QMR

QUEEN'S MEDICAL REVIEW

“In the game of political chess, who pays the ultimate price? “
Cover art by Linda Qu

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Letter from the Editors

Medicine is social science, and politics is nothing but medicine at a larger scale.
- Rudolph Virchow

Dear Reader,

We learn about twelve factors that determine health. Biology and genetic endowment is only one of them. Others are complex social issues – poverty, culture, social support networks are just a few examples. These issues often appear out of our hands as physicians, and we have to employ political powers to change and better them. QMR 9.1 will focus on the intersection of Politics and Medicine.

We will open with an interview with Dr. Chris Simpson, former president of the CMA and a Kingston cardiologist. Ilia Ostrovski (2019) and Adam Mosa (2018) interviewed him about physician assisted suicide, pharmacare, and how to balance medical practice with political engagement. Further exploring the ethics of physician assisted suicide, Mahvash Shere (2018) and Stanislav Pasyk (2018) discuss its applicability to individuals with mental illness. taking on different sides of the debate in 'Point/Counterpoint.' Arian Ghassemian (2017) and Jennifer McCall (2018) then offer a summary of pros and cons of implementing pharmacare.

Politically, the past year will be remembered as one of the most dramatic victories in Canadian history, with Justin Trudeau leading the Liberals in securing a majority government. Shannon Willmott (2018) and Jeff Mah (2019) outlined key healthcare issues and the Liberals' stance on them. Henry Ajzenberg (2018) offers a historical perspective of the precarious history of healthcare policies in Ontario and the current outlook.

Erica McKenzie (2018) took time to follow a physician caring for inmates at one of the Kingston's several penitentiaries to introduce us to some of the complex challenges of healthcare in this population. Ogi Solaja (2018) researched the unfortunate consequences of the U.S. 'War on Drugs' and emerging evidence for some alternative solutions to combat substance abuse. Grace Zhang (2019) tells us about patient recruitment, a ludicrous and unfortunate practice that is a consequence of primary physician shortage in Ontario. Nothando Swan (2017) discusses different avenues that students can take to begin political advocacy.

In conclusion, we offer two opinion pieces: Sachin Pasricha's (2020) editorial on Justin Trudeau's public image and Elliot Cohen's (2017) discussion on the extent to which medicine and medical professions should become involved in politics.

We hope you find this issue as timely, meaningful, and thought-provoking as we did.

Editorially yours,

Luba Bryushkova

Adam Mosa

Interview: Dr. Chris Simpson

ILIA OSTROVSKI, CLASS OF 2019
ADAM MOSA, CLASS OF 2018

Dr. Chris Simpson is a Professor of Medicine and the Chief of Cardiology at Queen's University. He is also the medical director of the cardiac program at Kingston General Hospital and Hotel Dieu Hospital. In 2014, Dr. Simpson was the President of the Canadian Medical Association. He obtained his MD from Dalhousie University in 1992. Following this, he completed his internal medicine and cardiology training at Queen's University, as well as a research fellowship in Cardiac Electrophysiology at Western University. Dr. Simpson's primary research interest is health policy, specifically healthcare access, wait times, medical fitness to drive, and referral pathway development amongst others. In this interview, QMR's Ilia Ostrovski and Adam Mosa sat down with Dr. Simpson to discuss physician assisted suicide, balancing a career in medicine with political engagement, and pharmacare.

SECTION 1: PHYSICIAN ASSISTED SUICIDE

QMR: On February 6th of this year in the landmark case of Carter V. Canada, the Supreme Court decided that "sanctity of life" includes "passage into death", and ruled that Canadians have the right to physician assisted suicide. What role did you, the CMA, and doctors in general play in the advocacy process that led up to this decision?

Traditionally the physician community and the CMA had taken a stance against PAS and the last time it was discussed in detail was 20 years ago with the Sue Rodriguez decision. The Supreme Court at that time determined by a very narrow margin (5 to 4) that it would uphold the law banning PAS, but a year and a half ago it became clear that public opinion was going the other way. A lot of physicians were split on the issue but the polls showed that the doctors were more opposed than the general public. I think that was largely because of the role we were being asked to play. If you asked the average physician what they would want for themselves at the end of life, that answer would be more closely in alignment with what Canadians as a whole would say. It was the notion that we would be coerced into it when maybe we weren't comfortable. So we decided to do a series of town halls across the country in partnership with Mclean's magazine and that was a huge eye opener. We heard really compelling stories on both sides of the issue and at the end we brought a motion to our general council that essentially stated that we would respect patients' right to make the decision and we would support the physician if they were functioning within the bounds of the law. We said that if broader society decides this is something we're going to embrace then the CMA will support its members if they choose to participate. That was a turning point on a major ethical issue. There's still a lot of controversy about it but that allowed us to be granted intervener status at the Supreme Court. This meant that we were there as a friend of the court, not taking a position as pro or con but sharing what we learned at the town hall. Consequently, at the ruling we saw a lot of our language being used in helping them come to the unanimous decision. I've never said whether I'm personally pro or against because that's not my role in the CMA leadership, but I'm very proud of the way the organization took probably the biggest ethical issue of our time – something physicians were steadfastly against – and were able to move with society on this and help the Supreme Court come to this decision.

QMR: When the law was passed, the Supreme Court gave Ottawa one year to craft federal legislation governing physician assisted suicide. Could you give us some insight into the progress that has been made towards producing such legislation?

From the time the Supreme Court decision came until now there really has been zero movement at all from the federal government. It became a very political issue. They appointed a federal panel which began its work but had to stop before the election period and now has started again. There's also a provincial and territorial panel led by Ontario's provincial health minister, Eric Hoskins. The CMA has done more work on this than any of those panels, and we have a principles based document which is ready to go. We've offered this to both of the panels but my biggest fear is that the federal government could choose not to replace the legislation so when the existing legislation expires one year after the supreme court decision in

February, we would then have an absence of a law which is what happened with abortion. The worry is this is going be left up to professional and regulatory authorities and there's going to be a patchwork quilt of different rules depending on which province you're in.

QMR: what do you think are some of the reasons for the delay in creating the legislation?

The political/cynical view would be that the Supreme Court decision was simply opposed on ideological grounds by the conservative government and they just chose to let the clock run out as a way of protesting. That would be consistent with many other court decisions, from refugee cuts to many other things where the federal and Supreme Court would rule against them and they chose to ignore the ruling. But again, with the change of government, early signs suggest there will be a different approach.

QMR: In passing its ruling, one of the provisions the Supreme Court included was that this option would only be available to adults. Likewise, a palliative care centre in Sherbrooke Quebec that's preparing to be the first facility to offer PAS said it will only be available to cancer patients. We wanted to know what equitable access to PAS means to you? Does it include children? Does it include people with diseases other than cancer?

I think the starting point for that discussion is what the Supreme Court said. They said that this clearly only applies to adults. There are jurisdictions in Europe that broadened the indication but in Canada I think that's clearly off the table in the short term. The big worry I have is that people sitting at home thinking about this are thinking that they want to be able, as a 75 year old person, to say that when they develop dementia, when they get to a certain point, whether that means they don't know people around them or lose control of their bladder – there're lots of undignified things that characterize the descent into dementia – they want to be able to define the trigger point up front. However, my interpretation of the Supreme Court decision is that this will not be allowed and I think when people realize this they're going to say that's got to be the next step. When my friends and relatives think about this, they don't think about ALS and all these other diseases that tend to be the poster-children for the cause, they're thinking of dementia and the Supreme Court clearly says it has to be a competent adult. There can't be a substitute decision maker and as far as we know, an advanced directive – even if you write it when you're competent – can't define some nebulous period in the future that would trigger the process. I think we're going to have a set of rules that are far more restrictive than what people actually think. The reality is going to be way behind public opinion on this. Ultimately, I think it's going to be an ongoing source of debate for years to come.

Doctors all know this because we know the dark humour that Brian Goldman talks about in medicine. We all know, having seen all the bad case scenarios what we would be willing to tolerate and what we wouldn't, and it really highlights the democratization of medicine. Physicians tend to be very conservative with our own health. Studies have shown that when we get older we don't want aggressive treatments, we are the first to sign a DNR. So what does that mean? If we're doing that, but practising differently or expecting our patients to have a different standard applied to them? It implies a real inequity. Or does it mean that we're glass-half-empty people, and we've seen all the worst of it and maybe not as optimistic as we should be? I think it's more the former, I think it's that we have knowledge of the system and we march with our feet.

QMR: It calls into question the notion of informed consent, because making decisions about end of life treatment with a medical background puts you in a position of power. It must help, for example, knowing what it means to truly have a full code run on you. I imagine that the discussion about this is just getting started, but is it ever possible to rectify this imbalance between how doctors and patients perceive end of life treatment?

I think that's exactly right and one thing we can do better is we have to stop having the conversation with people when they're in a crisis. It has to be moved upstream. For example, I can talk to you as a peer, but as soon as you're in a bed in crisis that power relationship is there and it's much more difficult. In the hospital we talk about needing a "code status" on a patient as though it's some tick box, but it's a complex conversation and it requires a lot of trying to understand what that patient's view of life is and what their normal situation is and what their goals and values are. I can't do that properly when they're in a crisis. So this whole notion of advanced care directives being done upstream is important because we're all going to die after all. I think its very important and we're getting better and better at that but there are still too many conversations had at the crisis point.

QMR: Do you think it's the responsibility of the practitioner to initiate the dialogue or do you think patients will become empowered and engaged and the conversation is increasingly going to be initiated by them?

It's more and more the latter and the story that I tell is about a woman who was in her eighties who was referred to me to have a defibrillator put in. She met the criteria by the guidelines and so the family doctor dutifully sent her along to me. So I said to her "your doctor has sent you here to talk about having a defibrillator implanted" and she asked me "what's that?" and I said well it's a device that we put in and if your heart goes into cardiac arrest it'll shock you back to life. She just smiled and said "why ever would you want to do that?" So she had no intention of having this done and what I thought was so wonderful about that is that unlike a lot of people in her generation that would sort of do whatever the doctor said, she just thought that it was a funny little joke and how silly I was to even be contemplating this. She was totally in control of the interview. That's what we're going to see more and more of now, patients are becoming the holders of knowledge and we're going be there to help contextualize and support them in making decisions and that's very positive. It's far more rewarding as a physician to have an engaged patient like that than one that comes in scared and is just there to hear what you have to say. That's what I always imagined when I thought that I wanted to be a doctor, was having those kinds of conversations and assisting them in making decisions. So yeah that one was a really good one, she was great, and she's still alive by the way.

QMR: Building on that, how do you think our skills as practitioners will have to change as our patients become more informed and the role that doctors have to play in the medical encounter changes?

