I say, 'I'm sorry, I think I missed what you said. I heard something really racist and I'm sure you didn't say that,' she said in a comment to the *Medical Post* earlier this year. "This can be a way of 'calling in' rather than 'calling out.' I'm slowly learning that 'calling out' people on their comments leads them to become more firmly entrenched in their position. By giving them an out, it seems to give people a way to save face and maybe, just maybe, rethink what they were saying."

Semi-retired Kingston GP Dr. Frank Poce said expressing disappointment is an effective way to shut down an out-of-bounds comment. "I (would say), 'That thought you mentioned disappoints me. Consider that many of the greatest achievements in science, medicine and world leadership and much more, have been made by many of these (insert group) that you have just mentioned.' Simple, but always effective."

Another tact? Misunderstand them and ask them to repeat and explain what they said. "Having to explain what they said is usually embarrassing for their author," said Dr. Selby Frank, a family physician in Vegreville, Alta.

HOW TO . . .

# Negotiate rent with a clinic

Rent can be your medical clinic's biggest expense. Before entering into negotiations and signing a lease, it's important to understand your rights and obligations so that you are not stuck with hidden costs or other surprises—and so you can reach an agreement that meets your needs.

"Generally speaking, physicians are very good tenants. Landlords recognize and value that, so you can leverage that," said Huy Lam, principal at Periscope Realty in Toronto, which specializes in healthcare properties.

"Also, from a landlord's perspective, they want a physician who generates foot traffic. So depending on what type of medicine you practise, you may be able to negotiate better rates."

Here are some tips to help you negotiate a lease that will work to your advantage:

**Find out about inducements:** Lam recommends asking the landlord about inducements. For example, you may be able to negotiate for a few months of free base rent or to have the landlord pay for renovations or to finance them over the term of your lease.

**Research market rents:** Before negotiating, Lam suggests getting an idea of market rents in the neighbourhood. You can talk to a commercial realtor to get up-to-date market lease rates, which could help you negotiate a lower rent. Lam says that often the landlord will pay the realtor's fee.

**Be aware of all costs:** "People just look at how much space they are getting and the monthly rent. I want people to think about the total cost of the contract," said Dr. Alykhan Abdulla, medical director of the Kingsway Health Centre near Ottawa. "Who is responsible for what? If the power shorts out or the elevator needs to be fixed and you work on the top floor. . . . In one of my buildings, the toilet broke down and it became my responsibility."

Dr. Abdulla also says to find out about the financial penalties surrounding terminating the contract. Also, be sure to understand when and how the lease will be renewed and whether you have the option to renew.

Lam suggests looking at property tax increases over the past few years to get an idea of what you may be paying. Also consider maintenance costs, such as roof repairs or repaving the parking lot. "The cost is generally amortized over the lifetime of the property, so it's hard to get a handle on additional costs. Just be cognizant of what historical additional costs have been in the building so you can plan going forward," said Lam.

**Choose the length of the contract:** A typical lease term is five years, Lam says. A shorter contract gives you more flexibility while a longer contract provides more security in your payments, he says, adding that due to the expense of setting up a medical practice and providing stability to patients, physicians usually remain in one place long-term. "If you extend, after the first five years, there may be a demolition clause," said Lam. "This means if they sell the building to a developer or if they demolish the building, they can terminate the lease without cause or a penalty. You may be able to negotiate compensation if that does happen."

**Be familiar with contract types:** "A lot of people look at what the monthly rent is, but they don't know about things like triple rent adjustments. So if they do any upgrades in this particular building, you have to pay your proportionate share on those," said Dr. Abdulla. "A lot of people don't know that and they just

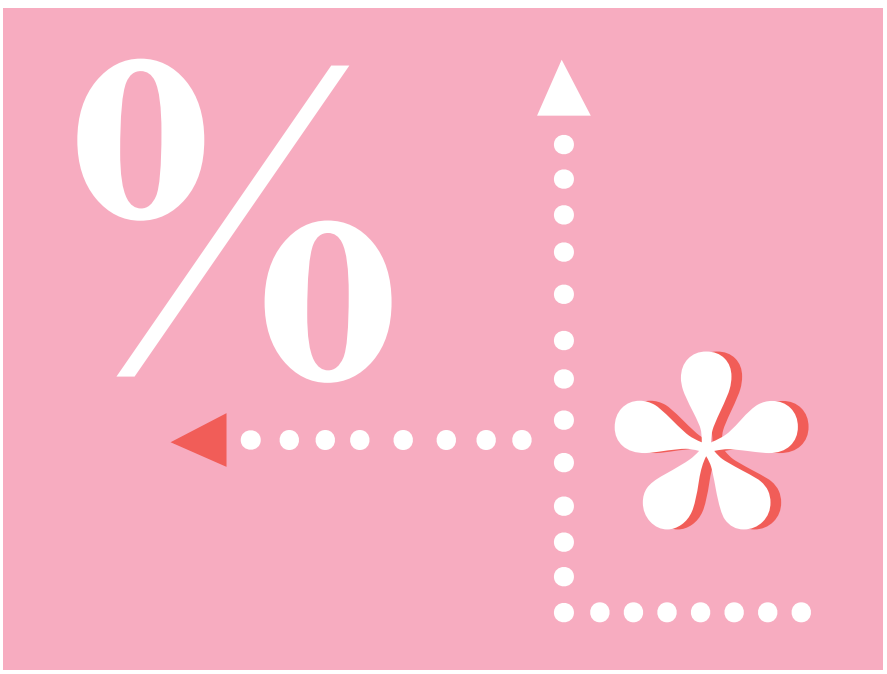
**"Generally speaking, physicians are very good tenants. Landlords recognize and value that, so you can leverage that."**

think they are getting a great deal."

For example, according to the Business Development Bank of Canada, in a gross rent lease, you pay a single amount to the landlord for base rent and utilities, property tax, insurance, maintenance, repairs and services, such as snow removal and grass cutting. In a net lease, you usually pay for the base rent plus one of the following: property taxes, insurance or utilities. Your landlord pays for all other expenses. In a double net lease, you pay base rent plus property taxes and insurance. In a triple net lease, or triple rent adjustment, you usually pay base rent, plus property taxes, building insurance and utilities, as well as other operating and maintenance costs.

**Think about location:** "It's not just about picking a place and getting a good lease amount," said Tammy Rea, regional manager, professional banking at TD Business Banking in Surrey, B.C. "I think it's really important to know who the providers are around you. See how many other allied care providers are close by who you may want to work with. What are the demographics in the community? Do you prefer working with seniors or young families? What's the future growth plan of the community?"

Other location-based factors to consider include parking spaces, says Rea. Are there enough spaces for you and the other tenants? Will you be able to attract locums? "If you are in a more



HOW TO . . .

# Keep overhead costs down

Throughout his 34 years as a general surgeon, Dr. Jeff Way has worked to keep his medical practice costs down. But he says it's a major challenge.

To avoid laying off staff during the 1990s healthcare budget cuts in Alberta, Dr. Way terminated his cleaning services contract and staff did the office cleaning for a while to save money. More recently, he has had to shoulder the increased costs of personal protective equipment and hand sanitizer due to the pandemic. Office staff try to reuse supplies as much as possible and have equipment repaired rather than replaced when possible. His office manager also tries to negotiate the best rates for phone, internet and other services.

"It only goes so far, but we do our best," Dr. Way said. "I do everything I can to keep my overhead costs down. We have no ability to pass on costs, which are continuing to increase. It's a tough problem for all physicians."

In fact, according to the Ontario Medical Association (OMA), office overhead expenses typically account for 35% to 40% of gross income for most physicians. Reducing that figure can have a major impact on a clinic's bottom line.

"Physicians don't always consider themselves as an entrepreneur or business manager. Their mentality is that they deliver healthcare, and there's a bit of a disconnect between the two," said Tammy Rea, regional manager, professional banking at TD Business Banking in Surrey, B.C. "Physicians also have (a) complex billing system and restrictions that they have to work within. So the dynamics of a clinic are completely unique from any other business model." Despite this, Rea says there are steps physicians can take to lower overhead costs.

Hire a specialist: Rea recommends working with an accountant specializing in healthcare. "A specialist understands the industry and can tell you how you can optimize your billings or how much in billings you need to offset increases in costs to your practice," she said.

Because billing is so complex and provinces update fees so often, Rea says it is also important to regularly train any staff who are handling billing.

Take inventory of your expenses: The OMA publication, Revenue management: Prescriptions for a

expensive area, you may pay a premium, but it may be easier to attract physicians to join you who can help provide services and share the costs," Rea said.

**Consult a professional:** It is important to take your time to make sure you understand your lease agreement, says Lam. He also suggests reaching out to a commercial real estate professional or commercial lawyer for advice.

