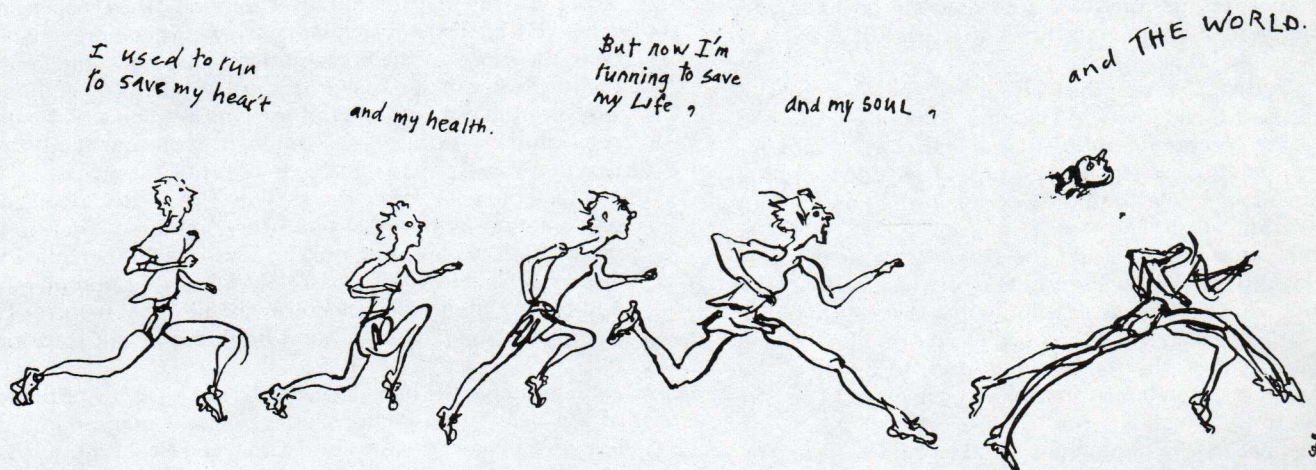


# critical condition

The Medical Reform Group of Ontario

Fall 1980



G. Byrd in "This Magazine"

## EAST SIDE STORY

Hamilton is a city with two distinct faces. One is the pitted polluted face of the Steel City, with Industry dominating it's North and East Ends. The other face reflects the influence the University has on the West End and it's suburbs. And as surely as moths are attracted to a lamp, community agencies and health professionals have followed the popular credo and "Gone West, Young Man", leaving East Hamilton and Stoney Creek underserved by comparison.

For 30 years, East Hamilton residents have been trying to redress this imbalance. Despite vague promises by government and the periodic allocation of potential land sites, little has been actually done to remedy the situation and many problems have come more obvious since the arrival of MacMaster.

For example, the East End has the highest patient physician ratio in the city, no ambulance station within it's confines, contains only 69 of the 1,300 chronic care beds in the region and has no specialists offices. Psychiatric services are almost non-existent, and the tight catchmenting policy of MacMaster is a source of frustration and anger for local residents and G.P.'s alike. All this in an area of 100,000 people, the only growing area, moreover, in the city.

There are also less apparent deficiencies. No occupational health centre, in a heavily industrialised region with a multitude of environmental hazards, no facility for the disabled and no psychotherapy or D.T. Services.

Despite this, there have been no moves to build a health facility to meet these needs. Instead, the 1960's saw the development of MacMaster medical centre, not in the East End, where it would have been convenient for local residents, but in Westdale - more convenient perhaps for medical staff.

In the 1970's a decision was finally made to rebuild the General hospital, and largely as a result of pressure from local residents, who managed to keep the issue alive, the local District Health Council (D.H.C.) set up a Steering Committee to examine Health needs in the East End.

Their report, full of inaccuracies and misrepresentations, highlighted some deficiencies but recommended no in-patient facility be built. It is by no means clear that an in-patient hospital would be the best solution to the problems of the East End, but the Steering Committee avoiding examining any alternative possibilities.

