Battling the berserkers

A. M Todkill

The doctor dilemma: public policy and the changing role of physicians under Ontario medicare
S.E.D. Shortt
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Medical professionals wait nervously on the shore, "divided among themselves and perceiving attack from without," writes family physician Sam Shortt in *The Doctor Dilemma*. Imagine a Viking dragon-ship full of berserkers from government, academia and the public, leaping onto the strand, brandishing their war axes. What will be the outcome of this raid? Will physicians survive, huddled next to the driftwood fire of medicare, or will they be forced to embrace a foreign culture imposed by the marauders? Shortt's answer is that a sea-change is inevitable and that assimilation within a new culture will be the best outcome for physicians.

Shortt sets the scene by recounting the amusing and preposterous attempt by a disgruntled physician to force the premier and the minister of health of Ontario to undergo psychiatric assessment for their inappropriate behaviour. He then considers five key policy areas: payment of physicians, supply and distribution of physicians, quality assessment in ambulatory care, the relationship between physicians and hospitals and the role of technology. Although most of these issues are familiar, this book is better than most accounts in both its perspective and its thoroughness. With his experience as a family physician, historian and policy analyst (he is now director of the Health Policy Research Unit in the Faculty of Medicine at Queen's), Shortt is well placed to put these issues in context. The book is rich with plundered treasure, containing over 400 references. It presents a clear-eyed synthesis of an important issue facing the profession, namely integrated care. Shortt is careful, however, to point out that this term is often confused with similar ones such as managed care, devolution, regionalization and comprehensive health organizations, and he admits to using these interchangeably.

The book is well written, and Shortt is not afraid of a vivid phrase for emphasis. There is an inevitability to each chapter as he outlines the issues, judiciously considers the evidence and reaches balanced conclusions. Published evidence, where available, is put to good use, and the constraints imposed by its lack are acknowledged. Two recurring themes are (1) that the anomaly of public payment for private practice has been directly responsible for the adversarial nature of physician–government relations, and (2) that the days of private practice are numbered and will eventually be replaced by public payment through some type of integrated system.

Hugh Malcolm

The Doctor Dilemma will interest physicians who are puzzled about how events seem to be overtaking them and want to know where the profession is heading. Policy-makers anywhere in Canada who are mulling over the introduction of integrated health systems should read this book carefully. Shortt strongly advocates a crucial role for physicians in charting the future course of the health care system. No doubt there are one or two bruised bureaucrats who will beg to differ.

Many physicians will not like Shortt's central message that the introduction of integrated care will mean a shift from fee-for-service to some other form of reimbursement. This is likely to be a mix of sessional payments through an alternative funding plan for specialists at academic health sciences centres and a modified form of capitation for family physicians. Some may interpret the proposed policies as an attempt to control doctors, but Shortt maintains that they are about accountability, not control. A clear message is that until physicians learn to distinguish between the two they are unlikely to reside comfortably in the Canadian health care system.

How will the dilemma be resolved? Shortt argues that some form of integrated care is inevitable and will likely be for the better. He feels that the policy levers are already in place in Ontario and that it is time for some strong political hands to start pushing them. As it happened, Norse culture spread peacefully and gradually through Europe and the North Atlantic countries over several centuries. I rather think that this is how a new system, whether it be called integrated care or something else, will be diffused. Already, the Health Services Restructuring Commission of Ontario is soliciting pilot sites for integrated health care systems. Physicians would better serve the profession and their interests by becoming part of this process rather than having integrated care imposed on them. *The Doctor Dilemma* has the best interests of the profession at heart. It is worth reading for that fact alone.

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Room for a view

A line in the sand

It was near the end of my first rotation in the intensive care unit. A ray of sunlight shone into the ward through a window; outside, the day was beautiful and cloudless — quite a contrast to where I stood. Twenty patients lay in the unit, some with fractured limbs and vertebrae, others with overwhelming infection, some comatose with cerebral edema, several rubbing shoulders with death.

Among them was a young woman who had come to emergency in acute respiratory distress. The cause had been identified: *Pneumocystis carinii* pneumonia. Apart from having had several boyfriends over the past few years, she had no risk factors for HIV.

Her condition deteriorated quickly, but before intubation was needed she had given consent for HIV testing. After intubation, her agitation prevented adequate oxygenation and required both muscle paralysis and sedation. The test result arrived: she was HIV positive. By now, she was comatose.

Not only was her condition precarious, but the issue of confidentiality was problematic. Although she lived with her mother, she had not listed her as next of kin at admission and had named two friends instead. Their whereabouts were unknown. Would she want her mother to know her HIV status before she did? What if she died before she learned her diagnosis?

Art Explosion

These questions were hotly debated by the ICU team. We resolved that the house staff on call would not tell the patient's mother the underlying diagnosis that weekend. We would hold a family meeting on Monday and disclose the seriousness of her condition then.

