Dispatch from the medical front

Matters of trust

Hi Amy," the phone call began, "I'm working ER tonight and there's a guy here with SVC syndrome I think. Could you come by?" I trotted in to the hospital and met George, a patient with a 75-pack-a-year smoking history, a very large neck and a mass on his chest x-ray. We spoke with the radiation oncologist, who felt radiation was urgent enough to send him down — on December 24 — for treatment. I did some quick explaining to George, and we sent him off to the big city.

A month later, he sat in my office; the tumour had melted away, but I explained the need for a tissue diagnosis. He looked puzzled, but agreed to go back to the teaching hospital for a mediastinoscopy and bronchoscopy. Unfortunately, only necrotic material remained, and I did my best to explain this to George.

A few months later, a supraclavicular node popped up, and one of our general surgeons removed it, for a final diagnosis of small cell lung cancer. I strongly encouraged George to consider chemotherapy, and told him I would be happy to organize a referral to the oncologist.

"Look doc," he interrupted politely, "I don't read, and I don't write much, but if you tell me what to do, I'll sign my name. But I'm not going back to Edmonton again. I'm sorry — my wife is sick and my boy works up at camp." I suddenly realized I had no idea who George was, or what he wanted; and yet, he somehow trusted me. A fearsome thought.

He never met the oncologist in person, only on a television screen. Through telehealth we arranged for his chemotherapy in Yellowknife. He saw me occasionally to discuss side effects, and one spring we discussed his progress. "Doc, when do you think it will come back? Could it be back now?"

I had learned at least enough to ask him why he brought up the question now. "Well, doc, every summer I go out and cut wood. I have a little cabin; it costs maybe $2000 to get it up-and-running for the summer. There's not much out there; no neighbours or anything, and I take my own propane and food. I maybe cut enough wood to break even."

The large man leaned forward on his chair, and his voice intensified. "You wouldn't believe the birds out there, doc. In the evening, I just sit and watch them, and listen to them singing all night long. They don't have those kinds of birds in town — every colour you could imagine! I'd love to have another summer out there, but if I get sick again I can't afford to start up the camp for nothing."

My eyes were full as I signed the chest x-ray requisition, hoping I could reassure him and wish him a good summer. The birds would make everything else worthwhile. — Amy Hendricks MDCM, Yellowknife NWT

CMAJ invites contributions to Dispatches from the medical front, in which physicians and other health care providers can provide eyewitness glimpses of medical frontiers, whether defined by location or intervention. The frequency of the section will be conditional on submissions, which must run a maximum 350 words or be subject to our ruthless editorial pencils. Forward submissions to: Wayne.Kondro@cma.ca

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Legal actions against doctors down 50% in past decade

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New challenges face Canada's doctors, and "our environment is likely to become more, not less threatening," Dr. Peter Fraser told the annual meeting of the Canadian Medical Protective Association on Aug. 22 in his last report as outgoing president.

The event in Vancouver focused on the increased risk of liability from factors ranging from new technologies to wait lists. The meeting of the not-for-profit mutual defence organization was followed by a combined session with the Canadian Medical Association (CMA) to discuss wait times and medical liability.

The good news is that legal actions against physicians have declined over the past decade, reported Fraser, from about 26 per 1000 members to 13 per 1000 members.

"Our members are roughly half as likely to be involved in a legal action than they were 10 years ago," he said, attributing the cause to "the growing emphasis on patient safety, risk management and the prevention of adverse events."

But the bad news is that system costs of medical liability have increased, he said, with annual damages and legal and expert administration costs rising from about $170 million in 1997 to more than $400 million in 2006. The median damage cost increased from more than $30 000 in 1996 to nearly $100 000 in 2006.

Fraser also warned about a trend of "increasing intrusions on a physician's right to due process" in the name of patient safety, and stressed that the association believes that professional accountability, liability and support to patient safety "are separate but supporting functions."

The association has 71 164 members, with membership increasing at about 3.6% per year, reported Dr. Guy Gokiert, chair of the association's audit committee.

