Letters

Correspondance

Questions of trust

On behalf of 53 000 members, from Quebec and from across Canada, the Canadian Medical Association considers that the editorial of September 17, 2002,[1] is seriously flawed.

- The editorial claims that physicians have broken the trust that underpins the patient–physician relationship. It specifically fails to provide evidence, from the main stakeholders in Shawinigan-Sud, to support the stark condemnation of the behaviour of these emergency physicians. In the absence of specific evidence to support this claim, it amounts to an unwarranted attack on the whole profession.
- Canada's health system is being held together by the exceptional efforts of physicians and other health providers. This is especially so when it comes to caring for those in emergency situations. The editorial fails to recognize this fact.
- The editorial ascribes to physicians the responsibility for the severe inadequacy of the emergency services. This again fails to recognize the real-life experience of emergency physicians and their unique set of circumstances. This is further complicated by the specialty status of emergency medicine in Quebec.

Based on these serious flaws, the conclusion that physicians have betrayed a trust which we all hold at the very heart of medicine is repugnant. Our colleagues in Quebec deserve a retraction.

Dana W. Hanson
President
Canadian Medical Association
Ottawa, Ont.

Reference

1. Quebec's Bill 114 [editorial]. *CMAJ* 2002;167 (6):617.

Questions de confiance

Au nom de ses 53 000 membres du Québec et de partout au Canada, l'Association médicale canadienne estime que l'éditorial du 17 septembre 2002[1] comporte de graves failles.

- L'éditorial prétend que les médecins ont trahi la confiance qui sous-tend la relation patient–médecin. Il ne présente aucune preuve de la part des principaux intéressés de Shawinigan-Sud pour appuyer un jugement aussi sévère à l'endroit de ces urgentologues. En l'absence de preuves à l'appui, cette déclaration équivaut à une attaque gratuite contre l'ensemble de la profession médicale.
- Le système de santé du Canada est maintenu grâce aux efforts exceptionnels des médecins et des autres professionnels de la santé, ce qui est d'autant plus vrai dans le cas des soins d'urgence. L'éditorial néglige de reconnaître ce fait.
- L'éditorial fait porter aux médecins la responsabilité de la déficience grave au sein des urgences, négligeant une fois de plus de reconnaître la situation vécue par les urgentologues ainsi que leur situation particulière, qui se complique d'autant plus étant donné le statut de spécialité de la médecine d'urgence au Québec.

Conclure, malgré ces failles majeures, que les médecins ont trahi une confiance qui est au cœur même de la médecine, voilà qui est tout simplement sordide. Nos collègues du Québec méritent une rétractation.

Dana W. Hanson
Le président
Association médicale canadienne
Ottawa (Ont.)

Référence

1. La Loi 114 du Québec [éditorial]. *JAMC* 2002; 167(6):619.

CMAJ's editorial on Quebec's Bill 114 suggested that, "Physicians broke that trust by not staffing the ED [emergency department]."[1] You do not offer any evidence that individual physicians have failed to live up to their responsibilities. The government has long since taken over responsibility for managing the system. To place on each physician the responsibility for the community as a whole is unreasonable.

It is no secret that physicians are feeling overwhelmed with work and are struggling to keep up with their demands. Your comment was misdirected.

Stephen D. Chris
Physician
Toronto, Ont.

Reference

1. Quebec's Bill 114 [editorial]. *CMAJ* 2002;167 (6):617.

[The editors reply:]

It was not our intention to offer condemnation of physicians in Quebec or elsewhere, and we regret that our phrasing (and its translation) invited this interpretation. The case of Claude Dufresne in Shawinigan-Sud was a tragic demonstration of the untenable stresses on emergency services in Quebec. In referring to a "broken"[1] (not "betrayed") trust, our purpose was not to pass judgement on individuals but to reflect on the damage done by such events to the relationship between physicians and society[2] — a relationship that, more and more, is being mediated by economic forces. Our editorial points to many factors that have contributed to the current difficulties in Quebec and is critical of the government's legislative approach to a remedy. We welcome the open exchange of views on these issues by all stakeholders.

John Hoey
Editor
Anne Marie Todkill
Senior Deputy Editor
CMAJ

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References
1. Quebec's Bill 114 [editorial]. *CMAJ* 2002;167(6):617.
2. See, for example, the public response reported by Jeff Heinrich in the *Montreal Gazette* 2002 July 26; Sect A:1.

