

MRG Newsletter

Medical Reform Group of Ontario P.O. Box 366, Stn. J Toronto, Ontario M4J 4Y8 (416) 920-4513

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OCTOBER 1986

MRG General Meeting

October 24, 25, 1986, Toronto

Friday October 24: An evening with the Health Minister

Health Minister Murry Elston will be the featured speaker at the Friday evening session. In the Oakham Lounge, second floor, Oakham House, 63 Gould St. (near Church and Gerrard, Toronto).

- 7:00- 8:00 Coffee will be available
- 8:00-10:00 Meeting
- 10:00-11:00 Beer and conversation (cash bar)

The Friday evening meeting will be open to MRG members only.

Saturday, October 25:

South Riverdale Community Health Centre, 126 Pape Ave., Toronto

- 9:30 Coffee and registration (Registration fee \$20, includes lunch)
- 10:00-12:30 Business meeting
 - Reports and Updates
 - Steering Committee
 - Membership and Financial
 - Chapters
 - Extra Billing: Past and Present
 - Ontario and Canadian Health Coalitions
 - Evans Review of Health Care
 - Select Committee on Privatization
 - Pharmaceuticals
 - Midwifery Task Force
 - Abortion
 - New Business
 - Steering Committee elections
 - Resolutions
- 12:30-2:00 Lunch (will be ordered in)
- 2:00-4:00 Panel discussion: The College of Physicians and Surgeons: Its Role with Respect to Society, the Profession, and Government
 - Panel Speakers:**
 - Dr. Peter Granger, Past President of the College of Physicians and Surgeons
 - Carolyn Tuohy, Dept. of Political Science, University of Toronto, author of publications on the professions, public policy, and the role of the college.
 - Gail Donner, Past President, Registered Nurses Association of Ontario
 - A representative of the Schwartz Commission reviewing health disciplines in Ontario.

DRUG MANUFACTURERS' MAILING

MRG members will shortly be receiving a mailing from the Canadian Drug Manufacturers Association giving the Association's views on the proposed drug patent legislation and related issues. The MRG Steering Committee decided to permit this mailing because it felt that MRG members would be interested in the information and viewpoints which the CDMA is disseminating. As with other organizations which have been permitted to mail to the MRG mailing list from time to time, this privilege does not imply that the MRG or its Steering Committee has endorsed the organization from which the mailing originates. As always, the mailing list remains confidential: the CDMA provided sealed, stamped envelopes to the MRG Secretary, who affixed the labels to them.

NURSES FOR SOCIAL RESPONSIBILITY

The nursing profession has begun to awaken from a prolonged period of passivity and take a more active role in the shaping of both the conditions within which we work and the society within which we live.

Nurses for Social Responsibility (NSR) is a group of nurses who are committed to advocacy, education and to the implementation of change strategies with respect to social, sexual, racial, economic, peace and justice issues. NSR believes that a new definition of health encompasses more than the absence of disease, and view health as a quality of life which should be regarded and defined in a positive fashion. NSR believes that promoting health includes health education, legal and environmental controls and influence in social and economic factors. NSR advocates for the elimination of inequality, oppression, violence, and aggression.

NSR actions to date have included:

- educational presentations on nurses' role in social activism and the peace movement to lay, professional groups, and the media;
- publication of a newsletter;
- participation in numerous rallies and demonstrations including the "Feed the World, End the Arms Race", International Women's Day, Anti-Apartheid, and Take Back the Night demonstrations;

NURSES FOR SOCIAL RESPONSIBILITY (cont)

-1985 Hiroshima/Nagasaki Week "Shadow Project"; NSR was responsible for shadows painted on Hospital Row

-members of 1986 coalition to End Extra-Billing

NSR welcomes both nursing and associate members.

For more information contact Cathy Crowe
13 - 550 Ontario St., Toronto, Ontario
M4X 1X3, 461-2493(W); 961-5660 (H).

Private Practice, Public Payment

CANADIAN MEDICINE AND THE POLITICS OF HEALTH INSURANCE, 1911-1966

C. DAVID NAYLOR

Private Practice, Public Payment is the first detailed overview of medical interest group activity during the formative period of the Canadian health insurance system. David Naylor follows the evolution of Canadian health insurance from 1911, when attention was focused on the issue by British developments, to the enactment of the Medical Care Act by Parliament in 1966.

Naylor's particular concern is with the nature and extent of opposition by the medical profession to government-administered systems of health insurance at both the provincial and the federal level. He details various developments in medical politics and policies, including the dispute over a state health insurance plan in British Columbia during the Depression, the national health insurance program drafted by the King government, the doctors' strike in Saskatchewan in 1962, and the development and eventual governmental rejection of prepayment plans sponsored by organized medicine.

