"Now I've seen that the private sector has a role to play," Day adds. "It can complement the public system and yet all of the rhetoric is built up around the 'anti-private sector' component, notwithstanding the fact that 30% of the health care in Canada is already private."

Day and his wife, Dr. Nina Bland, a family physician and former Canadian tennis champion, have 4 young children: Alexander, Jamie, Stephanie and Andrew. Day has 2 children by his first marriage, Christopher and Jonathan.

"The most stressful thing I do is go watch my kids play soccer," the Everton football fan says. Notoriety, by contrast, "doesn't stress me out." — Wayne Kondro, *CMAJ*

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Ontario overhauls medical audit regime

Ontario's medical audit system will become less onerous this fall as a result of recent provincial legislation that limits the worst abuses of its widely criticized predecessor, the Ontario Medical Association (OMA) says.

The new system addresses many of previous system's shortcomings by providing "transparency and fairness," says OMA President, Dr. Janice Willett. "It will also provide accountability on physician billing."

"The legislation is ... a big improvement," she added.

Bill 171 (the Health System Improvements Act, 2006), which was passed in June, establishes the Physician Payment Review Board, charged with determining whether a physician's billings to the Ontario Health Insurance Plan (OHIP) for medical services have been appropriate, and/or whether a physician must make repayment for claims that were false. Each year, Ontario's 24 000 physicians bill OHIP $5 billion, about 100 doctors are audited and $5 million in payments is recovered.

The new regime replaces one formerly run by the Medical Review Committee of the College of Physicians and Surgeons of Ontario, which was pilloried by former Supreme Court Justice Peter Cory in an April 2005 report. Cory found that audits took too long to complete, the methods of assessment and collection were unfair and the hearing process left doctors feeling they were presumed guilty from the start.

Cory wrote that "The medical audit system in Ontario has had a debilitating and, in some cases devastating ... effect" on physicians.

Cory recommended adopting most of the reforms suggested by the OMA, including establishing an independent physician audit board.

Willett says the new system incorporates many of Cory's recommendations. the OMA plans to continue working with government to set up the committees.

The new Physician Payment Review Board will comprised between 26 and 40 members, at least 20 of whom must be practising physicians. Panels of 4 (including 3 physicians) will handle individual cases.

If the agency decides the medical services weren't provided, weren't medically necessary, were unprofessionally delivered or were misrepresented, the physician will be notified and have the option of either accepting or challenging OHIP's decision before an independent panel. The recorded hearings must be held in accordance with procedural standards, and findings can be appealed to the Divisional Court of Ontario.

The board will have to power to suspend a doctor's right to bill OHIP and must report all findings of misconduct to the college. Among other changes are a new method for calculating interest awards, a provision that allows doctors to recover legal costs and limitations on the authority of auditors to "extrapolate" and order reimbursement for a large number of claims based on the review of just a few. — Wayne Kondro, *CMAJ*

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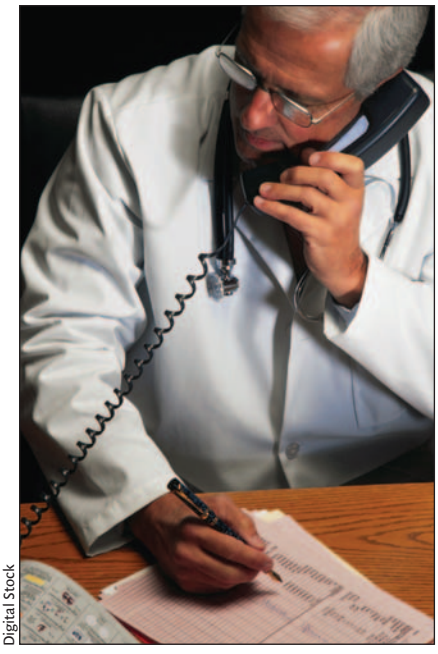

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Ontario's new audit system introduces a measure of natural justice and due process.

C. difficile outbreaks in Gatineau, Sault Ste. Marie

A virulent strain of *Clostridium difficile* that has killed close to 2000 people in Quebec spread to a Gatineau hospital this spring, hospital officials have confirmed.

There were 15 cases of this strain of *C. difficile* at the Santé Service Sociale de Gatineau's Hull hospital campus in April and May, says Denis Saint-Jean, the hospital's director of communications. As of July 5, 3 people remained ill with *C. difficile*.

