Let's discuss

Recently our profession has faced a number of controversial issues—physician-assisted dying, narcotic prescribing for nonmalignant pain, and the use of medicinal marijuana to name a few. I'm not an expert on any of these issues so naturally I will tell you how things are.

The process of legalizing doctors to aid in the deaths of their patients has brought forth strong emotions on both sides of the issue. Words such as "killing," "murder," "torture," "inhumanity," and more have been used to bolster one position or the other. I believe most patients, if offered good palliation, would choose not to end their life. But, on the other hand, how do you effectively palliate conditions such as amyotrophic lateral sclerosis? To observe your body dying around you is not a death I would wish on anyone.

The College's recent standards and guidelines on prescribing narcotics for chronic nonmalignant pain have raised the ire of a number of physician groups. Walking the line between reducing prescription drug abuse/deaths and alleviation of suffering is difficult indeed. However, in my over 20 years of clinical practice,

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I can count on one hand the number of patients for whom daily narcotic use for chronic nonmalignant pain improved quality of life.

The ever-increasing use of medicinal marijuana is also quite polarizing. I have had a number of dying patients report that marijuana eased suffering and made their last days more comfortable. However, I now have patients using medicinal marijuana for fatigue, insomnia, depression, fibromyalgia, musculoskeletal discomfort, and more. These prescriptions didn't come from my hand, but none of my patients had any trouble obtaining them. I am troubled by the large number of people taking a central nervous system active substance with little scientific evidence to support its use.

Why bring up these controversies? The *British Columbia Medical Journal* is the perfect place for BC physicians to share their points of view on all topics. It is an honor to publish the various opinions of our readers and act as a vehicle of respectful discourse in all matters. We might not always agree, but we are definitely in this together, so please continue to send in your thoughts and musings.

—DRR

The future is not what it used to be

Over the years hundreds of millions of tax dollars have been spent on over 300 government health care task forces and commissions; 25 years ago BC's Royal Commission on Health Care and Costs (the Seaton Commission) made its recommendations for health reform. Ministers of health, deputy ministers, and health bureaucrats across Canada embraced and implemented many of the BC proposals, including the following: "The commission recommends that the Ministry of Health and the BCMA give priority to the joint development of a program to limit the number of physicians."

Their rationale was that doctors and patients were to blame for rising costs and if we stopped treating patients costs would fall. This assumption was based on now-discredited theories that failed to recognize that rationing leads to delayed care and that waiting costs more. The legacy of their actions was a shortage of doctors, as Canada dropped in the rankings of doctor supply to 26th in the world (when I started practice we were fourth). Commissioner and UBC economist Robert Evans had earlier written, "A central cause of the problem was the oversupply of physicians, which tended to generate greater utilization of services; there are too many doctors; and a supply-induced demand; a bed built was a (hospital) bed filled." His philosophies dominated the report.

When reflecting on the frenzy and turmoil that consumed communist China in the 1950s during Mao Tse-tung's Great Leap Forward, volunteers commented that what seemed completely normal at the time seemed like madness after the fact. I believe we will look back on our current health system with similar sentiments.

More recent commissions have also been failures. The Romanow Commission endorsed the status quo. Senator Kirby's Commission made creative suggestions, such as patient-focused funding and a care guarantee. These would empower patients and limit the monopoly control of governments. The report of the BC Select Standing Committee on Health concluded, "Your Committee recommends improved wait-list management not a health care guarantee." (Translation: let's study and manage wait lists, rather than fix them.)

Other tax-funded experts endorsed this approach. They have dominated health policy in Canada. Jonathan Lomas, former executive director of the Canadian Health Services Research Foundation, made his views clear when stating, "I think we have to be very careful about empowering the consumer because they will make choices that are not in their own health interest."

Dr Charles Wright, former VP at Vancouver General Hospital, wait-list consultant to the BC Ministry of Health, Health Council of Canada member, and recipient of an $850 000 grant to study wait lists, stated, "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."

Yet another expert, Dr Gordon Guyatt, a former NDP candidate, cofounder and leading spokesperson of Medical Reform Group (which later evolved into Canadian Doctors for Medicare), wrote: ". . . 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 wait-list issue suggest careful study and planning before we try to solve a problem that may be much smaller than we imagine." These examples reflect the arrogance of government-funded advisors and explain why input from patients and practising physicians has been discounted.

Reform may come soon as patients gain their freedom after an objective and impartial evaluation of the facts and evidence by the courts. After an almost 8-year delay, our constitutional trial begins this September. I foresee that within 5 years following the judgment all patients in Canada will have rapid access as wait lists are dramatically shortened. Medicare will be expanded to cover prescription drugs, physiotherapy, dentistry, prosthetics, etc. (areas now inexplicably excluded by arbitrarily designating them medically unnecessary). Funding will come from the economic savings of shortened waits and added revenues as wealthier Canadians are encouraged to contribute more than the less wealthy.

In Canada, lower socioeconomic groups have the least coverage, poorest access, and worst outcomes. Both Statistics Canada and independent study groups around the world have verified this. In 2010, Italian health law expert Giandeomenico Barcellona, wrote, "I am very fond of Canada, one of the best countries in the world, but this (Canada's health) system is tailor made just for very rich people, who can get medical care abroad."

Change is on the way. In the hybrid system that evolves, the poor and economically deprived will benefit as wait lists disappear. The only advantage the rich will experience is their ability to access timely care in Canada. Governments and citizens will enjoy the massive economic benefits that result from reduced disability and work loss.

Sadly, for some health policy experts and economists, they will find that the end of wait lists will mean that their tax-funded grants to study them will likewise disappear.

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