Medical Reform

Newsletter of the Medical Reform Group

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GORDON GUYATT

The legitimate aspirations of advocacy groups such as the Medical Reform Group are to influence the way individuals think about issues and to ultimately influence public policy. Groups work hard to get the message out – in the case of the MRG sometimes with considerable success, sometimes with less success – to gain media exposure, and to secure the ear and the attention of policy-makers, including the government.

Media attention is a reward, and allows one to think that perhaps one is having an influence. Public action consistent with one's beliefs – for instance, the recent Ontario government decision, in the face of federal government withdrawal of funding for refugee health, to step in with support – also allows a sense that perhaps efforts have had an impact. There is always, however, uncertainty. Of all the many, many, forces at work, to what extent has a particular contribution played an important role? Or indeed, if one is pessimistic, any role at all.

These considerations bedevil any reflections on the importance, and impact, of the MRG on public and health professional attitudes, and on public policy. Nevertheless, it is worth reflecting on the state of health care policy at the time of the founding of the MRG in 1979, and how things have evolved in that time, seen through the lens of MRG activity.

Following the introduction of Medicare as a federal government plan in 1968, and buy-in from the 10 provinces in the next couple of years, the program had a honeymoon of acceptance by doctors (whose income increased appreciably as a result of the program) and enormous popularity among the general public. Indeed, it was in this initial period that the notion of Medicare as representing a core Canadian value developed.

By the mid-1970's doctors were becoming dissatisfied with Medicare remunerations which, with less vigorous economic growth, were not keeping up with inflation. The result was "opting out" – charging additional fees to patients. The practice became sufficiently widespread, and the magnitude of the fees sufficiently great, that many – including the newly formed MRG - started to question whether the intent of Medicare, access to physician services without barriers of payment that would create care inequities, was being seriously undermined.

In 1980, the short-lived government of Joe Clark, recognizing the problem, asked Emmett Hall to Chair a commission looking at the

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INSIDE

After 35 years, the Medical Reform Group decided to wind up operations in June, 2014. To mark the occasion, members were invited to offer reflections, reminiscences, and analysis on the history and role of the organization in our political landscape. Here are the contributions we received:

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Editorial committee this issue: Ahmed Bayoumi, Steffen Thomas de Kok, Janet Maher

The Medical Reform Group is an organization of physicians, medical students and others concerned with the health care system. The Medical Reform Group was founded in 1979 on the basis of the following principles:

1. **Health Care is a Right.** The universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary or other deterrent to equal care.

2. **Health is Political and Social in Nature.** Health care workers, including physicians, should seek out and recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication.

3. **The Institutions of the Health System Must Be Changed.** The health care system should be structured in a manner in which the equally valuable contribution of all health care workers is recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

GORDON GUYATT (continued)

issue. Justice Hall had, in the mid-1960's, been responsible for the first Hall report that laid out the plan for what became Medicare. The MRG, in its first major public action, submitted a brief to the second Hall Commission. The Commission's recommendation that premiums constituted a regressive tax and a deterrent to equal care and should gradually be phased out and that user fees, including extra billing and opting out, threatened the very principles on which national health insurance was constructed, and must be eliminated. The conclusions were completely consistent with the MRG submission. Did we have an influence? As always, we do what we can and hope the answer is yes.

Hall's recommendations lay dormant until, in 1984, federal Health Minister Monique Begin introduced the Canada Health Act, initiating a furious public debate in which the MRG vigorously participated. MRG members spoke at educational sessions sponsored by the Ontario Health Coalition, presented a submission to the House of Commons health care committee, and countered the misleading statements made by the OMA and the National Citizens Coalition concerning the Canada Health Act. MRG members debated representatives of the OMA. The public support for the act was ultimately such that it was passed unanimously by the federal parliament.

During the two years after the passage of the Canada Health Act, provinces introduced legislation to stop extra billing. The Ontario legislation, introduced in December 1985, precipitated an OMA-led rotating doctors' strikes that began in February, and became a full strike in late May. The government passed their legislation on June 20. The strike collapsed in the following weeks; the OMA called it off at the beginning of July.

During intense and often acrimonious debates, the MRG was spectacularly effective in presenting its position in support of the legislation. We repeatedly pointed out fallacious arguments the OMA was using: that extra billing was an effective way to control costs; that patients didn't suffer as a result of extra billing; that extra billing was a mechanism to reward superior physicians; and that physician autonomy in practice would be compromised by the legislation. Credible challenges to these points could only have come from within the profession, and our responses compromised the OMA's ability to spread misinformation.

With each major event in the drama, the media described both the OMA position and the MRG reaction. This was true of newspapers, radio, and television. The MRG was included in special news presentations about the extra billing legislation and the doctors' response, and our position was presented in major published articles in the Globe and Mail and Toronto Star (op-ed pieces in both), the Hamilton Spectator, and the London Free Press.

One testimony to our impact was an editorial that appeared in Ontario Medicine, the OMA's official journal, after the strike was over. It castigated the media for its coverage of the MRG, providing a good description of the MRG's effectiveness: "Perhaps the most disturbing breach of journalism ethics evident in some of the news media, particularly the Toronto Star, the Globe and

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Mail and the CBC, is their insistence on including, with virtually every comment by the O.M.A., a contrary statement by the Medical Reform Group. It isn't so much their statements that rankles, but the fact that such an insignificant rump group is given "equal time" with the recognized representatives of Ontario's 18,000 physicians."

Did the MRG widely-publicized position, hugely undermining the image of a medical profession united against the legislation, help firm up the Ontario government's resolve to pass the legislation? Perhaps. We do know that Monique Begin was expressing gratitude for the MRG's support for the Canada Health Act and the legislation it fostered several decades after the event.

The Canada Health Act and the subsequent provincial legislation muted the debate about universal health care for a number of years, but it heated up seriously again in the 1990's with the recession and large reductions in federal transfer payments to the provinces. Opponents of Medicare began to talk about sustainability – a buzz word prominent in the debates since that time. The attacks reached a crescendo prior to Roy Romanow's appointment as a single person Commissioner to study Canadian health care.

Again, the MRG participated vigorously in the debate engendered by Romanow, whose conclusions in his 2002 report were completely consistent with MRG policy: that Canadians place a high value in equitable health care and that universal health care is not only necessary for equity, but is far more efficient than private health care alternatives. Again, the debate settled, this time only for a couple of years. Attacks on Medicare, claiming inefficiency and unsustainability, have been a regular part of the public discourse since.