The author concludes that physicians regarded medical insurance schemes over which they had little administrative control, or where coverage was not limited to the indigent or to those earning below a modest wage, as threats to professional incomes and autonomy. His analysis of the evolution of the professional perspectives, policies, and pressure-group activities suggests that in dealing with regulatory legislation, organized medicine is as likely to act in defence of its members' economic and social interests as any other occupational collection. The final chapter touches on the role of professional ideology in legitimizing this interest-group activity, and also briefly links current conflicts to political precedents described in the book.

David Naylor is a medical historian and physician currently specializing in internal medicine. He lives in Ontario.

UPDATE ON PROPOSED CHANGES TO THE PATENT ACT

On June 27, the federal Conservatives introduced the long awaited changes to the Patent Act -- almost. Through a series of bungles that are difficult to believe, the new legislation did not arrive at the House of Commons in time and therefore the bill could not be presented. What the government finally did release was a list of proposed amendments which would become retroactive to June 27 once passed. The actual bill was scheduled to be introduced when Parliament resumed sitting in early September but with the proroguing of Parliament the MPs will not be returning to the House of Commons until October. Furthermore, the cabinet shuffle over the summer saw Harvie Andre replace Michel Cote as Minister of Consumer and Corporate Affairs. Andre's sympathies on the issue are clearly in favour of the multinationals. (This reading of Andre's position is based on a personal meeting between Andre and two MRG representatives.)

Generic drugs and the Canadians who save hundreds of millions of dollars annually from their availability are the losers in Mulroney's quest for a free trade agreement. The U.S. based multinationals have been putting enormous pressure on Mulroney, through the Reagan administration in Washington, to substantially modify the compulsory licensing provisions of the Patent Act. Mulroney appears to have totally caved in on the issue. Throughout the winter the multinationals individually and through their association, the Pharmaceutical Manufacturers Association of Canada, had been saying that they wanted ten years market exclusivity for new drugs. The proposed amendments give them ten years. In return, the companies are supposed to invest \$1.4 billion in research by 1995, but his is just a verbal promise on their part. There is, of course, no guarantee that the companies will keep their promise. There are also supposed to be 3,000 new "high tech" scientific and research-related jobs created by the multinationals, but again we have only their word that these jobs will actually materialize. The Eastman Commission Report estimated that Canadian consumers currently save \$211 million annually as a result of the availability of generic drugs. Under the proposed amendments there will be no generic competitors for new drugs for a least ten years after their introduction. The lack of generics means that there will be no pressure to reduce prices. The result will be more money out of pocket for those who pay for their own drugs. Provincial drug plans, such as Ontario's Drug Benefit Plan, will be faced with a dilemma. Either they can add the new drugs to their formularies and see the cost of the plan sky-rocket or they can control costs by not making some drugs available. Either way consumers will be the losers. The federal government proposes to give the provinces \$100 million between 1986 and 1990 to make up for the lack of generics, but after 1990 the provinces will be on their own. Of course, after 1990 the drug companies are not going to stop introducing new drugs. These drugs will also be without competition for 10 years so the provincial drug plans will go on being squeezed after the federal money has run out.

Over the summer, the Medical Reform Group has been active in the fight to prevent the actual introduction of the legislation. We have sent telegrams condemning the legislation to the Minister of Consumer and Corporate Affairs and the Liberal and NDP critics. On September 6, Joel Lexchin and Bob Frankford met with Harvie Andre. The MRG has also been participating in protests through its membership in the Canadian Health Coalition and HAI Canada. Individual MRG members are encouraged to write expressing their opposition to:

The Hon. Harvie Andre, P.C., M.P.
Minister of Consumer and Corporate Affairs
Place du Portage, Tower 1, 23rd Floor
50 Victoria St.
Hull, Quebec
K1A 0C9

P.S. For an excellent expose of the lobbying activities of the drug companies see the article on the August-September issue of *This Magazine* by John Sawatsky and Harvey Cashore.

--Joel Lexchin

Hon. Harvie Andre
Minister of Consumer and Corporate Affairs
Place du Portage, Phase 150 Victoria St.
Hull, Quebec K1A 0C9

9th September, 1986

Dear Mr. Andre:

On behalf of the Medical Reform Group, I would like to thank you for the opportunity of meeting with you and informing you of our position on issues relating to pharmaceuticals. As we indicated to you, we are concerned about the undesired consequences of patents, particularly the way in which they distort research away from real medical priorities. The market oriented approach of the major pharmaceutical companies makes it extremely unlikely that they will devote resources to basic research of the development of drugs for all but the most common diseases. It is easy to see that this is happening world wide and that changes in Canadian patent legislation would not make any difference.