Yeah I think our skills have to be completely different than what they used to be, and it comes back to the knowledge thing. Everyone can get the knowledge now, and increasingly we're going to see patients who know as much or more about their conditions than we do when they come to see us. But what we bring or should bring is judgement and context. For the patient the "n" is 1, while for us the "n" is much bigger and so we have a more balanced view. For instance, I had a patient a few months ago that said they wanted to talk to someone who had the procedure that I was proposing for them, so I said "do you want to talk to someone who had a good experience, a bad experience, or something in between?" It's this kind of story telling that as humans we want to hear. We want to hear that somebody else has had it. In my mind I'm thinking "this procedure works 98 percent of the time" and I told him that but he wanted to talk to somebody and was willing, presumably, to put all his eggs in whoever I presented to him to tell the story. Then he would think that that's the experience he is going to have and he trusts that more than the stats that I would provide him and I think that means that we have to learn to communicate in different ways. We have to stop talking about chances of success and chances of failure and complication rates and try to tell it in a narrative kind of fashion so patients can really understand in their mind's eye, what they are likely to expect from. That's a challenge for us because we think of risk as a scientific or technical kind of thing but most people think of risk in cultural or social terms and it's a completely different construct.

QMR: Where do you that think medical students should acquire that skill?

I would prefer to see it as modelled behaviour. In the training experience when you're working side by side with experienced clinicians you watch how they do it and acquire those communication skills. It's a difficult thing to teach but it's an easy thing to model, and hopefully we get better and better role models out there, but at the very core this is a simple respect for people. There's compassion fatigue in medicine. When you're burnt out yourself and you're tired and you're a little angry and frustrated because the province is trying to cut your pay, it's pretty easy to see it as a task and something you've just got to get through. What I found really helpful – and you know I have ups and downs emotionally just like everybody else – is you have to really make your focus a genuine concern and care for the patient and just enjoy the encounter. Just enjoy meeting somebody new who has had a completely different life. Ask them what they do, get to know them as a person a little bit, and then it becomes a very personal kind of mission. It becomes "I want to help a person's life get better" rather than "I have to see 20 patients today", and if you keep that at your core it remains interesting and rewarding and then that kind of empathy informs the ability to communicate better and do your job better. It sounds kind of Pollyanna-ish, but it's true you know, it works.

SECTION 2: BALANCING POLITICS AND MEDICINE

QMR: Your role at CMA has a political component, but there's a distinction between a physician who engages in political advocacy and a physician who becomes a politician, have you made the decision that that's the latter isn't a direction you'd go in?

Probably not, I mean it would be a great opportunity if it ever came up, but I think I've always resisted that temptation because I think I've been of more value in a non-elected role. But I wouldn't rule it out in the future. I do think for me it would be a great personal risk, I have four kids to support and to be out of a job and washed up as a physician probably wouldn't be a very responsible thing to do. One of the beauties of the CMA role is that I can be political and have influence at the political level but I'm still grounded in my clinical persona, so I can spend a couple of days in Ottawa doing that and then I come back and I implant pacemakers for a day and then I'm off to Toronto for a day for something else so it's really the best of both worlds. I do know some elected members of the provincial parliament or legislature that have managed to practice medicine on the side but it's pretty tough to do that.

QMR: How did you go from being a medical student to a physician who engages in the kind of political work that you do?

I have always had an interest in advocacy and in politics in general. My father was a member of the legislature in New Brunswick and when I was in University, I worked for Mr. McKenna just before he became Premier, and so I had some involvement with the group there. I should backup and say that when I was taking all the courses that you need to get into medical school I took all my electives in history, English and political science. I knew that I wanted to be a doctor but I didn't particularly get a great thrill from the chemistry, physics, and biology but always enjoyed music, humanities and politics. It's kind of funny that as my training and career progressed and I became a cardiologist, as much as I loved it, I really needed the other side of that as well. It's been kind of a unique academic profile but for me it's been the perfect hybrid and it really critically informed the way I approached the presidency of the CMA because I feel that even though it's a doctors organization, I really see the organization's accountability to be not just to doctors but also to society at large and I think that's because we have such tremendous clout and respect in general society. Getting involved with issues like physician assisted dying and health care reform and seniors care, which was my issue last year, are part of our civic professionalism. For lack of a better term, it's a way to demonstrate accountability to all Canadians and not just the members who form the organization.

SECTION 3: PHARMACARE

QMR: It would seem that an aging population makes a national Pharmacare strategy more necessary but at the same time more difficult to achieve and sustain. Do you agree with this and if so, how do you reconcile it?

We spend the 4th or 5th highest per capita of all the OECD countries on drugs. Part of the reason is that we have a very Balkanized system where every province negotiates differently. The council of the federation recently developed this organization called the Pan-Canadian Pharmaceutical Alliance. The idea is to bulk buy to save millions of government dollars. In general, the notion that we have 10 provinces and 3 territories all doing their own thing is dumb from a monetary and equity perspective. We're the only country with universal healthcare that doesn't also have some universal Pharmacare approach and certainly we know from surveys that there are between ten and twenty percent of people that don't take their medications because they can't afford it. We also know that there are differences in drug coverage. I know of stories when people move provinces just so they can have a drug covered.

There is also controversy about whether we should have first dollar coverage or catastrophic drug coverage. The arguments in favour for first dollar coverage are that it makes sense from an equity point of view. But what tends to happen is there's a national formulary, so someone has to decide what's reasonable and what isn't reasonable, and a first dollar coverage system is probably going to be a relatively bare bones system. It is going to cover the basics for everyone but it might miss out on the 20 thousand dollar chemotherapy that a kid need for lymphoma. Then you ask, does it make sense that someone like me that earns the money that I do can get aspirin on a prescription and have it paid for, while someone that needs a twenty thousand dollar drug has to pay for some of it? Clearly that doesn't seem equitable even though we all agree that first dollar coverage sounds equitable. But on other hand, I've seen lots of people that can well afford the drugs but even the $12.99 co-payment or dispensing fee can be just enough disincentive for them to not take it. It's hard to get people to take drugs because they make you bruise and have side effects and so if it's not a drug that makes you feel better, if you don't have that kind of immediate reward because it's a preventative drug then people don't really want take it to begin with. So the notion of any cost at all as a disincentive has to be worked into it as well, and I don't know that there's a perfect system. Certainly some people have great, private drug plans through their employment and they would say everything they possibly need is covered and they won't want to go under a public system where everybody is equal because they won't get as good coverage. There are competing forces, but if we go back to first principles and ask what we want to achieve, I think we want every Canadian to have barrier-less access to the drugs that they need. The trouble is defining need and whether it is reasonable to expect some people that have the means, to pay. If I have a strep throat or my kid has strep throat and you need to pay 30 dollars for antibiotics, I'm going pay that, and if me doing that allows someone with less means to have more that's what I want to do as one of the higher earning people.

QMR: So where do you see the money coming from and do you see it as being able to sustain the greater healthcare burden that the aging population will bring about?

That's the million dollar question. I don't have great data but I know that the Danielle Martin and Steve Morgan paper make the argument that it might actually save money in the long run but there's been criticism of the methodology so it may or may not be true. The general principle that more older people need more drugs is going to create a real challenge for sustainability going forward and that's what critics of first dollar are saying –that the formulary you create can't possibly be an inclusive formulary for every drug, it'll have to be bare bones. We've had a bit of a lull in the past ten years, there hasn't been a whole lot of new drug development and so a lot of these drugs that are used on a large scale are now generics – there's generic beta blockers, generic diabetes medication, generic statin. All these drugs that would be billions of dollars are now a fraction of that. But what happens when we get into the era of personalized medicine and a lot of these new fantastic technologies are really expensive? For instance, the new drug that cures Hepatitis C is one of the most exciting things in medicine in 20 years, but can we afford it? Well we're just lucky that it happens to be that not a lot of people here have Hepatitis C, but what if they came up with a drug that cured diabetes and it was twenty thousand dollars a pop, how would we possibly handle the ethical questions? So I worry a little bit about how we're going to handle what's going to be a real boom in innovative new treatments in the next twenty years.

QMR: As past president of the CMA, are you aware of whether there is a consensus amongst doctors about the need for a Pharmacare strategy, or are the opinions largely split?

It's a good question, my view is that like with every other segment of society there are people with left-leaning progressive views and others with right-leaning traditionalist views. I would venture to say that if you can demonstrate that universal Pharmacare with first dollar coverage had a pretty decent formulary and actually could save the system money overall, you'd have a consensus view. I think where a lot of people are nervous is they say it'd be great to have first dollar coverage for everybody but we don't have the billions of dollars in the budget to pay for it. The business case for it – although it's now starting to be made –hasn't persuaded everyone yet. There are also those people who think that we should just be incrementally moving towards this. Some would say 'let's get catastrophic coverage taken care of' and have a system where no family has to spend more than 3 percent of their income on drugs, at least that'd be a step forward. It's not a fix but it's a step forward, and from there you ask what barriers are still left and go from there. But yeah you'll find as many different views on this as there are physicians.

Ethical Implications of Physician-Assisted Suicide

MAHVASH SHERE, CLASS OF 2018
STAN PASYK , CLASS OF 2018

Canada's Supreme Court Ruling on Physician-Assisted Dying and the Implications for Patients with Mental Illness

To be, or not to be--that is the question:

Whether 'tis nobler in the mind to suffer
The slings and arrows of outrageous fortune
Or to take arms against a sea of troubles
And by opposing end them. To die, to sleep--
… 'Tis a consummation
Devoutly to be wished.

Disclaimer: Please note that the views expressed in this piece don't necessarily reflect each author's own views. We have found the conversation on this topic one that's worth having and have really tried to represent the different arguments and ethical frameworks that may come into play. We used "PAS" to mean Physician-Assisted Dying.

To Be or Not to Be…should be my decision

– by Mahvash Shere

Dignity in death is fundamental to the freedom of life. Beginning February 2016, Canadians experiencing unrelievable, unending pain will legally have the right to seek physician's help in the process of dying. A year earlier, Carter v. Canada became a pivotal case in informing the Supreme Court's position towards Physician-Assisted Death. The Supreme Court ruling remarked that "the prohibition on physician-assisted dying infringes the right to life, liberty, and security of the person in a manner that is not in accordance with the principles of fundamental justice".

The lifted ban on physician-assisted dying is contingent on two conditions: (1) that the patient is an adult who clearly consents to the termination of life, and who (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual.

Given the conditions of the current ruling, the Supreme Court's stance on physician-assisted dying, makes it an accessible option for those suffering from chronic, "grievous and irremediable" mental illness.

Much controversy exists around the subsection of the population who may be categorized as "vulnerable persons", and may seek physician-assisted suicide (or PAS) as a means to end their life in times of weakness. Those suffering from mental illness often fit this criteria, because suicidal ideation and feelings of worthlessness around life itself are red-flag hallmarks of many mental illnesses. But is severe mental illness, which burdens its patients with suffering that is so "grevious and irremediable" that it warrants a choice to die, any different from a physical illness that may do the same? And if so, why and how is it different?

Mental illness and physical illness are intimately linked. The argument to separate them is usually one of competence. Some argue that the chronically depressed patient may make choices that do not represent their true choices if they were not depressed. But isn't this a value judgement that we assign? How is the psychosocial impact of a terminal illness, where a patient recognizes that their quality of life is so severely diminished that they would prefer to die, different from overt chronic mental illness where a patient may feel the same?