In 1979, the government decided to build "a health facility" in the East End, and entrusted it's planning to a



Task Force of the D.H.C. Their guidelines were very clear. There were to be no in-patient services and the cost should be kept to a minimum, reducing the chances of a comprehensive health centre to almost zero.

Finally the Task Force, which itself was composed with members of the health professions set up a professional advisory committee. This body, for the main part consisted of representatives of a variety of interest groups, all seemingly more concerned with seeing their empires preserved undisturbed than being receptive to new ideas that might mean change. Conveniently then, their views coincided with the goals of the Task Force - to provide the bare minimum, although as the P.A.C. met just three times in four months the impact of their advice has been equivocal.

Throughout, the Task Force has maintained an air of secrecy about their discussions. As local citizens groups began to organise themselves, a token representative was co-opted onto the committee, and then told he couldn't divulge their discussions to his community group. Open meetings were out of the question and it was not even clear if briefs would be accepted.

It was at this stage that the M.R.G. became involved with the East End Residents Pro-Hospital committee. We had already been preparing our own brief and as a result of our meetings with the Pro Hospital Group we decided to submit complimentary briefs, with ours concentrating on the Out Patient Ambulatory, and Home services.

In this paper we analysed the deficiencies in the East End's Health service in the context of the needs of the residents, rather than health budgetary constraints, and also tried to bear in mind the need to co-ordinate existing resources within the community and to involve the community as much as possible in all aspects of the planning of their health centre.

We defined how a community centre - either existing on its own or by being integrated into a community hospital, could meet these needs, following on from the work by the Community Clinics work group. We outlined some of the essential component services including a mental health centre, a family practice unit, which would form the core of the centre, and explained how well woman and baby clinics, family planning and occupational health clinics, and specialist services could all be easily accommodated. We also included physiotherapy and occupational Therapy facilities.

We visualised all staff as being on a salary within a global budget and maximum involvement of the community at all levels of decision making. (This would include use of the facility for non-medical purposes after hours). We added an innovative idea - of using non-medical agency personnel in the work of the centre. This would avoid duplication and increase co-ordination of services, cement ties with the community and help move the centre away from the medical model in the communities eyes.

In addition, we envisaged a wide range of programmes provided by the centre for various target groups. Preventive programmes, Day Care for the aged or diabetics, Alcohol counselling, Home Care and an imaginative Home Hospital programme that would provide home supports for acutely ill patients who might otherwise need to be hospitalised were all considered. And unlike the other briefs that were prepared, ours put forwards practical ideas within a clear clinic model, covering the entire range of activities an East End Health Centre could eventually provide.

But on the day of our presentation (the Task Force refused to allow a public hearing allowing each presenter to be in the room for the presentation of their own brief only), the response of the Task Force was predictable. Although we were the only group of physicians in town who made a presentation, narrow self interest won out and their reaction was to try to devalue the M.R.G., as an excuse for not listening to our ideas. The Press described our presentation as the only time the committee came to life during the evening but only to ask us whether our idea wasn't similar to the Cuban Polyclinics that one member had heard about at a lecture six months before. The sentiment being "I see a good brief and I want to paint it red".

So although the final decision will not be made till the end of the year, the reactions of the Task Force and all the pointers suggest the East End will again be sold short. While we cannot say that there is a need for an East End Hospital, it is clear that the East End needs more than the token facility they will probably end up with. We shall continue to fight alongside the local groups we have worked with till now to bring this about. Our brief gives us a solid start, but I think our insights into the workings of Health Service democracy in Hamilton have been salutary, and don't leave us with too much optimism about the eventual outcome.

