OCP crash cart

I sprang into action when the loud voice reverberated through the hospital corridors. Grabbing my white coat I sprinted down the hall, stethoscope trailing in my jet stream, startled visitors and knowing staff scattered in my determined wake. Sliding around a corner I met Dr Smith and we headed toward the emergency together. Our anticipation grew the closer we came. I mentally refreshed the required steps and algorithms. Bursting into the assigned room we headed for the bed nearest the door. Knowing the situation was dire we decided to grab its occupant and run. Critical situations call for desperate action so we headed toward the intensive care unit, pushing furiously. We blew past the full ICU and the overflowing emergency department, eventually dumping the surprised patient out the front door. "Sorry, we are full," Dr Smith advised. "Really full," I added. "Didn't you hear the OCP level 3 announcement over the loudspeaker?"

Nothing changes after the announcement is made. No one seems to move any faster; none of the staff look concerned or even flinch. I have yet to see an OCP crash cart fly past.

A recent development in hospitals across our health region is the daily announcement of our over-capacity protocol (OCP) levels 1, 2, and 3. The message is triggered by the number of occupied stretchers in the emergency department and is sent over the hospital PA system at 9 a.m. Level 1 means the hospital is full, level 2 that it is more full, and level 3 that the hospital is really full.

The message OCP level 1 is stated loudly and repeated similar to the code blue announcement. I was visiting an older unwell patient of mine when she was startled by the loudspeaker. "Oh my goodness," she exclaimed, "what does that mean?" On hearing that it meant that the hospital is full she observed, "Well, that's just silly. Why would you announce that out loud?"

I completely agree. I wonder which administrator or committee came up with this idea. Nothing changes after the announcement is made. No one seems to move any faster; none of the staff look concerned or even flinch. I have yet to see an OCP crash cart fly past. The hospital remains just as full. Maybe it's a reminder for us physicians to discharge all the patients we have in the hospital unnecessarily, because that sure happens frequently. I'm sure some juggling and opening of temporary beds is required when the hospital is full, but couldn't this be managed with a phone call? I'm not sure a general announcement to make everyone a bit anxious is the best approach. It reminds me of Chicken Little's cries of "the sky is falling!"

I'm going to try to stop this process at my hospital, but I'm not sure I will have much success. I have been given the contact information for the vice president of community hospitals and programs, so I'll do my best. I was hoping to get contact info for the vice president of patient experience (yes, Fraser Health has one of those) because I would really like to know what this person does.

As an aside, I might start a daily proclamation in a loud, firm voice over my hospital patients' beds that they are sick, getting sicker, or really sick!

—DRR

Ethics on trial

Only days before the scheduled start of the Constitutional trial on patients' right to access care, and over 6 years since the launch of the action, the BC government informed the plaintiffs that "thousands of documents" were being released by the Ministry of Health. Government lawyers asked for another delay of at least 8 weeks. This is not the first false start. The laws being challenged in BC Supreme Court force BC patients to wait and suffer in pain, make private insurance illegal, and forbid dual practice by physicians. Over 150 young unemployed orthopaedic surgeons cannot get privileges because OR time is restricted. Correlate that with the fact that the longest wait times in the country are for orthopaedics and you have a prime example of what ails our health system.

Ethical arguments will feature in the trial. With one exception, those who support a system that infringes upon the rights of patients are, in my view, in violation of all ethical standards. That exception applies to lawyers acting for the defendants, who have a duty to argue in support of their clients. This exception does not apply to physicians and government experts who will attempt to justify the pain and suffering of the plaintiff patients and their families. Two of three adult plaintiffs with cancer have died. One of three children is paralyzed for life. They are the tip of an iceberg that comprises over 1 million Canadians on government wait lists. The Supreme Court of Canada has already ruled that patients are "suffering and dying on wait lists," and that "access to a wait list is not access to care."

The denial of a patient's right to obtain timely access outside the system, when it is not available within the system, is the current practice and is unethical. An ethical physician must advocate for quality health care that is appropriate, effective, and timely. When laws, policies, or regulations conflict with that role, we must reject them. The CMA Code of Ethics preamble states "Physicians may experience tension between different ethical principles, between ethical and legal or regulatory requirements, or between their own ethical convictions and the demands of other parties," but requires that we "Consider first the well-being of the patient." A citizen's right to spend their own after-tax dollars on the care of themselves or their loved ones is a right physicians must defend. Unethical laws and regulations are not uncommon. Laws that made homosexuality a criminal offence, and others that allowed racial and sexual discrimination, are examples that have existed in my lifetime.

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Our current health system, and the

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laws that maintain it as a self-regulated monopoly, is supported by a vociferous minority of physicians who are often not in clinical practice. In their enthusiasm to uphold the status quo, they have made pronouncements that illustrate a lack of insight and sensitivity into the plight of patients, and an arrogant disregard for the rights of individuals to exercise control over their own bodily health. Dr Gordon Guyatt, a McMaster-based health policy researcher, wrote in a major newspaper that "adverse health consequences among those waiting for care are few and far between… it is likely that there are areas of Canada in which certain patients—possibly those with cancer, heart disease—wait too long. But the complexities of the waiting list issue suggest careful study and planning before we try to solve a problem that may be much smaller than we imagine." Dr Charles Wright is a former VP at the Vancouver Hospital, consultant to the BC Ministry of Health, and member of the Health Council of Canada. He received a taxpayer-supported grant of $850 000 to study wait lists. In *Reader's Digest*, he opined that "Administrators maintain waiting lists the way airlines overbook. As for urgent patients in pain, the public system will decide when their pain requires care. These are societal decisions. The individual is not able to decide rationally." Dr Guyatt, Dr Wright, and others, including many supporting the government in the Constitutional action, do not represent the views of mainstream doctors, over 80% of whom supported the Chaoulli v. Quebec decision to legalize private insurance in Quebec.

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The BC government has refused to discuss its strategy or comment on the case because "it is before the courts." Our strategy will be to counter bias and hypocrisy with evidence and facts. Patients should not have to sue for access. We hope to persuade the court that Canadians should not be forced to suffer, and even die while they wait for care. Such an approach is not only unethical but, in our view, also illegal.[1,2]

—BD

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