As it happened, the patient's mother came in early on the Saturday and asked to speak to the doctor on call. I was the one on duty that day. All I could hope was that she would not ask for the diagnosis. If she did, I would have to withhold the truth.

As I approached the room I could see her sitting, quietly resolute, at her daughter's bedside. She wore a colourful dress and a simple sun hat. She looked as if she could have been sitting in the shade of an oak tree on a warm Sunday afternoon, sipping lemonade and chatting about the weather. But she was there to discuss her daughter's condition. I was there to protect my patient's right to confidentiality. I was there to draw a line in the shifting sands of disclosure.

She looked at me slyly. It became a game of cat and mouse: pleasant chitchat about her somewhat rebellious daughter was interspersed with probing questions.

"Doctor, please, if I may, what is the reason for my daughter's bad pneumonia?"

"This type of pneumonia is usually due to a weakened immune system," I replied. My tongue was dry.

"But just what kind of pneumonia is it?" she inquired.

I told her the name.

Her eyes narrowing only slightly, she formulated her next move. "Could all of this sickness be because of some sort of — what do you call them — virus?

"Yes, that's one possibility," I manoeuvred, begging all the forces in the world not to let her ask outright if her daughter had AIDS. There was that line I was not to cross over.

We paused, her inquisitive eyes resting on my guilty face. I hated this. It was evident how much she loved her daughter. She was suffering unfairly and her anguish was made more acute by my limited disclosure. In a way, she was being made the fool. The entire ICU staff —all strangers to her daughter — knew the diagnosis. Yet here she

One thousand words

D.A. McLaughlin / National Archives of Canada / PA-046810

Quarantine station, Grosse-Île, Quebec, circa 1900.

was, each day, watching her daughter die without knowing why. It became clear to me that she had the right to know, to make the proper preparations, and to grieve. Perhaps she suspected all along the word I dared not utter and was testing my moral fibre. Maybe I was being made the fool.

My pager suddenly rang, and we both jumped. I had never been so happy to assess x-rays for proper nasogastric tube placement. Before leaving, I asked her if there was anything else. But the momentum was lost. She looked almost resigned. I tried to reassure her by mentioning the family conference in two days. She smiled and thanked me graciously. I walked away, trying to justify to myself what had happened. I had done what I was instructed to do. I had managed to keep patient confidentiality intact. I had done right, hadn't I?

So why did it feel so wrong?

Rosaleen Chun, MD

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Lifeworks

Hazardous beauty

The three main occupational hazards of any serious artist are exposure to toxic materials, poverty, and bad reviews. Poverty was certainly the lot of Vincent van Gogh, whose art-dealer brother, Theo, kept him fed, housed and supplied with paints but only ever managed to sell one of his canvases. No articles were published on van Gogh's work until six months before he died; an ecstatic review, it made him "uneasy" just the same.[1] As for toxic exposures, in madness or despair van Gogh swallowed turpentine and pigments, although it appears that he poisoned himself more thoroughly with absinthe.[2]

Toxicity an exhibition now on view at the McMaster Museum of Art in Hamilton, assembles work from the Levy Bequest in the gallery's permanent collection to explore the artist's engagement with hazardous materials. The show is in part a reconsideration of the nineteenth-century aesthetic of "the sublime" — that is, beauty that inspires both admiration and terror. *Oblivion* (1995) by Anish Kapoor, a leading player in the "British New Sculpture" movement of the 1980s, is an indented fibreglass ball coated in pure prussian blue pigment. The velvety surface and saturated colour are intensely sensual, and the aperture pressed into one side, like a giant thumbprint in a lump of dough, makes the object look innocuously malleable. The viewer must resist the impulse to touch, knowing that contact with the pigment is ill advised.

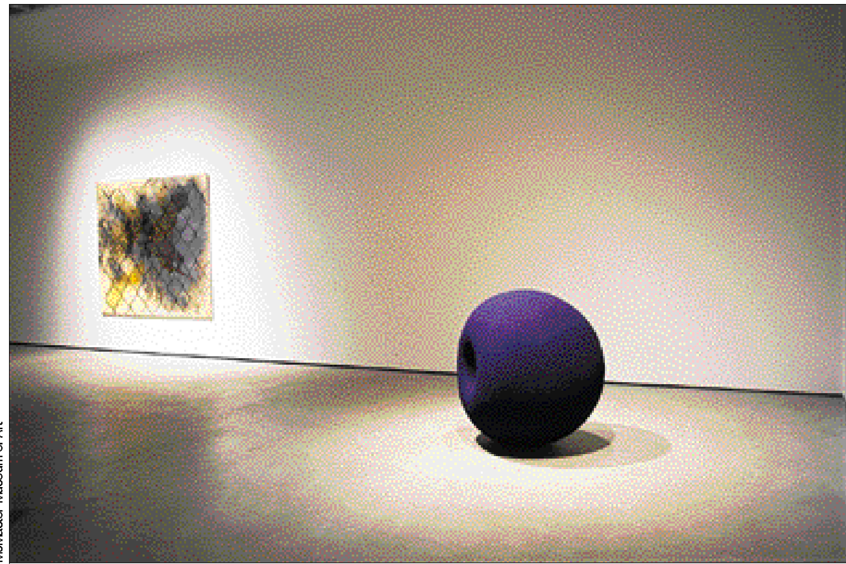
Isaac Applebaum

Anselm Kiefer, *Yggdrasil* (1985–1991). Emulsion, acrylic (partly charred) and melted lead on canvas. 220 cm × 190 cm.

