Whack

"Whack!" That was the sound of the sucker punch contacting my skull. Those who know me well would likely suggest more of a hollow sound. Perhaps *thunk* would be better.

I wrote an editorial, "Pinch me," in the July/August 2010 *BCMJ* outlining my reasons for distrusting government. I felt a little embarrassed to admit that these feelings arose during a meeting about developing a division of family practice in my community. During this meeting I found myself wondering what the government's real agenda was. In the editorial I went on to discuss all the recent good things that had happened through the GPSC (General Practice Services Committee) and how I was beginning to feel appreciated as a family physician. This was a strange feeling due to all the confrontation with government through my years of practice. I mused that perhaps dinosaurs like me would have to die off before a more trusting relationship could be formed between physicians, government, and the health regions.

Then, "thunk." I read outgoing president Dr Ian Gillespie's letter regarding our negotiations with government about renewal of the Physician Master Agreement. Apparently, after a year of informal, collaborative discussion and agreement on a number of issues the new government's negotiating team tabled some extremely unsettling proposals, including reinstating prorationing, removing the spending authority of the GPSC and Specialist Services Committee, changes to MOCAP (Medical On-Call Availability Program) and physician call coverage, eliminating PITO (Physician Information Technology Office) payments, and more.

Are you kidding me? They want to bring back prorationing? In case you don't remember, prorationing allows MSP to keep a proportion of our billings earlier in the year if it looks like we are going to exceed a fixed global budget for physician services. Obviously the government has forgotten Reduced Activity Days. Withdrawal of services is a foregone conclusion if they go down this ill-conceived path.

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I'm sure physicians will choose to close their offices and spend time with their families/friends, or play instead of working for free.

The government has also proposed that physicians provide call coverage whether they are paid for it or not. In addition, physicians on a MOCAP contract will be required to provide coverage at more than one facility. I'm pretty sure that if they try to make an obstetrician in Langley also provide emergency coverage to Chilliwack Hospital they won't have anyone left on a MOCAP contract. Furthermore, how exactly are they going to make physicians provide on-call coverage against their will? Send the RCMP to put us in cuffs? Perhaps we will have to wear those collars that give a significant electric shock if we try to get off hospital property.

The government also wants to eliminate PITO payments. After encouraging physicians to adopt electronic medical records and building a successful program they now want to pull the plug. The last and most troubling item surrounds the issue of binding arbitration. In an effort to avoid withdrawal of services and its resulting turmoil, the physicians of BC negotiated binding arbitration into the last Master Agreement. The government negotiators have already hinted that they won't necessarily honor any such arbitration decisions.

I'm hoping that by the time this editorial comes to print calmer heads will have prevailed and a more collaborative approach will have once again been adopted. However, the tabling of some of these proposals suggests to me that perhaps I'm not the only dinosaur roaming the earth.

—DRR

Physicians assisting suicide

As a result of two cases currently before the BC Supreme Court, the question of legalizing assisted suicide is once again in the media. The legal argument is straightforward: if suicide itself is legal then assisting suicide should be legal as well. Otherwise, the law against assisted suicide is the only one on the books that makes assisting a legal act illegal. This I can understand, although the legal nuances escape me.

What I have difficulty understanding is the assumption by several groups supportive of assisted suicide that physicians would be the ones to assist. While assisting someone to commit suicide can result in a decrease of suffering for the individual, it certainly contradicts the tenet "above all else, do no harm," which surely is the underlying principle of the practice of medicine. There can be no more harmful and irrevocable act done to an individual than killing that person, even though the person requests it.

Patients with progressive, debilitating, painful diseases require enormous courage to face each day. They also require and deserve compassionate and supportive care from their physicians. Where I have trouble is with the decision whether such care extends to helping them to commit suicide. This is not to suggest that such individuals do not have the right to take their lives—this I fully support. The really difficult question is who should (or should not) help them to die when they are no longer able to perform the act themselves.

If assisted suicide is legalized, care will need to be taken to make sure that there is no coercion applied to anyone involved in the process. This applies to the medical profession as well as to the patient, friends, and family. Some of my colleagues may feel comfortable assisting, but I would feel that I was breaking my oath of "do no harm."

—LML

Farewell Dr Lawson

A stalwart member of the *BC Medical Journal* Editorial Board since 1994, Dr Lindsay Lawson retired from the Board 26 August 2011. Among her many talents and attributes, we will miss her wide-ranging knowledge, compassion, energy, editorial precision, and dedication to the profession. We hope to see her byline on the pages of the *BCMJ* in many future editions.