**Consider buying:** Rea suggests physicians consider purchasing a building as an investment instead of paying rent. "The clinic can then pay the lease and you have the equity that's building up in a commercial property," she said. "If you're going to settle in for the long haul, why would you not purchase? You would have a lot more control and you know that you're not going to have a new landlord come in and jack up your lease or have a demolition clause that causes you to relocate." **—ABIGAIL CUKIER**

profitable medical practice, recommends doing a full review of your expenses so you know what you are spending in every area and can explore less costly alternatives.

Consider which technology platforms and other equipment you are using. "Are you opting into a five-star platform and only using 20% of it? I worked with one physician who had 11 platforms. I asked her if she had considered paying a higher fee for one platform that would increase efficiencies and save time," Rea said.

Employees are your biggest asset and your biggest expense, says Rea. "Ask yourself if you are efficient with the staff you have or if you have to let some staff go, which is never easy." In addition, the OMA recommends ensuring that staff are fully trained on processes and technologies to maximize efficiency and performance. It also advises avoiding redundancies where more than one individual is doing the same tasks and cross-training staff so they can fill in for each other during absences.

Negotiate: "Doctors don't ask for a better deal. We make the assumption that because it is a business expense, this is the expense. What happens is, we end up paying top dollar," said Dr. Alykhan Abdulla, a family doctor near Ottawa, who also advises other physicians on practice management.

Dr. Abdulla recommends using one company's prices to negotiate a better deal with another. He says not to be too shy to ask for a discount. "Think about building relationships with your suppliers and consultants, such as EMR providers, cleaners and IT services, because changing services can have many hidden fees."

Consider consolidation: "Maybe there are two clinics that no longer need so much space and there is an opportunity for consolidation. Or there may be an opportunity to have an allied care provider come in and share the lease to help you offset some of the costs," Rea said. Dr. Abdulla says many doctors rent out space, such as by providing a wall where an orthotics company can sell its products.

Optimize patient billing: Optimizing the number of patient visits to your clinic can help offset rising costs, Rea says. Ensuring efficient charting to allow the clinic to bill for the proper services is important. She also suggests seeing how you can use virtual care to complement in-person appointments. "If you are in a province that limits the number of in-person appointments each day and you are done by noon, for example, you can take a few hours to do telehealth," she said.

Hire a good office manager: Rea adds that it is important to pay your office manager well. "That is the person who allows you to just go in and practise medicine," she said. "They look at how to make the clinic profitable. It's the manager typically who is responsible for billing and optimizing patient flow. They have a really important role. If life is easier for you, be sure to compensate them well." **—ABIGAIL CUKIER**

**How to . . .**
## Be a good MD and parent

**During our** recent *Medical Post* M-Talk panel, we heard from Drs. Melissa Yuan-Innes (two kids) and Ginevra Mills (three kids).

Both emphasized they are fortunate in a way many parents are not: They have supportive, involved partners. They also have outside help. "If you can afford it," said Dr. Yuan-Innes, "hire help. It will save your sanity, it will save your marriage."

Next: Set boundaries and forget the guilt. "I always play the doctor card: *"Mommy has a night shift!"* said Dr. Yuan-Innes. "I (have slept) in a tent outside . . . and rented Airbnb's because I feel nobody messes with my sleep. If people aren't afraid to play the 'B' card, just do it. You're not going to survive otherwise."

Dr. Mills said that, "During residency and fellowship, I had my husband or nanny."

Eight months before she wrote her college exams, she moved into the spare bedroom in the basement. "I had a desk and a bed. I never saw my kids. I would eat dinner with them on the nights I was home. I would say goodnight and put them into bed, and on Sundays, I wouldn't study until they went to bed. My kids survived."

HOW TO . . .

# Deal with demanding patients

Patients banging their fists at reception, yelling at staff on the phone, demanding to be seen, insisting on certain tests, prescriptions or procedures: It does not make for an easy day at a clinic.

How to handle this kind of difficult behaviour?

Approaching the situation with compassion and empathy is what Dr. Marcus Greatheart, a family physician in Vancouver, recommends. For someone wanting to be seen now, he said that he and his staff try to understand what is behind the patient's urgency. "Sometimes folks just have to be heard and reassured," he said. "That's often what our nurses will do."

In some cases, patients may be addressing staff in a way that is normal or common in their culture. There's no malice in it; it's just how they communicate.

"Sometimes what we might perceive as demanding or challenging might be a cultural misunderstanding," Dr. Greatheart said. He said that a quick conversation with the patient usually changes the tone. Dr. Greatheart, a former social worker, teaches physicians about patient-doctor communication.

Dr. Greatheart said that physicians may need to see some patients with a trauma-informed lens. "Sometimes patients are doing the best they can to ask to get their needs met," he said. "It can be socially awkward or inappropriate, but oftentimes it is the best that folks have, so we can address that."

He said that doctors must remember that colonization has taken a large toll on Indigenous patients. "The onus is on us to understand that history and how it might create tension in the clinical space with our patients and it is up to us to address, to acknowledge and to support those patients."

## Unnecessary test requests

For people who are asking for a certain test or procedure, Dr. Greatheart just reiterates what he can offer based on the medical evidence and his training. His script goes like this: "We can offer this, or that, however the test or treatment you are requesting is not something I can offer today," he said. "And then I shut up."

Dr. Nadya Sankat, a family physician in Brampton, Ont., takes time to fully explain why a treatment or test is needed, or why it's not recommended. "Generally, I find with a family practice patient, you get to know the patient and have an understanding of them and the reason for the request," she said. Dr. Sankat said sometimes she and the patient come to a compromise that they are both comfortable with and is medically appropriate. "However, there are always rare occasions that patients will not be satisfied with the end result, even with appropriate and effective communication and discussion."

Dr. Jabir Jassam, a family physician in Ottawa, also takes time to clearly explain to patients why a test or procedure might not be needed or required. He firmly declines requests when patients insist they need an inappropriate medical service. "The internet made people more demanding and anxious, and doctors more exhausted as they spend more time invalidating Dr. Google's plan of care," he said.

Dr. Greatheart said it is important to remember that the patient isn't difficult, the behaviour is difficult. Labelling a patient as demanding or difficult can create barriers in their future interactions with healthcare professionals.

If a patient is consistently displaying problematic behaviour, Dr. Greatheart will invite them in for a meeting. They discuss, "how we work together and what they can expect from us and we expect from them," he said. The clinic manager might join them in the meeting.

"There's always going to be disagreements between doctors and patients," he said. "The question is how we situate ourselves in conflict. If we situate ourselves across from the patient, and we are in conflict with them, then that's harder to resolve than if we align ourselves with them. If we are truly walking alongside our patients, to help them along their health journey, then we can address the problem together."

Basically, compassion and empathy—combined with firm refusal of inappropriate care—does work as a strategy to deal with quarrelsome patients. "It's easier to do than most people think and the positive impact it has on the doctor-patient relationship is extraordinary," Dr. Greatheart said.

—KYLIE TAGGART

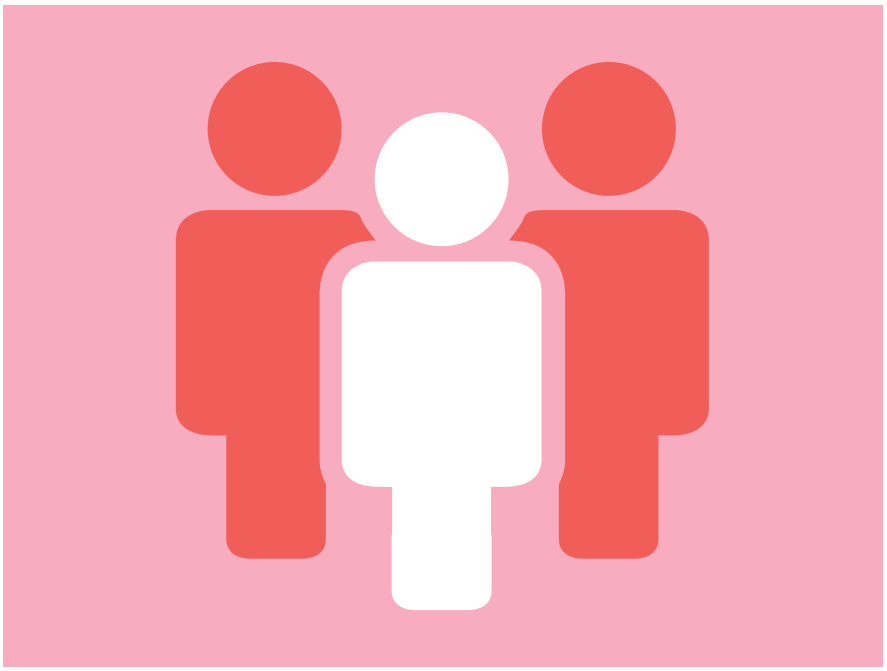
### How to . . .
### Get kids to do household chores

**Parent-doctors** may have an untapped resource when it comes to getting household chores done: their kids.

In a recent *Medical Post*'s M-Talks panel discussion, Dr. Ginevra Mills said she took a course online, Positive Parenting Solutions, which included an extensive list of age-appropriate chores for kids. (Download the list for free at positiveparentingsolutions.com).

