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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.

Interestingly, these letters come from practitioners who graduated from privileged Category 1 Countries.

It would be eye-opening to hear the harrowing, nightmarish experiences of Category 2 graduates in British Columbia instead, to really appreciate the extent of suffering and discrimination these doctors have experienced. I believe all these Category 1 physicians, especially if graduates of a foreign medical school, who have the privilege to practise in British Columbia, should enjoy this apparently unfairly earned privilege with dignified silence. Their vociferous indignation is misplaced and hurtful to too many of their colleagues from the "rest of the world."

—Gabriel V. Salvadori, MD
Anchorage, Alaska
by e-mail

References

1. Mackey P. No special treatment given [letters]. *Can Fam Physician* 1999;45:2585.
2. Davidson H. South African saga continues [letter]. *Can Fam Physician* 1999;45:2586.

Is this good palliative care?

Do Not Go Gentle? I have never written a letter to *Canadian Family Physician*, and so perhaps I could have found something more earth-shattering than a title on which to comment. Still, I take issue with the title on your December cover.

I am sure we were to understand the rest of the poem even without reading the inside cover! "Do not go gentle into that good night.... Rage, rage against the dying of the light."

Is that the goal of geriatric medicine or any care in medicine for that matter? I thought that perhaps one of the loftiest goals and most satisfying achievements of physicians included helping people go gently into the night. I have helped people rage at their death, and apart from a heroic story to tell, there is no joy in resuscitating someone who did not wish that or who ended up with a poor outcome, even if that outcome included life. Isn't this contrary to good palliative care? Isn't this why we do not need euthanasia in our society because we have physicians who respect life and death?

Perhaps I read too much into an innocent title. Perhaps I am biased by professional and personal experiences. I, however, recall being bothered by Dylan Thomas' words even in earlier days. Today I face a greater challenge, as I have a son with a degenerative neuromuscular condition. I know there will be nothing more difficult than the time when he will die, but I hope that I will have the personal strength, and I hope that I belong to a profession that has the strength, to allow him to go gently into the good night and not rage against the dying of the light.

—Suzanne Shephard, MD, CCFP(EM)
and Brian's mother
Kingston, Ont
by e-mail

Response

Thank you for your letter. I am sorry that the December cover struck the wrong note for you. I think you have interpreted it in a manner that was not intended: by no means were we suggesting that end-of-life care should be a constant struggle when all reasonable hope of recovery is gone. Rather, we were celebrating the power of human grit and determination to be involved in life even at an advanced age. The woman on the cover was not raging against dying but Jean Chretien's government. We thought this was a good image for the end of the Millennium and the Year of Older Persons.

Most people who have responded to this cover (and there have been many), felt very positive about the image. I hope with this background you can reconsider your opinion.

—Tony Reid, MD, MSC, CCFP, FCFP
Scientific Editor, Canadian Family Physician

Corrections

For the Practice Tip "Management of pregnancy-induced nausea," (*Can Fam Physician* 1999;45:303) only one author was identified. There were, in fact, two authors: Ellen R. Wiebe, MD, CCFP and Lois Cassels, RN BSCN.

Dans l'article en français « Améliorer les soins aux patients souffrant d'hypertension et d'arthrite » de la rubrique Actualités (*Can Fam Physician* 2000;46:490), une erreur s'est glissée dans le numéro de téléphone donné à la fin. Les numéros de téléphone exacts sont 1-877-838-2427 ou (514) 343-3353.

Le *Médecin de famille canadien* présente ses excuses pour cette faute typographique.

In the article "Bereaved children" by Dr Karen Schultz (*Can Fam Physician* 1999;45:2914-21), Table 3 was incorrectly referenced. The source of the table was Anderson F, Black FM, Blood PA, Braithwaite DL, Cairns M, Cummings L, et al. *Medical Care of the Dying*. 3rd ed. Victoria, BC: Victoria Hospice Society; 1998. p. 523.