critical condition

The Medical Reform Group of Ontario

Summer 1980

"We're from the A.M.A., Mrs. Schlecker. We have been given to understand that you are not taking proper care of yourself."

Edification and Enlightenment

The following do not neccessarily represent M.R.G. policy.

— AHH SWEET MORPHEUS —

Now that the Teplitsky report has given us a labour lawyer's acknowledgment that interns and residents work an average of 90 hours a week, it may be worth unearthing a 1971 article that considers the effects such hours have on a physician's performance. If the Teplitsky report has a firm grasp of the obvious, this article on "The Intern and Sleep Loss" (NEJM 285:201, 1971) has a vice-grip.

Fourteen interns were shown a continuous 20 minute ECG strip from a patient with a cardiac arrhythmia, and were asked to bracket (without interpretation) each arrhythmic episode as it appeared on the strip. Each person was tested the day after he or she had slept for a mean of seven hours and again after a night on call, when each one had slept about two hours. The same interns were also given a questionnaire which rated their mood at the times of the two tests.

Other research on sleep deprivation has shown that after 36 hours without sleep recent memory is impaired, the ability to perform tasks requiring sustained attention decreases, and dramatic behavioural changes often appear. Results from this study show much the same thing. Fatigued interns made twice as many mistakes on the ECG test as did rested interns. They also felt less vigour, elation, and social affection, and were sadder and more irritable. The authors concluded that "work schedules that deprive interns of normal sleep not only may produce negative mood changes and transient psychopathology but also may impair efficiency of performance." If epidemiology is the study of making sure that we know what we think we know, then this article is a paragon of the discipline.

How can the information from this study be used? Responses as to how to change call schedules to improve the resident's physical and emotional well-being, and probably patient care as well, would have to be balanced against the experience gained while on call. With a call schedule of less than one in four, some argue that a resident doesn't see enough patients, and therefore suggest that the length of the residency should be increased. In some residency programmes, on the other hand, the physician on call gets the next day off work. While this may be a reasonable solution in specialties like anaesthesia and radiology, where contact with patients is discontinuous, it may not work as well for ward care (or is "continuity of care" reduced to a slogan when patients get treated one day by the rested intern and then the next day by the "transient psychopath"?).

Anyone who proposes an alternative will have to contend with Alfred Mason, M.D., of Brooklyn, N.Y., and some of his colleagues who have less tongue in cheek. Mason wrote a letter to the editors of the NEJM in response to the sleep loss article:

> "I consider myself a tolerant man, ready to put up with the effusions of the younger generation -- but the Journal has finally turned me off. Students running our national conventions . . . radicals in our media, our political party, and our Congress . . . sex in the classroom, the nursery and the premature ward . . . revolution, pornography, and free love I can take in my stride. .
>
> But when the Journal prints an article suggesting that interns might need more sleep than they traditionally get, I draw the line. O tempora! O mores!"

By Sandy Buchman and Peter Rowe
for the Working Group on the
Mental Health of Physicians.

People may be interested in a review article "Psychiatric Illnesses in Physicians" by S.E.D. Shortt in CMAJ 121:283 (Aug. 4, 1979)

> Man's power over Nature is really the power of some men over other men with Nature as their instrument.
>
> -C.S. Lewis