In 1997, Janet Maher wrote "Medicare, the sacred trust of Canadians… is unlikely to survive the current round of deficit reduction and all too likely to undergo further attacks from NAFTA." Well, with some erosion around the edges, Medicare has survived and in areas of hospital and physician services, Canadians continue to overwhelmingly receive equitable high quality health care. The continual attacks on Medicare have been met by continual retorts and evidence presentations by the MRG, and the attacks have essentially failed. Am I drawing a cause and effect relationship? Well……

Before closing, I would like to draw attention to two MRG initiatives largely unrelated to the primary focus on universal health care. The MRG was very active in the abortion rights debate that ultimately led to Canadian women having largely unrestricted access to first trimester pregnancy termination. The MRG also played a major advocacy role in the ultimately successful fight for legislation establishing an important role for midwives in Canadian health care delivery.

While advocacy in such areas has been very important for the MRG, the major focus has always been on ensuring equitable access to high quality care without barriers of cost. Today, the Canadian Doctors for Medicare is leading Canadian physicians in defending, and advocating for extending, Medicare. CDM, with a national profile, funding greater than the MRG was ever able to generate, excellent leadership and superb political smarts, is doing a brilliant job for Canadian progressive health advocacy. As we pass on the torch to CDM, and to other health care groups that have shared the MRG mission (the Ontario and Canadian Health Coalitions, Health Providers Against Poverty, and many others), we can do so with great confidence that our mission will carry on as, or more, effectively than we have managed. We can do so with pride in what we have accomplished, and the role models we have set for subsequent generations of activist physicians.♦

CONTRIBUTION TO THE ONTARIO ARCHIVES

As part of our windup activities, we have been discussing the donation of our important documents with the Ontario Archives, and more information should be available on that process shortly.

If you have materials you think should be part of the donation, or have any other questions about our archive plans, please contact Janet Maher at medicalreform@sympatico.ca.♦

DANIELLE MARTIN

What inspired a group of physicians from across the country to start Canadian Doctors for Medicare?

In 2005, the Supreme Court of Canada released its decision in Chaoulli, the case of a Quebec physician who argued that his patient's constitutional right to security of the person had been violated under the Quebec Charter of Human Rights and Freedoms by the ban on private insurance in the province of Quebec. The court found that in the setting of long wait times, Quebec patients should not be prohibited from purchasing insurance privately if the Quebec government was not able or willing to respond to their need for timely access to medical care. The ruling, though applicable only in Quebec, was seen as a victory for advocates of two-tier health care elsewhere in Canada.

In the midst of this period of upheaval and uncertainty for Canadian health care and Canadian medicine, an outspoken advocate of health care privatization was elected president of the Canadian Medical Association. The election of Dr. Brian Day led many to believe that Canadian doctors had given up on Medicare, and that a "modern" health care system could not deliver on the fundamental promise of equitable access to health care based on need, rather than ability to pay.

Yet public support for Medicare has always been strong, and most Canadian physicians choose to practice medicine because they want to serve those patients who need care the most. As would be expected, the Medical Reform Group opposed the election of Dr. Day as well as the Supreme Court's decision in the Chaoulli case. The MRG had always been highly engaged in the protection and improvement of publicly funded health care, but its reach was mostly within Ontario and the range of issues on which it spoke out was broad. Galvanized by these threats to publicly-funded health care, and recognizing that a national voice was needed on a more narrow scope of issues to build a broad coalition of physicians who support Medicare, a group of Canadian doctors from across the country came together to launch Canadian Doctors for Medicare. Many of the founders of Canadian Doctors for Medicare came out of the MRG, myself included. As strong believers in the principles of Medicare, we knew that the majority of doctors needed a voice for their support of those principles. Thus, Canadian Doctors for Medicare was started to serve as the pan-Canadian voice for doctors who believe in "a high-quality, equitable, sustainable health system built on the best available evidence as the highest expression of Canadians caring for one another".

CDM has since grown into a vibrant organization with thousands of members in all 13 provinces and territories, and it has had significant impact in the policy debate. We were especially proud to see that just 2 years after the election of Dr. Brian Day, the Canadian Medical Association chose Dr. Jeffrey Turnbull as its president. Dr. Turnbull has received the Order of Canada for his work with people who are homeless in Ottawa. Subsequent presidents of the Canadian Medical Association have also forcefully argued that access to be care should be based on need, not ability to pay.

Supporting public health care does not mean being apologists for the status quo. Both the MRG and CDM know that we need to acknowledge the challenges and failings of our system, while advocating for innovations and improvements that will benefit all our patients, not just those who can afford to pay. From wait time initiatives to primary care innovations, both the MRG and CDM have been at the forefront of the movement to innovate and improve health care delivery through reforms that are based in evidence – not ideology – and that respect the fundamental values of Canadians.

As we mark this moment of transition for the Medical Reform Group, the Board of Canadian Doctors for Medicare wants to acknowledge our huge debt to the founders and leaders of the MRG. CDM, along with Doctors for Refugee Care, Health Care Providers Against Poverty, and so many other progressive physician groups, could not have found a voice without the trailblazing work of the MRG pioneers on issues of social justice and public health care.

We look forward to ongoing collaboration with the MRG's committed members, and offer you membership in CDM should you wish to continue your efforts to advance that legacy.♦

JOEL LEXCHIN

The Medical Reform Group has been an important part of my political life almost since it was formed over three decades ago. First, and most important, were the principles that the MRG enunciated. These were principles that I went into medical school with and that I still believe in – health care is a right, health is political and social in nature, and the institutions of the health system must be changed. The MRG also showed me that I was not alone in my beliefs. Going through medical school and residency, it's easy to believe that you're alone when you have these sorts of beliefs since political talk is not encouraged. Finally, the MRG supported me on the issue that I have focused on even before becoming a doctor – pharmaceutical policy including how drugs are promoted by the companies, the price of drugs, and the influence that the pharmaceutical industry has on government policy, the medical profession, and patients and consumers.

The MRG was a place where important health issues were debated including those about pharmaceutical policy. This is a complex topic and often one that is ignored or only superficially dealt with, even by doctors and academics. However, within the MRG there was always a core group of people who knew about the issues and were prepared to discuss them either early on in the organization's history when resolutions were brought forth or later on in informal discussions. On a personal level, I learned enormously from these debates and discussions.

