Signs

"Hey Bob, get dressed, the jig is up."

"Tell me it isn't true, Doc, what happened?"

"They've put up the signs."

"OMG, not the signs!"

"Afraid so, Bob. I know things haven't been very good at home with the wife but I'm afraid I can't hide you in hospital any longer. The hospital Bed Needs Report signs are up. Apparently, we have 20 patients admitted to Emergency and 15 patients in over-count beds/stretchers on the wards. When this happens the signs go up. These signs remind us physicians to discharge all the patients we have in hospital unnecessarily. So, I am sorry, but you have to go."

"How can you do this to me Doc?"

"Do this to you? What about me? You think you have problems? I now have to move my in-laws out of room 408 and let them stay at my house."

These signs have become a regular occurrence over the last decade at my hospital. The names have changed—Utilization Report, Decongestion Plan, Bed Needs Report, etc. — but the message has been constant. They outline how many patients are admitted to emergency and other "non-regular" beds. Somewhere on the sign is usually written, "Please help with discharges."

Does anyone else find this message offensive? Hey, maybe the problem isn't bed utilization but the number of beds? Does administration really think we have patients lying around hospital for no good reason? Do they think that misguided patients want to linger in our aging and occasionally smelly hospital? If this is the case, then these patients should definitely have mini-mental status exams and psychiatry consults. The problem isn't inefficient physicians or holidaying patients. The problem is the lack of acute and chronic care beds.

I am not going to discharge a patient prematurely just to satisfy a global overcrowding problem that I didn't create. Doctors don't make ill patients requiring admission. Our duty is to do the best for the patients under our care, and if that means keeping them in hospital longer than what administration deems, so be it. Inevitably, lengths-of-stay statistics are then quoted. These regional figures are touted as the standard of good care, but is it a good thing if an institution has a shorter average length of stay for hip replacements? This number does not measure the patient's suffering or associated strain on their caregivers.

So okay, I am a little annoyed. I am so annoyed that I am considering putting up my own signs. How about these? Food Terrible, Please Upgrade; or Floor Dirty, Administration to Clean; or Nurses Grumpy, Please Fix; or Physiotherapist Not Available to Walk Patient, Administration to Do; or, perhaps most appropriate, I'll Do My Job And You Do Yours.

I really think I need a holiday.

It just seems that the focus has shifted to getting patients out of hospital as soon as possible, instead of making patients the most comfortable while in hospital, thereby facilitating their recovery—the ultimate goal being their reintegration to their hopefully productive and happy lives. I have a feeling I would never survive as an administrator.

I think I'm getting grumpy in my older years. Pretty soon I'll be spending endless hours on my porch in a rocking chair complaining about the world. However, this would be short-lived as they would likely put up a sign discharging me to the basement.

—DRR

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Male Circumcision for the Prevention of Acquisition and Transmission of Sexually Transmitted Infections

The Case for Neonatal Circumcision

Aaron A.R. Tobian, MD, PhD; Ronald H. Gray, MD, MSc; Thomas C. Quinn, MD, MSc

The American Academy of Pediatrics (AAP) male circumcision policy states that while there are potential medical benefits of newborn male circumcision, the data are insufficient to recommend routine neonatal circumcision therapy. **Since 2005, however, 3 randomized trials have evaluated male circumcision for prevention of sexually transmitted infections.** The trials found that circumcision decreases human immunodeficiency virus acquisition by 53% to 60%, herpes simplex virus type 2 acquisition by 28% to 34%, and human papillomavirus prevalence by 32% to 35% in men. Among female partners of circumcised men, bacterial vaginosis was reduced by 40%, and Trichomonas vaginalis infection was reduced by 48%. Genital ulcer disease was also reduced among males and their female partners. These findings are also supported by observational studies conducted in the United States. The AAP policy has a major impact on neonatal circumcision in the United States. **This review evaluates the recent data that support revision of the AAP policy to fully reflect the evidence of long-term health benefits of male circumcision.**

(Abstract from Arch Pediatr Adolsc Med. 2010;164(1):78-84)

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In government we trust

Over the past 20 years Canadian governments have failed to anticipate the need for evolution in our health system. While many may criticize President Obama's health reforms in the US (recent polls show only 37% support), he did at least take on an issue that was controversial and difficult—an attitude rarely displayed by politicians in Canada.