Patient advocates of the right to die have promoted the abstract right , one that is integral to mental wellness of the individual, regardless of the underlying condition. In choosing the right to die, advocates have highlighted the importance of the freedom to choose death. This freedom complicates our understanding of life as an essential pre-requisite for any other rights or freedoms. However, advocates of the right to die have highlighted that the difference between assisted dying and removing life support is a semantic rather than a substantial one. Respecting a patient's choice for dignity in death then goes beyond the bioethical debate of "killing" vs. "letting die" and hones in on treating the patient's wishes in a way that best aligns with their mental wellness.

Hence, based on the current ruling, the choice to end one's life with dignity is a right of life – and one that applies to and should be accessible to patients with physical and mental illness alike. Many of our fears surrounding broadened definitions around this issue come from concerns about its potential abuse, or the fact that this choice may be a temporary choice (especially in a patient with episodic mental illness). Yet, more liberal interpretations of legal physician-assisted dying currently exist. For instance, Belgium's physician-assisted dying laws neither limit the ruling solely to terminal illness, nor do they have restrictions against patients with mental illness – and have wide public support. In Belgium, chronic depression forms appropriate grounds to request physician-assisted dying.

Proponents of restricted access to physician-assisted death often argue that "incurable and unbearable pain" that causes one to wish to end their life prematurely is the major guiding principle among patients with cancer or similar terminal illnesses requesting PAS, and a criteria that patients with mental illness often wouldn't fit. However, the Remmelink Report published in the Netherlands reported that pain was a relatively minor factor in motivating requests for PAS. Instead, the most significant contributors motivating these requests were depression, psychological distress, and perceived loss of dignity. This highlights the fact that the guiding principle behind patient requests for PAS is fundamentally a psychological one, and thus PAS should be accessible to patients with mental illness who may experience these same debilitating and irremediable feelings.

One of the most challenging sequelae of the ethical concerns surrounding PAS is defining the physician's role and degree of involvement in the patient's request for assisted-dying in a way that aligns with the patient's wishes and respects their dignity. In Canada, taking a patient in a vegetative state off life support is not illegal, yet administering a lethal drug to this patient who may have requested PAS would have been a punishable offence prior to this ruling. Many bioethicists have argued that this highlighted ethical continuum is an arbitrary one, and that when physicians limit their role and involvement by "letting die" instead of honoring the patient's request for PAS, they limit the dignified care that these patients are owed with their choices.

Many argue that "prescribing death" is against a physician's goal to heal and extend life. A physician's formative Hippocratic Oath is to "first, do no harm" and "never give a deadly drug". Yet this argument considers life and death as two dichotomous extremes instead of placing them on a continuum. PAS does not promote the desire to end life instead of treatment, but instead respects that decision for whom treatment is causing more harm than benefit, or not benefitting at all – in a way that is debilitating and irremediable. In medicine, when we cannot cure or have no treatment options, we support patients through their symptoms and choices through Palliative Care. Often understood as the study of death and dying, Palliative Care is immensely valuable for patients who may have terminal diseases, especially as they near the end of their disease. Yet when these same patients prematurely advocate for physician-assisted dying, we place restrictions on the circumstances under which they may have made this request and what aspects of the request we can honour. Suddenly, our restrictions actually take us away from "easing their suffering" and truly palliating.

PAS, once legalized, would mean that our role does not end at removing life support or prescribing lethal drugs, but may actually involve a more palliative role as we sit by our patient's bedside respecting the choices they have made, and supporting them and their families through their choices as caregivers. Death, just as much as life, requires palliation.

As we move towards a model of care that is patient-centered, we have to accept the active role of patient choice that extends throughout the course of illness – in choosing options for their treatment, but also their death. It requires our active involvement as physicians in defining the cases, assessments and safeguards that will make this option a truly valuable one defending the patient's right to die with dignity. A physician's involvement as an aid, then, doesn't go against our primary oath to care, but is rather based on the broadened understanding of a person we are caring for (physically, mentally, emotionally), and a recognition of their values of patient-centered care – even if that means assisted-dying.

A pathological desire to die is not good grounds for physician-assisted dying - by Stan Pasyk

It is estimated that up to 90% of individuals who die from suicide suffer from one or more psychiatric disorders at the time of their death. All too often, the lives of the mentally ill end in tragic suicide, devastating the friends and families of the departed. In severe cases of chronic depression, our society needs to consider whether physicians should be allowed to step in to provide safe and painless controlled suicide. While treatment-resistant chronic depression might appear to "fit the bill" for the Supreme Court of Canada's ruling on physician-assisted dying, physicians should not be allowed to assist the chronically depressed to die.

A Question of Competence

The choice to end a life is a significant and consequential medical decision; a decision like this must be predicated on the patient's competency. By the very nature of the condition, depressed individuals frequently and erroneously undervalue their own lives and self-worth. This is the very same value judgment that the patient must use in the decision-making process leading to PAS. Patients suffering from mental illness cannot accurately weigh the burden of the emotional pain they suffer against the value of their life if they pathologically cannot even see the value in their life. Competency, in these cases, is particularly difficult to assess.

The subjective gatekeepers of physician assisted suicide

If PAS were to become an acceptable practice for chronically depressed patients, psychiatrists would be best suited to assess the competency of the patient, and whether he or she should "qualify" for PAS. Unfortunately, regardless of the skill or experience of the psychiatrist, this assessment would ultimately be subjective. In this field, there would be no consistent metric by which a patient can be deemed suitable for PAS. This leads to a dangerous situation.

Imagine a chronically depressed patient seeking a physician assisted death. What is this patient to do if the gate-keeper, her psychiatrist, denies her this opportunity? What is to stop her from going to the next psychiatrist in hopes of a more favourable outcome? One major concern is that depressed individuals could 'shop around' to find a psychiatrist willing to grant them access to suicide. If PAS is allowed for only specific circumstances of depression, it will be difficult to stop those who are ineligible but determined to die in the care of a physician.

Sending the Wrong Message

One might argue that a determined patient can easily commit suicide at home, or even purchase a one-way ticket to a country like Switzerland, where PAS is granted for both the physically and mentally ill by an organization called Dignitas. Why would legalizing PAS for chronically depressed patients make this situation any worse? One important issue at hand is that the policy we implement reflects the physician's perspective and outlook on individuals suffering from this affliction. Helping depressed individuals die sends the message that our society welcomes the option of suicide for those who want it. It sets a poor precedent, and it normalizes suicide as a cultural practice.

Consider a society where we do help our depressed patients die. Depressed individuals are marred with feelings of worthlessness and meaninglessness. Helping patients commit suicide may be interpreted as an affirmation of these feelings and beliefs. Our healthcare system works hard to restore feelings of worth in these patients, small steps at a time. Now, we are contemplating a health care system which strives to simultaneously deter and abet suicide in chronically depressed patients. This practice is simply not compatible with the fundamental philosophy of medicine in mental health. Now more than ever there is a multitude of therapeutic options, both pharmacological and otherwise, for the treatment of depression. Discovering that some of these options are ineffective often takes weeks, and can be disheartening. Health care providers should strive to continue seeking effective treatment options rather than offering death as a solution. Even when all treatment options are exhausted, we still cannot legally offer suicide as an option due to aforementioned issues of capacity and consent.

As new therapies emerge for the effective treatment of chronic depression, the arguments for and against the role of PAS in chronic depression will hopefully become moot. Until such a time, we cannot let a patient's pathological drive towards suicide govern our ethical principles and actions.

Concluding Remarks

Overall, the discussion around Physician-Assisted Dying is a complex one. While we recognize that the capacity for making medical decisions is sometimes diminished among the mentally ill, mental illness is already disenfranchised and is a domain where, unlike certain physical illnesses, "letting die" is not really an option for honouring patients' wishes. Separating pathological suicidal ideation and attempts from the valid request for dignity in death is of paramount importance within this population. It is for this reason that we need to advocate for better provincial and federal regulations surrounding Physician-Assisted Dying. We need to balance both the gravity of this request and the vulnerability of the population we are dealing with – by instituting appropriate frameworks for comprehensive and critical longitudinal assessment when a patient requests Physician-Assisted Dying. If the practice of PAS becomes available to patients suffering from mental illness, we envision multiple physicians and psychiatrists involved in the assessment process to validate competence and the consistency of this request over time, while also advocating for this vulnerable population to seek dignity in death if their illness is "grievous and irremediable".

Doctors Choosing Patients

GRACE ZHANG, CLASS OF 2019

It is estimated that there are currently about 900 000 Ontarians without a family doctor [globeandmail2011]. Until about four months ago, I was one of them.

Growing up, I had the fortune of seeing an experienced, caring paediatrician – a man who was pre-booked more than 6 months in advance at any time. Unfortunately, this also meant that as soon as I turned eighteen, I was forced to fly the coop. Granted, there were referrals to other family physicians, but a combination of geographical inconvenience and poor timing allowed that to fall through: when the next year rolled around, I didn't have a family doctor to see. And things stayed that way for a while. Because I didn't grasp the amount of effort I would have needed to put into the family physician search process, I gave up after only a handful of rejections. It was only this past summer that I buckled down and made the requisite 20+ phone calls until I found a doctor who was willing to take me in. Then, I assumed that my acceptance into his clinic was simply due to him having openings at the time of my request; it never crossed my mind that there might be a selection process happening on the other side.

The possible "cherry-picking" of patients by physicians has been a controversial topic of discussion in the past decade. It's a phenomenon that is provincially relevant and especially locally evident. The Kingston Academy of Medicine, the local branch of the OMA serving the Kingston area, has adopted a decidedly pessimistic attitude regarding the physician search. On their webpage titled "How to Find a Family Doctor," advising people to "not be offended if the receptionist is not too helpful" and solemnly warning that it's "not uncommon in Kingston to be searching for years." The instructions go on to devolve into something reminiscent of sales-pitching coaching: potential patients are instructed to "stand out from all of the competition." "Why should the Physician take you on rather than one of the twenty other people who inquired that day?" the webpage asks [kingstonmedicine]. The approach and message being delivered here seem to contradict core values. In a country that heralds established access to health care as a fundamental right rather than a privilege, are people being called upon to essentially "sell" themselves to their future doctors?

We are concerned that the shift from paternalism to patient-centred care, while both necessary and beneficial, is beginning to create a culture of health care consumerism, whereby the doctor's role is primarily to provide the services that are requested by the patient, with little participation in that decision-making process. However, this message hits at the flipside of health care consumerism, where physicians might also be "shopping" for the best patients to take in.

The College of Physicians and Surgeons of Ontario (CPSO) mandates that doctors "ensur[e] that all patients, or those seeking to become patients, receive equitable access to care," a principle that seems almost obvious in falling under the realm of physician professionalism [cpso – professional obligations]. In 2009, the CPSO released a policy statement specifically regarding the acceptance of new patients into practice, indicating that physicians should be accepting patients by a "first-come, first-served approach" and that it is inappropriate to be screening potential patients [cpso – accepting patients]. And even though the CPSO clearly indicates that introductory "screening" appointments to meet and assess potential patients are inappropriate, patients were found to be invited to one in 9% of cases [healthydebate].

If patient selection is a prevalent issue, it's not a well-understood or systematically studied one. Although most assume that given the opportunity, physicians would select healthier patients over their more complex counterparts. However, a study conducted by Dr. Michael Hwang in Toronto found that although socioeconomic status was a factor impacting patient admittance into family practice, requests from patients with chronic conditions were more likely to be accepted than requests for routine care [nationalpost]. Teasing out the specific motivations for patient cherry-picking is difficult, let alone determining whether these motivations are consistent across the profession.