[Réponse des rédacteurs :]

Nous n'avions pas l'intention de condamner les médecins, ni du Québec ni d'ailleurs, et nous regrettons que la formulation de notre texte (et sa traduction) aient suscité cette interprétation. Le cas de Claude Dufresne à Shawinigan-Sud a démontré tragiquement les pressions intenables qui s'exercent sur les services d'urgence au Québec. Nous avons parlé d'une confiance «broken» (rompue)[1] — non d'une confiance «betrayed» (trahie) — et nous n'avions pas l'intention de juger quiconque, mais de réfléchir sur les dommages que de tels événements causent aux rapports entre les médecins et la société[2] — rapports régis de plus en plus par les forces économiques. Notre éditorial signale les nombreux facteurs ayant contribué aux difficultés actuelles au Québec et critique l'approche législative adoptée par le gouvernement pour remédier à la situation. Nous accueillons favorablement les échanges ouverts d'idées sur ces questions par tous les intéressés.

John Hoey
Le rédacteur en chef
Anne Marie Todkill
La rédactrice adjointe principale
JAMC

Références
1. La Loi 114 du Québec [éditorial]. *JAMC* 2002;167(6):619.
2. Voir, par exemple, la réaction du public rapportée par Jeff Heinrich dans le *Montreal Gazette* 2002 le 26 juillet; A:1.

Medical newsletters: Can they be trusted?

In 1995, I wrote a letter to *CMAJ* about medical newsletters and the conflict-of-interest risks they pose.[1] These newsletters continue to flourish and, unfortunately, may become a major source of information for busy practitioners.

The newsletter format closely resembles that of a peer-reviewed journal. Undoubtedly, this approach is taken to reinforce the newsletters' claims that they provide an educational service reflecting peer opinions and facilitating physicians' understanding of current trends in medicine.

However, 2 recent newsletter articles illustrate that their ultimate goal is quite different.[2,3] Each describes only one of the available drugs in a given class. In each case, the drug described also happens to be the drug produced by the pharmaceutical company underwriting this particular "independent report."

In short, these newsletters offer no references, are not peer reviewed and present one-dimensional examinations of the issues they cover. For instance, 2 cardiologists writing in the newsletter offered their views on how a new drug class should be used in practice. The surprise was not that both arrived at the same favourable conclusions about the same drug but rather that their comments were identical — word for word (see Box 1 at www.cmaj.ca).[2,3]

I have no objection to these newsletters if they appear with a banner stating that they are advertisements. However, to call them educational is misleading.

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References
1. Brophy JM. Medical newsletters: funding and interests should be stated. *CMAJ* 1995;152(11):1744-5.
2. Refining the evidence: early use of GP IIb/IIIa inhibition confers greater-than-expected benefits in high-risk ACS patients. In: New frontiers in cardiology: a report from the American College of Cardiology 51st Annual Scientific Session, Atlanta, Ga., 2002 Mar 17-20. Beaconsfield (Que.): *Medical Frontiers International*; 2002.
3. Glycoprotein IIb/IIIa inhibitor therapy in acute coronary syndromes: management algorithm based on risk. In: New frontiers in cardiology: a report from the American College of Cardiology 51st Annual Scientific Session, Atlanta, Ga., 2002 Mar 17-20. Beaconsfield (Que.): *Medical Frontiers International*; 2002.

The lockout of '62

In her novel *Swimming into Darkness*, Gail Helgason exercises considerable artistic licence in depicting Saskatchewan doctors' partial withdrawal of services in 1962.[1,2] Although some called this a strike, it was more like a lockout.

The Co-operative Commonwealth Federation (CCF), now the New Democratic Party (NDP), had recently brought in legislation to provide for universal public insurance for medical care. This gesture of apparent social conscience was more than it seemed. Buried in the fine print was an abrogation of doctors' democratic right to negotiate their working conditions. Section 49(g) of the legislation stated, "The Medical Care Commission [i.e., the government] shall determine the terms and conditions of service."

The Saskatchewan doctors felt that they had to resist the loss of such freedom, not only for themselves but on behalf of others who might one day be similarly constrained. But this did not mean a strike; rather, most doctors decided that they would work outside the Act. Thus the doctors would have their freedom and the government its insurance, but the insurance would be between the patient and the government. This was in keeping with Premier Tommy Douglas' oft-repeated statement that "we only want to pay the bill" and its implication that there was no desire to control the doctors.

However, when Douglas became the first leader of the national NDP, he wanted to include medicare in his platform. To achieve this objective, Douglas' successor in Saskatchewan amended the Act in May 1962, adding section 28, which made it illegal for a patient to even voluntarily pay a doctor's bill. This measure, the government thought, would mandate doctors to work within the Act when the amendment came into force on July 1, 1962.

Saskatchewan's doctors could not tolerate this Star Chamber legislation, nor could we run our offices with no income. As a result, we closed our offices but continued to operate hospitals and emergency departments.