eas. Even though foreign specialists will not provide the ultimate solution to Canada's maldistribution problems, they are and will likely continue to be an important element of any solution.

I realize the act of accreditation involves tremendous responsibility and that authorities must ensure that only competent and capable specialists are allowed to practise. However, can we really exclude, carte blanche, entire groups of trainees from some countries? It seems arrogant to suggest that our training programs are of higher calibre than similar programs in Germany, France or Japan. It would be fascinating to see the data supporting this notion.

**Shabbir M.H. Alibhai**
Richmond Hill, Ont.
Received via email

## Patient confidentiality and the law

It is a pleasure to see that a medical student and practising physician are sufficiently interested in the ethical issues surrounding patient confidentiality to write a paper. However, the article "From Hippocrates to facsimile" (*Can Med Assoc J* 1997;156: 847-52), by Daniel Y. Dodek and Arthur Dodek, should not be considered a comprehensive guide to patient confidentiality in Canada. Some of the authors' conclusions are so general they are misleading and must not be taken at face value.

The authors based their article on the premise that patients have a right of "inviolate confidentiality" with respect to their medical records. No such absolute right exists. They seem to acknowledge this fact by citing the CMA *Code of Ethics*, which provides that patient confidentiality is to be respected except where it might conflict with the law or would result in harm to the patient or others. These significant limitations have become increasingly common, and they should not be regarded as minor aberrations. They must be recognized and respected by the profession.

Likewise, subpoenas requiring the release of patient records may eventually conflict with the confidentiality that would otherwise attach to patient records. However, the subpoena does not oblige the physician to turn medical records over immediately to the person requesting them but merely to bring them to court, where it will be determined whether they should be released. Therefore, complying with a valid subpoena will not automatically violate a patient's confidentiality.

The same problem exists concerning the mandatory-reporting obligations cited by the authors. They write that reporting AIDS, but not HIV infection, is mandatory in the US and in Canada. This is inaccurate. Although it may be true in some jurisdictions, there is strong authority that it does not apply, for example, in Ontario. The policy of the Ontario medical officer of health is that, pursuant to Ontario's Health Promotion and Protection Act, physicians are required to report cases of HIV infection. Likewise, rules on mandatory reporting of child abuse vary across the country. Finally, gunshot and knife wounds are *not* subject to mandatory disclosure. It may apply in the specific context of a criminal investigation or a coroner's inquiry for which a subpoena or a warrant has been issued, but the bold statement that all gunshot and knife wounds must be reported is unfounded.

The authors also state that the physician should ask whether there is any information the patient wishes to keep absolutely confidential. This is highly questionable advice. Keeping 2 sets of charts will create obvious record-keeping problems. Moreover, even though a patient and doctor have deemed something "absolutely confidential," it can still be produced under court order.

It is difficult to imagine when it would be in a physician's interest to consent to not documenting or deleting certain findings or medical information. Failure to record all relevant information will make it difficult to establish the facts upon which advice or treatment was based, and could lead to inappropriate treatment when someone relies upon the incomplete record. The evidentiary consequences in a malpractice action against a physician could serve to destroy an otherwise strong defence.

Finally, if a patient requests that only a portion of the chart be provided to a third party, the physician should let the party know that a portion has been withheld at the patient's request. For example, a patient with a heart condition who applies for life insurance might request than an expurgated version of the chart to be sent to the insurance company. If the company pays out a claim because of this, it could bring a civil action against the physician to recover its losses.

**Margaret A. Ross**
Gowling, Strathy & Henderson
General Counsel
Canadian Medical Protective Association
Ottawa, Ont.

**[The authors respond:]**

We appreciate Margaret Ross's comments. The article was not meant to be a comprehensive guide to patient confidentiality but rather a selection of the many direct and indirect ways in which patient confidentiality can be betrayed.

There are some very specific legal limitations on patient confidentiality, and physicians certainly must abide by them. We wanted to point out how easy it is to violate patient confidentiality.

Health and legal statutes do vary from province to province. In British Columbia physicians are not required to report patients who test positive for antibodies to HIV. We certainly do not suggest keeping 2 sets of records or charts: we advised that only the medical information pertinent to a request be sent to the interested party. For instance, medical information requested by an automobile insurance company should be specific to the area of concern.

There was no documentation or intent in our article to indicate that if a patient with a heart condition applied for life insurance an abridged or modified version of the chart should be sent to an insurance company. Where life insurance is concerned, all medical information must be divulged.

There is no misunderstanding here. The physician must be the patient's advocate and abide by the CMA *Code of Ethics*.

**Daniel Y. Dodek, BSc**
**Arthur Dodek, MD**
Vancouver, BC

## This experiment has failed

I thank Dr. Donald G. Marshall for his letter "Our future physicians deserve better" (*Can Med Assoc J* 1997;156:1701).

Medical students do indeed experience undue anxiety about making premature career choices. Discussions with my peers have been extremely disquieting. I am concerned that their preoccupation with their future may adversely affect their well-being. In the rush to choose a career and acquire a residency spot, students too often lose sight of the purpose of medical school and why they decided to enter medicine.

I have yet to find anyone who believes the current system serves the needs of the profession, yet it takes people like Marshall to make us admit what we have all known for a long time: this experiment has failed! If during a clinical trial an intervention is found to be detrimental to patients, the experiment is stopped. Should the next generation of physicians not be entitled to the same respect as such patients?

Despite government cutbacks and disillusionment among residents and practising physicians, I look forward to the future. I remember why I decided to become a doctor. I believe that medicine can be an exciting, noble and rewarding profession. I only hope my peers and future students can feel the same way.

To those charged with caring for our education system, I make this plea: let's have no more committees or resolutions to look into the matter. Let's fix the problem! I would be delighted to work with you to ensure that our medical schools turn out the world's most humane, well-rounded, content and proficient physicians.

**David A. Omahen, BSc**
Class of '99
University of Ottawa
Ottawa, Ont.

I heartily endorse the letter from Dr. Marshall, which says that requiring medical students to choose their future career path long before they know enough is grossly unfair.

The old system of junior rotating internships for everyone produced much more balanced graduates from both family practice and specialty programs. Very few physicians-in-training have a good sense of what true practice entails or whether they have the interest and stamina for it. Every branch of medicine deserves to have only those who want to be there. We have all experienced the lukewarm participation of those who would rather be somewhere else. For the sake of our students, our profession and, most of all, our patients, we must return to common sense in specialty training.

**George T. Riley, MD**
Oakville, Ont.

## Physician payment: incentives change with supply

The articles "Primary care reform: Is it time for population-based funding?" (*Can Med Assoc J* 1997;157: 43-40, by Dr. David Mowat, and "A new primary care rostering and capitation system in Norway: Lessons for Canada?" (*Can Med Assoc J* 1997;157: 45-50), by Drs. Truls Østbye and Steinar Hunskaar, examine different physician payment mechanisms.

Each of the recognized methods of payment results in different incentives, and these change when a certain line is crossed. The location of this line depends on whether there are too many or too few physicians in the particular market, or, more accurately, on whether the physicians involved believe that there are too many or too few of them in the market.

Fee-for-service payment provides incentives for physicians to work hard and efficiently when there are too few physicians, but when there are too many physicians with too little work it encourages the generation of unnecessary work. Capitation-based payment encourages patient satisfaction as long as the physicians are competing for patients; however, as happened in Britain, once there are too few physicians, all with full lists, this payment system encourages physicians to reduce work to a minimum. The effect of salary payment is less clear, but it goes something like this: if there are too few physicians in the system, the incentive is to reduce work to the minimum; whereas, if there are physicians trying to get into the salaried positions, the physician