Thoughts on Occupational Health and Safety

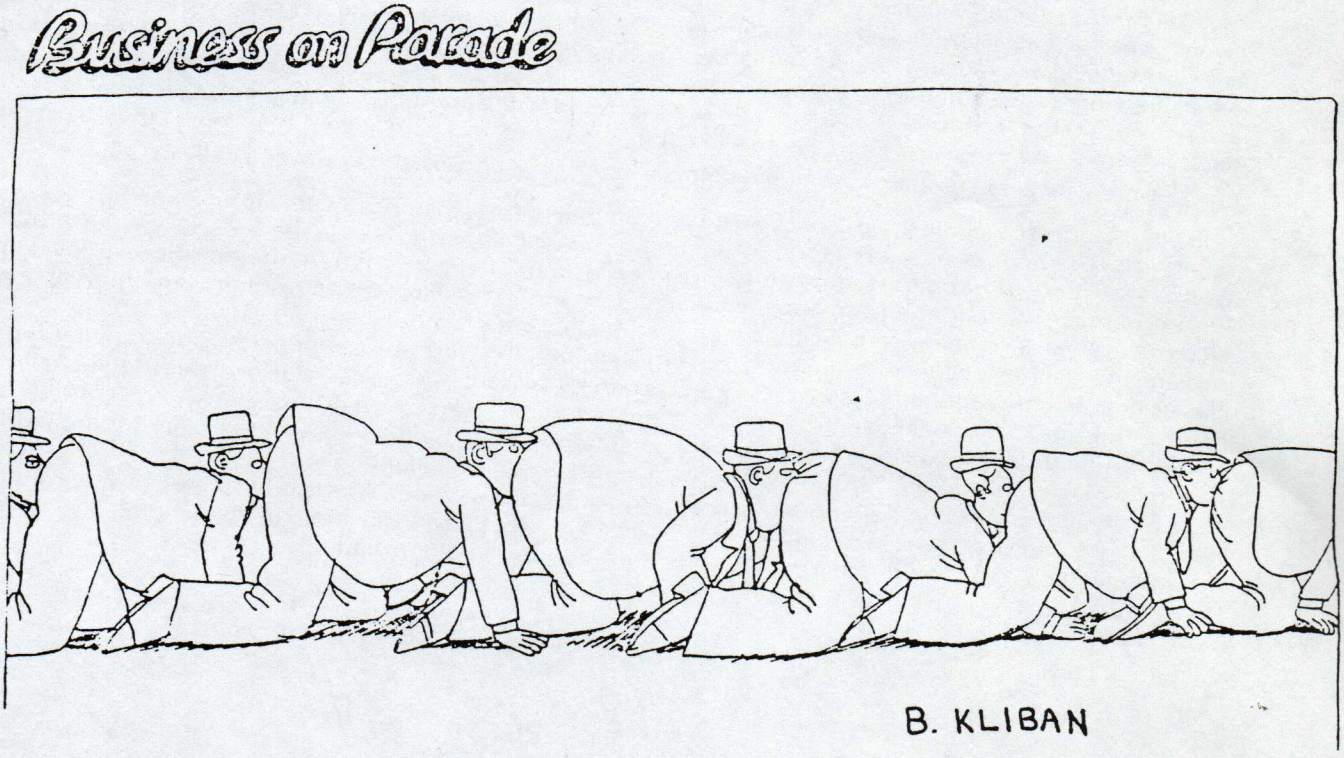
"It is no longer morally acceptable, for example, to state on a death certificate that a patient died from cardiac arrest when the truth is that he died from asbestosis. It's no longer morally right to treat workers for the flu when they are suffering from metal flume fever, and I guess what I am really saying is that it is no longer morally acceptable to be ignorant for whatever reason of the occupational health problems in our society."

This plea to the medical profession was made by Ed Hunt, a health and safety representative from labour at a recent CME seminar at McMaster University. His cry echoes many others heard across the country: From Elliot Lake uranium miners, who went on wildcat strikes, from Brantford autoworkers who walked off the job after a 4th man lost fingers at the same machine, from asbestos workers in Baie Verte, Thetford Mines, and Scarborough striking over asbestos exposure, from shipbuilders in St. Johns protesting zinc hazards, and from the many other militant demonstrations the message is clear: workers are no longer willing to put their health on the line in order to make a living.

Occupational health and safety has aroused growing interest over the past few years, as the toll taken by workplace-related hazards continues to be devastating. Canada has one of the worst records for work-related accidents and diseases of all industrial countries. In terms of the industrial death rate the only country to surpass Canada is West Germany. Every 16 seconds a Candadian worker suffers a disabling injury. It is estimated that over the last decade there were about 300 workplace fatalities/year in Ontario alone. Even more disconcerting is the estimate that for every death as a result of accident there are approximately 7 deaths due to job-related illnesses.[1] The National Cancer Institute estimates that 20-40% of all cancer is linked to the workplace directly - i.e. at least 10,000 Canadian workers die each year due to workplace exposure to carcinogens. The morbidity statistics on respiratory illness, hearing loss, musculo-skeletal or connective tissue diseases, linked to the workplace are equally as compelling.

As a result of labour's unrelenting pressure for improved health and safety, Bill 70, an Act Respecting the Occupational Health and Safety of Workers, became law in October 1979.[2] Like the minimum wage law, its enactment is a definite gain for working people. Nevertheless, the legislation misses the mark on some major points. Unlike U.S. legislation, which, at least nominally, guarantees the right to a healthy and safe workplace, the Ontario legislation merely outlines that employers must protect their workers. This includes measures such as providing protective equipment (respirators, ear plugs) but also includes terminating the employment of a worker whose health is endangered by continuing (Section 14 (2) g and section 15). The right to refuse unsafe work is hampered by denying the collective right to decline hazardous jobs. In practice, the individual, especially one without union protection or whose financial situation means that taking a pay cut would cause hardship, is often reluctant to take a firm stand and ends up taking risks that others would refuse. The right to information is limited, and the health and safety committees are essentially powerless. Furthermore, the act does not cover a large segment of the population, including farm workers, domestics, most teachers, and patients or inmates working under rehabilitation programs.

