Mr Trudeau

"Mr Smith, I realize that with your advancing age you've been having some trouble with your memory, so is it okay if I ask you a few questions?"

"Sure doc."

"Mr Smith, are the Canucks going to win the Stanley Cup this year?"

"Of course not, doc."

"So, okay, that question was too easy. Who is the prime minister of Canada, Mr Smith?"

"Trudeau."

"Which one?"

To determine their level of cognitive functioning, we ask patients simple common-knowledge questions. For years I noticed that patients with advanced dementia would often answer that Trudeau is the prime minister of Canada, and it is somewhat ironic that they are correct once again.

When I wrote this, the Liberal Party of Canada had recently dispatched the governing Conservative Party in a big way. Most people seem excited about the change in our federal government and are full of enthusiasm for the future. The Liberal Party's platform on health care can be summarized by the following statement, "We will make home care more available, prescription drugs more affordable, and mental health care more accessible." I try to keep abreast of every political party's health care platforms—either that or I took this from their website.

The majority of the population still views unlimited health care as their right.

Our health care system faces many challenges, the largest being how to maintain accessible, timely, and affordable health care for an aging population in the face of increasingly more expensive technological advances. I'm not sure I would want the job of deciding how to finance this bottomless pit. The Liberal's platform uses the words "available," "affordable," and "accessible," so it appears they are ready to take on this task. Can we really finance health care that is accessible and available without carving out a bigger piece of the budget? I am sure there are many intelligent individuals out there working on various solutions to solve this dilemma; I just don't happen to be one of them.

I would argue that our current health care isn't that available or accessible. Long wait lists persist for most surgeries and procedures. More and more patients are using private facilities to get their imaging and operations done. However, the majority of the population still views unlimited health care as their right, and political parties avoid the issue of health care reform because challenging this right is linked to political suicide.

So, I bid good luck to our newly elected governing party and its charismatic leader as they embark on this arduous health quest. Mr Trudeau has already faced some international crises with aplomb and polish and by all accounts is doing well. His grace period continues and his lustre shouldn't tarnish unless he does something silly like, say (chosen completely randomly), pay his nannies with public money.

—DRR

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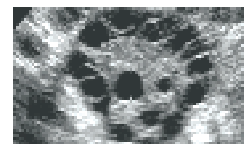

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We can't do that in the ER!

Emergency medicine has so many convenient reasons why something can't be done. "We should do what?"—said with just the right amount of incredulity. I am sure this attitude is partly due to the fact that the ER now functions as ambulatory care, outpatient clinic, inpatient ward, ICU, and OR, in addition to our usual pursuits. It is a happening place.

Our mindset can be: This is the emergency department; saving lives, stamping out disease; we are way, way too busy to [blank] (insert whatever initiative is suggested). But in many cases this isn't how it works. The classic example is hand washing—but there are others. Traditionally, the hand-washing laggards can be found working hard in the ER. There is no time to grab some hand cleanser when we get called STAT to the resus room. We do, however, have time to put on gloves, don a protective mask, put the prior chart down, and go. Consistent hand washing is really about incorporating a change into our carefully crafted, years-in-the-making routine. That is a very tall order. This example is near and dear to my heart as I recently received a very prestigious award for my hand-washing dedication. At our ER Christmas party, after several libations, to loud thumping dance music and squeals from the crowd, I was honored with the hand-washing fanatic award. I was thrilled, even though, on closer examination, the certificate was clearly from a dollar store. Today I don't walk past a hand sanitizer station in the ER without helping myself. I don't even break stride. Change accomplished.

Medication reconciliation is another "no can do" patient safety project that has struggled to get into emergency medicine. "Not our job," says the ER physician. "Already have too much to do," say the nurses. "We didn't write the admission orders," says the inpatient team. "We need a lot more staff to accomplish that," says pharmacy. Granted, it has taken about 5 years in slow increments and gradual improvements, but we now have a team-based approach that works, without more staff. I didn't think it could be done, but I was mistaken.

My next challenge is the illegible handwritten ER record, still in use in my and many other hospitals. Carbon copy technology from the 1930s—make that the 1830s—produces faint, smudged, unreadable copies for the family physician (if they're lucky). Handwriting that defies human comprehension. How embarrassing when a nurse puts my order back under my nose to ask what it says, and I can't read it either! That smarts.

But we can't dictate our records—it's too noisy in the ER, too time consuming, transcription is too slow, we need the copy right now, not next week. All true. How unfortunate that most of the health care team struggles to follow what we have documented. Handwritten charts can no longer be our best option. After all, it's 2016.

So I am starting FESR (front-end speech recognition) training next month, something the radiologists have been using for years. Imagine all my patient records typed and legible in real time. It will be slow, frustrating, and I am sure I will be shaking my head, thinking this can't really work in the ER. But my attitude has changed. My desire to get rid of deficiencies in practice will force me over the obstacles. And when I hold that first legible, error-free ER chart in my hands and watch it slip into that ancient three-ring binder, man, will I be happy!

—**AIC**

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