Nick Kates

## EL SALVADORIAN HEALTHWORKERS PROTEST RIGHTS VIOLATION

More than 600 doctors, supported by other health workers of both public and private health institutions have gone on strike to protest the violation of human rights of health personnel and patients. There have been tensions in Salvadoran hospitals for some time the incidence of armed men invading hospitals to look for injured "leftists" has grown. However, the months of April and May proved to be more than the health care workers could stand.

On May 15th, the bodies of two young doctors, Miguel Angel Garcia and Carlos Ernesto Alfaro were found. The two young men had been kidnapped, for the crime of treating patients who were considered to be part of the popular opposition to the government. Although there have been many murders in health institutions this was the first time health workers had been attacked for treating patients.

On the 21st of May, Leonel Menendez Quiroga, a Guatemalan professor working at the Central America University, was abducted from the operating room where he had just received anaesthesia prior to surgery. His whereabouts are still unknown.

On May 1st, Ernesto Flores Duenas and Victor Alfredo Gonzales were murdered in the Emergency Ward of a hospital in San Martin. The two men had been accidental witnesses to a massacre of eight campesinos in Barrio El Calvario on the 26th of April. The campesinos were assassinated when a military operation with more than 60 heavily armed men, some in civilian dress and others in the uniform of the National Guard, was carried out in that area. Flores and Gonzales chanced to arrive on this scene. They were pursued and overtaken upon reaching the city of



San Martin. Seriously wounded, they sought medical assistance at the emergency centre where they were killed a few days later.

In view of the situation facing Salvadoran health workers and patients, a petition has been presented to the Government by a broadly-based sector of health workers. Of prime importance in this petition are the following:

1. A guarantee of the physical safety of patients and health workers.
2. The recognition that health workers have both the right and obligation to render health care assistance to all those who seek it.
3. That the inviolability of health care establishments be recognized.
4. That guarantee be given that health care establishments will not be taken over by the military.

The health care workers have asked that a United Nations and Red Cross Permanent Commission for Human Rights be established in the country to monitor these guarantees.

International support for the Salvadoran health workers is very important, and will be instrumental in applying pressure to the Government of El Salvador to respect these very basic human rights. We would urge Canadian health workers to support their Salvadoran colleagues in this struggle by sending a telegram to denounce the repression against patients and health workers in El Salvador.

In order that the Salvadoran health workers know of your support, please send a copy of your cable to the Inter-Church Committee on Human Rights in Latin America (ICCHRIA).



OVER

## BARRIERS TO PREVENTION

The M.R.G. has a strong commitment to preventive medicine and a first step in acting on that commitment is to examine the barriers that now exist to the more widespread use of preventive measures. If we understand the barriers we may be able to overcome the inertia of the medical establishment in this area.

The medical establishment is not a solitary mass, different people in medicine have different reasons for ignoring prevention. In examining some of these reasons it is difficult to empirically determine which are the most important and whether some are, in fact, impediments at all. The following, therefore is not meant to be exhaustive and may include things that play only a minor role.

### - Tradition and Education -

In Western medicine prevention has rarely been seen as part of the doctor's role. The inertia of tradition has meant that young health-care workers have had no role models in this area. It has also meant that prevention has not often been incorporated into the educational process, which in turn, has led to ignorance on the part of many M.D.'s. For example, a recent survey in the United States showed that doctors knew less about basic nutrition than their receptionists. This ignorance has manifested itself as an unwillingness to try preventive measures, and possibly worse, contempt for anyone who does.

As has been often noted, Western medicine, since Pasteur, has had an intellectual tradition of looking at disease as a unifactorial process where environmental influences are not very important.

These traditions may take a long time to change but this can certainly be hastened if we give health-care workers the education and skills to feel comfortable with preventive medicine.

