Letting surgeons work

I read an article in the newspaper recently stating that the new president of the Canadian Medical Association, Dr Robert Ouellet, during his inaugural address, had called for an increased private sector role in delivering health care to Canadians. Specifically, he stated that surgeons working in public hospitals should also be allowed to perform operations in private clinics. His predecessor, Dr Brian Day, was often called Darth Vader for his stand on public medicine. I guess that makes Dr Ouellet the Evil Emperor as his initial speech was even more controversial. Dr Ouellet went on to outline how the private sector could intervene in a complementary way in areas where the public sector is unable to provide services. As usual his views were immediately denounced by various other groups as leading to the end of medicare. These stakeholders warned of decline of health care by bringing up the themes of commercialization, queue jumping, and pandering to the rich. Examples of other countries' failed experiments with a blended system of private and public systems were then paraded out.

I don't know which type of health care delivery system would best meet the needs of the population, or even if one system fits all of our diverse social and geographic groups. I can only speak of my own experience. It appears that the current gauge of health care quality used by industrialized nations is the length of surgical waiting lists. In my community, despite a rapid increase in the patient population, the number of surgeons and the amount of operating room time has increased only marginally. Numerous resources are used to train surgeons, whom we don't allow to operate. Surgeons in my town get 1 day a week to operate—if they are lucky. Their day is lost if it falls on a holiday, and they don't get any elective time during winter and summer breaks when the OR is cut back to an emergency level. These cutbacks are based on budget restraints and support staff availability, not on a lack of patients requiring surgery. On a daily basis surgeons can be bumped by emergency cases and are at the mercy of slow changeover times, mechanical problems, and staff breaks. Their lives are also made miserable by waiting in line with their colleagues for after-hours add-on cases. No one seems bothered by doctors sitting unpaid in the OR lounge for 2 hours in the evening waiting their turn to perform an appendectomy, but if those same surgeons request more regular operating hours or new equipment they are often labeled as unreasonable.

The reason that waiting lists are so long is not that our surgeons are working at 100% capacity. So how can we say that allowing them to work in private clinics is such a bad thing? Queue jumping already occurs and has for years. I suspect that the number of patients who have gone south to get their procedures is significantly underestimated. It must be a nice change for those Canadian surgeons who operate in private clinics. Imagine being sought after, appreciated, and well paid for your expertise and time. I think the tendency would be to enjoy this treatment and say the hell with socialized medicine. Yet, the majority of our surgeons stay. They stay because they are hardworking and care about their patients and, dare I say, socialized medicine. So why not let them operate in private clinics? This would only become a problem if we had operating room hours in the public system that weren't being used. As long as our surgeons are fulfilling their public duty, so to speak, why not allow them to use their skills to do what they were trained to do—operate? **—DRR**

Medicine, the media, and politics

We could be forgiven for being bored with politics. In a timeline of just a few months we have lived through Canadian and United States federal elections, provincial by-elections, and municipal elections. BC will soon face a provincial election. Having spent years immersed in medical politics (which some believe is even more challenging than the real thing), I am convinced that doctors must become even more politically active.

There are downsides to getting involved. I have experienced a full range of attacks, including demonstrations, lawsuits, verbal insults, and nasty letters. I have been called a variety of different names (the devil, the destroyer/Darth Vader of health care, the elephant in the room, Dr Profit, and some others that I cannot put into print).

Physician-directed patient services in Canada are largely government funded and health care costs are approaching 50% of provincial spending. In aiming to excel as clinicians, educators, and researchers, we must work to expand our leadership roles in health policy, planning, administration, and politics. A May 2008 Angus-Reid poll placed doctors—with a 94% rating—number one in terms of professions that the public respect and trust. We must build on and leverage that trust with governments.

