More recent evidence suggests that the problem is no longer episodic but constant. As such, hospitals have effectively curtailed their ability to deliver emergency services to meet cost-containment goals. Hospitals now have an obligation to advise the public and the provincial authorities of the actual level of service that they can provide.

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[The author of the review article responds:]

In his response to my article,[1] Daniel Kollek has identified the essential legal issue with which we are now faced: whether it is reasonable and ethical to hold a physician (or hospital) liable in negligence for failing to treat or for inadequately treating an individual in need of emergency care due to patient overcrowding, lack of personnel or equipment, or both. By the "reasonable person" standard, the answer may be "no"; however, it remains to be seen what the judicial response will be.

Since the Fleuelling case,[2,3] a second action has commenced in Ontario relating to the issue of emergency department overcrowding. In the Mitchell case,[4] a girl of 10 months died after a 5-hour wait in a hospital emergency department. The family has commenced an action against the hospital and the emergency department staff. In a separate action against the Government of Ontario, the family alleges that negligent actions and decision-making by servants of the government, including decisions to reduce health care funding, contributed to the overcrowding and the resultant delay in treatment. The Ontario government failed on a recent motion to strike out the statement of claim as disclosing no reasonable cause of action, and the litigation can proceed.[4]

Kollek has identified an obligation on the part of hospitals to advise the public and the government of the actual levels of emergency services that they can provide. Such disclosure may serve to emphasize the severity of the health care situation and may reduce public reliance on the services provided by emergency departments and staff. Although the court has identified a duty for hospitals to advise the public of emergency department closures and reductions in staffing, I would hesitate to conclude that a declaration by a hospital that it is no longer performing up to the accepted standard of care would protect it and its staff from legal ramifications, especially considering the recent trend in litigation.

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Decriminalizing nonmedical drug use

Robert Remis' commentary[1] questions the potential effectiveness of safe injection sites for secondary prevention because of the chaotic lives of many injection drug users. But Remis fails to mention that much of that chaos comes from users' struggles to obtain money to pay for their drugs and evade criminal prosecution.

As a family doctor with a longstanding interest in HIV, my practice has in recent years increasingly come to encompass hepatitis C, injection and other drug use, prescription drug abuse, harm reduction, Aboriginal and mental health, advocacy for access to the nonmedical determinants of health and liaison with prison health services.

I would suggest a far bolder approach than Remis advocates to minimize nonmedical drug use and its enormously (and increasingly) costly personal and societal consequences.

Government should confine its role to what it can do. It is surely by now beyond dispute that if an individual wants to use a particular drug he or she will do so. Drug price, poverty, the law, warnings and the risk of violence are clearly ineffectual deterrents. People make their own choices and have to live with the consequences. The important thing is that they comprehend the facts needed to help them decide so that the consequences are minimized. To achieve this (as with liquor and Al Capone), government must take over the supply and distribution of drugs from the gangs. The gangs' profit motivation ensures the constant recruitment and initiation of new users.

Decriminalization without regulation could do more harm than good. I suggest that the right to obtain, possess and use each drug — from marijuana through "party drugs" to injection drugs — should be subject to licensure. High quality, accurate primary preventive education for the specific drug concerned would be targeted precisely at each licence applicant. A government monopoly and affordable drugs would go a long way toward ensuring that safe and supervised legal injection sites would be accepted by users.

After an initial period of enforcement, this would result in a significant shift in human resources from police, legal and correctional service vocations to research and preventive work in the fields of health and the nonmedical determinants of health.

Rigorous scientific evaluation of the overall effectiveness of implementing this type of strategy in the short and long term, although challenging, could be achieved.

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Principles of influence

The recent article on the principles of influence in medical practice[1] applies to other important areas related to patient care. The authors focused on patient–physician interactions, but I have found that an understanding of the same principles is very helpful in understanding interactions between pharmaceutical representatives and physicians.

Over the past 10 years I have used video and structured interaction to help explain the process of the "drug detail" to students and physicians.[2] For the past year, this has been enhanced by the concepts discussed in an article by Cialdini[3] on the 6 basic behaviours that influence response.

"Reciprocation" applies to gifts, favours and concessions. The impact of gifts on attitude and behaviour is well documented[4] and may lead to bias in favour of a drug product. "Consistency" is best seen in the closing statement of an interaction, for example, "Will you be able to use product X in your practice?" An affirmative response is not irrelevant. Good data show that compliance with a request increases when agreement is acquired. In addition, "social validation" occurs through the drug company dinner. When a doctor hears that many colleagues are using a product, they are more likely to change their prescribing habits.

"Liking" is fundamental to representative–physician interaction. The skillful detailer can be described as a "stranger who co-opts the trappings of friendship."[1] This is the secret of the Tupperware party. The stranger in that situation is the seller, but the meeting is arranged by friends and conducted in the home of a friend.

Doctors, like others, respect and respond to authority figures. "Authority" is exemplified by opinion leaders. Opinions might be given during a sponsored talk, or perhaps a name is dropped during an interaction.

Finally, there is "scarcity." Drug sampling is one way of creating that feeling. By giving out a few small samples the representative makes it seem that the medication is something new and special.

Changing behaviour is difficult. Physicians know that from their work. Changing a behaviour in doctors, such as prescribing practices, is also difficult. Understanding the process can help physicians decide what they feel is in the best interests of their patients. Being aware is the best preparation.

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[One of the authors responds:]

Neil Shear's letter is one more development in a memorable series of exchanges over our article.[1] We agree completely with his insights: the basic point is that advanced training in medicine does not immunize clinicians against the forces of social influence. In this response, we focus on this last issue.

Before we submitted our manuscript to *CMAJ* we had received 5 dissenting external reviews at other journals. One reviewer said, "employing tactics of social influence violates principles of biomedical ethics." Another wrote, "medicine does not usually operate this way." And a third said, "social influence techniques will ultimately undermine autonomous motivation."

We recognize that researchers have