As physicians and other health care workers, we have the responsibility to become knowledgable not only about the pathology, epidemiology, and clinical presentation of occupationally-related ailments, but also with the state of affairs regarding prevention. In this context, familiarity with existing legislation is not only important in being able to advise our individual patients, but also in our larger role as health advocates seeking to influence government policy.



Differing Views on the Approach to Occupational Health

The traditional approach to occupational health has been a predominantly palliative one in which the physician's role has emphasized screening the individual worker rather than the work environment. A prominent occupational health text book states, without realizing the implications: "The pre-employment medical examination provides an opportunity to exclude persons who are likely to be susceptible to particular hazards. For example, those who have a history or other evidence of chronic respiratory disease or disability should not be employed in occupations which involve exposure to dusts or other aerosols which are likely to exacerbate their condition. Persons with a history of atophy or chronic skin disease should as far as possible be exclused from work which exposes them to irritants or allergens. A history of liver disease...would be a good reason for exclusion from a job which entails exposure to liver poisons..."

The Health and Safety Act enshrines this approach in legislation by obliging the worker to undergo such medical examinations, tests or X-rays as prescribed in the regulations (section 17). This seems reasonable, but actually lends itself to abuse. In a period of high unemployment, to be denied a job on the basis of a pre-employment exam can be devastating. Moreover, someone whose health has been marred by many years of work for a company can find themselves out in the cold (i.e. on welfare) if foiund no longer fit on a periodic health exam. Inadequate financial support inflicts a range of other health problems on the worker and his family (e.g. poor housing) - thereby complicating many fold the initial occupational health problem.

Responding to this Ed Hunt explained, "We now have what is known as the hypersusceptible worker syndrome wherein many companies, supported by the medical profession, believe that the solution (to the occupational health problem) is to remove those workers believed to be weaker by only hiring those deemed the healthiest in our society, the super workforce." Affirming the right to health and the right to employment, and comparing this "health discrimination" to "racial discrimination", he continues, "Would it not be more just, more safe, to, yes, do medicals, but do medicals on the workplace not just the worker, and remove all the hazards from the workplace that can endanger the workers' health."

Thus the viewpoint of labour, emphasizing the preventative approach of cleaning up the workplace, conflicts dramatically with that held by business and government. "Rather than replace a hazardous chemical substance or process, most employers would sooner replace a worker. Such is the reality of a system that places profit before human health."

Toxic Substances: "Sick of Being Statistics"

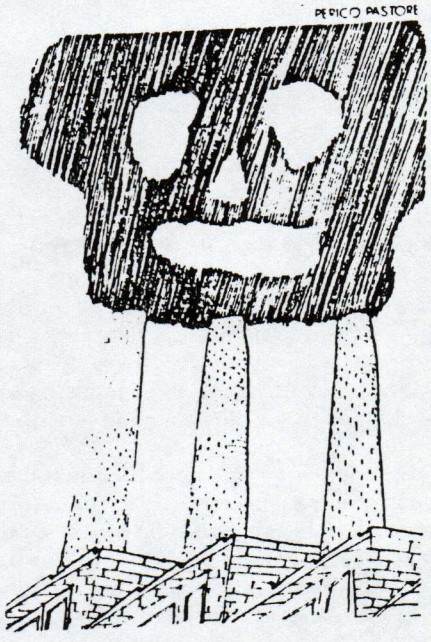
There are 15,000 toxic substances in use in industry with guidelines for exposure to prevent disease existing for about 400. 3,000 new substances are introduced each year in Canada. Already 1500 common workplace substances have been identified as potential carcinogens.[4]