"It really opened my eyes to what I could be expecting of my children," she said. "Our 11-year-old helps us with dinner every night, our nine-year-old does the dishes, our five-year-old sets and clears the table, and everyone helps with laundry.

Also a mother of three, Dr. Michelle Cohen, on M-Talks, agrees: "The house was a disaster during COVID, so . . . a few months ago we said, 'You, you're going to be doing laundry; the 12- and nine-year-old are making dinner once a week.' They are fully capable . . . you just have to get over the whining stage."



HOW TO . . .

# Squeeze in extra patients

A toddler with an ear infection, a weekend warrior with a sprained ankle, a school-aged child with a strange rash: There are many cases in family medicine that don't require a trip to the emergency room but still need to be seen urgently.

How to fit them all in between routine immunizations and regular check-ups with patients who have chronic illnesses?

Making sure patients have timely access requires planned flexibility: having systems in place to allow patients to slide in when they need help, and managing the patient roster so that no one has to wait long to get appropriate care.

Most physicians leave a few spots during the day to accommodate cases that merit same-day appointments, and the front-desk staff triage who needs them most. The reserved spots are not always enough if there is a flood of urgent cases. Dr. Jabir Jassam, a family physician in Ottawa, said that he or the nurse practitioner in his practice sometimes also have to schedule appointments during their lunch hour or at the end of the day. Dr. Nadya Sankat, a family physician in Brampton, Ont., does the same. The front-desk staff messages her beforehand to verify that the patient needs to be seen on the same day.

Dr. Leisha Hawker, a family physician in Halifax, practises in a large collaborative clinic, where someone is always available to see a patient on the same day. "Between the whole clinic we usually have several same-day or next-day spots," she said. "The front desk will try their best to fit that patient in with their usual provider." When she's not available, another physician will see the patient and make notes on the shared EMR. The clinic also has weekly rounds so physicians can share information on patients who are having a medical crisis (e.g., a new cancer diagnosis) and might be contacting the clinic for an urgent appointment or after-hours care.

Dr. Sankat also practises as part of a collaborative clinic at the Central Brampton Family Health Team. Like Dr. Hawker, if Dr. Sankat can't see her patient, staff can offer an appointment with the on-call doctor, the nurse practitioner or a family medicine resident. "Patients benefit from the Family Health Team approach," she said.

Dr. Hawker also practises at a clinic for new Canadians. There, language can be a barrier to booking appointments, so patients often just show up. Recently, the primary care providers in the clinic changed schedules so everyone has at least one early afternoon spot for a same-day appointment. Patients now know early afternoon is when they can be seen, which has helped both them and staff navigate same-day access.

"As a primary care physician, I think that it is important that we have some system so that patients connect with us urgently. There are so many things in primary care that need to be seen within 48 hours, and it is important that we offer that," she said.

## New patient cap

Every patient population is different, so there is no fast formula about how many patients a family physician can have in their roster. Dr. Jassam said he stopped accepting new patients when his wait time was longer than two weeks. For Dr. Hawker, her team temporarily stopped taking new patients when there was a six-week-long wait for routine appointments.

"What number is the right number for a community physician really depends on the community you're practising in," Dr. Hawker said. Her practice has a larger proportion of people who are insecurely housed or homeless. A number of her patients have addiction issues. These patients tend to have complex medical needs, so the number of people on her roster is lower, she said.

Patient populations can also change. Dr. Hawker practises with the North End Community Health Practice, which was initially designed to serve a certain geographical catchment area, but the area is transforming. It is being gentrified and now home to large condo buildings, so the patient population is changing both in magnitude and characteristics. The number of patients on her roster may need to be adjusted, with timely access to care top of mind.

—KYLIE TAGGART

HOW TO . . .

# Generate extra cash

Growing up, Dr. Alykhan Abdulla always seemed to have some business going, whether it was a landscaping service or a house painting company.

"That side of things always came naturally to me, but when I talked to my doctor colleagues, they would always say, 'How did you get the lease at that rate?' or 'How did you get the computer company to give you that discount?' Many people came to me and asked for help with contracts or things like that," said Dr. Abdulla, medical director of the Kingsway Health Centre near Ottawa.

For the past 10 years, the family doctor has also worked as a paid consultant to help other physicians navigate business matters such as selling or buying into practices or negotiating leases or contracts.

"It was a different type of business, where you could still be involved in medicine and you are helping your colleagues," Dr. Abdulla said. "I always thought it was fun and people appreciated it and then they started paying for it."

Many physicians are finding ways to generate extra cash flow outside of medicare. These side hustles can help guard against changes in medicine or their current role, help them achieve financial independence quicker and allow them to expand their network and to pursue other interests and passions.

Possibilities include:

- medical consulting
- serving as an expert witness
- medical writing or editing
- performing aesthetic medicine
- developing med tech or an app
- providing hearing tests
- doing travel medicine
- consult for insurance companies

"It is absolutely appropriate for doctors to be able to get into these businesses, because it's better than getting people who don't know anything about cosmetic medicine doing cosmetic medicine, for example," said Dr. Abdulla.

Dr. Abdulla advises physicians who are considering an extra role to do their research to build the skill set they will need. If you're being hired as a consultant or a doctor for a sports team—which Dr. Abdulla has done—he says to be sure to understand the contract and hire a lawyer to help you negotiate.

When considering whether a side hustle is worth it, think about how much you can make. What is your time worth? Is it something you are passionate about? Will it help create your ideal life?

Doctors are advised to consider whether they should just work more at their current job, says Tammy Rea, regional manager, professional banking at TD Business Banking in Surrey, B.C. "You may opt to do something else, which you are excited about, but actually not make as much money, given the number of hours you are working," she said. Rea recommends that physicians look at their billings and expenses and divide their earnings by the number of hours they work to find out how much they make per hour. "You may just be able to optimize your billings and be more efficient in your clinic."

Dr. Abdulla has similar advice. "There are multiple business lines and some are profitable and with some, you may break even," he said. For example, he says Botox training can cost between $2,000 and $10,000. Then you must stock the product in your office, take the time to sell it to patients and add other expenses, such as a credit card machine. "You really need to understand the business model. If you don't, you'll end up losing more money than you'll gain. You have to sell a lot of Botox to get the $10,000 in training back."

Despite this, Dr. Abdulla is a proponent of physicians taking steps to create extra cash flow. He says it will only become more difficult to earn money through public health insurance. "When I started in 1992, I could see 10 people in an hour. Today, I am lucky if I see four an hour," he said. "It is much more complicated. They require more documentation and I am responsible for so much more for that same service.

"The OHIP pool is going to get smaller and doctors need to think of extra jobs they can do on the side."

**—ABIGAIL CUKIER**

# The WISDOM OF YOUTH

## It goes both ways: Experienced MDs share what they've learned from those they train

BY LOUISE LEGER

**DR. CLOVER HEMANS**
*Primary care physician and past-president of the Federation of Medical Women of Canada in Burlington, Ont.*

**Never underestimate** the power of lived experience. Trainees and students bring a new lens/perspective that might be missed in those with multiple exposures (in itself a type of bias—though I'm not disrespecting or dismissing this type of conventional, experiential wisdom!).

Students and trainees offer you multiple opportunities to learn from their challenges if you listen and reflect. They are often able to bring more details from patients that can change/add opportunities for care, rehab, reintegration back into their own community.

Years ago, I was facilitating a session with students, patients and some faculty on maternal-child health and the multiple challenges and opportunities associated with teenage pregnancy, birth and child rearing. A young mom noted that in the delivery room, everyone was giving her the disapproving eye.… They seemed only focused on the pitfalls of having a baby as a teenager to the point that when the baby was born, not one person congratulated her on successfully delivering a healthy child! What a wake-up moment! It was a profoundly uncomfortable (for me almost heartbreaking) moment. Before I could comment, a student stood up in class to apologize for our arrogance and bias.

The bias we carry as healthcare personnel who believe we know more/know better was exposed in that moment. The student clearly saw this and authentically sent a long overdue apology in the moment. I have never forgotten it.

Age might bring wisdom, BUT lived experiences—particularly the difficult, anguish-filled ones (and yes, occasionally the true, pure-joy infused ones) impart an existential bridge to learning about what really matters in life.

Wisdom is not restricted by age, status or educational ranking.

That's another thing I learned from my mentees, students and trainees. In life, we are all in it together. How you live it is influenced by how you see it.

**DR. ERICA LASHER COATES**
*FP in Meteghan Centre, N.S., and preceptor for learners from the Dalhousie family medicine residency program, South West Nova Teaching site*

**I still remember** the first time I was asked by our department if I would be willing to take on a family medicine resident for a two-year preceptorship. My instinct was to say, "Who, me?" I wondered what I had to offer as a preceptor, as a mentor . . . I assumed I would gain something valuable in teaching medical students and residents but I don't think I realized it would become such a passion.