As we told you, we are also concerned about the lack of useful and objective information to prescribers in this country. We also raised this question in our oral presentation to the Eastman commission. We would assume that responsibility in this area is shared by you and the Minister of Health. Professor Eastman asked us if the Medical Reform Group had considered putting out a version of the Medical Letter (an excellent US source of prescribing information). This has been obviously beyond our resources. Since the presentation, it has however become possible to easily obtain the Medical Letter on line by computer. Could we perhaps consider ways of distributing a Canadian version electronically to doctors. This seems a greater priority than hasty decisions to change the Patent Act. We enjoyed the meeting and hope that you found our input of use.

Yours sincerely,

Robert Frankford, M.D.

ANTI-ABORTION TEACHERS TARGET STUDENTS

Separate and public school teachers who are anti-abortion met in Toronto this summer to plan to convey their views to their students. The conference was organized by Teachers for Life. Members of the Toronto branch of Teachers for Life have been meeting regularly at the school board's headquarters.

At the conference, teachers were instructed in ways of teaching the anti-abortion message, and introduced to educational materials such as a slide presentation by Right to Life, whose spokespeople are often invited to speak in classrooms. The narration accompanying the slides tells the students that "Babies up to 16 weeks old are first torn apart limb by limb by the abortionist's tools and then sucked out of the mother's womb, broken and crushed by the powerful suction apparatus". As the narrator continues, the screen becomes full with the dismembered limbs of aborted fetuses. -Globe & Mail, 11/7/86

VANDALS ATTACK OFFICE OF WOODSTOCK MD

The Woodstock office of the former chief of Dr. Henry Morgentaler's Toronto abortion clinic was vandalized and spray-painted with anti-abortion messages earlier this summer. Dr. Leslie Smoling, 57, who left the Morgentaler clinic two years ago to set up a general practice in Woodstock, had his office sign and steps smashed during a spree of vandalism. Dr. Smoling was acquitted of abortion charges in 1984. --Toronto Star, 22/7/86

PRIVATE ANTI-ABORTION CHARGES IN QUEBEC

Quebec anti-abortion activists have begun a campaign of laying private charges against doctors performing abortions. The Quebec government has no longer been laying charges against abortion clinics after juries acquitted Dr. Henry Morgentaler in three successive trials. Two doctors, Dr. Yvan Machabee and Dr. Jean-Denis Berube, have been charged by anti-abortion crusaders and are scheduled to appear in court.

--Globe & Mail, 20/8/86

B.C. PREMIER ORDERS REVIEW OF ABORTION POLICY

B.C. Premier William Vander Zalm has asked the B.C. Health Ministry to review abortion policies in British Columbia hospitals. Mr. Vander Zalm, a Catholic who has publicly opposed abortion, said that he ordered the review because "there's a danger abortion is being used as a form of birth control".

-Globe & Mail, 26/8/86

P.E.I. ABORTION COURT CASE UNLIKELY

Women's rights advocates say a court challenge of Prince Edward Island's lack of abortion access is unlikely unless a pregnant woman steps forward. "Our legal advice is that a reference case wouldn't stand much of a chance in court," said Alice Crook, provincial spokeswoman for the Canadian Abortion Rights Action League. "Basically, we need a plaintiff and we can't get one." P.E.I. has no abortion facilities at all, so Island women needing abortions have to travel to the Morgentaler clinic in Montreal or a clinic in Bar Harbor, Maine. Hospitals with abortion clinics in Nova Scotia and New Brunswick will not accept P.E.I. women. Federal and provincial politicians have refused to deal with the issue, both sides saying the responsibility lies in the other's court.

--Globe & Mail, 15/9/86

ABORTION DOCTORS CHARGED, CHARGES STAYED

Doctors Henry Morgentaler, Nikki Colodny, and Robert Scott were charged with performing illegal abortions by Metro police only days before the Supreme Court of Canada began hearing an appeal of the previous Morgentaler case. The charges had been ordered by Metro Toronto Police Chief Jack Marks, as a result of an investigation ordered by Ontario Attorney General Ian Scott. However, when the charges were laid, Mr. Scott immediately ordered a stay of proceedings until the Morgentaler case is decided by the Supreme Court. Women's rights and pro-choice activists condemned the charges as harassment. Chief Marks told the media that the charges were prompted by changes in the status quo at the Morgentaler clinic. He seemed to imply that the changes were the opening of a second clinic in Toronto by Dr. Robert Scott. The Scott clinic is not connected to the Morgentaler clinic. Dr. Morgentaler denied that there had ever been a deal with the police to keep services at their present level at his clinic.

--Globe & Mail & Toronto Star, 25/9/86

ANTI-ABORTIONISTS CONTINUE HARASSMENT

Toronto anti-abortion activists are continuing their campaign of harassment against people associated with the Morgentaler clinic. Pickets have demonstrated outside the homes of a doctor, a nurse, and a security guard at the clinic, and have called for a boycott of a locksmith who repairs the locks at the clinic when they are damaged by protestors. They have also picketed the home of a man who lives near the clinic who was acquitted of assault after an altercation with an anti-abortion protester.

