Centre for Medical Education in Montréal, Quebec. "If we are not trusted as a profession, we are limited in our ability to provide input to public policy."

To ensure that public trust in the profession of medicine doesn't decline further, its members need to do more than just discuss the problem, says Cruess. They need to perform actions to reassure the public that doctors have the best interests of patients at heart. "The only way public trust will be maintained or increased by medical professionals is not by just projecting an image of concern for the welfare of society, but by acting, by actually helping society."

If the distrust at the profession level were to be translated to the individual physician level, many experts believe the doctor–patient relationship would suffer and, along with it, the health of patients. "Without trust, you can't really heal," says Dr. Sylvia Cruess, a professor of medicine at McGill University's Centre for Medical Education. "Would you let someone cut open your stomach for money rather than for your own good?"

Without trust, physician–patient interactions could become more like consumer transactions at a shopping mall. A patient might demand this test or that procedure and expect a physician to merely sign off on it. That might work in certain scenarios, but probably not in complex cases with many treatment options.

"There has to be an element of trust," says Dr. Sharon Johnston, assistant professor of family medicine at the University of Ottawa in Ontario. "If you have ever been really sick — really scared and vulnerable — you'd know there is no replacing it."

A long-term trusting relationship can benefit both physicians and patients, says Mary Dixon-Woods, professor of medical sociology at the University of Leicester in the UK. Doctors, who are human and make mistakes, receive more grace from patients, while patients appear more willing to follow through on recommended courses of treatment, she says. "Once that secure trust has been developed, patients are more forgiving of doctors' minor lapses. The quality of the relationship is also important to a patient's willingness to comply with what a doctor is suggesting." — Roger Collier, *CMAJ*

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Editor's note: Eleventh in a multipart series on medical professionalism.

Part I: **The "good doctor" discussion** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4200).

Part II: **What is it?** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4211).

Part III: **The historical contract** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4230).

Part IV: **Can it be taught?** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4232).

Part V: **Social media outreach** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4207).

Part VI: **Social media mishaps** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4209).

Part VII: **Logging on to tell your doctor off** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4205).

Part VIII: **Assessing physician behaviour** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4240).

Part IX: **How payment models affect physician behaviour** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4250).

Part X: **The view from outside medicine** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4257).

The fiendish puzzle of health inequities

Medieval cartographers once depicted monsters and bogs on the borders of their maps, as if foraying into uncharted territories put one at risk of unimaginable and unpredictable consequences.

It might be said that Canada's physicians find themselves in a bit of that predicament after embracing the notion that they have a major role to play in addressing health inequities and the social determinants of health, such as housing, education and poverty.

As they discovered during sessions of the Canadian Medical Association's 145th annual general meeting, held in Yellowknife, Northwest Territories, the solutions aren't readily identifiable, and definitely not easily achieved. Broad policy solutions, like ones offered in a keynote lecture by internationally renowned epidemiologist Sir Michael Marmot, are not generally palatable to governments or consistent with prevailing political winds, while more local action, and even measures taken at the physician–patient level, can quickly devolve into classic conundrums.

Still, it's remarkable, in and of itself, that CMA's annual general meeting would even have health inequities as a conference theme. Just a few years ago, as a market research and strategic communications expert told delegates in 2009, the public perception was that if the nation's physicians were speaking, the subject had to be the inadequacy of their compensation (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-3021).

But with the election of Ottawa physician Dr. Jeffrey Turnbull to the CMA's presidency in August 2010, the association tacked sharply in the direction of civic responsibility, to the clear delight of many a physician, as delegate after delegate rose to their feet in Yellowknife to say they were proud that CMA was becoming more representa-

tive of the idealism that had led many of them to medicine and delighted that it was contemplating advocacy on behalf of the disadvantaged.

The solutions, though, lie at the borders of the maps.

The eloquent Marmot cast them as entirely a function of political will and readily achievable because they should be driven by moral imperative. Sketching six policy objectives that emerged from his review of health inequalities in *England, Fair Society, Healthy Lives* (www.oahpp.ca/resources/documents/presentations/2012may30/Canada%20webinar%20May%202012.pdf), the former chair of the World Health Organization Commission on the Social Determinants of Health labelled health inequities as "a stain on our societies."