Over the years, I have submitted numerous briefs to various governmental bodies on behalf of the MRG and spoken to the media as a MRG representative. It was very important for me to know that what I was saying was not going to be seen as just my opinion but that it was going to be backed up by the MRG, an organization that represented doctors who are intimately involved with pharmaceuticals at many levels. The support of the MRG was crucial in having what I said be taken seriously.

The exact topics that I wrote and spoke about on behalf of the MRG are not that important but the values that were behind the various communications are. In the early 1980s, the MRG appeared before the federal Eastman Commission, which was looking into the use of compulsory licensing. This was a policy that was instrumental in getting lower priced generics to market. We were talking about making sure that people would be able to afford the drugs that were being prescribed for them; in-other-words, about social equity. When the Conservatives under Brian Mulroney were getting rid of compulsory licensing because of provisions in the Free Trade Agreement with the US, the North American Free Trade Agreement and the World Trade Agreement, the MRG was there again defending the right of people to have access to affordable medications.

In 2003, the MRG testified in front of the House of Commons Standing Committee on Health and talked about the problems with the Canadian drug approval system and how drugs of questionable value were being marketed in Canada. We also talked about how drugs were being promoted to doctors and to the public and how this was leading to the misprescribing and misuse of prescription drugs. The MRG was back before the same committee in 2005 pointing out the necessity for transparency in the drug approval process; that Canadian doctors and patients had a right to have access to all of the information about the effectiveness and safety of drugs, not just what the drug companies wanted us to see. We also emphasized that relatively little was being done to monitor the safety of drugs once they reached the market and called for the government to devote considerably more resources to making sure that safety was prioritized.

The MRG was not only active on drug issues on the federal level but we also were being heard at the provincial level. In 2006, we made a presentation to the Standing Committee on Social Policy of the Ontario Legislature about the importance of making sure that generics were available in a timely fashion so that they could be listed on the Ontario Drug Benefit Formulary and be made available to patients who needed them and also to help the government save money on its growing drug bill.

There is no way of being sure how much of an impact the MRG made on its own, but on drug issues it was usually part of a group of progressive voices speaking up for social values and that made it hard to ignore by the media, politicians and bureaucrats. On many of these occasions, the MRG was often in the lead.

The opportunity to appear before all of these committees and politicians was valuable to me on a personal level as I learned how to interact with people in power and how to be able to make a case for the issues and values that I believed in. The MRG also was an entry to meeting people who I would otherwise

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JOEL LEXCHIN (continued)

probably have not known. Being part of the MRG meant that I was in contact with organizations like the Canadian Health Coalition and as a result, I became part of its network of people around pharmaceutical policy issues, a role that I continue to fulfill.

Finally, and on a completely different note, the MRG is responsible for me meeting and marrying Catherine Oliver, who was also a MRG member. When Catherine was working in Moose Factory in the early 1980s, she came to one of the early MRG meetings in Toronto. Later, when we were both at a general practice update in Montreal, she was looking through the list of attendees and recognized Bob James' name from the MRG meeting she had attended. She came over to say hello to Bob, Bob introduced her to me, and the rest is history.

Other physicians' organizations have formed since the MRG started and are gradually taking over from it and continuing to fight for the values that the MRG has stood for, but without the MRG I don't think that we would be seeing these groups. The MRG broke the ground and showed doctors, politicians and the public that there were doctors who were willing to stand up for progressive social values and be heard.♦

ROSANA PELLIZZARI

My earliest recollection of the MRG dates back to 1983, when I was working as a community organizer in First Nation communities. Somehow, I came across the organization, just at the same time that I was reading Vicente Navarro's book, "Medicine Under Capitalism". I had made the decision to apply to McMaster for medical school and much to my surprise, had been accepted. Hence, Navarro's book. One of the first resolutions I made that summer, as I was preparing for admission, was to join the MRG as soon as possible. I thought of it as one of my lifelines, and in many ways, that's what it became.

Becoming a physician was never on the cards when I was growing up in my Italian, immigrant family. I was the only sibling to obtain any post-secondary education, and I did it on my own dime, working three jobs to keep myself housed and inadequately fed. By the time I started my medical studies, I had two young children and a husband that worked for an international development NGO. We happily survived on a shoestring. We set up my desk in the same basement room where we hung the diapers to dry and found a carpool buddy. It became apparent within hours of my first day at Mac that I was swimming in a new sea with unfamiliar species unlike anyone I had ever known previously. I desperately needed to align myself with others who had a yearning for social justice and for whom medicine was a social good and access to health care, a right. I became an active member of the MRG as soon as it was physically possible.

Looking back now, my two children learned to say "EM-ARE-GEE" early in life, and added the acronym to their expanding vocabularies. They got used to seeing groups of people coming in to our living room for monthly meetings of the Hamilton chapter of the MRG, and to hearing lots of chatter and animated discussion as background noise to bedtime stories upstairs. "Gord" became another adult friend of the family who has remained on a first name basis with them as they have grown up. Besides the learning of medicine, my engagement in the MRG provided both the context and the frame of reference; the bright ideas; and the vehicle for advocacy that filled in the gaps and helped to make those years of medical formation so much more meaningful. And of course, it also served as the introduction to great minds and great souls like Clyde Hertzman, whose legacy in early childhood development lives on despite his untimely death.

I looked forward to those semi-annual meetings held at the South Riverdale CHC both as an opportunity to see steering committee members in action, but also to meet the Toronto members. I remember spending moments in the kitchen with Mimi Divinsky as she fluttered about, making sure there was fresh tea for everyone *[Editor's Note: Mimi died in 2007]*.

I recall how much I enjoyed the debates between veterans like Michael Rachlis, Philip Berger, John Frank and others, so much wiser, if not older, than I.

Being a part of the MRG steering committee, from my introduction to this privileged and esteemed profession, has itself been an honour and a privilege. I can think of no better foundation for medical leadership, education and leadership. And although its time has run its course, how comforting to know that new medical students across this country have the option of joining Canadian Doctors for Medicare as a national movement to ensure that access to health care is protected in all 13 provinces and territories. It's been a great ride!♦

CATHY CROWE

I had the extraordinary experience of being one of the only non-physician members of the MRG for about 20 years. How I got there is relevant to MRG's long purpose and struggle for health and justice.