Agreeing to be a preceptor was career-changing for me. It reinforced the true passion I had (and have) for family medicine and my patients. Being a mentor allowed me to be a better and more conscious physician and reminded me why I chose this career for myself.

I can think of countless ways in which students and residents taught me humility, kindness, patience and so many other qualities that make me a better physician. I remember the times when they've challenged me and also the times when they made me dig deep for answers I didn't have.

I hope that each of them can one day know the joy of teaching/mentoring but also the impact that they have on their preceptors in return. We probably don't tell them enough.

**DR. ROD LIM**
*Associate professor and site chief, pediatric emergency department at the Children's Hospital at London Health Sciences Centre, London, Ont.*

**Sometimes, when** I am coaching and mentoring students, I see a better version of ourselves. We have a lot to offer the students on navigating the challenges of a medical career, mentoring them on how to keep their head above water, and sharing what decisions in our life we wish we had made differently.

They in turn remind us of our love of the profession, the mission to help and care for others, and lately, a better, more professional view of how we treat each other and those in the community. I love that through our learners, we are seeing demands on protecting vulnerable people, non-tolerance of the way a certain doctor behaves, and the hope of a balanced professional and personal life.

**DR. DANIEL EZEKIEL**
*FP in Vancouver, UBC professor*

**Many years ago,** shortly after starting my family practice, an old teacher of mine asked me if I had ever considered teaching medical students. I distinctly remember suffering from "Impostor Syndrome" in those early days of my career, and my immediate response was no, I could never do that. Fortunately for me, that old teacher did not take no for an answer and gently pushed me in the desired direction. Now, 24 years later, I am keenly aware that the experience of teaching medical students has given me so much.

I teach two quite different groups of medical students. The first group hails from my local medical school at the University of British Columbia. These students are in their first and second years and are still very green. They ask questions that are often so basic that it forces me to dig deep into the pathophysiology of diseases and think about things I have not thought about for many years. At this relatively late stage in my career, there are many things in clinical practice that I simply take for granted, but when a student asks me "Why is that so?" I take pause and really have to reflect on why I think that. Could there be an alternative I had not considered? Then, I have to explain my rationale to the students. As they say, you don't really understand something until you have to teach it to someone else!

The second group of students I teach are Canadians who are studying medicine abroad and are desperate to find a way home. These students are usually in their last year of medical school and spend some of their elective time with me in order to see the Canadian medical system at work and, hopefully, garner a positive letter of reference from me in support of their applications to Canadian residency programs. Some of them have never been exposed to family practice. These international students often come long distances for the experience and spend every day with me for a month. Initially, I was uncertain and apprehensive about the quality of their training, but I was dead wrong. They, too, are a joy for me to teach as they are ultra-keen to help in my office and ask many, many non-clinical questions, like how to build a practice, how we are paid, how we order supplies, how we negotiate a lease, and so on. It gives me great pleasure to spend time with them after the work day is done, just mentoring them on their journeys.

So go teach some medical students! Sure they might put you a little behind schedule, but you won't regret it!

**DR. MATTHEW MCINNES**
*Professor, department of radiology, University of Ottawa*

**One thing I have** learned from the many great trainees that I have worked with is that there are many paths to success. The path I followed is not necessarily the correct one for a trainee who is in a different situation. For example, sometimes I work with people from different countries who have already done many years of training in a different specialty. So understanding people's backgrounds, various skill sets and personal/professional situations is critical when developing a teaching and/or mentoring plan for them.

**DR. MIKE WADDEN**
*FP in Kentville, N.S., and preceptor for the Dalhousie family medicine residency program, Annapolis Valley teaching site*

**There is an old saying** that you really do not know something until you must teach it, and that is certainly true in medicine. Being challenged constantly by learners has spurred me on to do more reading and critical appraisal of evidence—and not just use treatments because of dogma. They have improved my practice. The different perspectives and novel ways of thinking of each learner add different perspectives to the care of patients. Even the most challenging learners teach you things about yourself both professionally and personally.

**DR. MELISSA YUAN-INNES**
*Emergency physician in Alexandria, Ont.*

**I was a bit nervous** about teaching at a tertiary hospital after being away from academia, but an FRCP(C) resident told me I was her best teacher because I asked her for her learning objectives, and then ensured that she got to attend a conscious sedation, even though it wasn't my case. I was touched.

A medical student taught me that we still have a long way to go. There was no dedicated pumping space at her school. New moms were expected to take a 20-minute shuttle ride elsewhere on campus. This is ridiculous.

Another resident opened my eyes to discrimination. Part of the bias against her, I'd say now, was the fact that she was an international medical graduate. So sad how physicians eat our own. **MP**

Photo of Dr. Matthew McInnes by Valerie Keeler, Valberg Imaging

COLUMN

# How to say no…just *No!*

## Learn to say it and mean it and forget about it

BY DR. MELISSA YUAN-INNES

Theoretically, this is simple. My female colleagues counsel each other on this all the time.

"No is a complete sentence."

"Open your mouth. Say no. Close your mouth."

But people keep asking. Patients demand to be seen now! Instantly! For as long as they want! They don't care if your clinic is running late, they have a list! And their mothers and sisters need to be seen! They drove here, so see them too!

Administrators ask. See more patients. See them faster. While using our crappy electronic medical records. Stay late. Don't get paid more—get paid less! And if you made a mistake, hey, enjoy getting hung out to dry! While you're waiting for your lawsuit, here, have a few more patients/night shifts/complaints!

Families ask. Baby: Waaaah!!! Husband: Hey, you didn't make a big deal out of my birthday. In-laws: Could you look at my mole? Kids: Mommymommymommy.

Solution: No. And mean it. If you say no, but hesitate and look agonized, they will go for the kill. And you are the one who'll get killed.

You have to believe in yourself. It's a superpower. It's a shield that you erect around yourself, so when they pelt you with objections and try to shame you or curse you, you may ignore them or laugh at them or vaguely notice them as you go on about your day.

Last step: Forget about it. You said no, you meant no, and now it's not your problem anymore. Vent and move on. It's not your job to think about that person anymore.

Remember, you only get one life. It's yours to enjoy and to protect and defend.

Getty Images/Corlorstudio

One last point. Family doctors are under attack. They're sideswiped by toe complaints that turn into mental health issues. Patients demand to see them and then claim their family doctors aren't open. I was so astonished when a friend told me about all the things her patients expect that I wrote a letter for her. Feel free to use it if you like, and let me know how it goes!

*As of October 1, 2021, Dr. No's practice will change:*

**1.** When you book your appointment, please state if you have a mental health concern. Many people are struggling with depression and anxiety right now. Her secretary, Noelle, will screen all callers for mental health.

**2.** Dr. No will address one concern per visit. Any further concerns may require rebooking.

**3.** If you have any health issues, mental or physical, you must book an appointment through Noelle, even if you run into Dr. No outside the office. Please do not stop Dr. No at the hospital or contact her personally with a question about you or your family's health, no matter how small the issue may appear. This is true even if you work at the hospital yourself. It's always in your best interest to have her sit down and spend the time with you properly at an appointment.

**4.** Noelle will give you the next available appointment. She is in control of Dr. No's office bookings. Contacting Dr. No won't change your appointment. If you believe you need to be seen more urgently, please go to the evening clinic or to the emergency department.

**5.** Dr. No will no longer contact you for normal results (normal lab tests, imaging, etc.). She will still contact you if anything is serious. No news is good news. If you still have a question about your test, simply book a followup appointment.

**6.** Dr. No is not available for hospital meetings or patient appointments when she is on vacation. She is not immediately available for administrative questions when she looks after the hospital's admitted patients for up to 10 weeks per year.

None of these decisions have been made lightly, but the pandemic has strained everyone, especially those who work in healthcare. These changes are essential to safeguard your health, the health of all patients in the practice, and Dr. No and Noelle's well-being.

Thank you for your understanding.

**DR. MELISSA YUAN-INNES** *is an emergency physician in Alexandria, Ont. Her website is melissayuaninnes.com.*

**"Dr. No will no longer contact you for normal results (normal lab tests, imaging, etc.). She will still contact you if anything is serious. No news is good news."**

**How to . . .**

## Get the word out to build your practice

**When you're** starting out, you may wonder where your patients will come from. In a recent "Solve my Problem" column, several physicians weighed in on their tactics for building a practice.

Dr. Christine Nicholas, a plastic surgeon at Halton Healthcare in Milton, Ont., started her practice in 2020. She suggests sending faxes to local family doctor offices in your area explaining who you are and what you specialize in. "Often they are happy to send referrals your way if you are a specialist because you will likely have shorter wait times since you are starting out. You can find doctors' offices on Google. If you have a hospital-based practice, you can drop flyers in the mailboxes of physicians who work at the same hospital to boost your referrals."

Nanaimo, B.C. general internist Dr. Hector Baillie suggests holding CME events for other family physicians and other specialists, such as at a local restaurant. "Your audience puts a face to a name, comes up and asks good questions, and understands what you're all about."