"Through surveillance by our infection control team, we found out that the strain we have now is the same more strenuous strain that they have in Montréal," Saint-Jean says.

Officially known as NPA1/027, the strain produces levels of 2 kinds of toxins that are 16–23 times more potent than the common strain of *C. difficile* (*Annals of Surgery* 2007;245:267-72).

"Just to be on the safe side, we now take all our sampling and send it to Montréal, so they can really identify that it's the same strain," says Saint-Jean.

The hospital surmised that the strain was probably introduced into the institution through a patients transferred from Montréal. No one has died

from the outbreak in Gatineau, which has now ended.

Dr. Michel Brazeau, head of professional services at the hospital, says the outbreak was handled appropriately and that staff were "very observant."

According to October 2006 data from l'Institut de la statistique du Québec, *C. difficile* has been directly responsible for 1900 deaths in the province since 2002.

Earlier this year, the Office of the Chief Coroner of Ontario investigated 26 deaths at the Sault Area Hospital in Sault Ste. Marie, Ont. The investigation concluded that hospital-acquired *C. difficile* caused 10 of those deaths, contributed to the deaths of another 8 patients, but wasn't a factor in the final 8 cases. — Laura Eggertson, Ottawa

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News @ a glance

Organ crackdown: The Chinese government will significantly curtail organ transplants for foreigners as part of a crackdown on transplant tourism. The new regulations severely limit the number of hospitals that are authorized to perform such transplants, require them to get authorization from health authorities before performing a transplant on a foreign patient and prohibit them from conducting Internet advertising to attract foreigners. The regulations also state that foreigners who visit China on a tourist visa cannot receive a transplant.

Living wills: Nova Scotia's largest district health authority has implemented a policy whereby every patient who is admitted to hospital is asked if they have advanced directives and if they'd like more information. The policy, 11 years in the making, does not advocate for or against living wills but, rather, seeks to ensure that all patients know what a living will is and how it is used. Those patients who have living wills have copies attached to their charts. — Wayne Kondro, *CMAJ*, and Donalee Moulton, Halifax

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Dispatch

From the medical front: Treadmills

I was asked to see John for intermittent chest pain. The tough Inuit hunter waited until his granddaughter returned to his bedside to translate, and I gradually learned his story. *Like many patients from the high Arctic, John had undergone thoracoplasty for tuberculosis in the 1950s. He had probably spent months or years far from his family during his treatment, but I didn't delve into his previous social history. He was a man of few words, and I decided to reserve them for the task at hand.*

I wasn't sure who had voiced concern regarding his chest pain, but it seemed to be a combination of family members, the nurse in charge in his community and the hospitalist who had admitted him. His cardiac risk factors were questionable — most relatives had died on the land with no diagnosis. High blood pressure? Never checked. A lipid profile had been ordered — HDL 2.3, LDL 1.8, triglycerides 1.3 — and he wasn't on a statin.

"What does he eat?" I asked his granddaughter, "char and caribou?" She nodded. "Sometimes muktuk, but he mostly likes dried fish." I silently wondered how many drug dollars could be saved if post-MI patients adopted the Arctic coastal diet.

Many cardiologists would not have even put John on a treadmill, but I was reluctant to send him back to his community without some sort of reassuring result on his chart. John earned his living as a harvester and would not welcome another medevac from his community's single-nurse station when a trapline needed his attention. So I led him down the hallway for a stress test, with the granddaughter in tow.

John eyed the treadmill with amusement and suspicion. I walked a few steps on it to show him what to expect. "He has problems with his knees," warned the granddaughter, so I chose a gentle protocol, explaining that most patients exercise about 8 to 12 minutes during the test. The nurse attached the leads, the granddaughter translated for consent and John wrote his name in syllabics on the consent form.

Fifteen minutes later, John hadn't broken a sweat. At each stage, I asked about chest pain; he shook his head and walked on. Finally, he turned to his granddaughter and spoke a few words.

"He wants to know how long he has to keep doing this," she told me. "Until he gets tired," I responded — but he frowned after the translation. Evidently fatigue was not on the horizon. I soon decided I had enough information to call the test negative and sheepishly told him it was finished and that he could go home.

Both John and I learned our lessons. The doctor would put the next hunter through the standard treadmill protocol. And the patient, for better or worse, would never mention chest pain again. — 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. Without intending to restrict options, the front can be defined as any unique confluence of time and event, whether in developing countries, war zones, inner-city clinics, in the North, or with a novel surgical technique 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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