WHAT DID *YOU* LEARN AT THE CAEP CONFERENCE IN CALGARY?

To the editor: CAEP 2009 started with a bang. Lewis Goldfrank, a man who leads by example and was a civil libertarian before it was in vogue, gave the opening plenary speech. He stated that we all have a duty to advocate for ALL of our patients. I first read about and admired Dr. Goldfrank in *Emergency Doctor* (published originally in 1987).[1]

Then there was a surprise gift. John O'Connor, a family physician who went to Fort Chipewyan, Alta., discovered high rates of rare malignancies at younger ages in the population. The malignancies began to show up after the population's homeland became downstream of the Athabasca oil sands. According to his report, Health Canada and the Alberta Medical Association (AMA) have attempted to silence him. There is still a pending complaint from the AMA that he is inciting fear in his patients. His patients will tell you he has given them hope. He too says it is our duty to advocate for our patients. Watch the documentary *Downstream*[2] and be prepared to be enraged.

Grant Innes, in his plenary address, advised us to be a part of the solution, for if you are not, then you are part of the problem. Overtreatment equates to denial of care because we must not only be aware of the patient immediately in front of us, but also the patient who is waiting.

Which brings me to the point of this letter. I went to a session in which the speaker debated the ethics of a letter that my colleagues and I handed out to selected patients regarding the unsafe situation in our emergency department, which was a result of overcrowding and hallway "medicine." It was suggested that involving patients in this manner and perhaps inciting fear, or coercing vulnerable patients might not be ethical. I can't help but wonder if we really think patients are that stupid? When my patients are lying in the hall, they already know it is an unsafe situation. When they are in the waiting room on stretchers, with patients expelling all varieties of bodily fluid beside them, and they are in pain and not being treated, they know it is wrong. We all have seen the headlines of a patient who died after sitting or lying unnoticed in a waiting room for 32 hours. Doing nothing is unethical, and using the excuse that you might incite fear is shameful. The outcome of our short-lived campaign, although not a complete victory, definitely improved the plight of our patients and others in British Columbia, and forced the government to pay attention. Would I do it again? In a heartbeat.

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REFERENCES

1. Zieglar E. *Emergency doctor*. New York (NY): Ballantine Books; 1988.

2. *Downstream* [documentary film]. New York (NY): Babelgum; 2008. Available: www.downstreamdoc.com (accessed 2009 Aug 5).

Letters will be considered for publication if they relate to topics of interest to emergency physicians in urban, rural, community or academic settings. Letters responding to a previously published *CJEM* article should reach *CJEM* head office in Vancouver (see masthead for details) within 6 weeks of the article's publication. Letters should be limited to 400 words and 5 references. For reasons of space, letters may be edited for brevity and clarity.

Les lettres seront considérées pour publication si elles sont pertinentes à la médecine d'urgence en milieu urbain, rural, communautaire ou universitaire. Les lettres en réponse à des articles du *JCMU* publiés antérieurement devraient parvenir au siège social du *JCMU* à Vancouver (voir titre pour plus de détails) moins de six semaines après la parution de l'article en question. Les lettres ne devraient pas avoir plus de 400 mots et cinq références. Pour des raisons d'espace et par souci de concision et de clarté, certaines lettres pourraient être modifiées.

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