When trying to understand physician motivation for anything, compensation models are inevitably a key element in the discussion. Capitation, which pays the doctor per patient per year, is the funding model currently employed for approximately 4000 of Ontario's 9000 physicians. [healthydebate] In this case, steady patients with no major medical conditions are heavily favoured over patients with complicated cases or chronic conditions requiring regular visits, from a financial perspective. A 2012 study on primary care models found that physicians paid through capitulation are more likely to have wealthier and healthier patients in urban areas, whereas physicians still on the fee-for-service model tended to have lower income, less healthy patients in more rural areas. [ices] However, this finding is more a result of physicians choosing the more profitable funding model, rather than from selectively taking in patients.

From a physician's perspective, the cherry-picking phenomenon is the unfortunate result of infrastructural factors: a larger family physician work force and more balanced methods of compensation will alleviate the pressure to be selective about the patients doctors take in [globeandmail2008]. However, the bottom line is clear. As said by former CPSO President Dr. Marc Gabel: "Professionally we go into medicine to take care of people. Not to take care of only x or y, but to take care of the entire alphabet." [healthydebate]

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Election Stances: a Primer

SHANNON WILLMOTT, CLASS OF 2018
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Post-Election Politics – What You Should Know About Hot Topics in Healthcare

There was little public discourse of healthcare in the time leading up to the recent federal election. Does this mean healthcare is not a priority for the new government and PM? We sure hope not. In this article, we identified four "hot topics" that every medical student should be aware of. Although elections are over, we should still be active in holding our new government accountable.

Hot Topic #1: Health Care Accord

What's the issue?

The health care accord is an agreement between the federal and provincial governments about where the funding for healthcare comes from, what the standards are, and the important issues to address in healthcare. For example, the last accord, which was in effect from 2004 to 2014, required 6% annual increases in funding from the federal government (a number derived from increases in health care need as well as inflation), and it focused on reducing wait times for emergency visits, common surgeries, and family physicians.1

The accord was not renewed by the Conservative government when it expired in 2014. They had instead promised to fund 3% annual increases, and any additional funding would be tied to the strength of the economy. The argument against a new accord was that the 2004 accord required the federal government to pour a lot of money into the health care system, which, as reported by the Globe and Mail, was "grabbed by health care employees". Wait times for the targeted surgeries as well as emergency room visits dropped, only to return to where they were when the accord was signed.2 Proponents of the accord counter that having a federal-provincial agreement promotes cohesiveness of the healthcare system and attempts to ensure safe, equitable access to health care across the entire country. The 6% increase is tied to inflation and increased need, and thus was a reasonable amount to increase funding yearly.1

What can we expect?

The Liberals promised to, "[r]enegotiate a new health care agreement with provinces and territories as full partners, which would provide the jurisdictional flexibility to ensure the transformative changes needed to sustain Medicare are achieved," and to "[e]nsure that accountability of results in this new agreement will focus on measurable outcomes including cost-effectiveness, efficiency and timely access to care".3

Justin Trudeau promised a new health care accord to hold the federal government accountable for provincial health care, to increase access to home care, and to address drug costs. Information on how and when our new PM plans to implement this plan is lacking.

Hot Topic #2: Privatized Health Care

What's the issue?

There are two ways that healthcare can be considered "private": first that it is privately delivered, and second that it is privately funded. The former is common in Canada – physician services are an example (the physician privately provides a service, but usually bills the government rather than the patient or the patient's health insurance).4

However, private funding of health care is a more contentious topic. Privately funded health care services are those not paid for by the government – those paid for either out-of-pocket by the patient, or by insurance companies. A common misconception is that our "public health care system" pays for all medical services, but actually, our public health care system only funds those services deemed "medically necessary". The Canada Health Act (1984) is the piece of legislation that outlines this arrangement, but it doesn't specify what services are medically necessary. Historically, charging patients for publicly funded services is strongly discouraged, except in Quebec. Currently in Canada, approximately 30% of our health care is privately funded (think medications, dental, vision care, and nursing home care, among others).4 Some Canadians feel that more services should be allowed to be privately funded, for example, that physicians should be able to either bill the government or to bill patients for their services. Dr. Brian Day, a former CMA president, believes that wait lists and lack of family doctors may be due to the Canada Health Act and that the Act should be repealed. He feels that competition and a business model would save government money by treating people before their condition worsens.5

At the same time, many Canadians are proud of the public access to health care that the universal system provides. They argue that two-tier health care systems in other areas of the world have not reduced wait times in the parallel public system and that they leave expensive cases to the public system while "cherry picking" patients who are cheaper to care for. They worry that by having parallel systems, healthcare practitioners will be taken away from the public system, and that doctors in the private sector will have a "perverse incentive" to promote long wait times in the public system so that patients are more likely to pay for private health care.6

What can we expect?

The Liberal platform stated that they are "committed to supporting the Canada Health Act and ensuring that every Canadian must have access to publicly funded health care." Unfortunately, there was little overt talk about health care privatization during the election campaign. Nonetheless, it's an important hot topic in health care right now.7

Hot Topic #3: Public Drug Program

What's the issue?

Prescription drugs are an essential part of modern medicine. The World Health Organization has gone so far as to declare that all nations should ensure universal access to necessary medications. In line with this recommendation, every developed country in the world with a universal health care system also provides universal coverage for prescription drugs – except for Canada.

Currently, each province has its own public drug plan that covers a subset of patients based on factors including age, income and specific medical needs. These plans cover 42% of all prescription drug costs in Canada.8 Another 36% of prescription drug costs are covered by private drug plans often through employers. The remaining 22% is paid out-of-pocket. This multi-payer system diminishes purchasing power and has led to Canadians paying some of the highest drug prices in the world. In contrast, similar health care systems have been able to leverage the purchasing power of a single payer for an entire country to achieve drug prices nearly half of what they are in Canada.9

What can we expect?

The Liberal Party has pledged to join provincial and territorial governments to increase purchasing power and negotiate better prices for publicly covered drugs. In theory, this should allow provinces expand their coverage beyond what previously could have been afforded. While this plan stands to save provinces money, it will not benefit all Canadians. Those without public insurance will still have to pay inflated prices for prescription drugs. Universal Pharmacare would theoretically solve this problem, but the Liberals have been hesitant to commit to a plan of this nature.

Hot Topic #4: Senior's care

What's the issue?

Seniors (those 65 years of age or older) are the fastest growing demographic in Canada. According to Canadian Institute of Health data, seniors currently account for less than 14% of the population but consume approximately 45% of public health spending.10 If current trends continue, the CMA predicts this number will rise to 62% of health budgets by 2036 when seniors will account for roughly 25% of the population.11 Seniors tend to have greater needs for health services not simply because they are old, but because they are more likely to have complex chronic conditions that require more attention.

Across Canada, there is growing concern that the health care system is not prepared to appropriately handle the aging population. In response, the CMA released a report in August outlining a framework for a national seniors strategy.12 They identified areas for improvement in six key sectors: wellness and prevention, primary care, home care and community support, acute and specialty care, long-term care, and palliative care.

What can we expect?

The Liberals have promised $3-billion over the next four years to improve home-care and another $190-million to support Canadians who look after seriously ill family members. Previous funding for home care was insufficient despite being a cost-effective strategy in line with patient preferences. Home care has also largely been provided by unpaid friends and family. The Liberal strategy should address both issues.

But is this enough? The Liberals' plan addresses one of the six sectors in the CMA report – home care. To be fair, the remaining five do not fall directly under the mandate of the federal government. However, it is important that the federal government take on a leadership role in developing a national strategy that addresses current gaps. As the Liberals take office, it will important to monitor their involvement or lack thereof on this issue.

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Drug Abuse: Is Harm Reduction the Way?

OGI SOLAJA, CLASS OF 2018

In late October, a paper drafted by the UN Office on Drugs and Crime (UNDOC) garnered widespread media attention for its controversial recommendation to decriminalize narcotics worldwide. It called for an end to punitive measures for minor drug-related offences, namely possession and personal use, and stated that criminal punishment of these offences "has contributed to public health problems and induced negative consequences for safety, security, and human rights." This is ludicrous—surely, users of recreational drugs are prosecuted for a reason. It must be to protect people from their tendency to abuse drugs, defend the rest of society and protect public health… right?

"Wrong," says Ethan Nadelmann, founder and executive director of the Drug Policy Alliance, the largest drug policy reform organization in North America. Nadelmann, who sports a Masters' degree in International Relations from the London School of Economics and a Harvard PhD on international drug control, claims that the advent of drug criminalization in North America was motivated by political and racial prejudices, rather than health concerns. The principal users of opioids in the mid-to-late 19th century were middle-aged White women. As the 1870s and 1880s saw an influx of large numbers of Chinese migrant workers, who would often smoke opium at the end of a long day, the same way American men would sip whisky. The completion of the transcontinental railway was followed to the sweeping Anti-Chinese sentiment (also known as the "Yellow Peril"). The Chinese were painted as heroin-crazed gamblers, murderers, and rapists, resulting in the Chinese Exclusion Act of 1882 and the Gentlemen's Agreement of 1907, aimed at curbing Asian immigration.1 Amidst this fear, says Nadelmann, the first drug prohibition laws emerged in California and Nevada, quickly spreading and finally culminating in the Harrison Narcotics Tax Act of 1914, which made the production, distribution, and consumption of unregulated opium illegal.2 Nadelmann tells a similar story of the racially motivated cocaine and marijuana prohibition targeting Black and Mexican migrants, respectively, in the Southern United States. To this day, drug criminalization disproportionately punishes minorities; in the United States, where African Americans make up 17% of the population, they make up 37% of drug arrests and an astounding 56% of inmates incarcerated for drug crimes.3 That, however, is a grievance worthy of an entirely separate paper. Here, I wish to consider how effective punitive actions are in controlling drug abuse.