MANY DUMPS HAZARDOUS TO HEALTH

The Ontario government has found more than 3,000 underground garbage and toxic waste dumps around the province--and two-thirds of them are hazardous to people, according to a report from the Ministry of the Environment obtained by the Globe and Mail. Buried in the dumps are liquid or solid industrial wastes, sewage sludge, and ordinary household and commercial garbage. All three types of waste can contain toxic chemicals.

--Globe & Mail, 19/7/86

STELCO ADMITS IT GAVE MISLEADING DATA

Stelco, Canada's leading steel corporation, has admitted that it misled Ontario's Workers' Compensation Board by providing wrong information about a worker's on-the-job hazard exposure. The admission by Stelco, which recently was found in violation of the law for withholding medical information from its union and workers, is contained in a letter to the board concerning forklift driver Lloyd Goddall. Goddall's claim for hearing loss was rejected by the board in 1982 on the basis of misleading information from the company. --Toronto Star, 5/7/86

ELSTON CONCERNED BY RISING DRUG PRICES

Ontario Health Minister Murray Elston says that the costs of the Ontario Drug Benefit Plan are soaring, making it

ELSTON CONCERNED (continued)

necessary "to ask whether there is some inappropriate use of our drug benefit plan." Elston said that the increase in the cost of drugs alone and the growth in the number of senior citizens don't alone explain the increase in the use of the plan. He suggested that "perhaps too many medications are being used, too many prescriptions being handed out" by doctors. Costs under the plan were \$413 million last year, a 360% increase from 1978.

--Toronto Star, 30/9/86

COURT CHALLENGE TO MANITOBA LAW

The Association of Independent Physicians of Manitoba is considering a court challenge to a new provincial law that will force Manitoba to pay dues to the Manitoba Medical Association. About 400 of the province's 1,700 currently do not belong to the MMA.

--Globe & Mail, 30/8/86

NO DISCIPLINE PLANNED OVER DRUG FEE ABUSES

The Ontario College of Pharmacists will not discipline members or employers at 13 drug stores caught charging more than the legal \$5 drug dispensing fee on generic drugs last year. The college decided to take no action because overcharging was so common at the time. A complaint from Ontario Health Minister Murray Elston forced the self-governing body to investigate last September, after the Globe and Mail exposed the illegal charges. At the time, the college said that it knew that 80 per cent of its members were overcharging but decided to exercise "discretion" rather than enforce the law.

--Globe & Mail & Toronto Star, 19/8/86

B.C. DROPS ATTEMPT TO LIMIT MD NUMBERS

The British Columbia Government has abandoned an attempt to justify its limit on the number of doctors in the province. The surprise move was announced August 27 during a challenge in the Supreme Court to B.C.'s Bill 41, by the Professional Association of Residents and Interns of B.C. Under Bill 41, passed in May, doctors who wish to be given billing privileges within the province's health care plan must first satisfy "geographic" requirements of the government and show that they are needed in the community. The Association maintained that the legislation amounted to dictatorial state control.

--Globe & Mail, 28/8/86

ONTARIO PUBLIC HEALTH ASSOCIATION MEETING

The Ontario Public Health Association will hold its 37th Annual Educational and Scientific Meeting in Toronto on November 16 - 19. The theme of the conference is "Acting Now--To Shape the Future". For information contact Laura Wood, (613) 725-1317 or Val Kadach, (416) 791-9400 ext 218.

PRACTICE OPENING

Myles Lipton M.D. is opening a full-time psychotherapy practice in the downtown Toronto area of Spadina and College, (after 5 years of training and practice in Scarborough). The modality I use is primarily 1 to 3 days a week, face to face, individual, adult psychoanalytic psychotherapy, emphasizing the role of the transference and the unconscious. Referrals or any questions would be welcomed. 554 Spadina Ave., 3rd floor, 928-2911.

MRG MIDWIFERY BRIEF

The MRG Brief to the Task Force on the Implementation of Midwifery will be presented at 10 a.m. on October 20, 1986, at the hearings in the Hamilton Convention Centre. All welcome.

"LAST WISH: THE QUALITY OF DYING"

Dying with Dignity, the Ontario Hospital Association, and the Registered Nurses' Association of Ontario, are presenting a public forum entitled "Last Wish: The Quality of Dying" on Monday October 27 at 8 p.m. in the Royal York Ballroom, 100 Front Street West, Toronto. Speakers will be Haydn Bush, Director of the Ontario Cancer Foundation, and Betty Rollin, author of "Last Wish" and "Am I Getting Paid for This?" For further information call Marilynne Seguin at 921-2329 or 422-4178.

