care against the demonstrated minimal gains of "avoidable" ED visits and hospitalizations.

—Leila Salehi MD CCFP(EM)
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Competing interests
None declared

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Response

I thank Dr Ziomek for responding on behalf of medical regulators to this opinion piece that was published in the November issue of *Canadian Family Physician*.[1] It was good of Dr Ziomek, the President of the Federation of Medical Regulatory Authorities of Canada and the Registrar of the College of Physicians and Surgeons of Manitoba (CPSM), to both challenge the accuracy of the article and to confirm it in the same letter.[2]

Dr Ziomek rightly points out that this is the voice of a single physician, and I am glad that, despite the expanding powers of the professional colleges, a single physician can still express an opinion. However, as Registrar of the CPSM, and with the process around Statement 190,[3] she cannot pretend this represents a unique opinion. Her counterpart from the College of Physicians and Surgeons of Alberta could validate similar concerns in that province.

Despite rhetoric to the contrary, her letter confirms that the CPSM did indeed pass Statement 190 requiring coverage 24 hours a day, 7 days a week, because the After Hours and Vacation Coverage Policy was subsequently rescinded (more accurately not adopted into the new Regulated Health Professions Act). This was in large part owing to pressure from concerned physician groups (Physicians for the Future and others). The fact that the CPSM, in conjunction with Doctors Manitoba and others, is now looking at a "demonstration project"[2] with (hopefully) a more rational assignment of physician responsibility to after-hours access for patients, is exactly the point of my commentary.[1]

As for the position of regulatory authorities on physicians having a "collective rather than an individual obligation,"[2] I think most would agree that physicians must cooperate and work within the system. Unfortunately, the policies referred to in my commentary[1] are applied to individual physicians, and the language is very singular. Indeed, except where formal groups fall under the purview of professional colleges, these policies cannot be enforced on anything but an individual basis. Because the practical application of the policy is unattainable by some individuals, the policy by its very nature is improper. A solo rural doctor or regional specialist, for example, has no collective to call upon. No exceptions are noted in any of the policies, so these physicians have no ability to comply, save to be perpetually available. The policy also effectively outlaws part-time or solo physicians, a view that I do not believe the profession as a whole espouses.

It is interesting that the Federation of Medical Regulatory Authorities of Canada and its college members have identified patients as being "abandoned" after hours.[2] This implies that there was an agreement between the patient and the physician that such after-hours services would be available. I do not believe that most patients have an expectation that they should be able to telephone their dermatologist, surgeon, or even family doctor, any time day or night; nor do I believe that most physicians have ever implied such service. It also suggests that there is no other recourse for care. It is, of course, critical that the health system can deal with emergencies at any hour, but that need not involve the primary physician. Indeed, Dr Salehi's response to my article[4] highlights multiple studies demonstrating that such an approach is neither superior, nor does it achieve the desired system savings.

Dr Ziomek's comments inadvertently highlight what many physicians consider the drifting vision of our professional colleges. There is a feeling that the priorities of these colleges have become inverted. We, as self-regulating professionals, have the privilege of funding a professional college. The primary responsibility of our colleges is to "provide direction to and regulate the practice of the … profession" and "establish, maintain and enforce a code of ethics."[5] As physicians, we define our profession, defend our scope of practice, and describe our "reserved acts" (things we can do that others cannot)[6] through our professional colleges. Clearly the public must be protected within those definitions, but many physicians feel the professional colleges have become more interested in appeasing the public, even at the risk of compromising the integrity of the profession.

It is not ethical to define perpetual responsibility for patients' health care access as an individual professional responsibility.

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Competing interests
None declared

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Correction

In the cover story that appeared in the December issue of *Canadian Family Physician,*[1] an error was inadvertently introduced in the section on Dr Brian Day's court challenge. This section should have read as follows:

> Dr Day's challenge claims that provincial health legislation, which limits private funding and extra billing for medically necessary services, violates the Canadian Charter of Rights and Freedoms.

Canadian Family Physician apologizes for this error and any confusion it might have caused.

Reference
1. De Leeuw S. Aiming at the right things. Reflections on public health care, community, and social accountability [Cover Story]. *Can Fam Physician* 2016;62:1000-3 (Eng), e777-80 (Fr).

Correction

Dans le récit de la page couverture paru dans le numéro de décembre du *Médecin de famille canadien*[1], une erreur s'est glissée par inadvertance dans la section mentionnant la poursuite du Dr Brian Day devant les tribunaux. La phrase aurait dû se lire comme suit :

> L'argument du Dr Day invoque que la loi provinciale sur la santé, qui limite le financement privé et la surfacturation pour des services médicalement nécessaires, enfreint la *Charte canadienne des droits et libertés*.

Le Médecin de famille canadien présente ses excuses pour cette erreur et toute confusion qu'elle aurait pu causer.

Référence
1. De Leeuw S. Viser les bonnes cibles. Réflexions sur la santé publique, la communauté et la responsabilité sociale [Récit de la page couverture]. *Can Fam Physician* 2016;62:1000-3 (ang), e777-80 (fr).