### - Lack of "Scientific Certainty" -

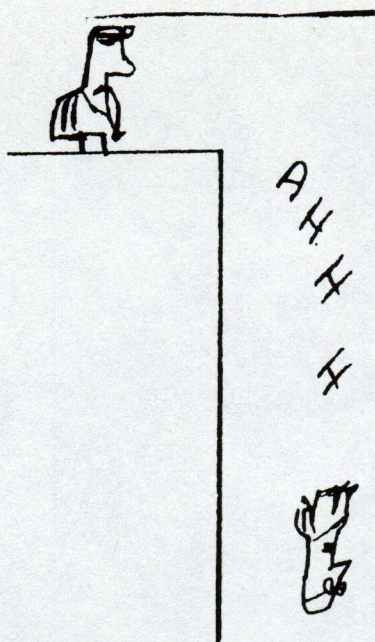
Many people who would otherwise be in favour of more emphasis being put on prevention become skeptical when faced with the lack of "scientific certainty" regarding its benefits. This argument should not be trifled with and definitely deserve more space than that allowed for it here, however a few points ought to be made:

Firstly, one's criterion for what constitutes good evidence seems partly determined by one's politics and self-interest. Hence, Johns-Manville's scientists contest the effects of asbestos fibres on its workers' lungs, because to install the equipment necessary to lower the fibre levels would bite into company profits. It thus becomes clear that a scientist's opinion will often tell us more about the scientist than about the evidence.

Secondly, "certainty" costs money and effort. Without the money and commitment to research on prevention our knowledge, our level of certainty will stay the same. Yet this seems to be a sort of catch-22 situation. The perceived uncertainty about the benefits from prevention results in less money being spent on its research and so uncertainty remains. This bias is clearly evident in cancer research where only a small percentage of total research funds are spent on prevention.

Thirdly, in a comprehensive analysis, certainty by itself, may not be of paramount importance. If something is of grave importance to an individual's or community's health one might choose to act in the absence of generally accepted levels of certainty. For example, air pollution in our cities may only double our chances of developing lung diseases (even this is contested) yet, because 80 per cent of us live in cities and have to breathe the stuff, it is obviously an important area in which to examine the possibilities of





"Canadian Forum" May 1980

prevention. Thus to talk only of whether pollution causes disease with  $p=95\%$  is simplistic.

Taking into account both the probability of being right and the consequences of being right is, in game theory, called expected gain and equals the probability of "winning" times potential "winnings" minus the cost of "playing". If this approach is used it became apparent that certainty, or lack of it, becomes only one of the things that must be considered in the decision to take preventive action.

Fourthly, the lack of certainty surrounding prevention does not explain why some well documented preventive measures are ignored by people in medicine. For example, while virtually every family doctor actively "treats" hypertension how many actively treat smoking. The evidence supporting the benefits of "treating" both these problems is very strong and so it must be something else, besides the lack of certainty, that explains the difference in emphasis placed on these two "conditions" (It is possible that it is mode of treatment itself that accounts for the difference, more about this later).

#### - The Attraction of Curative Medicine -

One of the major attractions of curative medicine is the feeling that you are actively improving, or saving, somebody's life. You treat someone and sometimes s/he gets better, often dramatically (whether it's because of what you did doesn't really matter). You become an actor in a human drama that you know is real because you can attach faces to it. This need to be involved in the drama may be human nature, and as they themselves freely admit, this is an especially important motivation among surgeons.

Preventive medicine doesn't always offer the opportunity to attach faces to the people you "save" and usually you have to exist in the ethereal world of statistics. This doesn't allow for much ego gratification and thus may lead to yet another bias against prevention.

Overcoming this bias may be difficult but is none the less comfortable with probabilities and statistics they may be able to attach the same amount of joy to helping someone to quit smoking, or improving air quality as they now get from treating a Myocardial Infarction.

#### - Morality and Politics -

Medicine has believed itself to be, in some regards, beyond politics. It obviously has had no problems in being political when discussing doctors' incomes or state intervention, but when somebody needs help, say a traffic accident victim, politics seems irrelevant. This attitude has been strengthened by the fact that virtually everyone, regardless of ideology, considers it the height of morality to treat someone who is in desperate need. This has left many doctors with the feeling that politics has no place in the workings of medicine. This attitude is clearly a bias against prevention because it is inherently political. Improving air quality takes political will and a coming to terms with the economic forces that create pollution. Even attempting to decrease the number of people who smoke involves overcoming a strong tobacco lobby.