I came to work at South Riverdale Community Health Centre and met MRG docs Michael Rachlis, Phil Berger, Debby Copes and Abe Hirsch, having worked for several doctors on Bay Street. This was during a period that saw Medicare at its worst: physicians with essentially a licensed monopoly to practice their profession under a fee-for-service system; the growth of private walk-in clinics, private diagnostic labs and other health businesses; and huge inroads by pharmaceutical companies to the doctors' waiting room ultimately influencing their prescribing patterns. Medicare's structure of course also meant that with the expansion of health care technology and specialization, physicians had powerful incentives to recruit a certain type of patient and provide expensive tests, services and therapies. I saw it first hand.

The Bay Street medical practice (read: business) of these general practitioners was considered to be an elite and executive one, catering to the business class and specifically corporations through the provision of 'executive physicals' – for a price. This was a period when extra-billing meant billing the provincial health plan (OHIP) plus billing over and above that to the patient or corporation.

These doctors were the medical directors for a huge number of corporations ranging from banks to publishing houses to companies delving into Canada's natural resources. For a hefty price, a complete annual physical would include pulmonary functions, an electrocardiogram, blood work and other procedures such as sigmoidoscopies. These doctors had the luxury to implement their own version of "cherry-picking" – refusing to take on new patients who would require too much care (seniors who might need home visits, people with chronic illness, women with children) and instead choosing a more easily manageable patient group. I recall an extremely fit patient population. Many of the men were marathoners with downtown fitness club memberships. Ironically, their extremely good health status had little to do with the quality of medical care they received. They already came quite healthy to the doctor and later, thanks to a few MRG members, I came to understand more about the role that income level plays in health and health care.

When the Bay Street doctors suggested I start extra-billing for my nursing services – that was it. I quit and fortunately landed at South Riverdale CHC where I literally went through many debriefs about my experience while I was re-orientated to what health and health care was all about.

I thrived during this period and was inspired by daily conversations either in the clinic or on house calls with the MRGers. I joined the group, attended lots of meetings and watched and absorbed as MRGers wrote press conferences, did media interviews, lobbied politicians, held workshops. Even more important, I saw their policy wins – a huge one being the ban against extra-billing.

In the 1980s I remember sitting in a circle at a MRG meeting where members were contemplating shutting down. I spoke strongly that they did not have the right to make that decision, that they were too valuable in the fight to save Medicare. Surely, that decision can be made easier in these times with social justice more ingrained in medical schools, with new and emerging groups such a Health Care Providers Against Poverty and Canadian Doctors for Refugee Care, to name a few.

With deep appreciation I thank all of the MRG members including Janet Maher who always kept me in the loop, welcomed me, and supported my work as I branched out in the area of homeless health care as a street nurse. For a long period, there was not a place for me as an activist nurse within organized nursing. I liken my time working with MRG members to an incubation period that clearly influenced my launching of Nurses for Social Responsibility, my advocacy role as a street nurse, and the founding of Toronto Disaster Relief Committee that declared homelessness a national disaster.

Health is justice!♦

RITIKA GOEL

Physicians have always uniquely straddled two worlds. We spend our lives in the service of others - diagnosing, treating, healing - often seen as being part of a noble profession. However, unlike really any other service providers, we are, in most Western nations, part of the economic and social elite. Spending many years in training with grueling call shifts and being put in stressful situations while simultaneously learning medicine's hidden curriculum, young idealistic medical students often turn into entitled wealthy doctors who fail to see the inequity between themselves and their colleagues, as well as themselves and their patients. Sadly, this has often put physicians at odds with the interests of the people they serve.

Unfortunately for us in the profession, we know all too well that physicians have stood in opposition, time and time again, to a universal publicly funded healthcare system in Canada. First in Saskatechewan in 1962, then in Ontario in 1986, and subsequently through arguments in favour of privatization brought forth by prominent physicians often leading key physician organizations. It is this reality that makes the Medical Reform Group that much more important in our historical landscape. As the exception to the rule, the MRG has always role-modelled what physicians should do in defense of our patients and society, rather our own class interests.

The day I interviewed for medical school at McMaster, I remember being asked to write a short piece about advocacy. At the time, this word was strange and unfamiliar to me, and I had little to write. My world of advocacy began with the Medical Reform Group. I, like many other students, freshly minted into this world of healthcare, yearned to understand the context of my future work, something rarely discussed in classrooms. I was one of those young idealistic medical students, knowing I wanted to help people and make a difference, but not understanding what any of it really meant. I met Gordon Guyatt in this context - a larger-than-life figure, introduced to us as the founder of evidence-based medicine, who taught us about the healthcare system, and told us about the Medical Reform Group, an organization of physicians, residents and medical students that supported publicly funded healthcare in Canada.

This was around the same time that Brian Day became president of the CMA. I attended one of his talks and it dawned on me how easily the story of Medicare in Canada could be twisted to make well-meaning medical students support privatization. The MRG was the first model I had for people in the medical field standing up for what they believe in and taking action to make it a reality. It was this fear of the potential consequences of uninformed young medical students getting manipulated, and a clear role model of physician activism in the MRG that helped us form Students for Medicare.

Michaela Beder and I from the MRG along with our friend and nursing student, Sarah Reaburn, wanted to have a student-led organization from across the healthcare disciplines, which engaged the future healthcare providers of Canada and challenged the faulty arguments regularly being presented in support of privatization. Working alongside the Ontario Health Coalition and the Medical Reform Group, we held conferences, debates and panel discussions and joined rallies to show our support for public healthcare. MRG members were always present - to speak at our events, to provide guidance in planning, and even helping fund our first conference held in honour of long time MRG member Mimi Divinsky who had recently passed away.

Many members of Students for Medicare went on to form Health for All, an organization that focuses on migrant justice and the access to healthcare for the approximately half million uninsured in Canada. Given what we knew about the benefits of a publicly-funded system, it felt egregious that such a right would not be extended to all people in this country, to truly have a universal system as we often call it. We brought in an analysis that included broader migrant justice, an understanding of Canada's complicity in global trends that lead to migration and made links with the history of colonization of this land. MRG members have also been instrumental in founding Canadian Doctors for Medicare, Health Providers Against Poverty, Doctors for Fair Taxation, and various other organizations.