Section 20, 1-3 obliges the government to "assess" substances they believe endanger health - that is, to obtain the generic names of the ingredients, the toxicological and exposure effects, protective and emergency measures, and effects of use, transport and dispersal. However, there is no legislation governing the exposure to these substances, albeit draft regulations have been issues for 7 designated substances. These are asbestos, silica, lead, vinyl chloride, mercury, isocynates and noise. Moreover, scientific evidence strongly suggests that the proposed standards are still quite inadequate in protecting workers' health. For example, the National Institute for Occupational Safety and Health (NIOSH)[5] recommends that lead level in the blood not be allowed to exceed 50 mg/100 ml; in Ontario the proposed safe level is 80 mg/100 ml. The supposedly safe levels for potential carcinogens such as asbestos and vinyl chloride is even more alarming, as there has been no demonstration that there is any safe level of exposure. A man in Britain, for example, whose only exposure to asbestos was during the war when he worked for a month in a shipyard, died thirty years later of a mesothelioma, a cancer linked solely to asbestos exposure. Because cancer appears to be an all-or-none phenomenon, the only safe level of exposure to a carconogen is zero exposure. Even disregarding this argument, it is now generally accepted that the original study that set the asbestos standards at 2 fibres/cm^3 was grossly unsound, methodologically.[6]

Exposure often continues with the glib explanation that there is insufficient data to warrant the expense of doing otherwise. As there is no mandatory pre-testing of chemicals used in industry for possible harmful effects to workers (as there is for pharmaceuticals before release for human use), it is only after the disease develops that the hazard is recognized, if at all. An occupational substance is considered safe until proven otherwise, and many workers are "sick of being statistics", adding to the body count to provide the evidence.

Using the "lack of evidence" argument, the refusal to alter the work environment is further rationalized by the classic cost-benefit argument "It costs too much given the benefits." On a societal level this argument is senseless. In the words of Dr. Samuel Epstein[7], "The cost studies which assert that it is too expensive to ban vinyl chloride or PVC manufacture, are based entirely on the costs to industry. The total economic costs of the 350,000 cancer deaths a year in the United States are approximately 15 billion dollars a year."

We, as health professionals, have a role to play in occupational health. This is undisputed. How we define our role depends on our perspective. Nonetheless, it is clear that the first step in being effective is to become knowledgeable.[8] The field is broad; it beckons our attention and our initiative.



Notes

1. These statistics and others are compiled in the Ontario Federation of Labour (O.F.L.) Health and Safety Manual, Feb. 1979. The O.F.L. Occupational Health and Safety Training Centre, located at 15 Gervais Dr., Suite 703, Don Mills, Ontario, also publishes a newsletter entitled *At the Source* which is well worth receiving.

2. Occupational Health and Safety Act, 1978, Statutes of Ontario, ch. 83. It is available in person from Ontario Government Bookstores for $1, or by writing The Publication Centre, 5th floor, 880 Bay St., Toronto.

3. Schilling, R.S., *Occupational Health Practice*, London, Butterworth, 1973, p. 415.

4. (A good brief statement of the magnitude of occupational cancer is found in Vol. 2, no. 3, May 1978 of Health Alert, the Health and Safety Newsletter of the Metro Toronto Labour Council. The article was written by John Marshall, and the newsletter edited by Jamie Meuser. For copies write 15 Gervais Dr. Suite 407, Don Mills, Ont.)

The Occupational Safety and Health Administration in the U.S. released a cancer policy establishing criteria for identification, classification and regulation of potential carcinogens in the workplace. The *Occupational Health and Safety Letter* is published in Washington.

5. The National Institute for Occupational Safety and Health (NIOSH) has released criteria for recommended standards for occupational exposure to many toxic chemicals. They also publish a number of reference texts including *A guide to the Work-Relatedness of Diseases,* U.S. Dept. HEW, Niosh pub. no. 79-116, and *Occupational Diseases: A Guide to Their Recognition,* Marcus M. Key, ed., USDHEW, NIOSH, 1977 pub. no. 77-181. All NIOSH publications can be ordered from Supt. of Documents U.S. Gov't Printing Office, Wash. D.C. 20402.

6. The original study by the British Occupational Hygiene Society in 1968 was declared unsound and re-examined in 1979. A definite safe level was impossible to determine.