Overcoming medicine's fear or contempt for politics will not be easy especially in a time when political apathy runs rampant. However, if, as many maintain, one's actions determines one's beliefs as much as one's beliefs determine one's actions, it is possible that as more health professionals become involved in prevention the bias against political action will disappear.

Related to this fear of the politics of preventive medicine is a concern for the ethics of prevention. Some doctors, mostly I think, the very conservative, would argue that telling people what lifestyles they should lead as opposed to telling them how to deal with a specific illness is very dangerous because the doctor assumes tremendous power. This argument centres around the act of "telling people". Is that what preventive medicine entails? It is more likely that prevention entails educating people and being forced, as in no other area of medicine, to encourage people to take responsibility for their own health.

Doctors don't seem very comfortable with the role of education, partly because they don't receive much training in it, but also because education is seen to be more value laden than prescribing a drug. It is probably this attitude that accounts for the lack of effort of family doctors to actively deal with smoking the way they deal with hypertension.

#### - Financial Obstacles -

It is sometimes argued that because medicine derives its income from treating sick people it is against its best interest to prevent illness. Personally, I don't think doctors deserve credit for thinking that far ahead. However, it is clear that the present fee schedule (and perhaps the whole fee-for-service system) provides few incentives to practice preventive medicine. Unless one has a small volume practice it's simply not worth one's while to do any serious counselling or educating.

This obstacle to prevention may be one of the easiest to overcome. A variety of approaches are possible; The fee schedule can be changed to give incentives for preventive work. The method of payment can be changed to salary or (with trepidation) capitation-negation. Another important approach might be to better utilize the available, but under-utilized medical talent in the form of nurses, nurse-practitioners, and other health professionals.

#### - "We'll Always Need Creative Medicine" -

Regardless of how effective our preventive measures are, people will still sick or receive traumatic injuries that will require curative care. This fact is often used to



argue that prevention will only reduce the amount of money and resources that can be spent on essential, creative services. By arguing this way the people opposed to prevention deny one of the most important lessons of 20th century medicine; That is, that you study and try to understand the whole disease process so that you are able to decide where your inventiveness will have the most effect.

For example, if an elderly man with arthritis in his knees, is repeatedly admitted to hospital for bronchial pneumonia you can keep on treating his pneumonia which would seem to be the life-threatening process. However, if you look a little deeper into the disease process it comes out that this man lives alone, rarely goes out because of his knee joints, and hence eats poorly. It's clear then that the management of such a patient would benefit greatly from dealing with his arthritis (even though an admission this seems to be a minor annoyance) which would allow him to go out and go shopping.

The moral of the story is that the planning of effective intentions will not allow for biases against certain ways of dealing with situations because they aren't considered part of the traditional, creative, approach. However, it is not only effectiveness that is important! Western medicine is obsessed with results, often to the exclusion of considering process. Yet often the process, the way in which an intention works, is vitally important. Because traditional medicine does not often think it such items it is difficult for it to evaluate preventive medicine in an honest and unbiased fashion.

If we know and understand these and other impediments to prevention we will be able to direct our efforts so as to overcome them. It may take a lot of time and effort but it is quite possible that prevention will take its proper place in our health "care" system.

- Benjamin Loevinsohn

## THE DOCTOR'S SONG - Art Samuels

Oh doctor, Oh doctor with fever I sieze,  
My lungs so congesed I scarcely can breath.  
I've got all the symptoms, of what I don't know,  
Oh doctor, Oh doctor let's get on with the show.

Your case I shall presenty diagnose,  
But first let's examine the cut of your clothes.  
If you're poor don't you fuss, all you need's BROMIDE,  
If you're rich, your poor man, won't you step right inside.