The chain-link fence depicted in *Zaun (Mutlangen)* (1986) by German artist Sigmar Polke is rendered on a cotton canvas soaked with artificial resins and covered with various toxic substances such as ground metals and

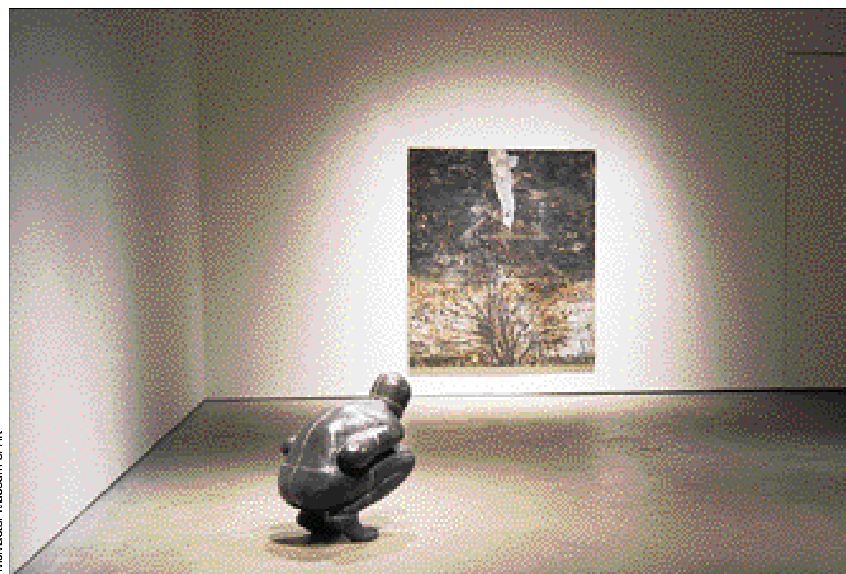
tellurium dust. Mutlangen is the site of a military base in Germany used to hold cruise missiles during the Cold War. The image of a fence cannot be extricated from only slightly less recent memories of concentration camps, and the random configuration of the pigmented materials is in itself menacing, evoking the senselessness of violence and oppression. The wire fence can be peered through but not transgressed: through the spilled paint two soldiers carrying guns are dimly visible.

Two other works in the show exploit the properties of lead, a substance whose great utility — it does not rust, it can be hammered flat or rolled into pipes, it shields against radiation and gives brilliancy to glass — belies the fact that it is poison. As Primo Levi's lead-prospector muses, "[I]f one goes beyond appearances, lead is actually the metal of death: because it brings on death, because its weight is a desire to fall, and to fall is a property of corpses."[3] The painting *Yggdrasil* (1985-1991) by German artist Anselm Kiefer invokes the Norse myth of the tree of life, whose three roots reached to the underworld, the earth and the realm of the gods, and which remained standing through all assaults. The canvas is worked in emulsion, charred acrylic paint and melted lead. A powerful image of environmental degradation, the archetypal tree is also an emblem of regeneration and the elemental forces of earth and fire.



McMaster Museum of Art

Toxicity installation (detail). Left: Sigmar Polke, *Zaun (Mutlangen)* (1986). Synthetic resin, acrylic medium, metallic and graphic pigments on cotton canvas. Right: Anish Kapoor, *Oblivion* (1995). Fibreglass and pigment.



McMaster Museum of Art

Toxicity installation (detail). Left: Antony Gormley, *Proof* (1983–1984). Lead, fibreglass and plastic. Right: Anselm Kiefer, *Yggdrasil*. Emulsion, acrylic (partly charred) and lead on canvas. 220 cm × 190 cm.

English artist Antony Gormley gives the properties of lead a more personal application in *Proof* (1983-1984). This sculpture is a cast of the artist's body made with plaster and fibreglass and coated with lead; the title suggests an imperfect or experimental rendering as well as an insistence upon personal *being*. The solder lines give the appearance of a nutshell that might be cracked open, while the sealed eyes, ears, mouth and nostrils suggest suffocation: the viewer may be put in mind of the archaic use of lead to line coffins. The curatorial notes observe: "This body is still, but not serene. Alert, taut, concentrating, it seems to perform a most basic corporeal function: defecation, an action which constitutes irrefutable proof of existence and which may keep terror at bay."[4]

The *Toxicity* exhibition includes a number of other challenging works from the McMaster collection and continues until August 15.

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Editor, The Left Atrium

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