The MRG's greatest success has been creating a precedent within the physician community, one in which activism is often frowned upon, and few are willing to discuss issues that implicate themselves such as income inequality. It has allowed space for us within this community to see the importance of speaking out and demonstrated the outcomes that can be achieved in doing so.

Today, we have a CMA president who has openly endorsed a national pharmacare program. We have

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RITIKA GOEL (continued)

a report from the CMA which endorses a national poverty reduction strategy and calls for investigation into guaranteed annual income. Today, we regularly hear conversations about the role of advocacy in medicine and increasingly, those of us involved in social justice work are being lauded rather than ostracized for our involvement. We have the MRG to thank for creating the conditions that have allowed all this to occur.

Throughout the years, as I have gone in and out of various organizations and worked on various issues, I have remained an active organizer with the MRG. It has always grounded me and has always been a place to come to for passionate conversation, engaging in action, mentorship, and friendship. In recent years, we have frequently debated the role of the MRG given the new issue-based health activist organizations that have developed. The beauty of the MRG has always been its flexibility as being more than a single issue group, but rather, the progressive voice of physicians in Canada. To me the 'Medical Reform Group' was always more like 'Physicians for Social Justice' and that is how I will remember it.

To those who were around until the end - Gordon, Ahmed, Janet, Michaela and Reed - you have become close friends and allies, and I look forward to continuing the struggle alongside you, perhaps under a different banner, but always for the greater good. For me, the MRG will never end. It lives on in our hearts, and in the form of dozens of new organizations borne out of the seeds of passion and activism sown by this wonderful group of people. The MRG has helped shape my understanding of activism, and our collective consciousness which impacts our daily work, our conversations, our analysis, and our shaping of the medical community. I am proud to call myself an MRG member until the last day, and can't wait to see how its lasting impact continues to push new young medical students, residents and physicians into the fight for social justice.♦

AHMED BAYOUMI

In 1986, the minority Ontario Liberal government, with the support of New Democrats, banned user fees for health care in accordance with the passage of the Canada Health Act. As many will remember, the Ontario Medical Association staged several rallies in the spring of that year and in June, several physicians' offices and emergency rooms closed (some closures remained in place for about 25 days after which the "doctor's strike" fizzled). The lead-up to the strike and its aftermath coincided with my second year of medical school. It was an emotional time – medical students were not exempt from the often excessive and vituperative rhetoric that would be used to "defend doctors". The OMA framed their position as an attempt to defend physician autonomy against meddling governments (or against the so-called socialization of medicine) and many medical students and doctors bought into this argument.

A few voices dissented. A very brave Rosana Pellizzari stood in front of our class and defended the MRG position. I was impressed. When a rally for students was announced, about 10 students decided to present an alternative position in favour of ending extra billing, defending Medicare, and opposing the strike (the rally, I was told, was "secretly" funded by the OMA. The poster depicted a plane dropping a bomb on doctors). While we were skipping class to prepare signs and leaflets, students who disagreed with us stood at the front of the lecture hall, denounced us as traitors, and implored us to miss the rally in order to avoid drawing away attention. In the end, we decided to attend the rally with our signs and to distribute our literature but agreed not to do any media interviews.

Soon afterwards, I and another student (who later went on to have a senior role in public policy) attended an MRG meeting at the South Riverdale Community Health Centre. Everyone was warm and welcoming. Phil Berger stayed afterwards and talked to us about the history and the purpose of the MRG. I was convinced and joined.

I am relating these stories in part for the historical record but more importantly because I think there are lessons for future progressive organizations addressing health care. Of the few students who were in favour of banning extra billing, I was the only one to join the MRG. It was to be a consistent pattern throughout the next 30 years – many progressive physicians were not interested in signing up. It's worth ask-

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ing why and I think the answers lie in several contradictions about the MRG.

First, the MRG was seen as both a place for activist doctors to form a community but also as an exclusionary physicians-only organization. Many have commented how important it was to find a group of like-minded doctors and medical students. The socialization within medicine is enormous. Many MRG members were truly courageous in taking on the medical establishment. Having an alternative physicians' cohort was important when the mainstream physicians' voice was conservative to the point of being reactionary. But times have changed – right wing doctors' feelings of alienation from the OMA are real. While it is still open to criticism, the 2012 OMA agreement included a pay cut for physicians, a commitment to reduce unnecessary lab testing, targeting of groups with high needs including isolated seniors, and an acknowledgement of primary care reform. I honestly don't think the OMA would be as open to such initiatives if the MRG (and others) had not been pushing these issues for years. We can and should count such advances as MRG achievements (it's also worth noting that it will be difficult for a national organization like Canadian Doctors for Medicare (CDM) to be as involved in provincial politics as the MRG has been historically).

However, it's also worth asking how much groups like the MRG or CDM gain by being exclusive to physicians. As a long-time member commented to me upon hearing of the decision to shut down the MRG, "this is an opportunity to recast the progressive forces in health in Canada, without the inherently elitist nature of the physician-based MRG." I have heard this argument from several of my leftist physician friends as a reason for not joining the MRG. I am very happy to use the privilege I have as a physician when it will help a cause that I believe in. But physicians are hardly the only (or even the best) experts on health systems or determinants of health. Many of us are committed to principles such as patient-centred care and community-based research. I believe that we should think carefully about what this means for future physician activism as well.

A second contradiction relates to the scope of issues that we addressed. We were never just about Medicare – we have also addressed the environment and health, harm reduction services, reproductive rights, immigrant and refugee health, physician incomes, primary care reform, the organization of hospitals, and many other issues. And yet we avoided some issues, particularly those not directly related to the health sector.

A few thoughts about Medicare: Although the Cambie decision might prove me wrong, I do not believe that Canadian Medicare is under existential threat. To be sure, there are relentless attempts to impose fees and collect payments for insured services. But the commitment of Canadians to Medicare is very strong; even under the most right-wing federal government in recent history, no fundamental changes have (yet) occurred. While there is a need for progressive health care activists to be vigilant about defending Medicare, I think it is a mistake to do so without placing this in a broader context. For example, while some hospitals' attempts to attract medial tourists need critiquing, it is important to do so from a perspective that acknowledges global discrepancies in health care and the potential for such arguments to draw on latent racist sentiments. And, of course, Medicare is unfinished. There is an enormous need to address Pharmacre.