CONTEST

Once again, the MRG's Fall General Meeting will feature a contest. This one is for the statement made by a physician during the recent doctors' strike most designed to discredit the medical profession. Entries will be judged at the Saturday October 25 meeting.

WHO'S IN CHARGE?

The Church of the Holy Trinity in Toronto (10 Trinity Square, by the Eaton Centre) is presenting "Four Evenings of Dialogue around Health Care Issues" under the theme "Who's in Charge?" on the evenings of October 14, 28, November 11, and 25, from 7:30 to 9:30 pm. The aim of the series is to address questions such as "Who has the power to make decisions about the kind and quality of health care? What is health and what is healing? Why is the church concerned about our health care system? The titles of the four evening sessions are "Where the Individual Meets the System", "Healers, Providers, Deciders", "Technology and Ethics--Priorities"; and "Dimensions of Health and Healing". For more information contact Susan Grady 598-4521.

MEMBERSHIP RENEWAL TIME

A new membership year began on October 1 for the Medical Reform Group. (Our fiscal year runs from October 1 to September 30). Members should have received a letter reminding you to renew, together with an information questionnaire. There are some additional questions on this year's membership renewal form, reflecting an effort on the part of the steering committee to be able to be more informed about who constitutes the membership of our organization.

New members who joined in the last three months of the fiscal/membership year (July, August, September) are having their membership for last year extended to cover 1986-87 as well.

Members are urged to renew promptly and to think about other potential members whom they might urge to join. A committed and growing membership is a key element of the MRG's credibility and effectiveness in putting forward its views of health care issues.

Members are also urged to consider being Supporting Members by renewing above the required rate. In the past several years, Supporting Members have made it possible for the MRG to operate in the black rather than the red.

Extra billing: what's up, doc?

perception Volume 9, no. 4

Dr. Susan Stock

As never before in our history, Canadians are now concerned with defining and protecting civil rights. The passage of the Canadian Charter of Rights and Freedoms is part of this process and, in turn, it has heightened our awareness of such rights. So it is not surprising that the current Ontario controversy over physician extra billing is expressed as a conflict between the right of all citizens to high quality health care without financial deterrents and the right of physicians to set their own fees and bill patients directly.

The Ontario government has recently proposed the Health Care Accessibility Act, which would prohibit doctors from charging patients above the Ontario Health Insurance Plan (OHIP) fee schedule for their services.

The history behind this legislation dates back to the late 1970s, when there was increasing concern expressed by consumer and other groups that the principles of medicare were being eroded by the imposition of user fees for hospital services and by doctors extra billing their patients. The Hall Royal Commission on Health Services was mandated to examine this issue and produced its report in 1980. It confirmed that extra billing and user fees were deterrents to the poor and elderly and deprived them of full access to health care. Among the Commission's recommendations was that extra billing and user fees be disallowed. This eventually led to the Federal government, with the support of all three parties, passing the Canada Health Act in 1984.

This legislation held out financial penalties to any province that permitted extra billing. The federal government deducts from its transfer payments to the province dollar-for-dollar any amount that the province permits its doctors to extra bill. In Ontario, this amounts to \$50 million a year. The legislation allowed each province three years to ban extra billing. If by 1987 it does so, all withheld payments will be transferred back to the provinces. By March 1986 only Alberta, New Brunswick, and Ontario had not banned extra billing, and Alberta's government has recently announced plans to do so.

Numerous presentations to the Hall Commission and to parliamentary committees during the debate on the Canada Health Act highlighted the extent to which Canadians believe that universal access to health care is a right of all citizens and must be preserved. In addition, there is much evidence demonstrating that extra billing is an economic deterrent and threatens universal access to high quality care.

Studies in Saskatchewan by G. Beck and J. Horne, which looked at the impact of doctors' service use charges imposed from 1968 to 1972, showed that utilization by the poor and elderly declined by 18 per cent, but overall utilization of doctors' services did not change substantially because there was a corresponding increase in utilization by higher-income earners.

These findings were supported by studies in 1980 done at McMaster University by G. Stoddart and C. Woodward. They found that 18.7 per cent of their respondents who were being extra billed did not seek care or delayed seeking care. According to these studies, most people did not discuss their bill with physicians. Among those being extra billed, 60 per cent said they would be embarrassed to ask their physicians to lower their fees. More recent studies in Alberta by R. Plain demonstrated that low-income patients are extra billed as often as middle- and higher-income earners. In 1984, the Alberta Medical Association found that 800 Alberta physicians extra billed patients receiving welfare.*

The doctors' claims notwithstanding, these studies clearly demonstrate the poor are being extra billed and that such out-of-pocket fees act as a deterrent to seeking care when needed.

