

How times have changed

Looking back at the College and general practice

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The 50th anniversary of the founding of the College of General Practice of Canada is an appropriate time to reflect on changes that have occurred over the past 50 years, in the College itself and in the concepts of general practice and the overall health care system.

I graduated from medical school in 1951, completed my junior rotating internship in June 1952, and began practice as an assistant to Dr Harold M. Taylor in Tavistock, Ont. Dr Taylor was about 20 years my senior and had a thriving general practice. About a year later, long before I got involved in the politics of organized medicine, Dr Taylor was approached by a contemporary of his, Dr Victor Johnston of Lucknow, Ont. He wanted Dr Taylor to arrange a meeting of general practitioners at our local hospital in Stratford, to talk about forming a national organization to promote the education and training of GPs as a distinct “specialty” within the practice of medicine. Dr Johnston left that meeting quite encouraged. And, if I remember correctly, Dr Taylor attended that founding meeting in Vancouver, BC, in June 1954 at the Palomar Supper Club, while I supplied continuous medical coverage in Tavistock.

Dr Taylor continued his work in the College of General Practice, and by 1959 he was elected President of the Ontario Chapter. He, in turn, infected me with the same enthusiasm, and I became President of the Ontario Chapter in 1967, and then President of the (renamed) College of Family Physicians of Canada in 1971.

Health care delivery long, long ago

Fifty years ago, most GPs did obstetrics, but shortly before my arrival in Tavistock, Dr Taylor stopped doing home deliveries. I recall one lady who insisted

that her baby be born at home, but I held my ground. Immediately after she delivered the baby in hospital, her uterus inverted. Fortunately for her and me, skilled colleagues were close at hand.

Also at that time, patients did not need appointments; they just came in during office hours when they wanted to see the doctor. Our busiest time was Saturday evenings after the grocery stores closed at 10 PM. We would be at the office until midnight.

In those early days we dispensed nearly all our patients' medications. Very few people in rural areas had medical insurance; a few who worked in larger neighbouring communities might have had Physicians' Services Incorporated, Windsor Medical Services, or Associated Medical Services. Some low-income earners qualified for a type of welfare benefit that was administered by the Ontario Medical Association (OMA). Our fees in Tavistock were usually less than recommended in the OMA fee schedule. For many patients, we charged what we thought they could pay—perhaps \$1 or \$2 for an office visit.

Another interesting aspect of physicians' fees in the early days of the College was that doctors saw and treated other doctors and their families, as well as clergy and their families, free of charge. When I was a medical student at the University of Toronto in the 1940s, I needed a hernia repair, which was done without charge by a surgeon at St Michael's Hospital, whose name I have never forgotten: Dr G.E. Pearson Wilson.

Services then were partially aimed to keep health care costs to a minimum, because patients were largely responsible for payment. For example, we did tonsillectomies and adenoidectomies at patients' homes on the kitchen table, with Dr Taylor doing the surgery and me doing the anesthesia. Any skills I developed in anesthesia were

largely due to an early program of the College known as the Upjohn Scholarships, which were worth about \$500. This allowed me to go to Cook County Hospital in Chicago for a month to study and practise my anesthetic techniques.

But all this changed when the national Hospital and Diagnostic Services Act was introduced. Many services were now covered without direct charge to patients admitted to hospital. I remember when we would order an upper gastrointestinal series, costing about \$25 to the patient, only if it seemed really necessary. Now patients could be admitted to hospital and have the x-ray examination and hospital stay for “free.”

Such were some of the economic issues of health care leading up to and in the early years of the College. Thankfully, the College stuck to its original concepts of promoting education, training, high-quality practice, and later, research, leaving the economic issues to the Canadian Medical Association and its provincial counterparts.

Look back to go ahead

Writing about events of 50 years ago is in keeping with comments made by Rudyard Griffiths, Executive Director of the Dominion Institute. In an article¹ in the *Globe & Mail*, he said, “How can Canadians go forward if we don’t know where we’ve come from?” I suggest that those politicians and health care experts who are planning the future of our health care system bear in mind some of the principles and values that prevailed during the early days of the College. Doctors and patients had responsibilities to one another and, in most cases, succeeded in fulfilling those responsibilities. Doctors provided a service, and patients paid for this service.

Some people fell between the cracks, however, due to their inability to pay. As a result, governments intervened with various types of services leading up to the Canada Health Act, where most hospital and outpatient medical care is covered by various provincial health care plans funded by tax dollars. But even people like Tommy Douglas and Judge Emmett Hall, both leaders in publicly funded health care,

intimated that the day might come when those who could afford to might have to contribute to the costs of the services they receive. Such a notion is frowned upon by politicians of the day who do not have the courage to implement such a plan.

Can the College, with 50 years’ experience, encourage politicians and health experts to introduce changes that would lead to greater patient and physician accountability and responsibility? With so many people preaching that our present system is unsustainable and that patients cannot regularly access timely care, such action by the College would be in keeping with its mandate to promote and improve high-quality health care.

Various proposals have been made, beginning with “user fees,” which Sweden, the epitome of the welfare state, introduced in 1980. The George Report² in Ontario a few years ago stressed the importance of addressing the overdemand in, and overuse of, our health care system. Studies have shown that 10% to 15% of health care services are not necessary, and some estimates go as high as 30%. Any changes must guarantee that no Canadians will be denied access to services because they cannot afford them.

In keeping with that value, various proposals have been suggested. The first essential is that patients have a right to know, and should be told, what every insured health care service is worth. This should be presented to them on an itemized year-end statement. That total would then, for income tax purposes, be deemed a “taxable benefit,” thereby added to their taxable income. Obviously, this would not affect the one third of Canadians who are not in a taxable bracket. For those who pay tax anyway, the amount added as a taxable benefit would be capped, such that, if you had a heart transplant, you would not end up in the poorhouse. Such a plan would make patients think twice before they requested services of doubtful need and would discourage doctors from ordering relatively unnecessary services.

In promoting such a plan, the College could reintroduce the doctor-patient relationship and mutual responsibility of 50 years ago, yet at the same time not deny care to low-income earners. The College

of General Practice of Canada was responsible for preserving and enhancing the role of general practitioners, now family physicians. Perhaps 50 years later, the College of Family Physicians of Canada can promote funding changes to encourage and provide high-quality family medicine in a sustainable health care system.



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The opinions expressed in editorials are those of the authors and do not imply endorsement by the College of Family Physicians of Canada.

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