7. Samuel Epstein is author of *The Politics of Cancer*, published by Anchor Books, N.Y. 1979.

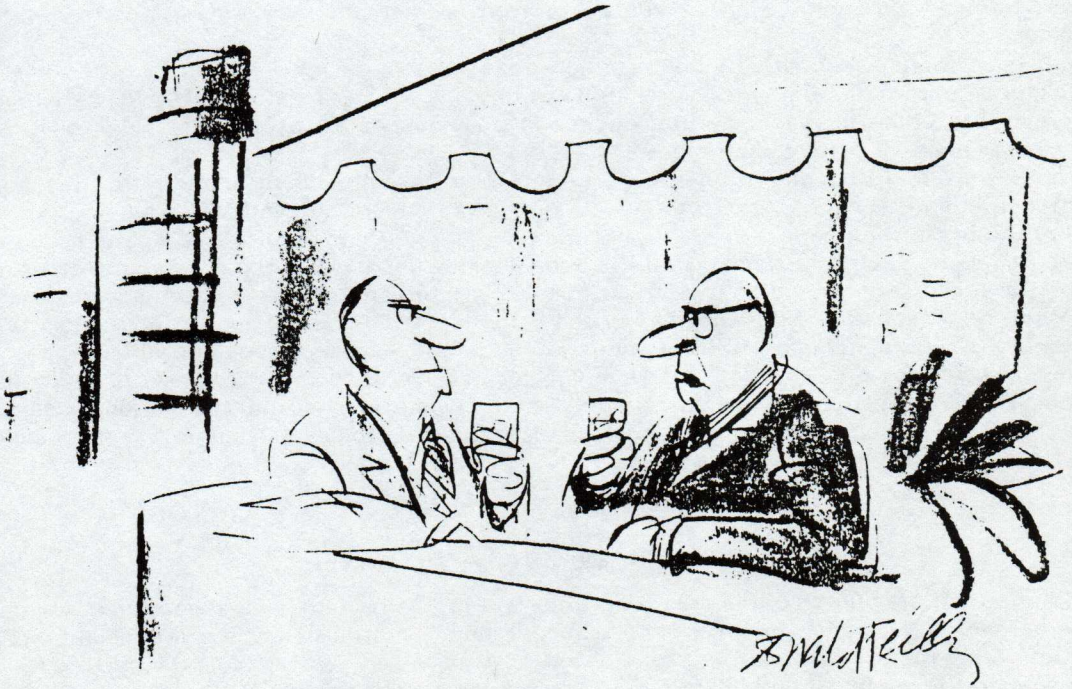
8. The Toronto Occupational Health Resource Committee has provided a comprehensive list of books, journals, resource people and audiovisual materials for the M.R.G.. The M.R.G. is organizing educational seminars on related topics.

Malnutrition and Starvation in Africa Ignored

While attracting little coverage, and even less action, malnutrition and starvation are sweeping through the African Sahel. The well known British Weekly, "The Economist" recently reported that 500 infants are dying from starvation **EVERY WEEK** in refugee camps in Somalia. The refugees are mostly former nomads from southern Ethiopia who have been driven into Somalia by war and drought. "The Economist" also reported that 1/3 of the remaining population of southern Ehtiopia are in "grave need". In a timely move, an American aid offer to Somalia of 29,000 tons of corn has been sharply cut back because of **"BUDGETARY CONSTRAINTS"**

At the same time a F.A.O. (Food and Agriculture Organization, an agency of the United Nations) sponsored missions to Uganda reported FAMINE conditions that are affecting half a million people. Aid efforts are being hampered by reports of cholera and attacks by armed gamgs of Idi Amin's former soldiers. The mission called for international aid totally 34,174 tons of foodstuffs, So far donars have pledged only 26,622 tons.

That more information is not available on the food and health situation all across the Sahel is indicative of the lack of concern of the developed countries and the western press.



"Yeah, my son's the same kind of phony liberal—billions for the Third World, zip for Chrysler."

Health Service Organizations: Criteria For An Appropriate Method of Financing

By the Community Clinics Work Group

This paper will briefly discuss the Ontario government's present approach to increased funding for Health Service Organizations. The government appears to be considering funding any group of physicians who have at least one non-physician auxillary health care worker in their employ. The delegation of funds would be on the basis of capitation negation. In this system, the province calculates the average per patient cost for specific physican rendered services. Then, for each patient on its roster who is registered with the Ontario Health Insurance Plan, the clinic receives on a monthly basis the average cost appropriate to the services it offers that patient. For a clinic delivering primary care, this cost is, at present, $3.70 per month. Therefore, a primary care clinic with 1,000 patients would receive $3,700 per month. The clinic receives the same monthly payment for each registered patient regardless of how many services it provides. However, if a patient on a clinic's roster uses another primary care service during that month the clinic does not receive the month's $3.70 for that patient. Following the first year of operation, corrections are made for the age and sex distribution of the clinic's population.

Further, the government is instituting an ambulatory care bonus. If a clinic demonstrates a rate of hospitalization which is lower than the average for its health region, it receives a bonus. The idea is to encourage the clinic to keep its patients healthier, thus avoiding hospitalization and saving the government money.

We have the following objections to the capitation-negation system:

1) The clinic is still encouraged to have as many patients as possible on its roster in order to secure the largest possible income. Therefore, the incentive to high volume practice which presently exists in the fee for service system does not appear.