Oh doctor, Oh doctor I'm in such terrible pain,  
I do believe it will drive me insane.  
On rising this morning I stubbed my big toe,  
It's not just a sprain it's a fracture I know.

Your problem might be your toe, as you said,  
But just to make sue I'll x-ray your head.  
Ah yes, the te, well that's not on my list,  
I'll have to send you to a big toe specialist.

Oh doctor, Oh doctor, I'm in such distress,  
My operation was not a success.  
It's terrible tidings I must now confide,  
I fear you forgot your scissors inside.

This news is frightful I'm tempted to weep,  
For surgical scissors today don't come cheap.  
But seeing as they weren't overly large,  
Let's simply forget there'll be no extra no extra charge.

Oh doctor, Oh doctor I'm gravely ill,  
I've no appetite after eating my fill.  
I've got pains in my bone, stomach and back,  
And when I close both my eyes everything just goes black.

You're gravely ill and that's a plain fact,  
I can hardly find one single organ intact.  
But you wheeze and you moan so I can't make you out,  
Go home and lie down, and if you pull thru  
Come back when you'e better, we'll see what's to do.

## Letter to the Editor

Dear Sir:

Recently the City of Toronto made a presentation to the Hall Commission on health priorities and on the threats posed to universal accessibility to quality health care in Ontario.

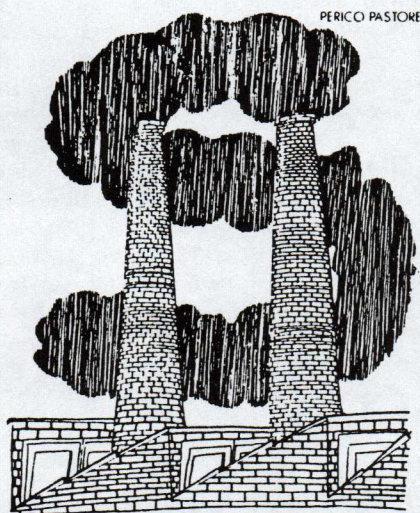
One of the motions which came from this policy and was approved by the Local Board of Health and City Executive suggested that the City should be sure that citizens had access to physician services that accept OHIP as full payment. In order to promote this position the City would consider sending out such information and would also exercise choice as an employer of physicians by avoiding employing opted-out doctors.

In retaliation the OMA passed a motion condemning the City's position and a further motion asking all physicians to boycott the City of Toronto. This decision is an expression of a new mood of militance by the OMA in their drive to change health in Ontario from a universally accessible right to a set of market relations based on ability to pay.

One might note that for three years the OMA has encouraged doctors to opt out of OHIP. This encouragement has been quite unsuccessful: only 16% of Ontario MDs have opted out, while more than 83% remain in the plan. It appears the OMA is representing a small minority of Ontario doctors.

I urge you to support the City of Toronto and its Local Board of Health in this struggle. We will monitor the results of the OMA boycott and keep you informed.

Yours very truly,  
Mayor John Sewell





# Jobs and Notices



City of Toronto

## DEPARTMENT OF PUBLIC HEALTH

The Local Board of Health of the City of Toronto recently carried out fundamental assessment of the most effective role for Public Health in Toronto. The report and policy adopted by City Council is called Public Health in the 1980's.

As a result, the Department of Public Health is now entering a multi-phased reorganization, with emphasis on:

- increasing public health responsibility for environmental, occupational and social conditions;
- multi-disciplinary professional working teams;
- a team management system;
- local area decentralization, with community involvement; and
- recognition that public health exists in a political context, and must take an advocacy position in many instances.

The City of Toronto is now undertaking a major search for a

## MEDICAL OFFICER OF HEALTH

The dynamism and willingness to explore new directions in public health will be reflected in the choice of this, the chief executive officer of the City of Toronto's Department of Public Health.