If you are a family physician, Dr. Michael Kam, an FP in Kitchener, Ont., advises that you examine what exactly is needed in your community and how your services fill the gap. Next, reach out to local media outlets by email or phone, explaining how your services can benefit the community and how you need assistance in getting the word out. "Often local newspapers have a section dedicated to small businesses where they will be more than happy to run your story," he said.

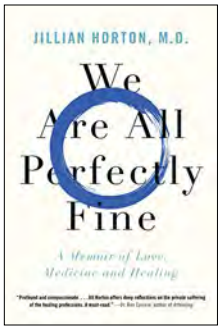
Dr. Kam also suggests running a fundraiser to attract attention to your practice. "Doing something good for the community is always a win-win for everyone involved. Also, make sure you have a good website and that you're listed on Google search, Instagram, Facebook and Twitter (for business). You'll be busy in no time with minimal out-of-pocket costs."

BOOKS

# Fighting despair

## Dr. Jillian Horton's book examines a period of burnout in her life

BY DR. GINEVRA MILLS




**We Are All Perfectly Fine** is Dr. Jillian Horton's bestselling memoir that chronicles her experiences at a five-day physician-only mindfulness retreat, as well as the events in her medical career that led her to the decision to embark on such an endeavour.

Dr. Horton was well into her medical practice, serving as the associate dean of student affairs, and attempting to actively participate in her family life when she was overcome by the raging flames of her own burnout. As she teetered on the edge of a multi-level collapse, a friend encouraged her to sign up for a five-day interactive meditation retreat developed specifically for physicians at Chapin Mill in New York State.

The memoir opens years into her successful general internal medical practice, but Dr. Horton easily shifts between her early life and the formative events that motivated her to pursue a career in medicine, her unexpectedly difficult years of medical school and residency training, her rewarding yet overwhelming experiences as a physician and student affairs dean and, of course, her experiences at the Chapin Mill retreat.

Although the retreat starts out as a relatively personal and keep-to-yourself meditative practice among strangers, it quickly becomes an intimate and interactive sharing experience between physicians from many specialties of medicine; all of whom have been derailed by the unrelenting fatigue and all-consuming guilt and fear or not being "good enough" in medicine. Dr. Horton aptly refers to this condition as a personal and professional "failure to cope."

Dr. Horton's mastery of storytelling, in part because of her master's degrees in English literature, allows her to effortlessly juxtapose compelling stories from her training and patient encounters, with the mindfulness exercises and personal reflections and revelations that came from her time at Chapin Mill. Many of the stories she shares from her own medical experience or those of her co-meditators will feel oddly reminiscent to those experienced by most physician readers. However, rather than inciting feelings of pride and accomplishment in the profession of medicine, the blunt and brutally honest way these stories are shared is enough to make those of us who have experienced similar situations (and we all have) cringe and possibly question the integrity of our profession.

Although Dr. Horton acknowledges that some of her own personal struggles contributed to her reaching a point of despair, she spends a substantial portion of the narrative shedding light on the significant role afforded to the flawed, dehumanizing, and competitive nature of medical education in setting the stage for physician burnout. She describes her training as "an apprenticeship in the art of self-immolation" and explains that no matter how much medical organizations encourage wellness and self-care in physicians, when you spend your life excelling at such an apprenticeship, "you don't just undo (that) overnight—if you ever undo it at all."

Dr. Horton likens medical education, particularly post-graduate training, to the Stanford Prison Experiment. She explains how when "you take a bunch of people who are altruists and perfectionists and have the same baseline predisposition to mental illness as the rest of the population, and you put

*Continued on page 51*


COLUMN

# How to be an effective locum

## Here's a few tricks of the trade from a doctor who has been locuming for almost 14 years

BY DR. SARAH GILES

The art of being an effective locum comes down to communication. An effective locum communicates ahead of time, during the locum, and in followup. They are prepared for the day, honour commitments, don't make changes for sport, and make sure the doctor they are covering for doesn't dread coming home.

After locuming for almost 14 years, I learned a few tricks of the trade. Before agreeing to a locum, I wanted to know a few key details ahead of time. How many patients will I be expected to see each hour? What is the call schedule? Am I also covering inpatients, the ER, obstetrics, or surgical assists? How much is the overhead? Who keeps the extra billings, such as workers' compensation and money from insurance forms? Where will I be staying? Will I be sharing accommodation? Will I have access to a vehicle? Will I have any days off? Knowing what was expected of me decreased my anxiety and helped me plan my days. If I was expected to see more patients per hour than I thought was doable, I'd ask to be accommodated or let them know that I wasn't a good fit.

Being an effective locum means letting the people who work in the office have everything prepared so you can hit the ground running. Send an email with all of your billing numbers and banking information ahead of time so that they can be put into the EMR. Finding out which EMR is used is helpful—you can ask for training before you start or rest easy knowing that you are familiar with it. Having your logins ready before you start also makes the first day more manageable. Also, telling receptionists which procedures you do or do not do can save some uncomfortable situations ("Sorry, I don't do scalpel-free vasectomy…").

An effective locum honours their commitments. In all my years of locuming, I cancelled one week of a locum a week ahead of time when I had pneumonia but still came for the second and third weeks. I cancelled another six months ahead of time. Doctors in full-time practice need breaks. Barring serious emergencies, it is unacceptable to bail on a locum without notice.

Doing a good job at locuming when covering a practice that sees existing patients rather than primarily consults takes time. While it might not be for everyone, I provided the best care when I had a chance to read the patients' charts ahead of time. I would come in early, or stay late, to read the most recent entries in each chart—this works best if the receptionists can give you an idea of why the patient is coming in. If they are looking for a result, I would make sure it was on the chart and I knew the relevant history. If it was for a medication refill, I would review the medications. Taking a few minutes to make sure that preventive health issues are also up-to-date does the patient and the doctor you're covering a great service. I would often print out requisitions for mammograms or fecal immunofluorescence testing prior to the appointment so I could just hand them to the patients. Some locums don't spend the extra time to review charts ahead of time but I have found that failing to do this leaves patients angry about retelling their histories and me running late.

At the end of the first day of a locum, check in with the clinic/hospital staff and ask, "How am I doing? What can I improve on?" Listening to the little pearls of information gleaned from these questions can make life much easier.

Every doctor has their favourite drugs. Perhaps you are used to prescribing perindopril but find that the patients in a practice are mostly on ramipril. As a general rule, an effective locum doesn't change medications for sport. If there is a problem with a medication, I won't hesitate to change it, but if I think that there's only the potential for a small benefit, I may leave a comment suggesting a change to the regular doctor and let them make that decision.

An effective locum does the paperwork. Nobody enjoys completing forms or signing off labs, but it's a necessary evil that locums must embrace. If patients want forms filled out, review the chart, determine if it's possible, and then invite them to come in-person to help them fill in the form. That appointment might not be covered by medicare but it makes it so much easier to complete the form!

When reading correspondence from other physicians, the effective locum enacts the suggestions (such as medication changes or tests to be ordered) but highlights the arrival of very important letters so that the regular doctor can know that it has been received. My method of doing this varied over the years. Sometimes I would sign off the document in the EMR but leave a paper copy for the doctor, other times I would create a document highlighting certain results in one place. No doctor wants to come back from vacation to an inbox full of results. Having a conversation about how to handle these pieces of information ahead of time can be helpful.

My final tip: A happy locum is a fed locum! Find out what time the grocery store(s) opens/closes the day you plan to arrive and pack accordingly. I routinely packed cereal, a tetra pack of soy milk, bagels and peanut butter so that I could make it through most of my first day without a stop at the grocery.

Happy locuming!

*See "Solve my Problem" on page 44 for more tips on locuming.*

**SARAH GILES** *is a family/ER physician who recently shocked even herself by buying a house.*

THE SCOOP

# Maple co-founder would love to go to space

BY DR. BRETT BELCHETZ

**DR. BRETT BELCHETZ** is the CEO and co-founder of Maple (getmaple.ca), a virtual care provider connecting patients with healthcare providers such as doctors and therapists for online medical visits in minutes. He's also a practising physician in Toronto, and a senior fellow at the Fraser Institute. In addition, Dr. Belchetz's passion for healthcare communication and policy have led him to work as an on-air medical expert for CTV and Global News, as well as a contributor to outlets such as the National Post. Previously, Dr. Belchetz worked as a management consultant with McKinsey & Company.

Dr. Brett Belchetz

**Which three people would you like to have dinner with?**
Albert Einstein, Mozart, Steve Jobs. I'd be fascinated to see how they would approach topics unrelated to their primary brilliance. How would Einstein feel about social media, what would Mozart say about global warming, etc.

**What book are you currently reading?**
I'm reading *Recursion* by Blake Crouch. It's an absolutely mind-twisting story that explores the concept of what would happen if we could go back in our lives and change what we consider to be our biggest mistake.

**If you were offered a free trip to space, the moon or to Mars, would you take it?**
I would, although my wife would not be happy! I am a huge sci-fi nerd, and going to space would be a dream come true.