2) A clinic which is in an area in which a high proportion of the patients are not registered with the provincial health plan (for example, an immigrant area in Toronto) would be at a significant disadvantage, for it would not receive the capitation payments for those patients.

3) Under the suggested system, astute physicians might establish a practice in a high income area with a predominantly young population. Epidemiologically, they would know that their patients would need significantly less care than the provincial mean. Therefore, their hours of work and their overhead would be lower, but not their income. since they would receive the monthly per patient fee whether or not they actually saw the patient. Of course, a clinic being established in a low income district would be at a significant disadvantage, for its patient population would require far more care than would be covered by the provincial mean.

4) Community clinics, to be a significant improvement over the present health care system, must be able to provide educational programs and improved home care resources. The present capitation-negation scheme makes no allowance for the cost of providing such services.

The ambulatory care bonus is equally misguided. First, it is unrealistic to expect a clinic operating in a low income area with an elderly population, however excellent its care, to produce lower rates of hospitalization than the mean for thearea. Secondly, rather than the physician keeping patients out of hospital by keeping them healthier, the result may be that patients who need hospitalization are managed in the community to earn physicians their bonus. Thirdly, the way that rates of hospitalization may be realistically expected to drop is by use of educational and home care programs. As mentioned above, the present government financing scheme provides no funds for such programs.

If the government is going to use the capitation-negation scheme it will have to provide some sort of adjustment for the demographic characteristics of the area in which the clinic is located. Secondly, if there is a genuine desire to improve care, some allowance for the educational and home care aspects which would be incorporated in a truly progressive clinic will have to be made.

An alternative to the capitation-negation scheme would be to provide the clinic with a negotiated global budget. Under such a plan any clinic (or H.S.O.) would define the patient population it is serving. An estimate would be made of the present outpatient services that the population would require, taking into account educational and home care needs. Such an estimate would also consider the demographic characteristics of the patient population. The cost of these services would then be calculated and the appropriate amount allocated to the clinic.

It would be reasonable, if the above approach were adopted, to be concerned about duplication of services. An unscrupulous clinic could fail to fulfill previously negotiated services and send its patients to other physicians and facilities for care. However, this problem could be circumvented by monitoring the clinic's performance on the basis of such parameters as the patient rota, number of patient visits to clinic, number of home visits, documentation of educational activities and attendance at such, clinic admissions to hospital, clinic research activities, clinic patient visits to other health facilities and so on.

Much More Than "Opting Out"

At the general membership meeting in Toronto on May 24th, numerous resolutions were adopted that more clearly defines M.R.G. policy on a variety of issues. Below is a brief synopsis of the resolutions that were passed.

1) Community Health Centres

We support the establishment of community health centres as a major method of primary health care delivery. The health centre would consist of a team(s) of health care workers, operating out of a single location, and dedicated to the practice of health promotion, health education, and the diagnosis and management of illness.

Financing of the health centres should: 1) take into account the demographic characteristics of each centre's population. 2) eliminate incentives to high value practice 3) provide funds for education and home services 4) be negotiated between government and the centre. The power to decide on the disposition of the funds of the centre would be shared by centre users and staff.

2) • Occupational Health and Safety

We reassert the fundamental right of every worker to a safe work environment and access to full information on the physical, chemical and biological agents s/he is exposed to. This information would include 1) what they are 2) what is known about the hazards they present 3) what remains uncertain or unknown about them. We believe that workers, individually or collectively, must be fully involved in the identification, evaluation and control of the hazards associated with these agents. Also we recognize that the right to refuse work, without penalty, is the ultimate protection from exposure to hazards. This right must be further expanded to include the collective right of a group of workers to refuse unsafe work.

In order to prevent unforseen diseases all new substances should be tested by the best methods currently available before they are introduced into the workplace. As part of our commitment to Occupational Health we feel all physicians should acquire and maintain adequate knowledge of occupational medicine and that Canadian medical schools should 1) upgrade their undergraduate curricula in occupational medicine 2) provide adequate CME programs.

3) Women and Health

The MRG believes that abortion should be decriminalized and be recognized as a matter of a woman's personal conscience. Therefore any physician unwilling to be involved in abortions or abortion counselling should be obligated to promptly refer a woman desiring these services to another physician or agency. In order to make abortions safer, less difficult for the woman, free abortion clinics should be established. We also support the establishment of primary care centres where contraception, abortion, prenatal etc. counselling and education would be available.

We feel that breast feeding and natural childbirth should be actively supported by physicians and that facilities and resources be provided for the latter. All health care workers should receive more training in women's problems in today's society as well as in office gynecology, sexuality and marital an sexual dysfunction.

