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Letters ❖ Correspondance

Equal access to health care

At the heart of the December editorial[1] on poverty and health is the issue of what we as physicians can do about the problem.

Dr McGregor clearly reviews the evidence that poor health is one of the miseries attributable to poverty. While accepting that reducing poverty in this country is beyond the capabilities of doctors, she does urge us to be advocates for tackling the socioeconomic causes of ill health.

I go a step further by pointing out the one aspect to this whole issue of the disparity between the health of the rich and the poor that is very much within the sphere of influence of physicians: access to health care.

I have been dismayed by the hypocracy of doctors who, in one breath, extol the value of such things as screening mammography, antismoking campaigns, exercise, and healthy diets; and then suggest that there is nothing wrong with a two-tier health care system. As long as a basic service is available to everyone, it would be all right to allow a private "superservice" for those who could afford it.

It is very easy to support health promotion initiatives when they do not conflict with our own financial interests or our own political agendas. There is no doubt that a two-tier system, one public and one private, would widen the disparity between the health of the rich and the health of the poor.

We as physicians have a special duty of care to our patients that is one of the cornerstones of our profession. We accept, in fact are proud, that this duty to put the best interests of our patients ahead of our personal interests is a moral, ethical, and legal duty that sets us apart from those in other careers. I believe that this duty of care applies to those who have not come to our offices or emergency rooms, or who are not on our waiting lists, but who, nevertheless, might well be in need of our services.

Dr McGregor urges physicians to be on the front lines of educating our communities about the devastating effects of poverty, bad housing, and illiteracy on the health of patients. To this, I add that we as doctors can play an important role in supporting a system that ensures, as much as possible, equal access to health care, regardless of socioeconomic status.

— C. Anthony Johnson, MD, CM, CCFP, FCFP
Kingston, Ont
by mail

Reference

1. McGregor M. New understanding of poverty and health. What does it mean to family physicians? [editorial]. *Can Fam Physician* 1999;45:2837-40 (Eng), 2841-5 (Fr).

Make your views known!

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Excellent idea

I enjoyed reading your Practice Tips column[1] in the December issue on tracking immunizations for patients.

I suggest adding, however, an MMR shot to be given at 4 to 6 years along with the DPTP shot. Aside from that, I think this tracking system is an excellent idea!

— L.C. Vicente, MD
Toronto, Ont
by fax

Reference

1. Ford-Jones A. Immunization tracker for primary care physicians [Practice Tips]. *Can Fam Physician* 1999;45:2875.

Are physicians treated equally?

I found the vigour and defensive tone of the letters[1,2] of two of our rural readers in British Columbia quite amusing. These letters sternly claim that the writers, one a graduate from a South African medical school, the other from an Australian one, were NOT given preferential treatment by the British Columbia College of Physicians and Surgeons to obtain a licence to practise in British Columbia. Incidentally, the British Columbia Human Rights Tribunal has just found the British Columbia College of Physicians and Surgeons guilty of discrimination against graduates of "Category 2 Countries" (the rest of the world) in favour of graduates of "Category 1 Countries" (Australia, Britain, Canada, Ireland, New Zealand, South Africa, United States), regardless of merit.

In its conclusions, the British Columbia Human Rights Tribunal is also expressing concern with the College's current licensure policy (created in 1993), which might still put graduates of Category 1 Countries at an unfair advantage when trying to obtain a licence to practise in British Columbia.