advantage of MSAs, as Gratzer puts it, is that they "would reinvigorate the doctor–patient relationship with financial ties."

Gratzer should be commended for attempting to freshen the sometimes stale health care debate in Canada, and MSAs do deserve close scrutiny. Again, however, Gratzer cherry-picks the data. Yes, Singapore (where everyone has an MSA) spends less than 4% of GDP on health, compared with more than 9% for Canada. But Singapore has always spent less than Canada; in fact, health care expenditures rose faster after the introduction of MSAs than before. This seeming paradox has a simple explanation: hospitals competed not by lowering prices but through marketing and by offering the latest fancy doodads. Yes, health care spending fell by 27% in two Chinese cities after the introduction of MSAs, but this may have been the result of concurrent reforms that limited the use of imported drugs and expensive diagnostic tests.

In the end, Gratzer leaves the most important health policy questions unanswered. For example, how do we structure our health care system to deal effectively with chronic and preventable illnesses like obesity and diabetes? How do we shift resources from often futile end-of-life treatment to early diagnosis and prevention?

Should you read *Better Medicine*? It depends on your outlook. If you share Gratzer's ideology, you will delight in his analysis and enjoy his contributors' clear prose. If you find yourself on the other side of the political spectrum, you will benefit from giving *Better Medicine* a critical once-over. But the ideologically unattached must continue to wait for the great, unwritten health policy book that explains it all.

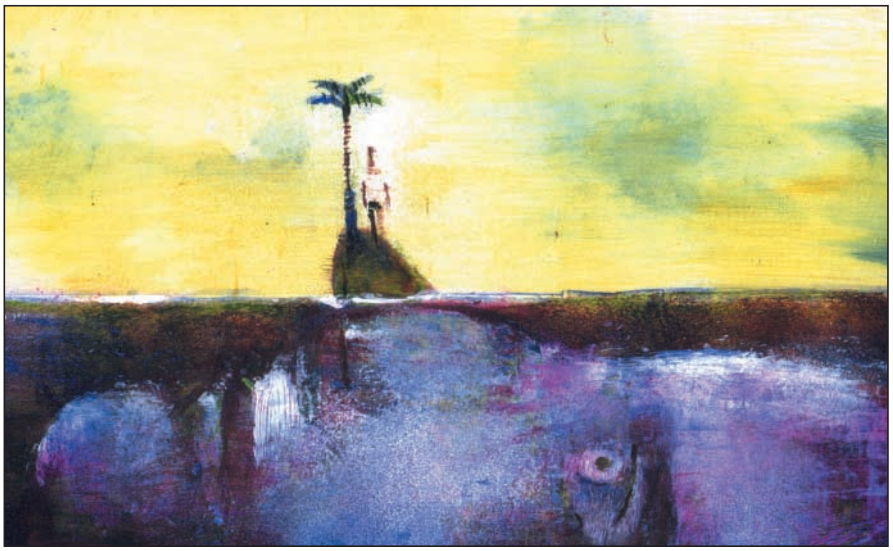
Irfan A. Dhalla
Medical Student
University of Toronto

Room for a view

Alone

The first time I attempted to raise the dead was during my pediatric residency, when I was summoned to deal with an otherwise normal newborn infant who simply refused to breathe. The nurses offered the laryngoscope and endotracheal tube while I bagged the baby, trying to persuade her to start living in this world. After the elapsed time that this furious ritual required, I looked at my watch and declared the end.

I then tried to understand what had happened, and why. I had to convey to the distraught young mother that I had done all that was necessary, but it simply hadn't worked. But fate was certainly looking at this episode differently. The resident colleague who relieved me shortly after the incident noticed that the sheet covering the deceased baby was moving rhythmically. He called me on the phone to declare laconically, "You remember Baby Smith? The one that just died? She's okay now." I ran up the three flights of stairs to the newborn nursery. The baby was pink, breathing and alert, and all that was left for me was to tell the amazed and delighted mother that there had been a slight mistake.



Fred Sebastian

In all of my other resuscitation attempts I was on my own. The second one occurred during an otherwise boring on-call evening at the chronic disease facility of our hospital, where we normally did very little except authorize a change in medication dosage. I received an emergency call to the playroom, where the adolescents were having a party. A young girl with rheumatic heart disease had been allowed to attend as long as she rested in her chair. But the music was too much, and the impulses of youth took over. She had joined the dancing crowd and, before long, suddenly dropped to the floor. I reached her side, diagnosed cardiac arrest and screamed (yes, screamed) for the resuscitation cart. Her sick friends were a sea of faces above me as I tried to initiate the resuscitation ritual alone. By the time the cart arrived it was too late. There was nothing left to do.