There is also a risk that extra billing will lead to a return to a two-tiered health care system. In Ontario some doctors extra bill in their private offices but not in their hospital clinics. The poorer patients are therefore more likely to be "streamed" into the hospital clinic, where they may wait longer for appointments, are often seen by medical students or residents (doctors in training). Their consultation time with the specialist may also

be shorter than in his or her private office — not unlike the situation prior to medicare.

Moreover, as health care economist Pran Manga points out, extra billing "redistributes the burden of financing health care costs from all taxpayers to the sick." This is particularly inequitable when one realizes that health status is strongly associated with socio-economic status. The poor in Canada are more likely to have significant illness than the more affluent segments of society.

In contrast to the arguments about patients' rights to equal access, the Ontario Medical Association argues that the rights of doctors are being infringed upon — the right to set the value of their medical services. OMA lawyer Aubrey Golden argues that the proposed Health Care Accessibility Act violates the Canadian Charter of Rights and Freedoms because it deprives doctors of their freedom to contract for their services and denies them equality under the law by having them finance part of the cost of their medical services.

In fact only 12 per cent of Ontario doctors and less than five per cent of general practitioners extra bill. Extra billing is concentrated in certain specialties: anesthesiologists (58%), ophthalmologists (40%), urologists (38%), obstetrician/gynecologists (34%), orthopedic surgeons (30%) and psychiatrists (28%). Less than four per cent of internal medicine specialists and less than three per cent of pediatricians extra bill.

The practice is also much more common in certain regions of the province. For example, 60 per cent of all opted out physicians in Ontario are in the "Golden Horseshoe" area of Toronto-Oshawa-Mississauga.

Entrepreneurs or Civil Servants?

If 88 per cent of all doctors do not extra bill, why are most doctors so opposed to this legislation? For many, it is not extra billing *per se* that is the issue. It is the perception that their professional autonomy is being infringed upon. Many doctors fear that this act is the first in a series of legislative changes that will erode professional autonomy

and dictate how and where doctors practice. Doctors who see themselves as entrepreneurial independent professionals fear becoming "civil servants" hampered by a bureaucratic maze of arbitrary and unfair rules and regulations. It is this fear that has led doctors to make such heated and emotional outbursts and to oppose the bill so vehemently.

Yet in spite of how threatened many doctors feel, this bill in fact is only concerned with billing patients and does not affect the practice of medicine as such. It does not alter patterns of practice, nor does it make doctors "civil servants" any more than they have been before the legislation. Those in private practice operate as small businesses and bill the provincial insurance plan for each service. For the vast majority of doctors, even billing practices will not be affected. They will continue to set their own hours, decide on the number of patients they are willing to see, and determine how they will manage their patients' medical problems. There are no added constraints inherent in this legislation except the right to bill above the OHIP rate. The OMA will still bargain with the provincial Ministry of Health for percentage increases to the OHIP fee schedule. It will also still decide how much each medical procedure or service will be worth and how the money will be divided among the specialties.

Legacy of Mistrust

Opponents of extra billing claim that if physicians are dissatisfied with their incomes and believe the fee schedule is inadequate, they should use the considerable lobbying power of the OMA to bargain for better fee schedules. But doctors distrust the bargaining process. On several occasions in

recent years, the previous Conservative government rolled back previously negotiated fee increases. As Pran Managa explains, "Physicians justifiably complain that in most provinces there is no genuine and meaningful bargaining over fee schedules. . . There is no doubt that we badly need to reform the legislative framework and establish formal structures and processes within which bargaining between medical associations and governments can take place." Doctors may need to demand binding arbitration and a clearly defined bargaining process.

As it stands, the legislation does infringe on the economic right of physicians to set their own fees — the right to be free market entrepreneurs. But the vision of doctor as true entrepreneur may be outdated and unrealistic. Doctors are dependent on highly trained staff and technologically sophisticated equipment that are very expensive and currently paid for by government. The public purse also pays for 95 per cent of medical education costs. According to University of Toronto historian of industrial relations Desmond Morton, "Most Canadians seem to believe that society has too big a stake in the price of health to leave it in the control of a professional monopoly."

He believes the OMA is unlikely to convince the courts that doctors' rights guaranteed by the Charter are being infringed upon because property rights are not guaranteed in the Charter.

"The once sovereign rights of private property have been in retreat for a long time. A hundred years ago, Ontario's new Factory Act robbed manufacturers of the right to run their work places as they pleased. A decade ago,

Ontario's rent review program robbed landlords of the right to charge residential tenants all that the traffic would bear. The courts did not save those property rights and they are unlikely to rescue extra billing."

