Dangerous ideas

Top 4 proposals presented at Family Medicine Forum

The Dangerous Ideas Soapbox is a session presented annually at Family Medicine Forum by the College of Family Physicians of Canada's Section of Researchers. Originating with the Society for Academic Primary Care in the United Kingdom, this forum invites innovative ideas as a demonstration of the first step toward advancing our profession through family medicine research. A Dangerous Idea presents a cutting-edge or out-of-the-box proposal for how to improve family medicine care, why it is dangerous (ie, what is the challenge?), and why it matters. Sessions give the audience the opportunity to challenge the presenters, culminating in a vote to decide the most dangerous idea. Submissions for each year's Dangerous Ideas competition open in January. Do you have a "dangerous" idea that could improve your practice or the health of Canadians?

Here are the top 4 abstracts that were selected for the Dangerous Ideas Soapbox session held at Family Medicine Forum in November 2016 in Vancouver, BC. Following the finalists' presentations, audience members voted for which proposal they believed was the most compelling idea.

Fourth place: Project Trauma Support for first responders and military personnel

Project Trauma Support is a novel program being initiated in Canada to address the moral injury component of posttraumatic stress disorder in military personnel and first responders. This is an intense, experiential residential program that relies heavily on peer support. It is dangerous because the stakes are high; most of the ideal candidates have regular suicidal thoughts or have attempted suicide. It is controversial because it uses meditation, ceremony, tradition, and myth to help participants find meaning in their stories and to help them connect to something greater than themselves. Furthermore, the truly therapeutic value of the program sometimes calls for calculated testing of the traditionally rigid physician-participant boundaries. We completed 3 "cohorts" in 2016, with a total of 36 participants (11 female). Almost all the participants found the program to be transformational. One said he had gotten more out of the 1 week than he had in all his previous 10 years of therapy sessions. Many have been motivated to become peer supporters themselves. Others are now returning to work in some capacity. The program is cost-effective, especially because it leads to long-term peer connections for ongoing support. Not only does it promote positive growth among military and first-responder participants with posttraumatic stress disorder, it also rekindles their innate desire to serve, making them among the most valuable contributors to society once again.

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These abstracts have been peer reviewed.
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Third place: Advanced wellness life support

You approach your next patient: "The good news is, the test results are all negative. The bad news? I don't know

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA
SECTION OF RESEARCHERS • SECTION DES CHERCHEURS

Dangerous Ideas Soapbox

An idea that is not dangerous is unworthy of being called an idea at all.
Oscar Wilde

Do you have a dangerous idea about clinical practice that you think could make a difference to family practice? To health care delivery? Or to patient health?

The Dangerous Ideas Soapbox offers a platform for you as an innovator to share an important idea that is not being heard, but needs to be heard in the family medicine community. A dangerous idea could be very controversial, completely novel, blue-sky thinking, or something that challenges current thinking. But it must also demonstrate a commitment to moving the idea forward—to making a difference.

Each speaker will be given 3 minutes to present his or her idea. Audience members then have the opportunity to challenge the speakers, critique the ideas, and cast their vote to choose the most potent dangerous idea. Presented ideas will be published in *Canadian Family Physician*.

Submit your Dangerous Idea to **ideasubmission@cfpc.ca.**
Ideas will be accepted until **June 1, 2017**.

Submissions will be selected based on the following:
- creativity (is the idea new?),
- the challenge it offers (is the idea dangerous?), and
- suitability for dissemination (can the idea make a difference?).

Submissions must meet the following criteria:
- be in the form of a single paragraph,
- be a maximum of 300 words, and
- describe an idea and how it will make a difference to family practice, health care delivery, or to patient health.