**So what advice would you give to your 18-year-old self?**
First of all, cut your hair. Those photos will be used against you eventually! Second, I'd say to take chances, to dare to follow a path that is different. It took me many years to learn that the safe path was not the one that fulfilled me most.

**Do you meditate in a traditional or other form?**
Never. I've never felt the need for mental stillness. My thoughts wander a lot and this is something I've actually always enjoyed.

**If you weren't a physician, what do you think you'd love to do or be good at instead?**
I would have loved to be an architect. I am enthralled by architecture and design.

**What is one cool website or app that not everyone knows about?**
I really like Flipboard. It's one of my favourite ways to scroll through the news and magazines I'm interested in.

**What's your favorite hobby?**
My favourite hobby is travelling—the more adventurous the better. I can't get enough of exploring the world. MP

SOLVE MY PROBLEM

# How do you create positive locum experiences?

## GIVE TRAINEES A TRIAL RUN

One key in obtaining locum/associate physicians is having regular trainees come through the clinic. I have been teaching PGY-2 family medicine residents for the past nine years. I enjoy teaching and giving back to the profession, plus the learners get a "trial run" in the clinic. Generally, community clinic experiences are quite valuable for residents and they are able to see that a well-run clinic and hospitable workplace sells itself! It is always wise as a locum/potential associate to either know an existing physician in a clinic, or else spend some time as a resident there so you get "the lay of the land."

**– DR. PAUL JOHNSON**

## CREATE A WIN-WIN SITUATION

Back when I was a gastroenterologist and on a salary ceiling at Western University, I would ask the senior GI resident after their Royal College examinations and graduation to do a one-month summer locum for me. The office would be fully booked and I covered all the office expenses. He/she took home everything that was billed. I asked only three things: 1. Continue to practise at the high standard I had observed during their training. 2. Leave me detailed notes on next steps for patients. 3. Give Joyce, the office secretary, a really nice present in thanks for looking after them. I would leave on a Friday and return four weeks later on a Monday, relaxed and refreshed. Joyce took her holidays scattered through the year. We had a happy office and I was a happy GI Guy.

**–DR. STEPHEN SULLIVAN**

**"They also said there was literally nowhere for me to stay, not even a spare room in the entire town due to tourism, and suggested I camp outside of town since I like camping."**

## ARRANGE ACCOMMODATION

Put some effort into making your locum feel welcome. I had a locum booked in an underserved community that claimed to be "desperate." They expected me to start with a night shift in the ER without orientation on the busiest weekend of the entire year. They also said there was literally nowhere for me to stay, not even a spare room in the entire town due to tourism, and suggested I camp outside of town since I like camping. But I called the Visitor Centre and they had almost a dozen hotel rooms available, so it was clear the host did not even try to help me find a place to stay. Needless to say, I cancelled the locum.

**–DR. EKATERINA SLIVKO**

**DR. PAUL JOHNSON**
A family physician in Sherwood Park, Alta.

**DR. STEPHEN SULLIVAN**
A retired gastroenterologist, Victoria

**DR. EKATERINA SLIVKO**
A family physician in Vancouver

**DR. SELBY FRANK**
A family physician in Vegreville, Alta.

## DON'T FORGET THE COFFEE

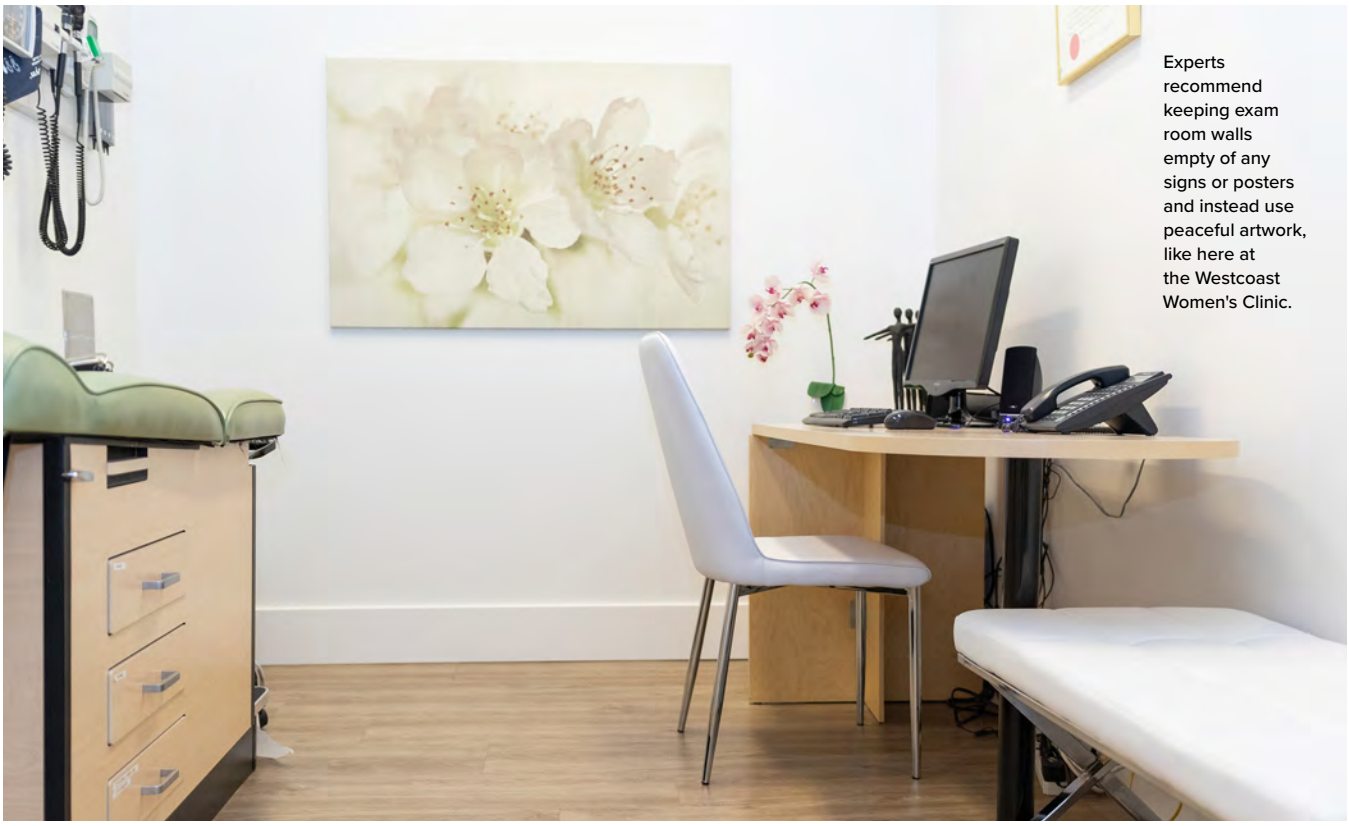
Although remuneration is certainly important and visiting exotic places stands high, a lot of the attraction for a locum will only be appreciated *during* the locumship. A smoothly running office with friendly MOAs/nurses and an understandable medical record system is good for a locum. (Don't forget the coffee.) Comfortable lodging with some sort of downtime interest/activities is attractive. If the locum is expected to cover in the local hospital, expedited privileging is essential. (Don't forget that coffee.) Lastly, the locum needs to remember that he/she is a guest in a different environment and his/her attitude will be reflected by his/her hosts.

**–DR. SELBY FRANK**

### Next Problem

How do you best balance teaching responsibilities with patient care and clinic admin work?

Send solutions to lleger@ensembleiq.com by Sept. 17.



Experts recommend keeping exam room walls empty of any signs or posters and instead use peaceful artwork, like here at the Westcoast Women's Clinic.

PRACTICE MANAGEMENT

# Clinic decor

## How the right physical environment can lead to happier patients and staff

BY LOUISE LEGER

By their very nature, doctors' offices can be uneasy places. Patients are worried, phones are ringing, babies are crying, staff might be hassled, physicians perhaps rushed and stressed.

But, of course, that doesn't mean the space has to be uneasy. In fact, it's no secret that the space around us can soothe and reassure us—change our mood, even—whether patient, receptionist, nurse or doctor.

Marilyn Lawrie is president of Vancouver-based BizShrink, which offers HR services and interior design for doctors' offices.

"A big mistake that people made years ago was in thinking doctors' offices had to look like hospitals," she said, a mistake new physicians setting up practice can avoid. "The business at hand is different, and therefore the environment should be different. People aren't coming in for urgent care, they're coming in to talk about their personal struggles. And so, you want to make them feel comfortable and welcome."

For established clinicians, if ever there was a time to renovate, it's now, said Lawrie, given that the pandemic has left everyone weary.

"Updating decor can have a major impact on patients and staff. The easiest way for people to understand change, to feel change, is to see it," she said.

"So if you've got goals in mind for your clinic, start with something that's visual, and you can get your team engaged. Everybody likes to see positive change. And once they see it, they feel it."

Even having the same old not-so-clean furniture, especially after the spread of COVID, can have a disheartening effect, she said.