Oedipus Revisited

(or Isn't the Test Tube Babies Thing Going Too Far)

In Vitro Abe, the test tube babe,
Was feeling rather glum,
Denied a loan to buy a cloan
Of his beloved ailing Mum.

He sought his pop, a synthetic fop,
From whom he had been bred,
In vitro, In Vivo, In real and placebo
It seemed that his father was dead.

Abe so it seems, had spilt pop's genes
The latter had naturally died
Abe felt remorse, it was of course
A case of overt Gene-o-cide.

Abe it was learned, later returned
To find a woman reclining
In sexual bliss, the discovered this
Sex sure beats recombining!!

Abe, the bum, had laid his mum,
Causing himself much distress
He said with a sigh, a tear in his eye
I'm just an ersatz Oedipus.

- B.L. & M.L.

Women in Medicine: We support the struggle of women to become full and equal members of the medical profession. This will be easier if 1) maternity/paternity leave and day care are made available to all interns and residents 2) part time streams in medical schools and residencies are established.

Daycare: The MRG supports free and universal daycare because it is necessary to enable the full participation of women in the social, political and economic life of society.

4) Torture

The MRG is unalterably opposed to the practice of torture under any circumstance and opposes the participation of physicians in monitoring and/or resucitating its victims for the purpose of continued torture. We consider it illegal and immoral for physicians to suppress evidence of torture or to participate in the administration of the death penalty. The membership called upon the C.M.A. to take a similar firm stand against torture.

5) Health Economics

The MRG calls upon the provincial government to increase its support experimental programs in which significant numbers of physicians would be paid by salary, capitation, and fee-for-service. At the end of an appropriate period the benefits, in terms of cost, quality of care, and patient/physician acceptance be assessed in a public forum to help establihs future health-funding mechanisms. We believe that a suitable bargaining procedure, acceptable to both doctors and the public and conforming to accepted labor practices, would make negotiations between doctors and the government more reasonable. We realize that this process may end in binding arbitration but it would put an end to a separate OMA fee schedule. We further agreed that no public remunerations should be given to any doctor practicing outside OHIP, nor should the patient of such a physician be reimbursed.

The Frontlines

Reports From the Working Groups

A National Magazine For The M.R.G..

A number of M.R.G. members have expressed interest in the idea of establishing a magazine for M.R.G. members, other progressive health care workers, and people interested in health issues. We feel a magazine would accomplish the following;

1) It would serve as a means of educating ourselves and others on health issues. It is now, very difficult, especially if one is busy, to keep abreast of issues in health care delivery, health economics, environmental and occupational health, health and development, etc.

2) It would help to bring progressive health care workers, health activists, and interested people together. It could serve as a means of communication between different groups involved in similar struggles, or between people who may need specific information and resources that other people have.

As well, the feeling of working alone often breeds disillusionment that can be easily dispelled by the knowledge that there are other people out there of like mind and commitment. A national magazine could maintain that feeling of collectivity.

3) A magazine would make the research, expertise, and analysis of the M.R.G. working groups accessible to a large audience. Research and expertise that remains accessible to only a few isn't especially valuable.

4) This magazine could go beyond the pure mechanics of medicine and explore the relationships between health care and society, something that is usually avoided in medical journals. If you would be willing to help us or if you have any articles (or if you know some one who might write one), graphics, comments, or suggestions, or good contacts, please send them to;

Benjamin Loevinsohn
151 Robinson St.
Hamilton, Ont. L8P 1Z6
(416) 522-5051

Economics Working Group:

This group has been relatively dormant since it presented its brief to the Hall Commission in April. Three resolutions were developed out of that brief, and these were presented to the full membership meeting the weekend of May 24.

Our work for the next few months consists of maintaining contact with any reports from the Hall Commission; and when its final report appears (presently expected to be in September), to be prepared with a response. As well, we are putting some thought into future directions. Some possibilities include: present funding options available in Ontario for clinics and hospitals; further work looking at other province's medicare schemes. And suggestions would be welcomed.

Community Health Centres

The community clinics work group has completed its recommendations regarding how we believe a community health centre should be organized and financed. Two resolutions were proposed and, with minor modifications, accepted by the general membership at the MRG meeting in Toronto on May 24th. As well, we have prepared a paper entitled "A Study of Community Clinics: Evidence, Conclusions and Recommendations" which details our research. A second paper, which is reprinted in this newsletter, describes our position regarding funding f community health centre. For anyone interested, both papers are available from Bob James (416-627-3914). We are asking two dollars for those who would like a copy of the paper to cover printing costs.

