Reforming fee-for-service medicine

Anyone expecting valid research results to emerge from the pilot sites of Ontario's new reformed fee-for-service practices will be disappointed. One of my patients, who still attends my practice 2 years after leaving Cambridge because he cannot find a physician in his new community, tells me he is hopeful he will be accepted by one of the pilot practices.

First, though, he has to go for an "interview" to determine if he is acceptable to the practice. From this I assume that the pilot sites are already being selective in whom they accept and that the selection will be weighted in favour of patients who are least likely to use physician services.

Capitation systems have always militated against medically "troublesome" patients, as anyone who has practised British medicine well knows. And it seems our "reformed" fee-for-service practices will be no different.

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So where does our duty to warn stop?

Ye gods! On the basis of the recommendations in the article "Defining the physician's duty to warn: consensus statement of Ontario's Medical Expert Panel on Duty to Inform," by Lorraine E. Ferris and colleagues (*CMAJ* 1998;158[11]: 1473-9]), whom do we *not* report? Only good drivers? Only good-tempered, calm patients who don't or won't hit anybody?

Most of my work is done in jails, where bad-tempered people tend to collect and where threats are not uncommon. I've certainly felt the danger, but never in 31 years of such work have I reported a threat without my patient's consent. The problem was always worked out in some other way. The "mandatory standards rather than guidelines" for reporting recommended by the Expert Panel would greatly cripple such work and deny access to help for those very problems it purports to address.

We are told that the panel represents various of our colleges and associations, but a conspicuous absentee, at least from my perspective, is the Association of Physicians in Corrections of Ontario. Another one, although it was consulted belatedly and informally by the College of Physicians and Surgeons of Ontario, is the Ontario Psychiatric Association, and a third is the Canadian Academy of Psychiatry and Law.

This discussion clearly suffers from the silence of those physicians most involved in these vital issues. When we finally hear from them, my old chief Bruno Cormier, God bless his soul, will rest a little easier.

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Lessons about racism

Nancy Robb's article about racism in medical schools, "Racism can rear its ugly head at medical school, study finds" (*CMAJ* 1998;159[1]:66-7), reminded me of how I witnessed 2 medical giants attack racism as part of their clinical teaching.

The first event occurred in 1952 when I, as chief resident in medicine at the Victoria Hospital in London, Ont., presented a case to Professor S.F. Brien during his Wednesday afternoon grand walk-around rounds — sessions attended by house staff, medical students and nurses. The case involved a young aboriginal women who had a strongly positive Wassermann test, and I stated that she had syphilis. Before he allowed me to discuss the case further, Brien stopped me and said: "Bill, you are prejudiced." He said I had concluded that the patient had syphilis because of her racial background and pointed out that the test result might have been a false-positive Wassermann reaction — a possibility that had to be considered before jumping to a diagnosis.

He also observed that if this patient had been the young daughter of a local bank president, I might not have reached my conclusion so rapidly. Being Jewish and thinking that I was completely unprejudiced, that encounter affected me profoundly. Brien had pointed out how subtle prejudices are and how strongly they affect our judgement.

The second event occurred at the Toronto General Hospital a year later, when an intern presented a case to Professor Ray Farquharson during his weekly grand rounds. The intern opened his presentation by saying, "This 50-year-old black male . . .," but Farquharson stopped him immediately. A person's racial background, he said, should only be mentioned if it bears a significant relation to the diagnosis; one potential example involving blacks is sickle-cell anemia.

Thus were 2 physicians able to impart to students and staff alike the notion that the humanistic side of medicine is as important as the scientific side.

I strongly believe that racism can be eradicated from medicine if medical schools develop clinical teachers who exemplify and impart to their students the importance of excluding

racism not only from their clinical activities but also from their personal relationships.

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This article struck a chord with me. As a resident in family medicine at Dalhousie University in 1993, I too faced racism from the most unexpected of sources — a patient. During my rotation on the geriatric ward at a local teaching hospital, a patient refused to be examined or admitted by me because of my ethnic background. However, the acknowledgment of the patient's blatant racism by hospital staff and the full support of my clinical supervisor ensured that the incident was not ignored and that steps were taken to resolve the problem constructively. I am very glad that Gaynor Watson, whose research was described in the article, has had the courage to bring this important yet sensitive issue to the attention of the medical community. Let's hope that as a result of her research, my story and those she uncovered will become things of the past.

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Debating the benefits of home care

I was perplexed by a recent exchange in the correspondence column, consisting of the letter "Where's the evidence for home care?" (*CMAJ* 1998;159[2]:135-6), by Dr. Aidan Byrne, and a reply (*CMAJ* 1998;159[2]:136) from Dr. Stuart M. MacLeod.

Byrne writes to ask for factual support for the opinion that home care has significant economic benefits, citing some evidence from the Institute for Clinical Evaluative Sciences that the benefits may be illusory.

MacLeod, a proponent of evidence-based medicine, replies that he bases his position on "common sense" and what is "obvious."

What are readers to make of this?

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[One of the authors responds:]

Dr. Mullens is seeking a black-and-white view on evidence-based rationing that would be inappropriate to a complex situation. A reading of the original editorial ("Evidence-based rationing: Dutch