"It's a major patient complaint that, 'I feel like I'm going back in there and nothing's really changed and their furniture is really old and dirty and the carpet is stained and there are really old posters on the walls."

Speaking of posters . . . just don't.

### Nix the notices

"We know people are already stressed out. When you've got notices on the wall, 'Don't do this. Don't do that,' 'Do this,' it's just really off-putting. And visually it looks like chaos. It's stressful clutter. Patients wonder, what does that mean? This looks pretty disorganized to me. . . . Are my medical records safe and secure here? Do these people not know what they're doing that they have to have signs everywhere? And some of the directives are to other admin staff, nothing to do with patients."

Whether it's in the waiting room or exam rooms, Lawrie says clinicians need to find ways to communicate the needed information in different ways—via email, phone or in person. "Take down all the 8 x 11 postings or directions!"

### The colours of nature

The hottest buzzword in medical design today, according to *paper gown* magazine ("The Push to Redesign the Doctor's Office"), is "Biophilia"—humans' innate tendency to seek connections with nature and other forms of life. The resulting design principles seek to incorporate materials, objects and colours derived from forests and fields.

Kavita Kent is owner of two Vancouver clinics—Balance Medical Centre and Vancouver's Women's Clinic—both of which integrate traditional and holistic approaches to medicine. The spacious clinics were renovated in the last few years "with the goal of creating a calming, supportive space for healing," she said. Decor elements include clean lines, uncluttered spaces and comfy furniture. The walls are a soft white and the lighting warm. Floors are birch, and the reception desks are birch and white marble. Plants and greenery throughout contrast the predominant white. Along with large windows, the space has "a feeling of calm and connection to nature," said Kent. Sparsely filled bookshelves also add warmth. Artwork on the walls "has a calm, beachy feel."

While lux interiors may not be affordable for many clinics, Lawrie says, the principles of uncluttered, soothing, welcoming design are attainable at all price points. Even a calming piece of photography or artwork can help, as can a fresh coat of paint. But what colour?

According to *The Direct Primary Care Journal* ("Paint Color Psychology, Inside Medical Offices"), in healthcare interior design, the colour green is often used to create a calm and relaxing atmosphere. Green, similar to blue, is soothing to the eyes. Designers use green in multiple shades or in combination with other calm and soothing colours, to create a restorative effect.

At the same time, according to Lawrie, there isn't really any rule about which colour to use.

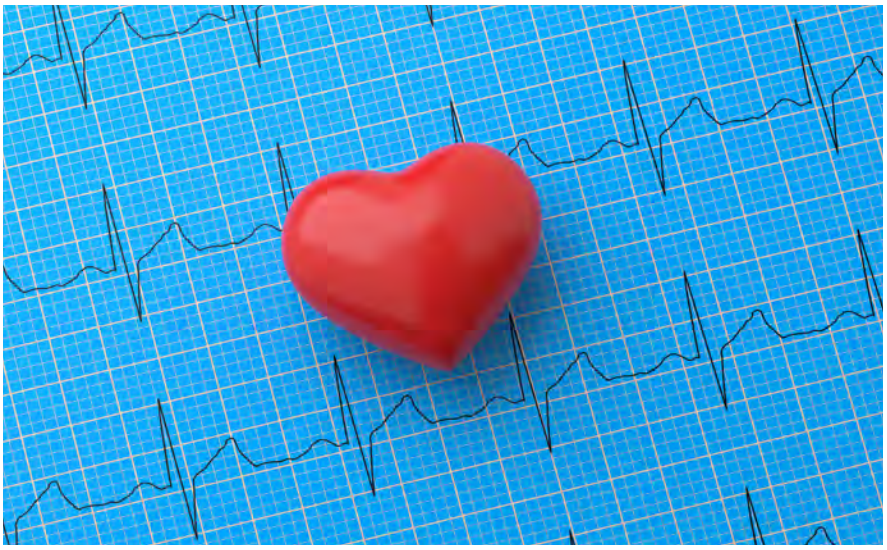
"Obviously most people don't paint their practice walls chartreuse or bright pink, but I don't think it's because you can't. Ask, what feels good to you? I always take in paint chips and say, 'What do these colours feel like to you?' If you feel really good about what your space looks like and how it feels to you, your patients will feel it too."

And, of course, it's not just about the patients. The colour and decor affects the whole team, who don't just visit the clinic for an hour, but live in it all day, every day.

"The look and feel of the space impacts the mood of your staff, so if your waiting room is really old and dirty and not nice to look at, your staff are going to be affected by that—it's depressing." If it's fresh and uncluttered, it's energizing, she said.

Bottom line: "If you want to really give your practice a boost in the arm, it's really about changing visually." **MP**


Decor at the Balance Medical Center and Westcoast Women's Clinic both use whites and natural elements to create a peaceful environment.



CLINIC

# All about anticoagulation with AF

## Five clinical pearls for managing anticoagulation for patients with atrial fibrillation

BY KYLIE TAGGERT

It's usually up to family physicians to prescribe and manage anticoagulation in patients with atrial fibrillation (AF) in order to reduce the risk of stroke.

While guidelines make recommendations on anticoagulation, the guidance can get complicated and often changes thanks to the latest clinical research.

Here are five pieces of advice on how to manage anticoagulation for patients with atrial fibrillation.

### 1. Just do it

Family physicians may look for reasons not to provide anticoagulation to a patient with AF because they "are never congratulated for having prevented something, but are blamed for any bleeds that occur as an adverse event," said Dr. L. Brent Mitchell, cardiologist at the Libin Cardiovascular Institute of Alberta and professor of medicine at the University of Calgary.

Basically, providing anticoagulation to patients with AF is now the default option, Dr. Mitchell said. Evidence from clinical trials suggests that anticoagulation provides a significant reduction of risk of stroke for the majority of people with AF. For example, studies have shown that even frailty or a risk of falling are not reasons to avoid anticoagulation, he said. "It is something we need to do even if we don't want to do it," he said.

The only time anticoagulation is not recommended in patients with AF is in those who are younger than 65 who have no thromboembolic risk factors as determined by the Canadian Cardiovascular Society (CCS) algorithm (CHADS-65), outlined in the 2020 CCS/Canadian Heart Rhythm Society guidelines for the management of atrial fibrillation.

In order to treat AF, and initiate stroke prevention, AF has to be identified. The guidelines recommend that all patients over 65 years old should be screened for AF, simply by taking a patient's pulse. "Not very highly technical but highly beneficial," Dr. Mitchell said.

### 2. Tailor the anticoagulant to your patient's existing medication regimen

For most patients, direct oral anticoagulant (DOAC) medications are recommended over warfarin. There are four options of DOAC medications in Canada, and they are considered interchangeable in most patients given that there are no solid randomized control trials comparing the efficacy between them.

When deciding what to prescribe, consider the patient's existing medication regimen and choose a DOAC that easily fits into the patient's daily life. Apixaban (Eliquis) and dabigatran (Pradaxa) are taken twice a day; and edoxaban (Lixiana) and rivaroxaban (Xarelto) are taken once a day.

"If they're only on a once-a-day medication, prescribing a BID medication, now you're at risk of not having very good adherence," said Dr. Clare Atzema, scientist at the Sunnybrook Research Institute and an emergency physician at Sunnybrook Health Sciences Centre in Toronto.

Adherence is important with DOAC agents. While it was safe to miss a dose or two on warfarin, there are repercussions if you miss doses of DOAC medications, including thromboembolic events, Dr. Atzema said.

### 3. Review prescriptions coming from the emergency department

Dr. Atzema published a study in 2019 that showed patients with AF who were given a prescription for anticoagulants in the emergency department were significantly more likely to fill their prescription compared to patients with AF who were told in the emergency department to consult their family physician for a prescription.

Getty Images/Hatice Gocmen

While prescribing in the emergency department may help adherence, emergency physicians will only prescribe for 30 days, because they are unable to follow the patient to adjust dose and monitor side-effects. Family physicians need to provide the followup, and they may want to adjust the prescription.

"Don't just go with what the emergency doctor has started. If you know a drug or you're more comfortable with a different DOAC, you can always switch them," Dr. Atzema added.

Dr. Atzema said that most family physicians will continue with the medication the emergency physician prescribed, but they should still review the medication and its dosing based on the patient's risk of bleeding. An emergency physician doesn't have time to do that assessment, she said.

There are standardized followup tools to help with the regular assessment of bleeding risk available from Thrombosis Canada.

### 4. Seek help when managing patients with multiple conditions

Between 20% and 30% of patients with AF have coronary artery disease (CAD). Others may have other medical conditions, such as renal failure, diabetes or cancer. Keeping the dosing of anticoagulation agents straight with so many factors involved can be complicated.

"You can't know everything about everything, and I think we all need to recognize our limitations in that way," Dr. Atzema said. "I tell my colleagues, just tell cardiology if you're not sure."

Dr. Atzema also advises physicians to encourage patients to go to one regular pharmacist. "They know all the drugs you're taking and they can check for any interactions," she said. "It's nice if we can do that as well but we're not pharmacists."