Our work group is presently deciding on a direction for future activities. Two areas of possible involvement are with the East End Facility and with the occupational disease clinic at Stelco which may be established in the near future. For those interested, the next meeting of the work group will be at 43 Charlton at 1930 on June 26, 1980. Everyone is welcome and we are always eager to hear new ideas and approaches.

Occupational Health Work Group

The Occupational Health Work Group has been quite active since October 1979 and currently numbers about 10. Its main objective from the outset has been towards the establishment of an educational and investigative service that can respond to the needs of workers in Hamilton. To do this, the work group has aligned itself with members of the Hamilton District Labour Council to form the Hamilton and Area Occupational Heath and Safety Committee. This committee is currently putting on a forum for workers in Hamilton entitled "Living and Dying with Asbestos". It is hoped that many further educational events along this line will be held. In addition to this members of the work group together with interested members from the Toronto chapter of the MRG recently drafted some resolutions adopted at May 24th general membership meeting.

Anyone interested in the O.H.&S. work group please contact Marty Schecter (525-2237).

Environmental Health Working Group

Four of us have been meeting in Toronto over the Winter and another two people have expressed interest in joining us. We have been talking among ourselves and with others in environmental groups around Toronto but have not felt ready for either workshops for MRG members or speaking to the public, as yet. Our discussions have been on alternative views of causes of environmental health problems, future directions in dealing with and preventing such problems and specific projects we could undertake to further such a struggle.

We saw our mandate as giving substance to part of the MRG's second principle concerning environmental sources of disease. Environmental health is, however, a very nebulous term. Various groups define a part of the environment as primary and tend to ignore the rest: e.g. a psychiatrist may focus on family to the exclusion of housing or work environments, or a toxicologist may focus on air quality in detailed quantitative analysis and neglect processed food intake. We felt it important to emphasize holistic, ecological principles in examining "environment" contrasting them with the narrow, short term activities they command. Discussions of Materialist Epidemiology, the Conserver Society, the Politics of Cancer and Human Ecology led by various members of the group have contributed to our collective understanding.

We have generated a slew of possible activities within some broad guidelines:

1) more occupationally related issues should be dealt with either jointly or alone by MRG's occupational health working group.
2) our limited experience with toxicology and monitoring methods would limit our role in detailed arguments on particular hazards without collaboration of other environmentalists.
3) as a pressure group of physicians some of our activity should be directed at medical training and the level of ignorance of environmental causation among physicians.

We started by contacting Toronto based environmental groups, both educating ourselves about their activities and enquiring about how we might be useful to them. Among the number of organizations we are looking for gaps in education/action where we could have an impact. We hope to produce a short catalog of resources for members of the MRG and others sometime by the Fall. (People in the City of Toronto Planning department are also developing an inventory).

Specific tasks we are undertaking include:

1) In conjunction with other groups, producing a report, by the Fall, on The Chemical Society which will look at the way in which we use chemicals and the health threat they represent. The report will attempt to deal with the general issues and principles involved, and suggest specific practical steps that individuals can take to protect themselves, as well as recommendations for the health professions, municipal governments and other levels of government.
2) Arising out of the above, a presentation for MRG members in the Fall.
3) We are investigating the possibility of developing and sponsoring a public conference or forum in the Spring, aimed at both health professionals, concerned environmental gropus and the general public.
4) We are going to examine the extent to which Human Ecology is taught in the health sciences, and particularly in medical school. Ultimately, one option would be to develop a course.
5) A new organization has grown out of a T.V. Ontario series on health and the environment. The Health and Environmental Network will link many concerned citizens, including some health workers, interested in finding ways to improve their health and that of their community through dealing with environmental concerns.

Those interested should contact:

Health and Environment Network
c/o Wendy Debiki
Dept. of Psychiatry
McMaster University
Hamilton

Donald Cole (416) 534-7761

Trevor Hancock (416) 278-4308

P.S. We welcome new members, their ideas and their energy!

Coming Events:

The Hamilton MRG is sponsoring a forum on toxic wastes Wed., July 8th 19:30, Rm. 3E26, M.U.M.C. Clyde Hentzman and a representative of the East-End Residents Group will be speaking.

'With A Little Help From Our Friends'

This issue would have been impossible without Evan Collins, Benjamin Loevinsohn, Denice Feig, and especially the article authors, Anna-Lee Yassi, Peter Rowe, Sandy Buchman, The Community Clinics Working Group, Peter Cameron, Ernie Loevinsohn, Trevor Hancock all made essential contributions.