The partisan politicization of health care is not healthy. Four-year electoral cycles discourage long-term planning that is necessary for sustainability. Governments prefer positive short-term results and returns. Reforms leading to long-term improvement that might reflect on a future rather than the present government are less appealing. We rightly preach that denial of access should never be based on ability to pay. The status quo, which is to deny care based on governments' failure to deliver, is equally unacceptable.

Neither of the main federal parties in Canada has taken a leadership role in health care. In the last federal throne speech, I listened as the topic of health care was virtually ignored. Not to be outdone, the Liberal Party of Canada sent out a pre-election questionnaire in which they identified "today's issues of crucial significance." Of 16 questions in their poll none related to health care. Yet voters consistently place health as a top concern at election time, and a recent Pollara poll revealed that 68% of Canadians believe we need major reform. In the past, governments have fought and lost elections on health care. The timing is right to win on this very issue. With 68% support, no political party need fear the opposition. There wouldn't be any. Governments may worry that a platform of health care reform would be a little controversial, but with polls in support, I would not rank it as overly courageous.

We all support funding essential care for all, but it is simply wrong to make unrealistic promises. The World Health Organization has stated unequivocally that when services are to be provided for all, not all services can be provided. This means we must come to terms with a societal question as to what we include in the "basket" of publicly funded services. The terms "medically necessary" or "medically required" are used widely in Canadian legislation, but have never been defined.

Physician loyalties must not be influenced by the fact that we and the services we deliver are almost exclusively government funded. Benchmarking for patients on wait lists is one example where we must tread cautiously. I do not know a single orthopaedic surgeon who believes a patient awaiting a hip replacement should suffer in pain for 6 months. Yet, because many waited much longer, we bought into that time line. We put the system ahead of the patients and accepted compromises that did not represent best practices.

Canada's health scheme should no longer be constrained by the outdated Canada Health Act (CHA). Its principles of comprehensiveness, accessibility, universality, portability, and public administration are, with the exception of the last, widely ignored. Some consider the law Orwellian. Initially designed to set a baseline level of care, below which no Canadian would fall, the CHA has been used to set a ceiling above which none shall rise. It was introduced on April Fool's day, 1984, and was based on the Saskatchewan Medical Insurance Act of 1961. Unfortunately, but perhaps not accidentally, Tommy Douglas's eight principles were whittled down to five (excluded were efficient, effective, and responsible). The last year that a grand slam tennis tournament was won with a wooden racquet was 1984. Tennis has modernized, evolved, and moved on. It's time for the CHA to follow suit.

My year as CMA president was demanding, but one of the great rewards was the travel and the camaraderie with colleagues in both urban and rural communities across all provinces and territories. In the long history of the CMA (it is just 3 months younger than Canada), I was the first orthopaedic surgeon to be elected president. I was occasionally roasted rather than toasted, facing introductory remarks like, "What's the difference between an orthopaedic surgeon and a carpenter? Answer: A carpenter can name two antibiotics." After the fun and socializing, the meetings turned to the serious and urgent business of improving health care delivery in Canada, and I found there was a remarkable consensus among doctors on how to achieve this.

Canada's system remains in a time warp, spinning in a vicious circle, in

which extreme rationing leads to limited access, reductions in workforce, limited technology, long waits that negatively impact the economy, resulting in funding pressures that force rationing. We must break that circle with measures that stimulate competition, efficiency, and accountability and we must recognize the need for sustainability. Canada must embrace and encourage private sector investment, while maintaining a system where no person is denied necessary care based on their ability to pay. We must borrow from the best practices of countries that have achieved that goal.

Doctors must increase their political activity as they continue to provide a reality check for the public, politicians, and the media. For the European Consumer Powerhouse to rank Canadian health care delivery in 2008 as last alongside 29 European countries in value for money, and 23rd overall in quality, should be a wake-up call. We are now beginning to see improvements from our efforts, but the momentum must continue. With leadership and a united profession we will achieve our goal of converting a dysfunctional scheme into an excellent patient-focused and physician-directed Canadian system.

—BD

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