Dr. Atzema often encounters patients with AF who take a baby Aspirin (81 mg acetylsalicylic acid [ASA]) as primary prevention for CAD. "Those patients can stop the Aspirin because if you do Aspirin plus a DOAC that's dual anti-platelets, and there's a big increase in the risk of bleeding," she said.

For patients with AF and existing CAD, the recommendations differ depending on the seriousness of the disease. Dr. Mitchell said, "The vast majority of people with CAD are stable and we recommend that anticoagulation alone is OK."

People with AF and unstable CAD, or people who have had a percutaneous coronary intervention (PCI), benefit from dual therapy (i.e., DOAC plus clopidogrel). Dual therapy is only recommended for a short time (e.g., from one month to a year), Dr. Mitchell said.

If a person continues to have unstable CAD, then triple therapy (i.e., OAC plus clopidogrel plus ASA) is recommended, but for only about a month, Dr. Mitchell said. He suggested a consult with an interventional cardiologist about switching from triple to dual therapy.

People with AF and other cardiac complications also often benefit from anticoagulation, Dr. Mitchell said. This includes people with hypertrophic cardiomyopathy or congenital heart disease.

The 2020 CCS guidelines have new recommendations for anticoagulation in patients with AF and chronic kidney disease and renal failure. While the CCS guidelines have a table with dosing recommendations for these patients, consulting a specialist may be best.

"My advice for family doctors and to emergency physicians is that if you have someone with significant renal failure, refer them to someone else to manage or at least set up a schedule," Dr. Atzema said. "It gets very difficult to follow. It's complex, and family doctors and emergency physicians have a multitude of other health issues to deal with and stay on top of," she said.

### 5. Be aware of changing guidelines

It is up to the family physician to follow new recommendations and the changing condition of their patient. The cardiologist isn't paying attention to the day-to-day management of anticoagulation, Dr. Mitchell said. "It's the longitudinal bits that we rely on family doctors for," he said.

Some Canadian-led studies are underway that could answer how best to prevent stroke in certain populations of patients with AF. Their results may change current guidelines.

**"Don't just go with what the emergency doctor has started. If you know a drug or you're more comfortable with a different DOAC, you can always switch them."**

The OCEAN (Optimal Anticoagulation for Higher Risk Patients Post-Catheter Ablation for Atrial Fibrillation Trial) will shed light on whether patients have to stay on anticoagulants following successful ablation therapy. It compares antiplatelet therapy (ASA 75 to 160 mg) to a DOAC (rivaroxaban 15 mg) for preventing cerebral embolic events following successful catheter ablation for AF. Currently, patients have to stay on anticoagulants indefinitely. Results are expected in 2024.

ARTESiA (Apixaban for the Reduction of Thrombo-Embolism in Patients with Device-Detected Sub-Clinical Atrial Fibrillation) will help determine if anticoagulation is needed to prevent stroke in patients with mild AF. It compares treatment of ASA (81 mg) or apixaban (2.5 mg to 5 mg twice a day) in patients where AF was detected using a device (i.e., sub-clinical). More than 4,000 patients have been recruited and results are expected next year.

A smaller study is investigating warfarin versus apixaban in patients with AF receiving dialysis. The results of SAFE-D (Strategies for the Management of Atrial Fibrillation in Patients Receiving Dialysis) are expected in 2022 or 2023. **MP**

*Continued from page 40*

them in 'jail' for five years … you limit their sleep, you limit their food intake, you cut them off from their loved ones; they kill a few people by accident and you tell them everything is their fault, but if they keep their mouths shut maybe no one has to know what they did." The result is a "misguided Clockwork Orange rewiring of the motherboard."

Unfortunately, Dr. Horton learned that the end of medical training didn't automatically signal the end of the toxic medical culture. Dr. Horton extends her prison metaphor, comparing herself as a staff physician to a prisoner who struggles to adjust to life after incarceration—there was more comfort and familiarity in her "jail" than in the big, uncertain world outside, making it easier to fall back into her maladaptive coping strategies from her training. And so, every year of medical practice became another year of "toxic culture . . . of sleeping with the enemy, or saying '(she's) fine' every time (she) wasn't," until "twenty years of shoving the snake back down into the can every time it popped up" led her to the precipice of unmanageable burnout.

While parts of the book can be somewhat dark and disheartening, especially those where Dr. Horton explores the particularly burnout-inducing aspects of our profession, many of the pages are filled with wonderful, humorous, and heart-warming stories. She candidly shares her cynical first impressions of the mindfulness retreat, her judgemental initial options of the fellow retreat attendees, and then the amusing and moving connections that dispelled those first impressions. She also opens up about some of her most meaningful patient stories and interactions that reinforce why she loves practising in the field of medicine and why she remains motivated to become a better physician, a better advocate for physician wellness, and a key player in the change to improve the flawed medical education system.

*We Are All Perfectly Fine* is a must-read book for any physician who is feeling the mental, physical, and emotional strain placed on them by virtue of being part of this profession. Dr. Horton gives a voice to every one of us who has struggled at some point along an arduous and noxious pathway from medical student to practising physician. She gives us permission to honestly accept that maybe we aren't always "perfectly fine," even though we're supposed to be. And most importantly, she sets an example and gives hope that we can find a place of balance and contentment in our lives and still love being a physician.

**DR. GINEVRA MILLS** *is a reproductive endocrinology and infertility fellow in Montreal.*


The Canadian Press/Justin Tang

PMHx

# The doctor who sounded the alarm

## Dr. Peter Bryce now recognized for trying to save Indigenous children from tuberculosis deaths

**Dr. Peter Henderson Bryce** is not a name most Canadians know. There are no statues of him and he does not figure in our history textbooks. But these days, almost 90 years after his death, the legacy of the Ontario physician is growing as he is being remembered for his attempts to stem the tide of the rampant deaths from tuberculosis among Indigenous children at residential schools.

In 1904 at the age of 51, Dr. Bryce was appointed the first chief medical officer of the Department of the Interior, and became responsible for the health of Indigenous children, then considered wards of the state and mandated to attend residential and day school once they reached seven years old.

Dr. Bryce spent months touring schools in the West and found buildings that were prone to fires, unsanitary conditions, poor health practices and a lack of ventilation. He discovered Indigenous people were dying from tuberculosis at a rate 20 times higher than that of non-Indigenous Canadians, and that up to one-quarter of the 1,537 pupils across Canada's residential schools were dead because of TB. In a report to the government in 1907, he wrote, "It's almost as if the prime conditions of the outbreak of epidemics had been deliberately created."

Dr. Michael Kirlew is a passionate advocate for Indigenous healthcare and a clinician who works in Northern Ontario. "The transmission of TB is a marker of inequity at the individual and population level," he said in an interview with the *Medical Post*.

"It is well-established that malnutrition, overcrowding and poor ventilation contribute to the development and spread of TB, and that these conditions were common in residential schools," added Dr. Kirlew, who has studied and written about Dr. Bryce, most notably in a piece in the *CMAJ*, "Dr. Peter Bryce (1853-1932): whistleblower on residential schools," which he co-authored with historian Dr. Travis Hay (PhD) and Dr. Cindy Blackstock (PhD), McGill professor and Indigenous advocate.

Dr. Bryce made recommendations for supervised medical care (nurses and doctors), better nutrition and better ventilation, but they were dismissed by Duncan Campbell Scott, then head of Indian Affairs, who stated that his goal was to "get rid of the Indian problem." Scott eventually terminated Bryce's funding for research, and thwarted his attempts to present his findings.

"Dr. Bryce was basically saying that we have evidence-based interventions we can use that have been used in other settings to prevent the spread of tuberculosis, but we're not using them," said Dr. Kirlew. "You don't solve justice and fairness and equity issues exclusively with medicine, you have to apply justice, fairness and equity."

Not one to be silenced, in 1922, Bryce wrote a booklet, *The Story of a National Crime: An Appeal for Justice to the Indians of Canada*, and had it published. He wrote about the government's role in establishing and maintaining conditions that led to the high death rates, and the government's deliberate decision not to take action. Dr. Bryce wrote, "This trail of disease and death has gone on almost unchecked by any serious efforts on the part of the Department of Indian Affairs."

Dr. Bryce died in 1932 and was buried in Beechwood Cemetery in Ottawa.

Drs. Kirlew, Blackstock and Hay wrote in the *CMAJ* article: "Dr. Peter Henderson Bryce stands as a hallmark of the moral conviction and courage it requires to enact the Hippocratic Oath and to transition reconciliation from an ideology to a reality."

Today, Indigenous advocates like Blackstock are working to reclaim Dr. Bryce's legacy. Several years ago, Blackstock helped erect a historical plaque at the cemetery and built a small garden at his tombstone she still tends. Beechwood Cemetery has a Reconciling History program that encourages school children to place rocks and paper hearts of gratitude and remembrance at Dr. Bryce's gravesite. **—LOUISE LEGER**