There is perhaps no better place to look than the United States, where $1 trillion has been spent since Richard Nixon declared drug use "public enemy number one", and moved to solve it by drastically increasing the size of federal drug control agencies, creating the Drug Enforcement Administration (DEA), and proclaiming a "War on Drugs". The following years saw a steady adoption of a zero-tolerance policy. The villainization of drug users during this time is exemplified by Los Angeles Police Chief Daryl Gates' famous comment that "casual drug users should be taken out and shot".4 Between 1980 and 1997, the number of people imprisoned for nonviolent drug offences increased from 50,000 to 400,000.5 At the start of 2014, a report by the U.S. Department of Justice showed that a whopping 56% of federal prison inmates were serving sentences for drug crimes.6 Another report found that of these drug arrests, 40% were for simple possession of marijuana.7 So, how well does this approach of caging drug users work? Well, in 2013, 9.7% of Americans had used illicit drugs in the past month; that is higher than it was a year before, which is in turn higher than it was in 2010. In fact, that figure has been climbing up since 2002, when is sat at 7.9%.8 Marijuana use jumped from 5.8 to 7.3% in that time, and the number of daily users increased from 5.1 million to 8.1 million from 2005 to 2013. The number of heroin users nearly doubled from 2002 to 2013, while availability increased and the price dropped.9 Methamphetamine lab incidents (a proxy measure of production) nearly doubled in the period between 2007 and 2009, despite increasing efforts by the DEA to control its domestic production.10 This final figure is perhaps the most jarring: in the United States, drug overdose rates have increased five-fold since 1980.11 In Canada, too, criminalization and aggressive law enforcement have failed to decrease drug use. To paint a picture of the Canadian government's approach, 73% of the $368 million anti-drug budget in 2004-2005 was spent on law enforcement, while treatment received 14%, research got 7%, and prevention and harm reduction programs each constituted a measly 2.6% of the pot.12 The list goes on and the statistics are clear—the "war" on drugs is simply not working. Yet, this should come as no surprise—a 1994 RAND (Research ANd Development) Corporation study commissioned by the Clinton Administration found that the cheapest way to decrease drug use was to focus on treatment, and that treatment was 23 times more effective at decreasing drug abuse than law enforcement.13

Portugal realized this in the late 1980s and 1990s, while in the midst of a huge drug problem. Although use among the general population was no higher than average, problematic drug use among addicts and associated harms such as HIV and hepatitis C infections were excessive, and growing. A 2001 study found that 0.7% of the Portuguese population had used heroin at one point in their lives, while 60% of the HIV-positive population were regular users.14 In 1998, the government put together a commission of activists, lawyers, doctors, and psychologists to come up with a solution; after 8 months of evidence-based analysis, the group suggested a radically different approach. Desperate for change, the government took their advice and approved a new National Strategy that came into effect in 2001. Under this new strategy, personal use of essentially all recreational drugs became decriminalized. Trafficking and production remained criminal offences, but possession of less than ten days' supply of drugs was simply an administrative offence and not enforced criminally. Critics of the policy called it ludicrous, expecting it to result in a rise in drug use and the establishment of drug tourism in Portugal. Supporters greeted the new policy as health-centered and based on science and evidence, rather than moralism and prejudice. They argued that not only was criminalization ineffective at decreasing drug use, but it was additionally harmful in that it stigmatized drug users and erected barriers to treatment. Portuguese drug officials admit that before 2001, the largest barrier to an addict seeking help was their fear of arrest and persecution. Under the new law, those caught possessing less than ten days' supply of drugs are ticketed and ordered to appear before a board within 72 hours, where they meet with two psychiatrists and a legal specialist. Here they discuss the individual's drug use, categorize their use as recreational, regular, or addiction, discuss risks of their use, and offer treatment. The panel also has the option of issuing a fine, yet 85% of those seen are sent home without a fine, while the majority of the rest receive treatment.15 Most importantly, the issue of drug control was re-allocated from the hands of the Justice Department to the Ministry of Health, indicating a fundamental shift in government policy and beliefs about drug use.16

The results of the Portugese "experiment" (rather, the informed, evidence-based decision) are as follows: levels of drug use in Portugal are now below the European average.17 Rates of drug use in the past year and past month—which are considered the best indicators for a country's current drug situation—have both decreased.18 Drug use in the 19-25 year old category (most at risk for initiating drug use) has also decreased.19 The number of newly diagnosed HIV cases among people who use IV drugs has dropped 94% since 2001, to only 56 cases in 2012, and a similar trend has been observed for Hepatitis infections.18, 20 Meanwhile, the number of heroin addicts receiving treatment rose from 23,500 to 40,000 between 1998 and 2010, and the same is true of other drug users15,21 The proportion of drug-related offenders in Portuguese prisons dropped from 44% to 21% between 1999 and 2012. Finally, the number of drug-related deaths also decreased from around 80 in 2001, to 16 in 2012.18 Perhaps the most significant change has been one of social attitudes about drug use; from a criminal or moral issue to a medicosocial one, allowing for open discussion of the issues and a focus on rehabilitation, rather than stigmatization and punishment of users. Of course, not all of Portugal's successes are a direct result of decriminalization alone. Rather, these achievements can be attributed to a larger overhaul in the way that the country dealt with drugs; a shift towards health-centered policy that focussed on rehabilitation and treatment. For example, the number of people receiving substitution treatment—in which illegal opioids are replaced with less harmful opioids under medical supervision—has quadrupled between 2000 and 2008.20

Treatments such as opioid replacement therapy fall into a broader category of harm-reduction programs. They include needle exchanges that provide sterile needles and syringes for IV drug users, safe injection sites that provide legally sanctioned medical facilities for drug users to inject under supervision, naloxone distribution programs that provide users with naloxone—a sort of opiate antidote—to be used in case of overdose, and distribution of drug testing kits to ensure that users know what they are taking. As of 2014, there were at least 90 countries worldwide running needle exchange programs, and 80 that provided some form of opioid substitution therapy.22 In many of these nations, however, the political focus remains on prohibition, and such programs may be seen to promote drug use despite punitive drug policy that, in extreme cases, may punish drug use with death. While the main arguments against needle exchange programs seems to be ideological opposition to normalizing or facilitating drug use, the evidence shows that they are effective at reducing infection rates without elevating rates of use.23

It is at this crossroads that Canada finds itself; in a position where safe injection sites legally sanction an illegal behaviour, but are clearly beneficial to health on a population level. The appearance of safe injection sites has been met with staunch opposition from the Harper government. In 2003, Vancouver's Insite became the first and only supervised safe injection site in North America. It came as a potential solution to an HIV epidemic in the city that Thomas Kerr of the B.C. Centre for Excellence in HIV/AIDS called "the most explosive epidemic of HIV infection that had been observed outside of sub-Saharan Africa." Its goals were to provide clean needles, medical supervision, mental health assistance, and emergency medical help to intravenous drug users, thereby decreasing morbidity and mortality from infection and overdose. Supporters argued that the sites would decrease public drug use, improve public health, and provide a bridge to treatment for addicts, who would be connected with available health staff and treatment programs. All in all, Insite has been emphatically successful at achieving its stated goals. While facilitating over 600 injections daily in one of thirteen supervised booths, Insite has never seen a fatality. This is despite 497 witnessed overdose incidents in 2012, which could have resulted in death on the streets.24 A 2010 study found that it prevented about 35 cases of HIV each year, with a net economic benefit of $6 million annually.25 The following year another study found a 35% reduction of overdoses in the Insite area, which was once plagued by drug-related deaths.26 As expected, users were also 35% more likely to enter treatment. They could do so at Onsite—the attached detox facility—where 400 people sought treatment in 2012 alone, and which boasted a 49% completion rate.24 Additionally, no adverse effects—such as perpetuating use and increased trafficking—have been reported. In fact, it has been well received, with 76% of the area's residents supporting the initiative.27 After dozens of peer-reviewed studies, the evidence is abundant and clear: Insite works.

Drugs are bad. I know that better than most; last year I lost a dear friend to a long-standing opiate addiction. But that experience has taught me something important; while drugs are bad, people who do drugs are not. Whether they take the form of a mentally ill homeless person or a bright-eyed kid with a 4.0 GPA, fining and caging drug users won't dissuade them from using nor save their lives when they make a mistake. But a system that chooses empathy and humanity would certainly maximize their chance of both.

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Pharmacare: Pros and Cons

JENNIFER MCCALL, CLASS OF 2018

Pharmacare

Pros	Cons
Social equity	Cost to government
Economic benefits	Bad time for cost
Patient safety	Inferior coverage for those with private drug plans
Improves knowledge and planning for drug shortages	Most people already covered + catastrophic expense funding
No lost R&D	Other models

National Pharmacare is extolled loudly by its advocates – many of whom are our teachers, mentors, and classmates. However, a Ms. Jenny Gu challenged recently that while the benefits of Pharmacare are touted frequently, there is very little information about its disadvantages, which makes it difficult for intelligent, critical-thinking QMeds to come to an informed decision about their stance on the issue. As such, I aim to lay out here a balanced argument for and against Pharmacare. As well, I would like to disclose personal biases on the issue and I advise you to consider this critically as you read on.

Essential to the argument is an understanding of Pharmacare as a policy, as well as how its current advocates envision it in Canada. Pharmacare would be a national drug coverage plan. It would be an extension of our current Medicare plan such that prescription drugs outside of the hospital would be free of cost to the patient. Similar to health care in Canada, Pharmacare would be a provincially-administered program with transfers from the federal government (about 25% of the program cost has been suggested by the publishers of Pharmacare2020.ca). In contrast to healthcare, a Pharmacare strategy would necessitate a federal component as it would require bulk purchasing on a national scale and a country-wide formulary to monitor prescription patterns and cost.

For:

1 in 10 Canadians cannot afford their prescription medications (1), affecting 1 in 4 Canadian households (2). This statistic addresses the heart of the pro-Pharmacare argument: social equity. Socioeconomically disadvantaged households are disproportionately affected by the cost of prescription medications. The Canada Health Act demands universality (and comprehensiveness), yet this does not apply to outpatient prescription medications. One way to reduce the effect of poverty as a social determinant of health would be to provide universal prescription drug coverage.

For a long time, the major argument against Pharmacare has been the cost. With this in mind, Canadian researchers including Danielle Martin and Steve Morgan set out to estimate the cost of Pharmacare for Canadians. Contrary to concerns of increasing costs, their research indicates that a national Pharmacare program would save between $4.2 billion and $9.4 billion (3), which the study's authors believe is likely to be an underestimate. The cost savings would be derived from bulk purchasing and rates of generic drug use. Some of the costs could not be estimated, including a more efficient administration of the currently fragmented prescription plans of private employers and unions, elimination of the subsidies given to employers to encourage such plans, savings to the health care system when medical crises are prevented due to medication compliance, and lost productivity due to medication-preventable illness, supporting the researchers' belief that their findings underestimate projected savings.

Patient safety is a third pillar in this argument. Currently, Canada has no national prescription monitoring program, resulting in a lack of data surrounding safe or dangerous prescription patterns. A national formulary would enable monitoring and, hopefully, changes in practice (4). Furthermore, a national bulk buying program would allow for more accurate and timely predictions of drug shortages allowing pharmaceutical companies, buyers (the federal government), and prescribers to react more effectively (5).

Finally, some scientists worry that pharmaceutical research and development (R&D) will be driven out of Canada if a national drug coverage plan comes into effect. However, the location of R&D is related to direct scientific investment rather than pharmaceutical spending (6) and many countries with comparable universal health insurance to what is being proposed in Canada have a higher per capita research investment than Canada (3).

Against:

You may have noticed above that the estimated savings from Pharmacare will be enjoyed primarily by the private sector, while the government will actually incur an increased cost (3). The study cited above predicts an $8.2 billion savings to the private sector, but a predicted cost to the government of $958 million with a high-end range of $5.4 billion. Furthermore, a study published by the Canadian Health Policy Institute reported that there would be additional indirect costs of $4 billion in the first year of the program (7).

In the current tumultuous state of the economy, $5 billion, or even $1 billion, would require squeezing other sectors that are already thinly funded and are also important to health, e.g. education, or increasing taxes, which reduces the net income that families are bringing home each year. Not only does this affect individual families, possibly pushing them below the poverty line (where 9% of families already fall (8)), but it also reduces disposable income, which stimulates the economy. The bottom line is: Pharmacare might be a good idea, but this is not the time to implement a costly program.