Yet Medicare needs to be examined within the Canadian social context rather than as a separate program. Perhaps the OMA has moved somewhat to the centre in the last 30 years, but society has simultaneously moved determinedly to the right. Income inequality is greater, poverty is entrenched, education is underfunded, public transportation is creaking and faltering – all of these are a direct consequence of neo-liberal economic policies. If progressive health activists only focus on protecting funding for Medicare while not addressing the broader issues of social investment across sectors, we risk making other issues worse. If the pie keeps shrinking but the health slice remains the same size, others are going hungry (sometimes literally so). This broad-based approach was fundamental to the MRG's vision and it was what most attracted me to the organization. Although not everyone always agreed with me, I thought social justice should be central to everything the MRG did and should be how we identified as an organization.

Our broad base might have been what alienated some from joining. Yet sometimes the steering committee avoided addressing broad issues because we feared alienating the membership by endorsing issues not directly related to health.

A third contradiction (the last I will discuss but certainly not the last within the MRG!) relates to our

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AHMED BAYOUMI (continued)

decision-making process. We have always relied on a small volunteer steering committee whose membership shifted over time and the scope of that Steering Committee mandate was never entirely clear. We never had a very effective method of eliciting broad input from the membership. While the steering committee composition was in some ways inherently democratic (anybody could join for any period of time), the lack of structure meant that when our steering committee membership waned, we also had no effective method for reviving it. An activist organization without an engaged membership is a contradiction that could not be overcome.

The MRG is dismantling at the right time. There are numerous activist groups working on diverse questions. The problem for activist and progressive physicians will not be finding an organization that they can join but rather deciding which one. I don't see any organization as the "natural" transition for the MRG. Perhaps the future for health activism, as with many social movements, lies in coalitions and collaborations rather than central organizations. The energy of the newest generation of physician activists – people like Ritika Goel, Andrew Pinto, Gary Bloch, Reed Siemieniuk, Michaela Beder, and others – is inspiring. The struggle continues!

A few years after joining the MRG, I got a call from Gordon Guyatt asking me to renew my membership (apparently I was late!) and I said that I would like to join the steering committee. When Ulli Diemer stepped down shortly thereafter as our administrator, I volunteered to help in hiring a replacement. Hiring Janet Maher was undoubtedly one of the best decisions the MRG ever made. She has been our treasurer, editor, public relations expert, advisor, and trusted friend. My last words as an MRG member are relevant for all of the membership but doubly so for her: Thank You and Solidarity Forever.♦

HARESH KIRPALANI

So the MRG is dead, long live the MRG!

We should remind ourselves of that old folk song:

"There is a season – turn turn turn, and a time for every season under heaven".

Well the season of the MRG has passed. What next?

Now that the MRG has made a decision to dissolve itself, it is apposite to ask what were its motive forces, what did it achieve and what led to its dissolution? Considering these issues, it is necessary both to praise the MRG – but also to critique it. To avert any misunderstanding, I must start by stating unequivocally my own view: The MRG was incredibly important in keeping progressive physicians aware of the need to actively organize to defend key principles. I believe it did act as a transmission belt of progressive issues in the "health-care" system to young medical professionals. However, if we should learn from the MRG history, and perhaps help future progressive movements – I believe it is also necessary to consider its limitations.

The MRG as a United Front – Successes and failures

A United Front aims to bring in the widest possible support to a particular movement or political position. As such it requires Principles that allow it to crystallize the essence of its goals, but yet resist the various pulls and pushes of contending forces that would narrow and limit the scope of its maximal possible support. The spirit of the United Front of the MRG was contained in the principles of the MRG. It is worth taking a moment to repeat these:

Health care is a right. The universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary deterrent to equal care.

Health is political and social in nature. Health care workers, including physicians, should seek out and recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication.

The institutions of the health system must be changed. The health care system should be structured in a manner in which the equally valuable contribution of all health care workers is recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

It was felt by the collective framers, that these clearly articulate

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a vision with which a wide range of progressive physicians would agree.

However, I would suggest that embedded in some of these principles (at least as worded) are contradictions for a United Front, that ultimately led to conflict within the MRG, and possibly limited its success. By contradictions, I mean here that the wording was such as to be so broad as to foster irreconcilable differences. To resolve these contradictions, it would have been necessary to have much fuller debate than was possible in the limited scope of the politics of the MRG. Moreover, these contradictions played out in some of the tensions in the MRG in the years of my involvement in the organization.

The First Principle is the most robust. There was (and is) relatively little to dispute in the first principle, and it can be said to serve as a unifying principle for revolutionary Marxists, for parliamentary socialists, and even for liberal humanists. Although "universal health care" is not actually what the Canadian system offers, even the most radical members would agree that in a broad comparison with the worst privateering individualistic models of the USA, the Canadian system remains far more responsive to people's needs. The key battle was (and is) the various attempts to move towards the magnetic pole exerted by the USA and its privately-based insurance system.

The MRG title had a 'codicil' "of Ontario" – and this indicates another potential Achilles heel of the first principle. To effect the Defense of Medicare in Canada, it was always necessary to have a cross-Canada presence and struggle. However - despite these quibbles, the First Principle stands the test of time in drawing progressives of all stripes to its banner.

I believe, however, that there were more problems with the Second and Third Principles. These served to attract physicians with the broadest vision of medicine. Indeed they remain very compelling even now.

As Virchow said: "All medicine is politics writ large". To back this up, Virchow took part in the barricades of the 1848 Revolutions. His formulation is not very distant from the intent (and indeed formulations) of the Second and Third Principles. So - as I see it, the problem of the Second and Third principles lies in that for fulfillment they require a perspective that is not contained in the word "reform". To be truly enactable, they require a very different vision from purely 'reformist' visions. Thus two contrasting visions were present in these two principles, and despite considerable discussion could never be resolved. To be blunt, the two visions were either the truly reformist vision of maximising the progressive possibilities within capitalism, or the class-based vision of a need to overthrow capitalism.

For example, some pointed to the need to police and restrict the delivery of new and expensive health care delivery systems for certain conditions so that more could be spent on the primary health care systems. This was contested by those pointing to "health needs" as being dynamic, and going beyond clean water and sanitation. High tech medicine (if it works) is desired by the population. New health care needs fostered by technological innovations, maybe "expensive" – but cannot be spurned. Some argued the choice is not necessarily between primary care and provision of ICU's. Rather, in a minor imperialist nation, it was for instance, more a choice of guns or primary care and ICUs.

