Letters

Correspondance

Bill 114: Who broke trust?

I was dismayed by your editorial on Quebec's Bill 114.[1] The claim that physicians broke the trust that forms the basis of the physician–patient relationship directly implies that, to maintain that trust, physicians have the primary responsibility for ensuring that emergency departments of major hospitals are staffed at all times. It also demonstrates an unfortunate lack of understanding of the critical physician-resource situation in this country and ignores the fact that emergency department physicians in a regional hospital require a unique skill set.

The relationship of trust is one that physicians hold dear and strive to protect and strengthen every day. Our patients trust us to provide an appropriate level of care at all times. Simply providing a warm body at a time of need is inappropriate: it poses a very real threat to the quality of care and to patient safety, and it threatens the very trust the editorial discusses. If we take it upon ourselves to staff important emergency departments with unwilling, overworked and underqualified physicians, we are doing both our profession and our patients a grave disservice.

Martin Vogel
General Practitioner
Shaunavon, Sask.

Reference

1. Quebec's Bill 114 [editorial]. *CMAJ* 2002;167 (6):617.

Your editorial[1] was based on poorly researched information, and the statement that "the ED had closed for the night because none of the hospital's 60 family physicians or internists were available to staff it" requires clarification. How many full-time equivalent physicians practise in the hospital? How many have recently left or retired who also used to work in the emergency department?

As chair of a committee on medical manpower for general practitioners in the Montreal area, I am aware that Quebec counts on its list of physicians many doctors who no longer practise or who now practise part time. Quebec is not alone: many other governments and organizations do the same.

If there is a manpower shortage, we can assume that it is due to the early-retirement program you mentioned and to a lack of incentives for physicians working outside major centres. But how much do physicians have to do to make up for the negligence of the system's managers? For example, must a GP give up a HIV practice to retrain in emergency medicine?

I agree that the physician–patient trust relationship is deteriorating, but it has been doing so since the government implicated itself in the health care system. As Osler said, "the physician must always retain control of the ward."

Mark Roper
Family Physician
Montreal, Que.

Reference

1. Quebec's Bill 114 [editorial]. *CMAJ* 2002;167 (6):617.

Your editorial[1] raises important questions about what it means to be a physician. These questions have a long history and often resurface when there are conflicts between individual physicians, medical organizations and third-party payers such as government and private insurers.

Ethical discussion surrounding such conflicts ranges from the view that individual physicians can choose when and how to work (such that a refusal to provide medical services does not reflect poorly on their professionalism) to the view that the duties and obligations of physicians are intrinsic to their professionalism and are a trust that they hold in the public interest.[2-4]

In the latter view, the privilege of self-regulation implies a collective and intrinsic duty to provide care to individuals and the public.[2-4] The fulfilment of this duty might be perceived as taking precedence over most other factors, sometimes including potential personal danger. From this perspective, a failure to provide emergency and other essential services does not meet society's acceptable expectations of the medical profession.

Most observers agreed that the Quebec government's handling of the potentially volatile situation there was likely to provoke strong reaction from physicians, who cherish their professional independence. On the other hand, the concept of the nonabandonment of patients is espoused by many as one of medicine's core values.[5,6]

Physicians in training and those already in practice should examine the implications of belonging to a self-regulating profession. Certain duties and obligations may result from our enviable status; these might include undertaking responsibilities that avoid putting individual patients and the public in general at untoward risk, especially during times of crisis.[7]

If we are willing to abandon our special duties and obligations as physicians, it is possible that we may inadvertently sacrifice some of the cherished ethical and professional values that we believe separate us from other members of society.

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5. Quill TE, Kassel CK. Nonabandonment: a central obligation for physicians. *Ann Intern Med* 1995;122:368-74.
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Your editorial refers to a breach of trust between patient and physician, and to damage to the relationship between physician and government as a consequence of Bill 114.[1] The Canadian Association of Emergency Physicians (CAEP) believes the only breach involves the physician–government relationship.

Our emergency departments are functioning solely because of the dedication of emergency health care providers, who deliver quality care despite the inadequacy of today's health care system. The public clearly understands that the disruption of service in Shawinigan this summer was yet another example of the many stresses being imposed on our emergency departments.

Emergency health services must be available continuously in urban and nonurban settings. However, governments that act in isolation are unlikely to establish successfully an effective emergency health care system for all regions. Canadians can develop and maintain a well-coordinated regionalized system of care by taking advantage of the unique perspective of emergency physicians, emergency nurses and other emergency personnel. If governments and administrators listen to these emergency workers and act on their advice, they will find the solutions they seek.

This is why CAEP is calling for a National Forum on Emergency Health Services. This forum, which must be supported by the federal, provincial and territorial governments, would focus on designing a template of excellence for emergency health services in all regions of Canada. It would move beyond mere guidelines and result in practical and applicable national standards that ensure the patient's right of access to the best emergency care. A national forum would also give an opportunity for input to all levels of government, emergency, family and rural physicians, emergency nurses, paramedics, hospital administrators and regional health authorities.

Although Bill 114 has exacerbated the schism between physicians and government, the real consequence is an infringement on patient rights. Now more than ever, a collaborative approach is required if we are to maintain an effective emergency health care system. This system is the Canadian patient's right.

François P. Bélanger
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Canadian Association of Emergency Physicians
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Reference

1. Quebec's Bill 114 [editorial]. *CMAJ* 2002;167 (6):617.

The situation that led to Quebec's Bill 114[1] is not unique, since all provinces are experiencing chronic problems in delivering emergency services. However, the obvious concern is that the ill-conceived and regrettable remedy chosen by Quebec will be duplicated elsewhere. Rather than pointing a finger, now is the time to step back and consider the numerous problems besetting emergency services in Canada and to reflect on ways to solve them.

The most significant problem is the overcrowded emergency department (ED). All parts of Canada are faced with overcrowded EDs.[2] The root causes are a shortage of acute care beds and inappropriate management policies, and we must no longer accept the rhetoric that extols the virtues of policies that divert patients away from EDs.

The human resources component of emergency services has been studiously ignored:[3] there has never been a comprehensive review of the needs of Canada's 850 EDs. The existence of 2 distinct training programs is an international anomaly, and neither has been proven superior to the other. Studies conducted in the early 1990s suggested that recent family practice graduates did not feel comfortable working in EDs because they lacked the needed skills.[4,5] A working group suggested that minimum prelicensure training should include 2 months of adult and 1 month of pediatric emergency medicine,[6] but no jurisdiction has implemented this.

As well, there are no enforceable minimum performance standards for EDs. The federal government last published guidelines in 1988, and despite its stance on maintaining standards of access consistent with the Canada Health Act, it has all but abandoned this component. Ontario introduced guidelines for emergency units in 1989, but a 1991 survey revealed that only 50% of EDs met the minimum requirement.[7] No standards currently exist in Ontario.

The Canadian Association of Emergency Physicians has developed a 6-point plan for restoring public confidence in EDs. Surely Canadians deserve an emergency service that will not let them down when they are acutely ill or injured, and surely no more Canadians should be turned away from an ED because of a demonstrable lack of system planning.

Alan Drummond
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Canadian Association of Emergency Physicians
Perth, Ont.

References

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