While a universal publicly funded system might be beneficial to those Canadians who currently have no drug coverage, it would be detrimental to those Canadians who already have a drug benefits plan (8). Public insurance plans often do not cover expensive, innovative medications; some private insurance plans do. Forcing Canadians to accept a public insurance plan may mean imposing upon them inferior medications or none at all. Furthermore, access to these drugs will not increase for people who are already covered under some form of public insurance.

Although only 36% of prescription costs are currently covered under provincial drug plans, only 22% of costs come from patients' pockets. (9) The rest are covered under private drug plans or compulsory social insurance policies. Furthermore, Canada has universal drug coverage for catastrophic expenses so that people are not launched into poverty when their medication costs become an enormous burden.

Finally, other countries around the world have shown that systems other than a federally-funded and –operated national drug coverage plan work efficiently. Such other systems include compulsory social insurance policies and mandatory universal private drug insurance systems. Both of these options would relieve the government of the economic burden of Pharmacare as it is currently designed.

Alas, questions remain. What is the best model for drug insurance in Canada? Is a universal publicly-funded drug coverage plan just too much cost for our economy to bear? Or should it be considered a matter of social equity on which no price can be placed? And finally, would the program disadvantage those currently under private plans more than it would benefit those without?

I leave it to you to decide.

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Macro, Meso, “Me Through” Advocacy

NOTHANDO SWAN, CLASS OF 2017

So you want to be an advocate?

One of the most difficult parts about identifying a cause and advocating towards its betterment is just that: advocating. As the Royal College of Family Physicians and Surgeons put it, “advocacy requires action,” and all too often, medical students feel that they are powerless or that they can’t affect change on a large scale. What are the next steps once you’ve decided where your efforts should be directed? How as medical students can we grab the attention of those in a position of public power? These questions can be paralyzing at times, putting well thought out ideas at a stand still. At the risk of oversimplifying these complex issues, I propose a straightforward approach to advocacy and then outline three levels in which this approach can be applied.

The Approach

We can advocate, that is raise attention to and provide support for issues, in four sequential (but often circuitous) steps. First, an issue is identified and invested groups are consulted in a collaborative manner. Next, a team with unique abilities and a unifying goal is created for joint action. With this team in hand, a method of program assessment is outlined to ensure that the advocacy project engages and benefits the intended group. And lastly, a project is implemented with the understanding that it will change with time, because it is not the shape of the project that matters, but rather the overall imprint that it makes once it is rolled out.

Macro

Macro-level change – the large-scale change that guest speakers who have led national and international health projects wow us with – is perhaps the most highly discussed level of advocacy. Certainly, interest in international clinical and research experience as well as nationwide student bodies is growing. The International Federation of Medical Students Association (IFMSA), a student-led organization, runs a number of programs that involve students in global health initiatives. These include the Standing Committee on Professional and Research Exchange (SCOPE and SCORE) – international exchange programs created from the belief that time spent in medical communities abroad is important in order for future physicians to appreciate the variation differences and similarities in medical practices worldwide. They have collaborated with 98 National Member Organizations to run these national exchange programs and they elicit feedback from participants and national exchange officers in order to improve these programs each year. This is just one example of macro-level advocacy of which medical students are already a part.

Meso

Meso-level advocacy – that which affects a defined group of people within one community – comes naturally to physicians. Our profession is centred on providing care to a group of patients and advocating for their health. Our practices, be they office, hospital or home-based create almost automatic change in a number of lives, a sort of “help me help you” set up. As Dr. Anthony Sanfilippo, Associate Dean of Medicine at Queen’s University explains:

> …[P]atient advocacy is a natural component of the care I provide. Interestingly, [physicians] never thought of what we do in those terms until the colleges developed their various competency frameworks. The reality is that they developed as natural expressions of how physicians have always provided care to their patients, not as something we needed to add on.

Similarly, learners are in a particularly convenient position to advocate for patients within a defined community. On a pediatric rotation, a clerk who does the initial history and physical with a young person is in the unique position to observe that child and his/her family over some time. The clerk might identify that this child’s health would be greatly improved if his/her caregiver were given some support. Next, the clerk might bring this point up with a faculty supervisor who could connect the parent with community resources and also follow-up in a couple of months’ time. Of course, the patient’s treatment could then change based on the analysis of the child’s improvement.

Me Though

Me though advocacy focuses on redirecting our voices, which we often use to help others, back towards ourselves. It centres on speaking up for our own care, something that medical students and physicians alike don't necessarily do well. An example might be a first or second year student who realizes that she needs more time to focus on her physical health. She might then call on her friends to help keep her on track as they sign up for yoga classes. The group of friends might attend class for the first month or so and then decide to practice their favourite poses at home as their school schedules got busier.

Creating this protected time in order to advocate for her own personal health is something that Dr. Danielle Martin, family physician and Vice-President Medical Affairs & Health System Solutions at Women's College Hospital makes a conscious effort of:

One of the ways I advocate for myself is by ensuring that I take time off work. We love to travel, but with the many roles I juggle it can be really hard to protect the time to do that. My partner is very good at pushing me to refuse to compromise on that front. We take 4 weeks together with our daughter every summer, and it's not negotiable.

Although the idea of advocating is often daunting, it is something that we are all capable of doing. Whatever approach we take to implementing change, we would be wise to remember that it can be applied on a large, medium-sized or personal scale.

The Ebb and Flow of Healthcare in Ontario

HENRY AJZENBERG, CLASS OF 2018

In Ontario, it appears that the history of health care is doomed to repeat itself. In an effort to deal with a ballooning provincial debt and the rising costs of health care in the 21st century, the Wynne Liberals have taken a hard line in their dealings with the Ontario Medical Association (OMA). Negotiations over the Physician Services Agreement, which details how much health care the government will pay for, have failed. Battle lines have been drawn.

The government argues that tough economic conditions require a reduction in health care funding and have painted physicians as an entitled and stubborn group that is whining about their pay. Meanwhile, the OMA and grassroots groups like Ontario Doctors Concerned About Health Cuts (see their Facebook group) deny that this fight is about compensation. Rather, they say, it is about how underfunding the health care system will cause patients to suffer. The truth probably lies somewhere in between, and may only emerge in retrospect. What is for certain, however, is that this is not a new fight. If Ontarians see their health care system as a static and reliable service, this view is an illusion. The financing and staffing of our health care system is in a constant state of flux. We can see this most markedly in times of economic hardship, when health care funding is inevitably cut. Lest we think our current problem is new, we need only look to the 1990s.

Health care cuts in the 1990s

The year 1990 marked the beginning of a recession in Canada, mirroring patterns of economic stagnation around the world. Though it only lasted for 4 quarters, recovery from that recession has been described as "anaemic" and took a lasting toll **[1]**. With growing public debt and a falling GDP, federal health transfers to provinces were reduced and real per capita spending on health care decreased for several years in a row **[2]**. By 1996, the average share of health care paid for by the federal government fell to just 21.5%, down from 30.6% in 1980 **[3]**. With a drop in the availability of federal funds, an explosive debt of our own, and a loss of revenue locally, the government of Ontario targeted public services – healthcare chief among them – to stop their financial hemorrhage.

In 1991, with Bob Rae's NDP government at the helm, thresholds were placed on individual physician billing, specifically those who billed more than $400,000 annually. Shortly thereafter, a global cap was imposed on Ontario's PSA (this is the total amount of money set aside to pay all doctors in the province). If collective billings exceeded this cap, all physician's fees were reduced in the subsequent year to refund the government. The significance of this cannot be understated. Furthermore, by 1995, caps were imposed on how much certain specialists could make **[4]**. In his book Chronic Condition, Jeffrey Simpson argues that a similar pattern of cuts across the country lead to over 700 physicians leaving Canada for the US annually in the mid-1990s, which was an all-time high **[5]**. Ironically, a perceived surplus of doctors at the time led Rae's government to place a cap on medical school enrolment, which significantly contributed to Ontario's doctor shortage just a few years later. Growth in the number of physicians per capita levelled out, physician consultations per capita fell from 7 to 6, and wait times increased **[6]**. In 1995, when Ontario's debt had reached 32% of provincial GDP (this is high), the newly elected Mike Harris Conservative government made further cuts to the health care workforce. More than 30 hospitals were closed and many more amalgamated into single corporations **[6]**.

The impact of these cuts was felt across Ontario. Between 1994 and 1999, the ratio of family physicians per 100 000 Ontarians declined by 8.6% **[7]**. By 2003, one quarter of Ontarians (approximately 3 million) did not have a family doctor **[8]**. It took over a decade to recover what was lost in health care.

Recovering from the 1990s

Recovering from the damage done took over a decade and involved a concerted effort from the government of Ontario. In order to bring physicians back into the province, and specifically to strengthen primary care (which had been decimated), initiatives were launched on several fronts. Ontario medical schools increased enrolment by 80% **[9]**. Major reforms in primary care were introduced. Queen's very own Dr. Ruth Wilson led the implementation of Family Health Teams (FHTs), which offered a better work environment and brought family physicians' compensation closer to that of specialists. As a result of these efforts, 2.1 million Ontarians who were previously without a doctor now have a physician to call their own **[8]**.

Health care cuts come again: our current state of affairs

After years of relative economic prosperity, the global economic recession of 2008 prompted several years of deficit for Ontario. By 2012, Ontario's debt stood at $267.5 billion and was 40.9% of provincial GDP **[10]** (compare this to 32% in 1995). In an effort to save money, the government has once again targeted health care, which makes up the biggest single piece of the provincial budget **[11]**.

Just as in the 90s, the PSA and thus physician compensation have recently taken major hits. The first cuts occurred in 2012, when a new PSA was negotiated and physicians took a 0.5% reduction in their fees across-the-board. Recognizing the general fiscal limitations of the times, 81% of physicians voted in favour of this cut in an OMA referendum **[12]**. However, when that PSA expired in 2014, and the government offered the OMA a 1.25% increase in the PSA, the OMA rejected this offer. The OMA has argued that this increase would not account for increased population, utilization, and inflation. In fact, the OMA counter-offered to take a 2-year pay freeze for all physician compensation if the government would fund enough growth in the PSA to cover the fact that there will be more Ontarians using more health care in the coming years. This was rejected by the government.

The government has since walked away from the table and unilaterally imposed an across-the-board 2.65% fee reduction to all physician services, effective June 2015. On October 1, a further 1.3% cut was imposed on all physician services. The OMA states that a total of 6.9% has been cut from physician services in the passed several years **[13]**. Additionally, a hard cap has once again been imposed on the PSA. If physicians collectively bill more than this cap, then the government will either withhold payments or take funds back from individual physicians until the difference is made up. These so-called "clawbacks" are problematic in that they make physicians solely responsible for health care utilization in the province. Between an aging population, 140 000 new patients each year, and inflation, the provincial government itself predicts that it will cost 3% more each year to pay physicians for these services **[14]**. This cap may actually provide a disincentive for doctors to provide more services than their budget allows, as doing so would be unpaid work.