The Medical Officer of Health will be a person with the leadership skills, experience, and insight to lead the Department in the directions set out in Public Health in the 1980's. Leading the Health Department's 600 staff into greater community activity is a prime function. The job requires both strong administrative competence and an ability to work in a political climate.

We require a Physician who is qualified or eligible to be qualified to practise in the Province of Ontario and who has a Diploma in Public Health or comparable specialized post-graduate training at the Master's level.

Salary Range: \$52,855 - \$66,100 per annum (effective January 1, 1981)

We offer excellent fringe benefits and salary will be commensurate with qualifications and experience.

All positions are open to women and men applicants.

Applicants are requested to submit a resume in confidence to:  
Personnel Services Division,  
Management Services Department,  
17th Floor, West Tower,  
City Hall,  
Toronto, Ontario. M5H 2N2

\*\* On May 23, 1980, a mail deposit containing cheques for \$657 in MRG membership dues was stolen. Later that same day, several MRG members had forged cheques presented at their banks. The forgery ring responsible has evidently been caught, but the cheques were not recovered. Your provincial treasurer sent out an explanatory letter and request for new cheques to all members whose cheques were known to have been in that deposit, but in some cases the sources of the cheques were not known. If you submitted your membership dues before May 23, 1980, and if your cheque has never been cashed, your cheque was probably among those stolen. Please send a replacement (regardless of which chapter you belong to) to the Toronto mailing address.

\*\* The Jesuit Centre of Social Faith and Justice has notified the MRG of several employment opportunities for physicians. One is as staff physician at the Cardiff and Area Health Care Centre (10 miles from Bancroft, Ontario), available this fall another is in Jamaica, practicing long or short term within the Government Service. More information on these opportunities can be had from Jim Webb, Jesuit Centre for Social Faith and Justice, 947 Queen St. E., Toronto M4M 1J9, telephone (416) 469-1123.

\*\* South Riverdale Community Health Centre in Toronto is looking for a fourth physician to work half-time with three other MRG physicians. This position is available immediately. Send a resume to Bogna Andersson, Administrator, South Riverdale Community Health Centre, 126 Pape Ave., Toronto M4M 2V8, or phone (416) 461-2494 for further information.

\*\* Reminder: Our 1980 membership year ends on December 31, 1980, and we must soon begin the arduous task of collecting 1981 dues. The fall general meeting can constitutionally change the membership fees, but old and prospective members are urged to pay their 1981 dues as soon as possible after the meeting. Dues should be paid to the local chapters in Toronto and Hamilton, and directly to the provincial chapter for members elsewhere. Cheques post-dated for January 1, 1981 will be welcomed.

## With a Little Help From Our Friends

Thanks to Debby Copes, Evan Collins, Nick Kates, Trevor Hancock, Benjamin Loevinsohn



\*\* We sometimes receive requests from groups or individuals looking for progressive physicians. Two recent Toronto requests are from the YWCA's Focus on Change program (a four month program for single mothers wanting to return to school or work), and from Injured Workers' Consultants. Physicians who would be willing to see clients from either of these groups are requested to contact: Vivian Green, YWCA Focus on Change, 961-8100, Mondays and Wednesdays  
Blanche Calahan, Injured Workers' Consultants, 461-2411  
(both GP's and orthopaedists are needed).

Yet another is with Medical Aid to Nicaragua, which is recruiting: 2 paediatricians and 1 obstetrician-gynaecologist for 2 years of practice under the direction of the Nicaraguan Ministry of Health. Volunteer will be funded by CUSO. Interested physicians should contact MATN, 175 Carlton St., Toronto M5A 2K3, or phone Dave O'Connor at (416) 961-3935.



Nicole Hollonder  
in "New Internationalist"

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S.B. Whitehead ON

Medical Reform Group of Ontario  
P.O. Box 366, Stn. 'J', TORONTO, ONT. M4J 4Y8

CANADA



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