Canadians now see health care as an essential service, like education or fire fighting, and therefore subject to government policy. This notion was even more clearly spelled out by Justice Emmett Hall in the 1980 Report of the Royal Commission on Health Services:

"The emphasis on the freedom to practice should not obscure the fact that the physician is not only a professional person but also a citizen. He has moral and social obligations, as well as self-interest to do well in his profession. The notion held by some that the physician has an absolute right to fix his fees as he sees fit is incorrect and unrelated to the mores of our time. The 19th century laissez-faire concept has no validity in its application to medicine, dentistry, law, or to any other organized group. Organized medicine is a statutory creation of legislatures and of Parliament. When the state grants a monopoly to an exclusive group to render an indispensable service, it automatically becomes involved in whether those services are available and on what terms and conditions."

It has been argued that physicians must define what real factors determine professional autonomy and negotiate to maintain these, rather than focus on extra billing. Health consumers appear to agree. Numerous polls tell us that between 70-80 per cent of Canadians believe that universal access to health care without financial deterrents is a right more fundamental than and supercedes the right of doctors to set their own fees and bill patients directly.

Susan Stock is a member of the Medical Reform Group.

*Note: It was the Alberta College of Physicians and Surgeons, rather than the AMA, which found that 800 physicians extra-billed welfare patients.

Labor ministry officials sabotaging laws to protect workers, brief says

By John Devereil Toronto Star

There is a "crisis of confidence" within Ontario's Ministry of Labor because management officials engage in "systematic regulatory sabotage" of workplace health and safety laws, says the Ontario Public Service Employees Union.

The union's scathing critique, endorsed by union president Jim Clancy, is contained in a brief to a closed investigation of the ministry commissioned last June by Premier David Peterson and Labor Minister Bill Wrye.

Among its 80,000 members, the union counts the labor ministry's non-managerial employees, including 205 workplace inspectors in the health and safety division, some of whom provided the inside ammunition for the union's report.

The inquiry team, led by management consultant Geoff McKenzie of Coopers and Lybrand and lawyer John I. Laskin of Davies, Ward and Beck, is expected to finish its initial work sometime before Oct. 14. It was asked to examine mismanagement in the ministry and alleged misconduct by senior officials.

'Crisis management'

The union paints a picture of an overworked, underqualified and powerless inspectorate trapped in a system devoted to "crisis management" and accident investigations instead of prevention-oriented inspection and law enforcement.

The front-line inspectors, the union says, are discouraged from recommending prosecution of violations by repeated stabs in the back from senior officials and an absence of effective support from the ministry's technical apparatus, including the health and legal branches.

(Since the McKenzie-Laskin inquiry began its probe, the official ultimately in charge of ministry organization and safety enforcement since 1978, deputy labor minister Tim Armstrong has been removed from his post. There are

widespread rumors that more heads in the upper echelon of the ministry's health and safety division will roll this week.)

Among the union's many criticisms:

□ Since May, 1985, a huge backlog of missed inspections has been swept under the carpet by "putting them on Code 99" — meaning that inspection occurs only in the event of a serious accident or work refusal. Thousands of workplaces will never be inspected under this bureaucratic edict "and at least 80,000 haven't even been registered, let alone inspected."

□ What little training there is for inspectors is hopelessly inadequate, barely touching on such topics as toxicology, ventilation, or work design. "In an age when many health and safety problems are often invisible to the naked eye, inspectors are sent out half-blind." The consequence is that inspectors recommend few prosecutions — only 116 last year in the entire industrial safety branch, of which only 56 were pursued.

□ The ministry's tiny legal branch has little time to prepare prosecutions, sometimes meeting an inspector as little as 30 minutes before going into the courtroom. Some prosecutions have been lost because the ministry lawyers failed to show up at all. Others were withdrawn without any consultation with the inspector who recommended charges be laid.

"When managers were asked to feed into Legal Branch their thinking about a new prosecutions policy, their comments on the branch's capability were considered so negative as to be libelous. Legal branch threatened to use its skills in libel and slander actions against the managers, and the matter was buried."

□ The ministry's year-old "get tough" prosecution policy is a misleading "public relations exercise. The lawyers are too overbooked and too isolated from the inspectorate to carry it out. They are also

convinced that many regulations are unenforceable. It seems even they were not consulted in the drafting process."

Cases cited

□ Inspectors trying to enforce the law against persistent offenders often run into "special consultations" and "mediation sessions" in which their superiors and employer representatives "act together in an effort to have the inspectors retreat from their original position."

□ The "internal responsibility system" is an administrative scheme devised by top ministry officials to place the main burden of compliance with the law on worker-management committees. It "is entirely inappropriate and ineffective as an enforcement mechanism," because it relegates inspectors to the role of mediators instead of enforcers. "The ministry's use of this system is in part responsible for the current epidemic of accidents and fatalities in the province." Because the inspectorate is hamstrung, its orders have become "meaningless" and workers have no effective recourse against hazards.

□ Inspectors are instructed to accept "at face value" toxic substance control programs negotiated between employers and workers whether they're effective or not. The result of this passive role is that in many instances Ontario's designated substance regulations "are not being enforced."