Consider this hypothetical situation. In 2015, the government hires a construction company to repair potholes on all of Ontario's 400 series highways, with a 1% increase in budget size from 2014. However, due to the aging roads, increased traffic, and changing environmental conditions, more and more potholes keep popping up. Since there is more work to do (and more employees to pay) than the previous year, company owners will need 2% more than last year to pay their employees. In response to this underfunding, they simply would not do the additional work that they were not being paid for. Now back to reality. Physicians are being underfunded. They, however, do not have the option to refuse work, due to a moral and legal obligation to their patients.

The cuts go deeper. Several key programs, which have largely been responsible for the comeback of primary care, are also being put by the wayside. Physicians will no longer be allowed to join FHTs unless they are in designated areas of high need; in the entire province, only 20 physicians per month will be allowed to join FHTs (halved from 40) **[15]**. This hit to FHT models is a 180-degree turn around for Ontario's health policy, which has spent the last decade aggressively promoting group practices in primary care. Family physicians will no longer get premiums for enrolling new patients, which previously allowed new doctors to finance running a clinic before they had a full roster. Income Stabilization, which is additional funding aimed at supporting new family physicians, is now limited to high needs areas. Fees for working afterhours and at walk-in clinics have also been reduced **[16]**.

This summer, the government also announced that it would be cutting 50 residency positions in Ontario over the next 2 years. From which specialities, it has not announced. Ontario currently has 214 physicians per 100 000 people, which lags behind the national average of 224 **[17]**.

At a time when more than half of Ontarians already cannot see their doctor on the same or next day and almost 1 million Ontarians are without a family physician, it is unwise to remove so much funding from primary care. In an effort to rebuild quality primary care infrastructure, a proverbial carrot was swung in front of prospective family physicians for more than a decade. This took the form of competitive incomes and the prospect of working in a group practice. With the recent cuts, these incentives are now largely gone.

Slashing budgets and restricting growth are the Wynne government's response to a very real and arguably out-of-control provincial debt. However, as we saw in the 1990s, short-term thinking can result in long-term problems.

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The Prisoner's Physician: Caring for Canada's Incarcerated Patients

ERICA MCKENZIE, CLASS OF 2018

"It is said that no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones."
- Nelson Mandela

We pull into the parking lot outside the Warkworth Institution, a sprawling campus of low concrete buildings constructed in the Brutalist style of government infrastructure, circa 1967. Within the medium-security prison's chain-link borders live nearly 600 men. Armed with only a stethoscope, I follow Dr. Peggy Robertson through the gated entryway for a day in the life of a prison physician.

What would medicine on the "inside" be like? The prison of my imagination was painted with the gloss and grit of primetime television. The evening prior, Dr. Robertson had cautioned, "Wear comfortable clothes, no cleavage and no short skirts. No white coat and no chunky necklaces, which could pose a strangulation risk. You will never be left alone with an inmate and since I never take risks with my safety, you will be safe."

Dr. Robertson is the sole primary care physician at the Warkworth Institution. She has worked in Corrections for nearly a decade. The prison clinic where she works is housed in a stand-alone former cellblock on the Institution grounds. Next to the clinic doors is a walk-up window where blister packs of pills are dispensed to inmates. Past the doors sit two corrections officers at a desk shielded by plexiglass, eyeing a line of waiting inmates. Before inmates may enter the clinic, they are frisked by another set of guards for homemade weapons and other contraband. Beyond the guards, there is a pharmacy, a nursing station, offices for two infectious disease nurses, rooms for the specialists who hold once-monthly clinics, and Dr. Robertson's office and examination room.

Precautions are taken in preparation for the morning clinic. Dr. Robertson hands me a piece of tape, which she instructs me to place over the last name on my medical student ID badge. She rarely feels unsafe at work, she says, but she is careful: she never turns her back on an inmate, employs a zero-tolerance policy for vulgar or aggressive language, and knows that her coworkers are always within earshot. To avoid bias in the assessment and care provided, the medical staff are typically unaware of the crimes of which each prisoner in their care has been convicted. A nurse, perhaps to reassure me, says, "I don't trust them, but really, these are the same guys who walk into any emergency room. I just know the kind of people I'm dealing with, and here they get patted down before they see me."

Dr. Robertson sends me to start the day with Steve, a corrections nurse who is in charge of the morning's direct observed therapy (DOT), the technical term for watching an inmate swallow his Dixie cup of pills. DOT is meant to ensure that medications are not pocketed or concealed under the tongue, and is used for drugs at high risk of diversion, including stimulants, sedatives, and narcotics. The DOT ritual necessitates a few moments of small talk with each inmate. Steve fills this space with his "question of the day," posed as each inmate is guided to the DOT station. Today I am tasked with choosing the question, and settle on the benign, "What's your favourite cartoon character?" These brief encounters reveal the inmates waiting in line to be the Roadrunner aficionado on methylphenidate, the Stewie fan on morphine, and the Mickey Mouse enthusiast on Tylenol with codeine.

Around 9:00 am, Dr. Robertson's first patient of day arrives. After he is cleared by the guards and assessed by the nurse in the hallway, Dr. Robertson leads him into the examination room.

The examination room looks almost like any other: its tiny footprint just barely contains a dated examination table, a few mismatched chairs, and walls papered with posters on diabetes and healthy eating. But there are steel bars across the window, and the door has been removed from its hinges and replaced with a thin curtain. The patient enters not in his customary gown, but rather the Federal prisoner's uniform of blue jeans and a blue t-shirt. The examination room is, in fact, a converted six-by-nine foot cinderblock-lined cell.

And yet, a prisoner becomes a patient when he steps into that room. While most staff address inmates by their last names – to avoid familiarity and reinforce hierarchy – Dr. Robertson uses the given names of the men who visit her clinic. The easy rapport Dr. Robertson has with her patients surprises me; I had expected a tension, hostility, and remoteness that I did not encounter. The first patient is a veteran of Warkworth, who confides in Dr. Robertson like an old friend, bemoaning the aches of old age and gossiping about the daily dramas of cellblock life. The next is a young man proudly wearing the tattoos on his skin like armor, who reluctantly drops the pretense of toughness as he seeks Dr. Robertson's counsel for depressive symptoms.

The histories I heard in Dr. Robertson's clinic that morning laid bare certain realities about who goes to prison in Canada. The men we interviewed were disproportionately Indigenous, lower-income, housing insecure, under-educated, learning disabled, mentally ill, and/or substance-dependent. Many told stories of ricocheting from institution to community to back behind bars, and some had spent more than half their lives in prison. Many were growing old and facing chronic disease and death in prison.

Living conditions in prison are hardly conducive to rehabilitation or health promotion. The Correctional Service of Canada recently slashed funding for special diets for prisoners, which include both religious and therapeutic diets. One patient with diabetes reported that the cafeteria had refused to provide him with diabetic-friendly meals. Dr. Robertson contacted Feeding Services to have his special diet reinstated, but in the meantime, she could only counsel him to eat around high-sugar items on his tray. The food provided to inmates, she explained to me after the patient had gone, is heavily processed, and while it technically meets Canada Food Guide requirements, she sees daily the toll years of prison food has on her patients.

A different patient we saw that morning presented with a rash that had been exacerbated by the cheap, harsh soap provided to prisoners. Another, who had a full house of cardiovascular risk factors, lamented that his yard time was limited to one hour per day. Another reported that he had been abruptly dismissed from his prison job building cabinetry after having missed a shift due to his illness.

Statistics tell a shocking story about health in Canadian prisons. The life expectancy of a prisoner is a full 18 years below that of the average Canadian male. 66% of prison deaths are due to "natural" causes, such as cardiovascular disease and cancer, and the prevalence of infectious diseases soars in the inmate population. 18.5% have Hepatitis C, 16.6% have latent Tuberculosis, and 1.2% are HIV positive. Prisoners in Canada commit suicide at a rate of 70 per 100,000 inmates; by comparison, the rate of suicide in the general population is 10.2 per 100,000. 24% of deaths in prison are due to suicide, homicide, accidents or overdoses. 30% of inmates have a diagnosed mental illness. At the time of admission, 80% of federally sentenced men have a substance abuse problem, and 25% have cognitive deficits.

And yet, the health care needs of Canada's incarcerated population are notoriously underserved. "In prison, I am the diagnostic test," Dr. Robertson explained. Her ability to order investigations and refer inmates to outside care is limited by the short supply of medical escorts, which must accompany prisoners on every medically necessary journey beyond the fences of Warkworth, whether for diagnostic tests, specialist consults, surgeries, or trips to the emergency room. The discerning physical exam is all the more essential when seeking tertiary care involves shackles and armed escorts.

The staggering burden of disease in Canada's prisons is stark evidence of the prioritization of punishment over public health. Over the past decade of "tough-on-crime" government, the federal inmate population has increased by 17.5% to over 15,000 prisoners, with another 7,700 offenders community-based corrections programs. Over the past decade, the number of incarcerated Indigenous men and women grew by 47.4%, the number of Black Canadians by over 75%. These groups now make up 22.8% and 9.8% of the prison population, respectively. Nearly one quarter of inmates are serving a life or indeterminate sentence, and one in five inmates is over the age of fifty. Of the Correctional Service budget of 2.6 billion per year, 216.7 million is spent on health services, translating to an average of $9,700 per male inmate. The costs, both human and economic, are sure to increase if the trajectory of a swelling and aging inmate population continues.

On the inside, you are told to never turn your back on a prisoner. Yet we, as a medical community, have turned our backs on the prison population. Prisoners will be our patients – as will individuals who have served their sentence and returned to the community, men and women at risk of incarceration, and those with loved ones behind bars. Particularly in Kingston, the so-called "Prison Capital of Canada," knowledge of the exceptional health needs of those impacted by crime and the corrections system seems essential. But prison health is absent from our medical school curriculum, and caring for the incarcerated seems an unpopular career choice. A tragedy – given that physicians have the potential to be powerful advocates of reform for a system that seeks to punish rather than heal, and the strongest allies for patients who also happen to prisoners.

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An Editorial on Justin Trudeau

SACHIN PASRICHA, CLASS OF 2020 (QUARMS)

C'mon Mr. Prime Minister: Let's get professional

He has a photo shoot in Vogue magazine. He has repeatedly been referred to as one of the sexiest politicians alive. American politics is famous for making celebrities out of politicians - this is probably part of the reason why Donald Trump has seen success in the polls. Here in Canada, we have standards. Our politicians keep their eyes on important issues of the day and leave the fashion and celebrity escapades to Drake and Justin Bieber… Or at least this was the case until our new Prime Minister decided to sexualize himself on the international stage.

Since Prime Minister Trudeau has taken office, most of his actions have been commendable and met with applause. There was the appointment of a diverse cabinet – balancing gender, race, religion, and geography. Ties with our allies to the South have been strengthened; he is the first Prime Minister in 19 years to be invited to a DC State Dinner. Most recently, he has begun to bring thousands of displaced Syrians to the place we call home. But his sideshow detracts from the meaningful reforms he brings to the table. More importantly, it shows an absence of political professionalism.

A bit of a juxtaposition, eh? Political professionalism? Believe it or not, it exists -and Trudeau seems to be ignoring it. Even prior to the start of the campaign, Trudeau showed slips of professionalism with his use of coarse language: "All that — your name, your fortune, your intelligence, your beauty — none of that f--king matters." Perhaps you're getting flashbacks of Rob Ford – but nope, that's your Prime Minister.