In a related argument, some saw "doctors as the enemy" – and simply 'Greedy". Others pointed to the class nature of doctors as 'petit-bourgeoisie' and not within one camp or the other – but stuck in the middle. The implications of the latter were that they could be won to various progressive positions.

In another example, the problems of a private pharmaceutical industry that is driven by the profit motive – and how to deal with this – had two rather differing possible solutions that could never be reconciled by the MRG. Since an underlying thrust for the MRG was to include policy-makers whether in Ottawa or at Queen's Park, this effectively silenced one of the two poles. Finally, how were the positions of the Third Principle to be won – with just the ghosts of "all health care workers" being present?

What Legacy Does the MRG Leave?

All progressive organizations leave their mark for those that follow. The spoor of Tommy Douglas' movement was the followed by the MRG, and the spoor of the MRG is followed by the Canadian Doctors for Medicare. Perhaps they have even learnt from the MRG's tensions in firmly limiting their scope to this Statement of Vision and Mission:

"A high-quality, equitable, sustainable health system built on the best available evidence as the highest expression of Canadians caring for one another. Our mission is to provide a voice for Canadian doctors

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PHILIP BERGER

Please forgive this free-floating recollection of the earliest days of the MRG – none of the facts have been checked and no cross-reference was conducted with the many MRG documents boxed in my home basement. But hopefully it will provide a sense and mood of the times.

Sometime and somehow in the fall of 1978, the names Gord Guyatt and Fred Freedman – two internal medicine residents at the Toronto Western Hospital- seeped into my consciousness. They were allegedly leftist physicians (I arrogantly presumed that Michael Rachlis and I were the only such types in Toronto) who were interested in bringing together like minded doctors and students, particularly on the issue of Medicare.

Although Wikipedia lists Gord and Fred as the founders of the MRG in 1979, they were more like catalysts and in fact they, with many others, founded the MRG after a full year of preparation. After an initial meeting in 1978 at which it was obvious that the collective energy and will existed to form a progressive doctors group, subgroups were established to draft a constitution (that was the job of myself and John Marshall, now a leading academic surgeon at St. Michael's Hospital), craft the three founding principles and prepare the initial set of resolutions. Gord has remained as the Father of the MRG ever since the beginning and has been an exemplar of principled persistence.

In the fall of 1979 the inaugural meeting was held at Hart House – over 100 people attended, most under age 30. The constitution, principles and resolutions were approved, a steering committee elected, and the MRG was officially an entity. The buzz in the air was palpable, the excitement barely restrained and the nervousness audible due to the impending coming-out of a left wing doctors' group.

We knew that we were headed into a direct collision with the Ontario Medical Association and we made the first move by announcing our formation in a racy Toronto Star article. MRG stalwart Debby Copes was fearless in putting her name forward and being quoted in the Star as I hid under my bed covers, as yet undeclared. It mattered not – we had been infiltrated by a high-ranking OMA member who secured a place on our mailing list and could not resist gloating about his success in a snarky letter sent to the MRG. Many of us were afraid of the repercussions and some followed, for years afterward.

Actually, members of my family dissociated themselves from me. In early 1986, my physician brother Samuel underwent a sigmoidoscopy. As he was on all fours, buttocks up high with the gastroenterologist about to insert the scope, the gastroenterologist asked: "Are you related to that Dr. Philip Berger", to which my brother promptly responded: "No, I spell my name with a "U"."

But the MRG's public campaign to rid Ontario of OHIP premiums and extra billing was on. Shortly after the MRG founding I was asked by CBC national radio to debate Dr. Ed Moran, Executive Director of the OMA. Ed was a tough, cigar-smoking but decent guy. I recall his butting out a cigar (he bummed me one in a show of professional camaraderie) on the carpet of a hotel OMA guest suite to which MRG members were invited during a Ministry of Health policy meeting. I was scared to debate Ed – it would have meant my publicly identifying as an MRG member. The day of deciding whether to debate Ed was pivotal in my career. After hours of solipsistic musing and existential angst, I realized that if I did not debate Ed for fear of the consequences, I would be shackled for the rest of my professional life. And so we had the debate and other than Ed calling me "son", it was fairly civil. For that decision alone I will be forever grateful to the MRG.

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HARESH KIRPALANI (continued)

who want to strengthen and improve Canada's universal publicly-funded health care system. We advocate for innovations in treatment and prevention services that are evidence-based and improve access, quality, equity and sustainability".

Equally, the stated goals are less open to radically different philosophical-political dissent:

1.To continuously improve publicly-funded health care in Canada.

2. To assist in the education of doctors, policy makers, other health practitioners and the general public on the value, efficiency, quality and equity of publicly-funded health care and the reality of alternative systems.

3. To effectively collaborate with other organizations that share similar objectives."

These are the very ways in which the MRG actually operated in fact.

So the MRG is dead, long live the MRG!

To the new generation of the progressive physicians in Canada.♦

PHILIP BERGER (continued)

The lead-up to the OMA withdrawal of services – "the doctors' strike"- in the spring of 1986 was a hectic time for the MRG; many late night meetings, car travel between Hamilton and Toronto which provided more opportunity for detailed strategizing, and rare conference calls. MRG members were quoted endlessly in the media but statements issued by MRG spokespersons were an amalgam of ideas and phrases arising from the entire steering committee and others. For inexplicable reasons, I still have seared in my mind an image of the undaunted Bob James enunciating a point that I repeated verbatim during a radio interview the next day. It was an authentically collective effort with individuals expressing views that were the coalescence of many.

The MRG engaged in polite guerilla type tactics during the years prior to the 1986 strike. Whenever the OMA had a press conference, MRG members would be present to counter their view and neutralize their position. The OMA leadership was apoplectic and occasionally brief yelling matches would erupt. The MRG was denounced as having a membership not constituted of real doctors because, for example, our members "did not sit on hospital committees" (if only that held true we would all have been spared the misery).

The OMA was not exactly a formidable opponent and our job was made much easier by the inane and hyperbolic pronunciations of the OMA leadership. In one instance a plastic surgeon and OMA representative spoke at a public debate with the MRG in Toronto's Parkdale neighborhood and after complaining about physician incomes was loudly booed and jeered. The crowd was so hostile that the MRG spokesperson felt impelled to intervene and protect the shocked surgeon. Nothing, though, topped the then OMA president's prediction that if extra billing was banned, doctors would become state employees and patients would be worse off than "under the Iron Curtain" – Yikes!

