Dark and stormy times

It was a dark and stormy night—at least it was while I was writing this editorial in late October. Hopefully by the time these words are published our neighbors to the south will have made history by electing their first female president.

I was born in 1963—the year JFK was assassinated and right in the middle of the American civil rights movement. My over 50 years on this planet has seen the fall of apartheid and the Berlin Wall. During my lifetime many significant positive strides toward racial and gender equality have been made. However, I am saddened that equality on all levels isn't the current world standard.

Nevertheless, I am proud of the progress that has been made. In my younger years I would have never believed that I would live to see a man of color become president of the most powerful nation on the face of the earth, let alone serve two terms. I think the majority of Canadians admire Barack Obama for the quality of his leadership. I can only hope the American people take the next step and elect a woman to the Oval Office. Gender equality has been a long time coming and remains an elusive goal in many areas of society.

Medicine has been one area in which much has been accomplished. My medical school class consisted of 50% women. My referral patterns aren't based on gender, but by the quality of the specialist in question. Pay equality is the norm. However, I realize my female colleagues have and still do face episodes of gender bias and discrimination, and sadly even harassment. Male-dominated holdouts remain in certain specialties and areas of medicine, but these are becoming fewer and farther between. Perhaps naively I believe opportunities in medicine are now being based on intellect and skill without consideration of gender.

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I have an amazing wife and a fabulous daughter who are full of talent and drive. My granddaughter is approaching her second birthday and her sister is due to arrive in the next few weeks. I want and need for them to have the same opportunities I had and not be limited by gender. Their dreams and goals should not be capped and should include the highest office of any country they belong to.

The current democratic candidate is not my favorite, but based on merit she is definitely the best suited for the job. I think all Canadians shudder to think what will happen if the Republican nominee is elected. Moving forward I dream of a world where the gender, race, and sexuality of political candidates isn't even part of the discussion.

Next step is for Michelle Obama to change her mind and give it a go.

—DRR

Postscript: While the election didn't go as expected, my hopes for the future are unchanged, so I have not revised my editorial.

Is there a medical professional on board?

I hadn't heard a call for inflight medical help for at least a decade. No longer was the call for a doctor but for a medical professional. While initially surprised, on reflection I realized that a critical care nurse or a paramedic might be of more value in an inflight medical emergency than a pathologist or a medical administrator such as me.

Years ago when I was practising emergency medicine, responding to a call for medical help was a reflex action. And I wasn't alone. When flying back from an emergency medicine conference a request for a doctor resulted in half the plane's call buttons lighting up simultaneously.

Today was different. Someone more clinically current than me should answer that call, but to my dismay nobody responded. What are the chances of me being the only medical professional among 250 passengers? Were they all waiting to see if someone would respond first and then magnanimously wander over, easing their guilt, knowing that they would be superfluous? Wouldn't it be embarrassing if a naturopathic medical professional responded? What if this was a real, life-threatening emergency? At that point concentrating on my Sudoku game became impossible, and when I saw the AED being deployed by the flight attendant, my exculpatory vacillation came to an abrupt end.

I introduced myself as a former emergency physician to the flight staff and to the pleasant elderly lady who appeared in no distress. The flight attendant stated that she had become concerned when the passenger had requested some Tylenol for her increasing chest pain. On reviewing her history it was apparent that she was in relatively good health, had no cardiac history, and other than her age had no cardiac risk factors. When asked when the pain started she stated that it happened soon after she lifted her luggage into the overhead bin. Within the limits of conducting a medical exam in public I found her to have a normal pulse and respirations and a very tender chest wall. I concluded that this was musculoskeletal pain that could be followed up on arrival in Vancouver on a nonemergency basis. She was happy with the Tylenol and I was happy it was nothing more sinister.

An hour later on landing in Vancouver, passengers were asked to wait to disembark until the awaiting paramedics could evacuate the medical emergency.

My initial response was indignity. Had the flight staff perhaps felt that as a former emergency physician my judgment was suspect? As I simmered down the realization struck me that I had provided a medical opinion as a Good Samaritan. I was not employed, contracted, or compensated by the airline and therefore incurred no liability for the care I had provided (except if it was grossly negligent). The responsibility for the passenger remained with the airline and they were merely practising good risk management.

Commercial airlines have done much to address inflight medical events, which occur at a rate of once every 604 flights. Medical kits are now well stocked, including oxygen and AEDs on larger planes. The medical kits even have emergency protocols for those of us who don't deliver regular emergency care. Airlines recognize that the wide scope of possible medical emergencies in addition to the reduced cabin pressure equivalent to 8000 ft. can be challenging to most physicians. Most airlines now contract with organizations that offer on-ground expert medical telemedicine consultation, so inflight medical care has become a collaborative venture.

Why should we respond to inflight medical assistance calls? For the most part there is no legal obligation to respond (unless you have a contractual obligation or of it happens to be your own patient who requires aid). Working in an unfamiliar environment, without lab or diagnostic imaging and venturing outside one's usual scope of practice is intimidating to say the least. There is no remuneration other than possibly some expression of gratitude in the form of flight reward points or upgrade certificates.

And when we do respond our actions are scrutinized by the watchful eyes of up to a hundred curious passengers who appreciate the live entertainment far above that provided by their little TV screens.

The answer is simple: we respond to medical assistance requests, and not only inflight, because it's part of our professional duty as physicians. We care. It's in our blood.

—WRV

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