Queue jumping
Social justice and the doctor-patient relationship

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A problem
I work alongside 11 other gastroenterologists in a clinic attached to an academic medical centre. Here we deal with an ever-growing number of patient referrals that strains our capacity to provide the services needed. To deal with this overload, we have developed a standardized referral format and system of triage. Each afternoon one of us is available for telephone consultations and reviews all of the current patient referrals. Based on the information provided, these are categorized as “urgent,” “intermediate,” “routine,” or “for screening colonoscopy.” Currently our first available appointment for “urgent” patients is in 5 months, for patients in the “intermediate” group is in 18 months, and for those referred for colorectal cancer screening is in almost 11 years. Our ability to deal with this backlog is undermined by sometimes inaccurate information provided on the forms we use for patient triage.

We have tried to improve access in several ways, including having patients bypass the clinic, having them go directly for endoscopy, and booking extra clinics for “urgent” cases. Many of the patients we accommodate on a priority basis have serious or potentially serious problems, but many do not. We regularly receive information regarding referred patients that overstates the severity of symptoms or that reports “alarm symptoms” that are entirely absent on evaluation. Assessment of patients with less-than-urgent problems delays evaluation and treatment of patients with serious symptoms who truly require urgent care.

Additional background
A recent report from New Zealand describes a national process of bringing equity in wait times to patients requiring elective orthopedic and cardiovascular surgery. The national process incorporates a formalized system of scoring and ranking of these patients based on their level of need. Physicians were actively engaged in its development. Unfortunately, the effectiveness of the system was seriously undermined in its implementation because some physicians and surgeons circumvented or manipulated it to gain advantage for their individual patients.1

The issues
Working within the doctor-patient relationship, we, as physicians, act independently as agents for the health needs of individual patients. We accept the responsibility of ensuring that each of our patients receives the best care possible. But what if the arrangements we make for our patients compromise the care that is available to other patients, particularly those who have greater need? We compete for resources that are in short supply; getting the necessary services for our patients has become increasingly difficult in recent years. In such circumstances it is increasingly necessary for physicians to include a broader sense of community responsibility in their practice of medicine. We cannot focus our attention exclusively on individual patients without regard for the needs of other patients in the community.

When we reflect on our ethical responsibilities as physicians, we are likely to be very sensitive to the principle of beneficence, the injunction “to do good.” It is central to our day-to-day work as caregivers. Another pillar of medical ethics, that of “justice” or “social justice,” also guides us. We are not as likely to have embraced this principle in our professional lives; it is a responsibility of which we might not be fully aware. Our current environment requires that we reconsider it. Our responsibility as physicians is not limited to doing good for patients individually; it extends to our patients in the aggregate, to the population as a whole. Provision of misinformation to gain advantage for individual patients on wait lists is inconsistent with our responsibility to uphold the ethical principle of justice.

Possible solutions
I also refer patients to other physicians and surgeons and have to deal with existing pressures and logistical barriers; but my challenges pale beside those of the average Canadian family physician. I can appreciate the frustration such practitioners experience in dealing with long wait lists, with increasing demands by specialist groups for patient information, and with wait-list strategies that are developed without their input and that fail to incorporate feedback.

Some writers2 have suggested that individual physicians should deny or limit care to individual patients when resources are scarce, but the notion seems to me to be untenable.

Partial solutions could include the following.
• We need to refocus our notion of the practice of medicine to include a greater emphasis on
population health for all practitioners. For most of us this will require additional education about management, and it will require a change in the culture and structure of medical practice. In essence, groups of physicians must advocate for the care of communities of patients. Such an evolution in the role of physicians was envisaged in the CanMeds 2000 strategy adopted by the Royal College of Physicians and Surgeons of Canada. In this vision practitioners with a range of interests and expertise come together to plan for the care of groups of patients. Planning includes the development of effective and equitable strategies to prioritize patients’ access to care.

- We need to extend the application of principles of management in health. We have made some progress in this area, but we have considerable distance to go in standardizing care, optimizing quality, and using our resources as effectively as possible. Again, physician education and reorientation of medical practice are key. Wait-list management is a good example of extending a systemic strategy for an important population health problem.

- Physician organizations, at a macro and a micro level, must pressure governments and those health institutions that control the purse strings to ensure that resources are sufficient to ensure that all patients can receive the care that they need; physicians cannot be responsible for rationing health resources. Physicians’ work in population health management must be recognized and adequately compensated. This need cannot be properly addressed through a fee-for-service arrangement; alternative payment approaches are needed.

To conclude

For the moment, we are stuck in a position of ethical conflict between the requirements of the doctor-patient relationship and our responsibility to the principle of social justice. Most Canadians clearly believe that equity is essential in our health care system. Until we deal with the systemic issues, we must rely on honest and trusting relationships between referring physicians and consultants to deliver on the promise of equity. Providing inaccurate information in order to move a patient up a wait list is unpalatable. If it were universally done, we would face a serious erosion of patient care. Other solutions must be pursued.

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References

Don’t laugh, Jo, gentlemen really are very necessary aboard ship, to hold on to, or to wait upon one, and as they have nothing to do, it’s a mercy to make them useful, otherwise they would smoke themselves to death, I’m afraid.

Louisa May Alcott (1832-1888)

Little Women