The then Minister of Health, Murray Elston, was also attentive to MRG analyses. The MRG once issued a press release stating that under the proposed legislation, which banned extra billing, doctors would still be able to determine when to show up for work, how many hours to work, how much holiday to take, how to dress for work, and would not be required to provide sick notes when absent from work due to illness (i.e., the nature of doctors' work would have no features in common with that of employees, never mind employees of the state). The press release was ignored but sure enough a day or two later Mr. Elston was quoted on the front page of the Globe and Mail saying that: "doctors would still be able to determine when to show up for work, how many hours to work, how much holiday to take…." – you guessed it, a near word for word quote taken directly from the MRG.

During the middle of the doctors' strike, our medical office secretary received a phone call from a man wanting to talk to me. The secretary advised the caller that "Dr. Berger is seeing patients right now". The man politely said "Oh, no. Please do not interrupt him but can I leave a message?" .The secretary replied "Of course, may I ask who is speaking?" The caller said "Please tell him David Peterson phoned". The secretary then asked "Are you a patient here?". Long pause in the conversation until the caller blurted out "No…… I am the Premier of Ontario". Even Mr. Peterson was paying attention and just wanted to pass on his appreciation for the advocacy of the MRG.

The MRG took its political work seriously. Members read thoroughly the relevant legislation, studied the economic arguments, were apprised of the history of health care in Canada and elsewhere, and knew the OMA's position better than the OMA spokespersons themselves. Our public statements were largely free of embellishment and self - righteousness. It all combined for an effective and ultimately successful political campaign and members carried with them the lessons learned from that period of activism for the rest of their careers.

The MRG's profile in the 1980s attracted a new cohort of members including progressive medical students. It was just after the doctors' strike that the then youthful and eager longish-haired second year medical student and now inveterate steering committee member Ahmed Bayoumi first appeared.

It was not all serious politics and heavy conversation in the MRG's first decade. Haresh Kirpalani taught some of us that good cooking and fine wine were not incompatible with progressive politics and that we were not actually part of the proletariat. Some ideas arose in the haze of smoky summer time banter. Occasional but transient romances formed and lifelong friendships were established. It was all good.

The MRG at 35 – it has been a trip and a half.♦

JANET MAHER

Although I had known of the Medical Reform Group from my earlier activist history on health, social planning, and the women's movement, accepting an appointment as their part-time administrator in the summer of 1995 has given me a unique perspective on health advocacy during a period in which many of our politicians have done their best to starve what could be a world-class health care system at the same time as they persist in spinning themselves as friends and saviours of Canada's best-loved social program.

Many community activists hoped when the Canada Health Act became law in April, 1984, that we could build on the foundation and vision most cogently enunciated by the Hon. Monique Bégin. Instead, the struggle to maintain the so-called 5 principles of Medicare has persisted to this day. Whereas in 1979, federal contributions accounted for nearly half of spending on provincial social programs, by 2012, that figure is under 20%.

What that has meant for provinces, including richer ones like Ontario, has been continued pressure on provincial coffers, and whenever provincial politicians of any party have succeeded in getting away with it, downloading to individuals in the form of user fees and similar strategies. This was the case in the so-called doctors' strike of 1986, and has continued in various forms over the intervening generation, as successive governments have attempted to delist various procedures, or hospitals, clinics or 'innovative' practitioners have sought ways to add novel user fees and charges to make up for the perceived stagnancy in their incomes.

What this has meant for individual Canadians has varied, depending on their income and expectations. For some, it becomes a bargaining chip for better health insurance coverage. But for the majority of us, it has meant adding these expenses to a tight household budget or adding to the deficit that keeps or threatens to keep us in poverty.

I think the history of the MRG can best be written as a history of resistance to the continuing threats to health care in particular, and as the story of a small group of dedicated physicians to portray this resistance as the voice of reason, providing leadership, vision, and high quality research evidence on the various user fee and delisting debates. These physicians made progress on primary care reform and the many equity and access issues (responsiveness to public health, national pharmacare, reproductive health care, access for those at the margins, whether living with HIV, in poverty, recent immigrants, refugees with limited resources) which have preoccupied MRG members for a generation.

Although it is often difficult to point to concrete "wins" since the Canada Health Act, I am sure that the resistance provided by groups such as the MRG has been taken seriously, and remains part of the reason our neighbours to the south continue to be envious of our system.

Working for Doctors

As someone whose direct knowledge of health care is still pretty much restricted to my own personal experience (and that thankfully limited), my experience as the part-time staff person provided a steep learning curve, especially in the first couple of years. Not only was it necessary to facilitate discussion on the policy issues themselves, but I also had to help shape a position that was credible coming from physicians, convey this to allies who valued us as coalition partners, and deal with the day to day need to match the appropriate MRG spokesperson with policy makers or media at the right time and place. I was hardly a natural at this.

Looking back, I think there is a noticeable change in the character of the profession—among the newer graduates, there are more women and more people of diverse backgrounds, most with a more socially-responsive background than a generation ago. Is this a tribute to the more comprehensive medical education advocated by their predecessors?

Moving on

After more than 50 years in the labour force, I have been slowly reducing my paid work over the last year or so, and my resignation from the Medical Reform Group is a part of that shift in my life. I hope I have many more years and ideas to contribute to advocacy and that I will cross paths with at least some of you again.

For the end of 2014, I have taken on a new twin challenge, to raise $10,000 in sponsorships for a favourite charity and have been training hard since spring for a 10 day mountain climbing expedition in Cuba.♦

FRAN SCOTT

In the early 1980s, when I was on the Steering Committee, the MRG organized a workshop using CPSO case examples to discuss system analysis rather than individual physician behavior. Clyde Hertzman was one of the Steering Committee members who led this initiative. One of the cases, I believe, was a meningitis death in Northern Ontario where I think there were issues regarding access to care and communicable disease reporting. I remember we had great discussions that went well beyond "blaming the doctor" who had been reported to the College. I wanted to ensure that Clyde was remembered as he was a passionate, energetic MRG steering committee member before he moved west.

[Editor's note: Clyde died in February 2013 and was remembered in our newsletter available at http://www.medicalreformgroup.org/wp-content/uploads/2013/05/Newsletter-2013-Issue-1611.pdf].♦

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