Membership growth from among international medical graduates now working in Canada was raised as a related concern. Increasing numbers of members are newly-licensed, "in some cases without rigorous speciality exams based on past training. ... I believe this may present us with some risk," said former CMA President Dr. Albert Schumacher of Windsor, Ont. "There may be a perception that the quality of some members ... is different from what the members until now have been."

Any licensed physician in Canada is eligible for Canadian Medical Protective Association membership. The association has no control over licensing. "We do share your concerns that this is an area that needs watching," said Dr. John Gray, executive director and chief executive officer. Gray added that the association "commits to work with the regulatory colleges ... to try and make sure issues of patient safety are raised at the community level, institutional level and that civil claims are addressed."

Gray also warned members to beware of risks from current national measures to tackle wait times. "Accountability and liability concerns may put physicians at risk," said Gray. "We do have concerns that may be lost in the debate about numbers and funding. There's a current lack of clarity."

Gray said it's not clear under wait time strategies who is responsible for what, and whether there's a potential liability for doctors if they're found accountable. "We risk the situation of 'having everyone accountable means that no one is'."

The danger is that if a patient suffers an adverse effect from a long wait time, the courts may assume that evolving guidelines represent standards and may hold doctors accountable to them.

"Physician groups and others should be cautious," said Gray, warning of "unintended legal consequences."

"Courts, regulatory colleges and patients will continue to hold doctors accountable to how they treat individuals, regardless of the pressures to treat waiting lists," he said.

The lack of reliable data also emerged as a wait time problem. Different jurisdictions are using different methods to collect data about wait times, said speaker Dr. Lorne Bellan, a Winnipeg ophthalmologist and co-chair of the Wait Time Alliance. Another problem, said Bellan, is that when wait times are calculated, they don't take into account the time between when a general practitioner refers a patient to a specialist, and when that first visit takes place. "Unless we measure that whole wait, we're really not getting a true picture," he added.

The lack of data may increase the risk of liability for primary care physicians, he suggested, because they have no way of knowing how long it will take for their patients to see a specialist after a referral. "You can't fix problems like this unless you can measure them." — Deborah Jones, Vancouver

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News @ a glance

Adverse events documented: An analysis of adverse event surveys and patient safety indicators by the Canadian Institute for Health Information reveals that Canada still lags behind other nations in reducing risk. The analysis states that in 2005, 1 in 10 adults with health problems reported receiving the wrong medication or wrong dose in the previous year. In 2006, 10% of Canadian primary care doctors said they routinely received drug alerts via email, significantly fewer than in the United States (23%), Germany (40%) or Australia, New Zealand, the Netherlands and the United Kingdom (80% or more).

Physicians take the challenge: More than 100 physicians and health care professionals donated all or part of a day's income to support primary health and development in rural Africa. The Canadian Physicians for Aid and Relief's World Health Day Challenge on Apr. 7 raised more than $60 000 — double what was raised during the inaugural challenge in 2006. Founded in 1984, Canadian Physicians for Aid and Relief works in partnership with vulnerable communities and diverse organizations to overcome poverty and build healthy communities in Ethiopia, Tanzania, Uganda and Malawi.

US Medicare won't pay for adverse events: The US federal government has decided that Medicare will no longer bear the financial burden of treatments caused by preventable errors, injuries and infections in hospitals. Among the conditions "that could reasonably have been prevented" are pressure ulcers, injuries caused by falls and infections resulting from the prolonged use of catheters. The plan will save Medicare about US$20 million annually; the hospitals cannot bill patients who suffer from these hospital-acquired complications.

Expand use of mosquito nets: New World Health Organization (WHO) guidelines recommend that long-lasting insecticide-treated nets be distributed either free or heavily sub-

Courtesy of CPAR

Orphans and vulnerable children at the Community-Based Childcare Centre, built by Canadian Physicians for Aid and Relief, in Chintheche, Malawi.