On another note, Trudeau evidently took a page from Obama's book in his use of Facebook, Twitter, and other social media platforms to reach young voters. That is not to discredit the strategy – it was intelligent and effective. Where his failure comes into play is when he embellishes the efforts of social media to capitalize on his good looks and baby handling skills. Our Prime Minister could have sent a message that he is an elected official, not the star of Entertainment Tonight, by refusing to engage with or indulge such remarks. Yet he made a decision – a decision to join the likes of George Clooney - by starring in a fashion magazine. Not to say Clooney doesn't make a dashing magazine cover – it's just that thirty-five million Canadians didn't elect him.

As future physicians, we are often taught of the importance of professionalism. It aids in the establishment of a positive relationship with patients. So where is the professionalism in politics? Is there no need for a positive relationship between elected officials and those they represent? If a surgeon brought their spouse in to operate with them, it would not only be illegal, but immoral. How, then, does Trudeau get away with it? If an oncologist sexually posed for People Magazine and then placed an enlarged version of the picture on the doorway of his clinic, would we not think twice before visiting this oncologist? A physician engaging in such behaviour would be considered downright unprofessional. Yet, no one seems to bat an eyelash when our Prime Minister swears, brings his wife to work, or treats himself as a sex symbol – at least not yet.

Physicians and politicians are social leaders working to better the lives of Canadians – whether it be through undertaking political reforms or ensuring we maintain a healthy quality of life. Thus both must be upheld to high standards of professionalism. As a medical society, we are lucky to have had that embedded in our education. Though politicians seem to have forgotten this, it is our duty as publically funded servants to remind them. And there's no better place to start than with reminding our Prime Minister that, contrary to the fantasies of college girls, he is an elected official, not John Travolta in the 2016 version of Grease.

Should Medicine be Political?

ELLIOT COHEN, CLASS OF 2017

In medicine, there is rarely a simple answer to a "yes or no" question. Should a patient with a hemoglobin of 74 g/L receive a blood transfusion? Should a patient with chronic abdominal pain and no red flags receive a colonoscopy? Should a man over the age of 50 receive routine PSA screening? The answers to these questions are, in short, "it depends." If posed any one of these questions, an astute physician would request more information in order to make a thoughtful decision, and his or her answer would be based on a number of variables. And of course there may be disagreement among physicians regarding the most correct answer.

When I considered the question, "Should medicine be political?" I realized there too was no straightforward answer. In fact, the question itself is vague. I interpreted it to mean, "Should medicine get involved in politics?" Because after all, like in any profession, we know that the practice of medicine itself can certainly be political; that is a topic of discussion for another time. The short answer to my interpretation of this question is "sometimes." So when is it appropriate and when is it not?

The ideal doctor is altruistic; his or her interests lie solely in the physical welfare of the patient. Moses Maimonides, a 12th century Egyptian-Jewish physician and philosopher, wrote the "Prayer of a Physician," and the following excerpt illustrates this age-old tenet of medicine:

> Preserve the strength of my body and of my soul that they ever be ready to cheerfully help and support rich and poor, good and bad, enemy as well as friend. In the sufferer let me see only the human being.

Maimonides believed it was the duty of the physician to heal the sick, regardless of any other factors biasing the physician otherwise. In other words, Maimonides would argue that medicine should not be political.

Save A Child's Heart (SACH) is a modern-day example of such medical altruism, and one that I was fortunate enough to be involved with this past summer as a medical intern. SACH is an Israeli-based global healthcare initiative that provides free cardiac care for children born in developing countries. Since its inception in 1996, SACH has provided treatment for over 3,300 children from 48 countries around the world. And in spirit of the wise adage about teaching a man to fish, SACH doctors have trained over 80 doctors, nurses, and other medical team members also from developing countries so that they may return home with specialized training in their field. About half of the children treated by the SACH team are Palestinians from Gaza and the West Bank. If you've ever read the news, you likely have heard about the Palestinian-Israeli conflict. "But this conflict does not interfere with what's important," Dr. Akiva Tamir, the lead pediatric cardiologist, told me one day during clinic at Wolfson Medical Center in Holon, Israel. "The conflict is between people up 'there' somewhere," as he waved his arms in the air. "In real life, we are just people, and in fact we are very similar because we have a similar culture." SACH is comprised of doctors and other medical professionals who are decidedly non-political; they overcome political barriers on a daily basis to provide excellent medical care to those who are most vulnerable and most in need. Thus SACH is a perfect example of when politics should not get in the way of good medicine.

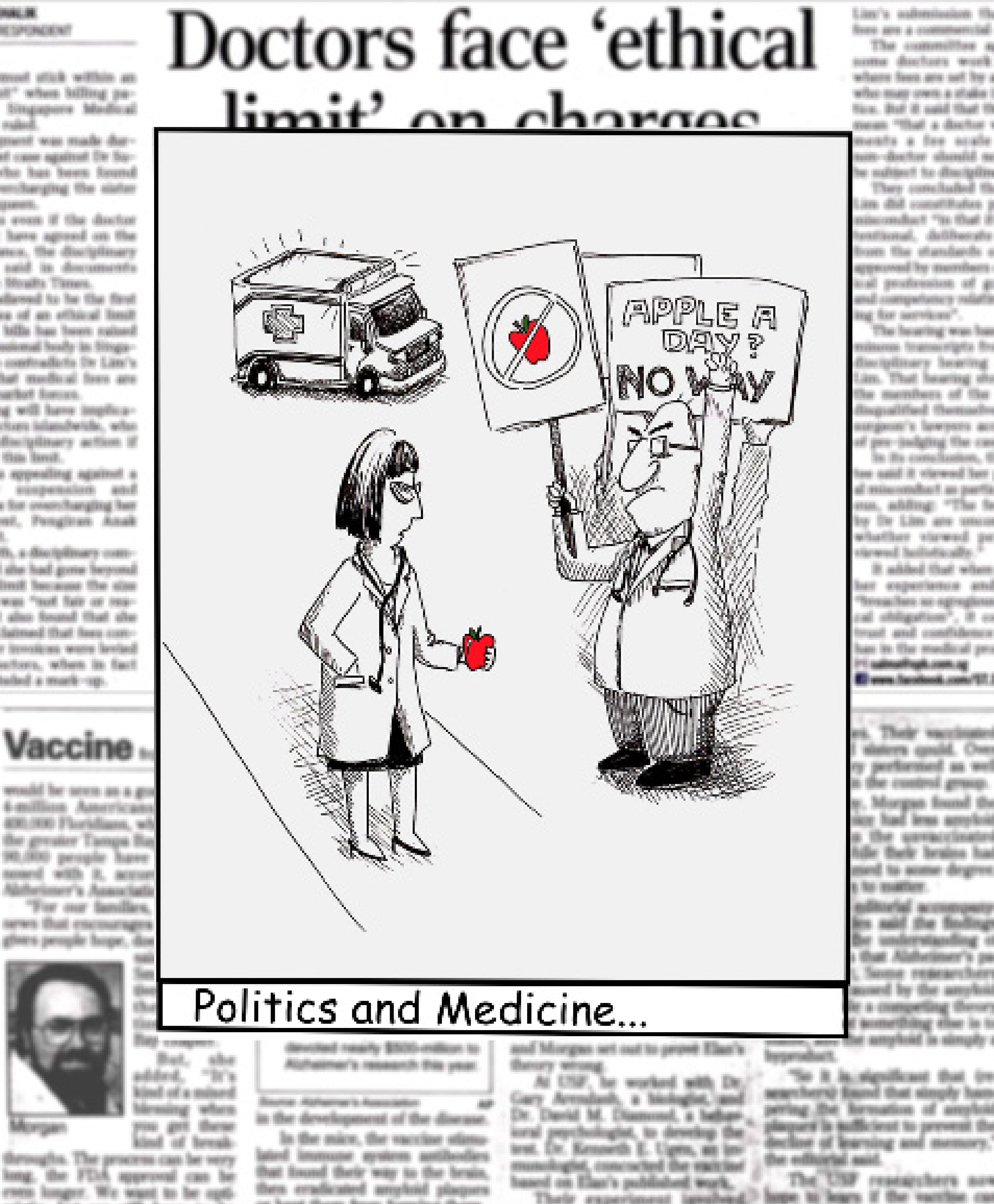
Politics and medicine, however, are at times inseparable. Medicine is a constantly changing discipline; not only does medical science advance relentlessly with time, the economic management of healthcare and perspectives on social issues affecting population health continuously evolve. And politics is a powerful medium for change and advocacy. This issue of QMR could not come at a more relevant time, as political discourse in our own country right now, particularly in Ontario, has reached a fever pitch with the announcement of further cuts to healthcare services and physician pay. Beginning October 1st, Kathleen Wynn and her Liberal government have promised to reduce the healthcare budget by 1.3%, which translates into $580 million slashed. This is on top of the previous cuts that occurred under former Premier Dalton McGuinty in 2012, totalling to a 6.9% reduction in healthcare spending in the last few years. After October 1st, if a physician's billing exceeds the arbitrary annual salary cap set by the government, that physician will go unpaid for any services he or she provides for the rest of the year. It also came as a shock when the government announced that new doctors will be barred from joining Family Health Teams, which were a laudable vision championed by

Queen's own Dr. Ruth Wilson. Needless to say, in the face of an aging population, doctors are baffled and outraged. Who will speak for the millions of patients in Ontario without a family doctor? Who will speak for patients as they face longer wait times for necessary, time-dependent medical care? Physicians are the voice of resistance against these short-sighted policies, and should view their involvement in these political issues as a duty to patients across the province.

I, along with the entire Class of 2017, was privileged recently to receive a lecture by Dr. Ryan Meili entitled "Social Accountability at the Heart of Medicine." Dr. Meili is a family physician in Saskatchewan and spends a significant portion of his time and energy advocating for a healthier society. His list of achievements is noble and impressive—he is worth looking up. His primary message to us was that our healthcare system is designed to encourage the practice of "downstream medicine." If a patient arrives with a lengthy history of IV drug use, sexual abuse, and homelessness, we do what we can for that individual to improve his or her circumstance. We might direct this patient to social services that provide addictions counselling, safe shelter, and medications that aim to reduce the risk of further drug use. These are all good things, but do they really get to the crux of the problem? Dr. Meili advocates for "upstream medicine." The underlying ailment this fictional patient suffers from is poverty. Poverty is a systemic problem, and we need a systemic solution. Dr. Meili presented his approach to this problem by quoting Rudolph Virchow: "Politics is[…] medicine on a large scale." It is through political activism that the waves of change can truly be realized. As Dr. Meili explained, working in a street health clinic treats patients one at a time, but speaking up in one's community has the potential to treat countless patients now and through the future. This is a crucial aspect of preventative medicine, which I think most physicians would agree is the best kind.

So, should medicine be political? There are clearly times when we should overcome the barriers posed by political conflicts in order to deliver the best, purest medicine. But there are other times when serious political and social issues intrinsic to medicine directly affect health outcomes, and, therefore, simply cannot be ignored.

Back cover by Alyssa Lip



Politics and Medicine...