What is your Dangerous Idea?

what's wrong with you." How good are we as family physicians at running a slow code on a patient in *wellness arrest*? Increasing numbers of patients are not yet sick but are definitely not well. Conventional medicine excels in the diagnosis and treatment of *disease*. We have weaker traditions for promoting *wellness*. The accumulated science that we currently have in hand for the things that cultivate physical resilience, emotional calm, increased energy, and disease prevention offers up the prospect of taking our unwell patients and guiding them toward a genuine health transformation. The problem is, the information arises from so many disparate fields, our visits are so short, and wellness is not an emergency (for the *individual* at any rate—it is arguably a *public health* emergency), so it easily slips to the bottom of our agenda. Other advanced life support courses arose out of the need to provide a structured, algorithmic approach to a situation that might otherwise be overwhelming and lead to decision paralysis. I argue that wellness arrest, while not emergent, can be equally daunting, but for different reasons. A 2-day advanced wellness life support course will provide the clinician with the *evidence-based* high points of what we know about nutrition, sleep, exercise, stress, substance overuse, spirituality, behaviour change, and several other key areas. Many primary care providers know some of this material already. Most, however, have not been given the tools to efficiently spot wellness arrest, identify patients ready for intervention, and structure priority areas (based on available science and patient preferences) for a multivisit treatment plan, all tailored to the family practice setting where concurrent issues are being managed under considerable time constraints.

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Second place: Changing "cradle to grave" to "cradle *or* grave"

During my family medicine residency there was a strong push by our program for family physicians to do obstetric deliveries. Time and time again it was thought that if we exposed enough young physicians to the joys of childbirth that they would incorporate obstetrics into their practices. Sadly, this has not been the case. Fewer and fewer young family physicians and new graduates are providing intrapartum care. There are a number of factors that contribute to this trend, including medicolegal liability, maintaining competency with physical skills, hospital policies, the pressures of a busy practice, difficulty acquiring experience, and the unsociable on-call hours involved in intrapartum care. I humbly submit that family medicine residents would be much better off learning to provide end-of-life care for a variety of reasons.

- It is a skill set that relies more on communication and symptom management skills than on physical skills.
- Theoretically it could benefit every patient (we all die after all).
- While end-of-life care still requires access 24 hours a day, 7 days a week, patients can be managed by telephone with the assistance of skilled nursing.
- It is easier to form call groups for palliative care than obstetric care to distribute the load.
- It would increase primary level palliative care provision by family physicians.
- It would reinforce home and community care.
- Providing better palliative and end-of-life care contributes to the sustainability of our health care system.
- It would prevent unnecessary acute care hospital deaths.
- There is currently a greater need for palliative care than intrapartum care in our system.

Palliative care rotations should be mandatory in all family medicine residency programs, including longitudinal experiences. While the College of Family Physicians of Canada promotes comprehensive family practice, given a choice between providing intrapartum care and end-of-life care, I humbly submit we will have greater success and uptake with end-of-life care than intrapartum care. Residents who plan to provide intrapartum care should continue to be supported and encouraged. However, for those residents who have already decided that intrapartum care will not be a part of their practice, the resources being used to promote intrapartum care should be repurposed to support end-of-life care.

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First place: We need more conversations about assisted dying

In the Netherlands and Belgium, where assisted dying has been available for decades, about 4% of deaths are assisted by doctors. Most of these doctors are family doctors assisting their own patients or consulting with their colleagues and aiding their colleagues' patients. More important, almost 10 times as many patients (or 30% of all patients at the end of life) have conversations about assisted dying with their doctors. In these conversations, patients might get an "emotional insurance policy," ensuring that if their suffering ever becomes unbearable, they have a way out. It should not be surprising to find out that, compared with Canada, more Dutch and Belgian patients receive palliative care, more die at home, and more receive palliative sedation. About 12% of Dutch and Belgian patients receive deep sedation before death, compared with less than 1% of Canadians. An international assessment of the general quality of end-of-life care showed that it is higher in those 2 countries

compared with ours. Just by talking about assisted dying early in the course of a terminal illness, you might help a patient face the future and cope with the disease symptoms, the surgery, drug side effects, etc. Talking about assisted dying and having it available have been shown to prevent "social death"—that means really living until you die. Let us have more conversations about assisted death with our patients.

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