His plan is, in many ways, flawed. It will leave 17 million uninsured. It does not address the enormous cost of "defensive medicine" forced on health workers and institutions by the malpractice issue (some specialists pay over $300 000 a year for insurance). It is perhaps significant that trial lawyers are major donors to the Democrats. The bill will be administered by a treasury chief who didn't pay his taxes and includes a clause exempting members of Congress who passed the bill from its negative parts. While Obama promoted the savings that will arise through disease prevention, his arguments are tarnished by the fact that he is a chain smoker. Not the way to build public confidence.

None of this should surprise us. In Canada hypocrisy on the part of opponents of change is widespread. Such hypocrisy is evidenced when our politicians preach the gospel of the status quo, and then apply a double standard to their own care. The late Quebec premier Robert Bourassa went to Bethesda, Maryland, for melanoma treatment. The doctor of former prime minister Paul Martin is head of Canada's largest chain of private clinics. Former prime minister Jean Chrétien flew to a Minnesota private clinic on a Canadian government jet, paid for by Canadian tax dollars. Opposition leaders Joe Clark and Jack Layton opted for surgery at the private, for-profit Shouldice Clinic. Senator Ed Lawson (former Teamsters Union leader) had heart surgery in the US, and, more recently, former member of Parliament Belinda Stronach and Newfoundland premier Danny Williams sought surgical treatment there also.

Dare I even opine that many physician promoters of the status quo in Canada also exhibit hypocrisy? Many are beneficiaries of private "two-tier" insurance (drugs, dentistry, physiotherapy, ambulance care, etc.) that provides them with superior health coverage. If they truly believe in equitable health care they should opt out of their private plans. Others, including some of the most vociferous proponents of "equality" in our system, repeatedly use the queue-jumping technique of the personal phone call to expedite care for themselves or their loved ones. And patients treated at our Cambie Surgery Centre include a "who's who" of union leaders and politicians of all political stripes.

American doctors and their patients do not have the same trust in government that Canadians do.

American doctors and their patients do not have the same trust in government that Canadians do. In Canada, doctors are compelled by law to share confidential medical files with government inspectors who have the right to inspect any patient's file. A Canadian's health record is considered public property. Patients are not only denied the right to block government access, but their consent is not needed, nor are they even notified when their private records are examined. I have personally witnessed a situation in which a defeated provincial cabinet minister had his medical file reviewed by the newly elected government.

The good result of the debate in the US has been that health care has been catapulted to its rightful place as the most important area of public policy. Canadian politicians will soon have to deal with the need for health reform. Unfortunately, the US debate sidetracked us into the tiresome debate of which system is better, American or Canadian, when, in reality, neither performs well. A hybrid solution —universal care without a monopoly funder and provider—is clearly the option both countries need to explore.

The lessons are there to be learned from countries like Switzerland, the Netherlands, Belgium, Germany, and many others that offer universal care, including coverage for drugs, dentistry, and ambulance. These social democracies, like Canada, believe that those without resources require good basic health care. They have achieved that with a government role and oversight, but without the monopolistic control that Canadians suffer under.

The US health care debate should drive home to Canadians (including some in our profession) that we need to transform our system and we need to act now. As 30 million additional Americans acquire health insurance, there is a strong probability that our health workers will be recruited to service these newly insured patients. With 5 million Canadians already lacking access to a family doctor and, in our system of specialist access by referral only, having limited access to specialist consultations, an expanded brain drain could spell disaster.

Newfoundland premier Danny Williams, in responding to critics of his trip to the US for heart surgery, said, "It's my heart, my health, my choice." Yet his, and other governments in Canada, deny that same choice to Canadians in their own country.

An Angus Reid poll in February 2010 revealed that 68% of Canadians believe that many changes or a complete rebuild of our health system is necessary. When will governments begin to listen to the people?

—BD