Professionalism under siege

One of the cornerstones of professionalism is the expectation to place the interest of others before one's own. In recognition of this higher calling, society grants special privileges to professions, such as the ability to self-govern. For physicians, the first fundamental responsibility in our Code of Ethics is "to consider first the well-being of the patient." This is a testament of our commitment to be professional.

If life were only that simple.

We physicians are human and must ensure our mental and physical health to be able to competently care for our patients. Consider the overwhelmed, sleep-deprived surgeon operating on yet another case because of surgeon shortage. Consider the small-town physician left with 10 000 patients to look after when his or her associates have left. Naturally, physicians cannot be on-call 24/7, and no one would argue that alternate arrangements for patient care would have to be made. Physicians, in curtailing their services in these circumstances, would hardly be in breach of patient care obligation.

However, consider a situation where physicians are overburdened as a result of changes in hospital or health administration policy. Examples would include changes in the obligation to provide on-call services or demands to care for increasing patient volumes. Not to ignore the elephant in the room, what if there is an irresolvable conflict about remuneration? Unlike trade unions, physicians have ethical and professional obligations to their patients that leave them very few protest options, a fact not lost to the bargaining strategy of hospitals and health authorities. Holding patients hostage in these situations by job action or precipitous service withdrawal is not only unprofessional but is also contrary to the College's policy on withdrawal of medical services. For physicians to leave town to another jurisdiction is also problematic, not just for our professional careers, but for our families as well.

As physicians, we are aware that we are not immune to workforce redistribution and changes in remuneration methods. This is the prerogative of responsible health care administrators. However, the foundation for making these changes lies in mutual respect and understanding. Once this is eroded and parties take legal adversarial positions, the result is entrenchment.

The College is often inappropriately dragged into situations like these, situations replete with incursions into professionalism and bad-faith bargaining. Meanwhile, patient care suffers.

The time has come for a new Master Agreement to include processes to resolve these types of contractual issues. This can only be addressed by provisions that include binding arbitration.

Such an agreement cannot come soon enough.

—WRV

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