The union document puts forward a series of cases that it says demonstrate "an inherent reluctance" among senior officials to enforce the law.

□ In one case in early 1985, a prosecution started by the legal branch was withdrawn, it says, after the owner of a construction company complained to Conservative MPP Lorne Henderson, who

relayed criticism of the inspector to then-minister Russell Ramsay.

□ A recommendation to prosecute Ontario Hydro for a second

offence on the same hazard at its thermal power plant in Thunder Bay was rejected after a Hydro supervisor with friendly links to the ministry pleaded for "sympathetic consideration."

□ In 1983, the legal branch, executive director of the health and safety division and deputy minister decided not to prosecute a construction company after one of its employees was killed dismantling an unblocked boom on a mobile crane,

apparently because the deceased was a relative of the employer.

The company already had a poor safety record. Recently the dead worker's father, another relative of the owner, was killed while operating a bulldozer for the company.

□ In 1982, an inspector recommended prosecution of a logging company after a bushworker was killed by a falling dead tree on a site that hadn't been properly prepared. The prosecution was blocked, apparently because the inspec-

tor's superior had previously approved the illegal cutting method.

□ In 1984, an inspector recommended prosecution of the Hamilton General Hospital for improper control of asbestos during a renovation project. No charges were laid, and the inspector was told by his manager that the director of the construction safety branch said the exposure of hospital patients to asbestos was "too sensitive politically" to air in court.

Laying the blame for a political catastrophe

IN THE aftermath of the Ontario doctors' strike, concerned physicians might hope for an honest and forthright appraisal of the conditions that led the profession down such a perilous path. Yet Dr. Morton Rapp's diatribe against the media (Here are 10 ways to bash a doctor—Sept. 16, 1986) is just another illustration of the profession's notorious inability to confront political reality and its alarming propensity to look foolish with almost every utterance.

Take Dr. Rapp's 10th "ingredient" of doctor bashing—the "mention (of doctors') apparent nesting grounds at a golf course" . . . another example of "the vulgar press." But opening the September, 1986 *Journal of the College of Family Physicians of Canada* one reads the college's executive director, Dr. Reg Perkin, comparing despairing doctors (after the strike) to "a golfer who has driven his ball into the rough." Amusing irony—enough to make any reader smirk at Dr. Rapp's lament.

No, it was not the media that bashed doctors around. The media only recorded for the public the statements and actions by vocal members and the leadership of the Ontario Medical Association (OMA). It was physicians who compared Premier Peterson to Hitler, who claimed that physicians in the Soviet Union were freer than those in Ontario, who jumped barricades to scream epithets at retired senior citizens working as security guards at Queen's Park, who claimed 2,400 people attended a protest rally in a room that could accommodate

no more than 700, who ran to the media proclaiming the introduction of so-called administrative fees—all the while disclaiming that money was an issue or the issue in their protest.

It was doctors who went on record stating they wanted the service withdrawal to promote anxiety amongst patients and their relatives, who on film claimed it might be necessary for one patient to die during the strike in order to save hundreds later, who dispensed office political lectures to patients despite the unethical nature of this interaction, who threatened to keep patients in hospital longer under the guise of practising "ideal medicine" (yet being unable to explain what physicians had been doing until then).

But the greatest blame for the political catastrophe that beset the profession must be laid at the doorstep of the leadership of the Ontario Medical Association. The leadership failed to articulate the notion of professional independence and abused the sanctity of this concept in its fight against Bill 94.

There never was any provision in the legislation that challenged the right of doctors to freely and independently deliver medical services. The leadership could never explain why the right to make individual financial contracts with patients was essential to the doctor-patient relationship. And by comparing the OMA's "struggle" to that of Mahatma Gandhi and Martin Luther King and to other "fights for freedom" the leadership make a mockery of

the real struggles of physicians for human rights in such countries as the Soviet Union and South Africa.

The OMA leadership also failed its own membership. Instead of advising its members of the literature and arguments against extra-billing it spewed out reams of empty rhetoric leaving individual physicians uninformed and at the mercy of an increasingly informed public and media. The leadership stubbornly refused to hold a secret vote amongst its members either on the issue of a prolonged strike or on the package offered by the government. The medical associations in both Alberta and Saskatchewan provided this opportunity for democratic input to their members in recent disputes with their respective governments.

The OMA leadership did not consider the inevitability of the extra-billing ban, did not bargain for the economic and professional interests of its members and did not seem to care about the political fallout of a prolonged strike. The leadership did not lead.

The media and government did what everybody else did during the doctors' strike. They observed the spectacle of a respected profession committing political suicide. Until our profession's leadership recognizes the political reality of the 1980s and responds appropriately, it will continue to bluster and blunder along to the detriment of physicians and patients alike. We desperately need some change.—Dr. Philip Berger, Toronto.