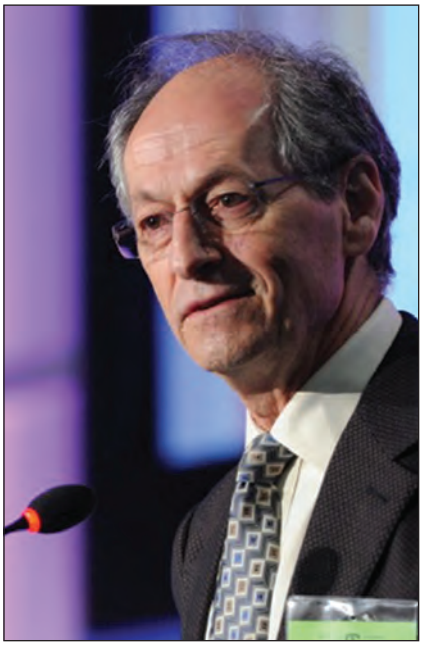
The six objectives? "Give every child the best start in life. Enable all children, young people and adults to maximise their capabilities and have control over their lives. Create fair employment and good work for all. Ensure healthy standard of living for all. Create and develop healthy and sustainable places and communities. Strengthen the role and impact of ill health prevention."

Do that, Marmot said, and Canada "can be a beacon, not just to Canadians, but to a much wider audience around the world."

Delegates of a more practical bent and a sounder grasp of the realities of Canadian politics surmised that the initial efforts to reduce health inequities have to be undertaken at a more local level.

Abbotsford, British Columbia delegate Dr. Barry Turchen surmised that physicians might best address "our own sense of impotence" by simply "acting as good citizens" and following the lead of Turnbull, chief of staff at the Ottawa Hospital in Ontario and creator of the Ottawa Inner City Health Project, which offers integrated medical services to the homeless.

In a similar vein, Ottawa physician Dr. Eoghan O'Shea speculated whether doctors are "meeting our patients in the right locations." A physician presence in schools with student populations more representative of the poor and disadvantaged might serve to prevent some from an inevitable march toward the "unemployable underclass," he noted.



Mark Holleron/CMA

By setting and meeting policy objectives to address health inequities, Canada "can be a beacon, not just to Canadians, but to a much wider audience around the world," says renowned epidemiologist Sir Michael Marmot.

Others urged community advocacy, perhaps in conjunction with other associations, as well as education reforms aimed at graduating medical students with more competence in recognizing the social and economic determinants of health, as well as more familiarity with community programs aimed at redressing obstacles faced by marginalized populations.

At a more clinical level, delegates surmised that advances in health equity might be achieved by including questions aimed at ascertaining patients' socioeconomic status while taking their histories, or, for example, inquiring whether a patient can afford a brand-name pharmaceutical, as opposed to a generic, when writing a prescription.

But such information can itself be problematic, said Yellowknife physician Dr. Shireen Mansouri, describing a case in which she'd inquired when a patient had last seen a dentist, only to discover that she didn't own a toothbrush.

Others, such as Summerside, Prince Edward Island, physician Dr. Roland Chiasson observed that it was somewhat unreasonable to expect physicians to glean a patient's socioeconomic status within the parameters of a "three-minute" visit. "You can't put 50 pounds of potatoes in a 5-pound bag."

Several delegates noted that the advent of team-based practice would alleviate some of the responsibilities, as nurses, pharmacists and other health professionals involved in a team could be made responsible for collecting socioeconomic information, while College of Family Physicians of Canada President Dr. Sandy Buchman noted that many of the issues disappear under the rubric of interdisciplinary "medical homes," which the college has proposed and is championing (www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf).

Delegates, in turn, were asked to prioritize areas in which they'd like CMA to flesh out policies, and they voted for the association to first identify or develop payment models that adequately compensate physicians for their efforts to promote health equity, and then to develop a "toolkit" that might assist them in dealing with patients.

In short, the complexities of the solutions mirrored the complexities of the problem of health inequities.

But Turnbull appeared unperturbed. "That's one of our greatest challenges, this concept that this is like boiling the ocean," he admits. "We're not skilled in all of those other things like housing and poverty reduction strategies, et cetera. But on the other hand, I do believe that, at an individual level, we have to pay much more attention to it in our practices. At a group practice level, as we work within communities, we have to be much stronger advocates within our communities. And then, at a national level, this gives us the forum to work with our national partners to bring together the chambers of commerce, the economic clubs, the teachers and start to say: 'we're all in the business of health, directly or indirectly.'"

"This is a substantive change in the direction we're going," Turnbull adds. "But you know what? It's what the public wants. It's what doctors want and it's the right thing to do." — Wayne Kondro, *CMAJ*

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