A plea, an apology and a revelation

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Let us never forget that we are all on the same team, whose only goal is the patient's well-being.

I work in a rural community of 5000 people nestled between 2 mountain ranges on the Trans-Canada Highway. I am a general surgeon and the only specialist in town. Ours is an 8-bed hospital, with a single operating room (smaller than most people's bedrooms), a delivery room and a 5-bed emergency department, including a recently renovated trauma bay. We have 6 units of packed red blood cells on hand, no platelets and no fresh frozen plasma.

Recently, a 67-year-old patient with diabetes presented to the emergency department with a 12-hour history of pain in her foot that now involved her leg up to the groin. This was despite peripheral neuropathy that normally left her foot completely numb. A plain film radiograph revealed extensive tracking of subcutaneous air in what remained of her foot following a mid-foot amputation a year ago for end-stage vascular disease.

This could have been the case of the 4-month-old baby with *Staphylococcus aureus* septicemia, the 2-month-old infant with acute congestive heart failure or the 59-year-old patient with acute gastrointestinal bleed from a duodenal tumour. Regardless, in each case, urgent tertiary care was required. In this particular case, our emergency physician contacted transport agencies, and 2 hours later we were speaking with a consultant who proceeded to question the necessity of the transfer: "If she has no fever, she can't be that sick"; "If you think she has necrotizing fasciitis, why don't you just incise the skin to see if the fascial planes are involved?"; "Her white count is normal? Well, she can't be that sick." The thought process was obviously driven by a desire to find a reason not to accept the patient in transfer.

I know, because I used to be on that end of the line. Until 5 years ago, I practised as an academic surgeon in that very same facility. I remember the telephone calls from physicians in rural communities late in the evening after I had finished 10 emergency consultations and still had 4 cases to attend to in the operating room that night. I honestly can't recall the tone of my conversations, but, if I was ever rude, I sincerely apologize.

I do remember, during my days of training, the close relationship that existed between referring physicians and consultants. One of my preceptors still had a family physician who would come to assist when his patients were having surgery. Medical professionals from rural communities would contact a consultant directly by telephone because they had a personal and professional relationship, which greatly facilitated communication and the understanding of a patient's problem.

When I left the big centre, I believe some of my colleagues were dismayed: "Why would you want to throw all this away?" "You're going to give up all your skills?"

Well, let me tell you. I share an office with a fine group of family physicians, each of whom has expertise in a particular domain: anesthesiology, obstetrics, emergency medicine, critical care, bedside ultrasonography and alternative medicine. My own expertise is one part of the services we are able to provide. Consultations can take place almost immediately and occur in both directions. Just as I am able to assist with a surgical issue, someone is always at hand to assist me with a nonsurgical

aspect of a patient's problem. I believe we are able to provide a more holistic approach. Far from losing skills, I've gained an entirely new set of abilities.

Decision-making now involves many more factors: availability of diagnostic tests, medication and equipment; skill level of staff; time to transport; weather; road closures; and course of a condition with or without treatment. Sometimes a situation occurs in which it is necessary to perform a more complex procedure than we would normally consider. When the patient says, "Doc, do what you think is best, I trust you," I feel the weight of the world on my shoulders. For all intents and purposes, each patient is a neighbour. A surgical procedure never has a guaranteed outcome. The reward comes when I meet that same patient in the grocery store and they tell me, "Doc, I haven't felt this great in a year," or "You know, I'm glad you talked me out of that operation."

The chasm between urban and rural medicine has been revealed to me. They truly are 2 solitudes. I see the growth of bureaucratic systems intended to manage increasingly more complex organizations getting in the way of collaboration between urban and rural practitioners. Rural communities are left with more difficult access to diagnostic tests and treatments. Physicians in urban centres have more than enough work. Both have increasingly limited resources, and they don't know each other. There really is no incentive to take on the problems of other communities. To compound the problem, provinces are becoming more protective and limiting out-of-province patients from accessing their services, which negatively affects small border communities.

I don't have a solution in my pocket, but I know there are a lot of highly qualified hard-working people in the trenches who continue to do the best they can with what they have. Whether you are requesting or providing assistance, think of that the next time you pick up the telephone to speak with a colleague.

Competing interests: None declared.

Country Cardiograms

Have you encountered a challenging ECG lately?

In most issues of *CJRM* an ECG is presented and questions are asked.

On another page, the case is discussed and the answer is provided.

Please submit cases, including a copy of the ECG, to Suzanne Kingsmill, Managing Editor, *CJRM*, 45 Overlea Blvd., P.O. Box 22015, Toronto ON M4H 1N9; cjrm@cjrm.net

Cardiogrammes ruraux

Avez-vous eu à décrypter un ECG particulièrement difficile récemment?

Dans la plupart des numéros du *JCMR*, nous présentons un ECG assorti de questions. Les réponses et une discussion du cas sont affichées sur une autre page.

Veuillez présenter les cas, accompagnés d'une copy de l'ECG, à Suzanne Kingsmill, rédactrice administrative, *JCMR*, 45, boul. Overlea, C. P. 22015, Toronto (Ontario) M4H 1N9 ; cjrm@cjrm.net