The attending psychiatrist immediately organized a debriefing session for the staff. "How do you feel?" she asked me. Angry, Ma'am. Angry at the inefficient system that didn't get the cart to me in time, angry at the reckless adolescent who defied orders, angry at her friends who let her dance. Above all, angry with myself for failing.

Then, some years later, there was the Saturday morning at the neighbourhood swimming pool, where — my family still asleep — I was enjoying some quiet time alone. A sudden commotion diverted me from my newspaper. My name was being shouted; I looked up to see a neighbour emerging from the pool, a small boy in his arms. The child was a purple-black colour and looked truly lifeless. I pounced on him, started to breathe into his mouth and pounded his chest, again conscious that I was, professionally, alone; that the task was awesome; that I did not want to be there. Then suddenly a cough, a joyful spurt of vomitus, the welcome sounds of retching and crying. He was saved, I the saviour. I handed him over to the ambulance and returned to my life, glowing in the newly won status of glorious physician and saver of life.

Years passed by. I had left the world of acute care, and now spent my time in management. The stethoscope seldom hung around my neck, and my clinical skills were little tested. A neighbour called me as I lay in bed on the edge of sleep. He was agitated: his wife was sick, throwing up. I found her vomiting on the floor of their room. They had enjoyed a heavy meal, with perhaps a bit too much wine. I knew she suffered from gastritis from time to time. I waited until she felt better and told her husband to call me again if necessary.

The next morning I checked her again. She looked pale, was still nauseous, and was not drinking. I suggested getting her to the ER, in case she needed IV fluids. She smiled, dismissing my concern. I returned home and was immediately called back. "She's collapsed." Having just seen her, I wasn't too worried. Probably she'd had a fainting spell when she got up. But I still walked back to her house, perhaps a little slower than I had the night before.

I entered her room and immediately experienced that old emotional volcano, the eruption of horror out of comfortable, clinical concern. She lay lifeless on the bed. I was alone again. I, the pediatrician, dragged her to the floor and started CPR, struggling to remember the adult ratio of beats to breaths, screaming instructions to call for the mobile ICU unit, to call another doctor. I thumped, blew, shouted, begged. Surely she would suddenly gasp and start breathing like the boy at the pool. More physicians arrived, and the ICU team. The minutes dragged by. Intubation, IV, drugs, electrical shocks. Deep down, I knew it was over.

Whom do I blame? My clinical skills? Her lifestyle? Her physician? The ambulance that could, and should, have arrived five minutes earlier? Or did the finger that directed baby Smith to live simply turn this time in the other direction? What is the recipe for bringing someone back from the banks of the River Styx: knowledge and skill, timing, location and luck? Which will determine life or death? Does it matter whether I am alone or not? Would it make any difference if I were surrounded by the whole team? In these cases, I am not sure. Perhaps the slightly consoling thing is to try to remember one's place.

Basil Porter
Medical Director, Southern Region
Maccabi Health Services
Beersheva, Israel

Lifeworks

Escape artist

The Jack Pine (1916–1917) is Tom Thomson's iconic painting of the Canadian wilderness. It is also an icon of the status that Thomson himself achieved after his unexplained death on Canoe Lake in Algonquin Park, Ont., at the age of 39. This status originated among his peer artists, who later formed the Group of Seven,[1] and his patron, Toronto ophthalmologist Dr. James MacCallum (1860–1944).[2] In the exhibition *Tom Thomson* the National Gallery of Canada presents a comprehensive and intriguing look at both the artist and the icon and reveals the extent to which the two coexist.

Thomson's fame as an artist rests on five short years of production, beginning in 1912, after his first trip into Algonquin Park. It is apparent in the over 140 works in the show that his abilities as a painter increased exponentially during this period — which, had he lived longer, would have been considered his formative years. Largely self-taught, Thomson developed his painting skills through connections with several future Group of Seven artists who, like Thomson, were employees at Toronto's Grip Limited, a graphic arts firm. Thomson was already interested in painting landscapes out-

National Gallery of Canada, Bequest of Dr. J. M. MacCallum, Toronto

Tom Thomson, *Sunset* (summer 1915). Oil on composite wood-pulp board. 21.6 cm x 26.7 cm