MRG NEWS LETTER

MEDICAL REFORM GROUP OF ONTARIO
P.O. BOX 308, STATION "J"
TORONTO, ONTARIO M4J 4Y8

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MRG GENERAL MEETING:

SATURDAY
OCTOBER 22, 1983
9:30 AM SHARP
MCMASTER CAMPUS*
HAMILTON, ONT.

* At the time of writing, the actual location had not been established. Please keep in touch with your Chapter representatives and/or members of the MRG Steering Committee.

- As this is a one-day only General Meeting, delegates are urged to be on time for 9:30 am registration, and for the start of proceedings at 10:00 am, at which time the meeting will be called to order.
- The morning will deal with MRG reports:
  - o Steering Committee
  - o Chapters
  - o Canada Health Act update
  - o Abortion Committee
  - o Quality of Care
  - o Economics

  During the morning session, some current matters will be brought to the attention of members concerning recent meetings with other groups that MRG has attended through the Steering Committee.
- Lunch will follow the morning sessions, at a place to be announced.
- From 2:00 - 4:00 pm, there will be session of major interest:

A CRITICAL LOOK AT PREVENTIVE MEDICINE

PRESENTERS WILL BE: John Frank, Gord Guyatt and Fran Scott

This will be a discussion on preventive medicine, screening for risk

factors, and several other important areas for consideration and study.

- NEW BUSINESS will follow, and there are some major issues to be introduced.
- Plans for dinner and other social activities following the meeting have yet to be finalized, but there will be some program arranged.

(We understand there is a conflict of date with the nuclear demonstration. MRG will be sending a telegram in support.)

- RESOLUTION PROPOSED FOR ACCEPTANCE AT THE OCTOBER GENERAL MEETING

Whereas the prices charged for drugs by the multinational drug companies are expensive, and

Whereas the availability of generic drugs can result in substantial savings to the Canadian public, and

Whereas the proposed amendments to the patent act would reduce the future availability of generic drugs,

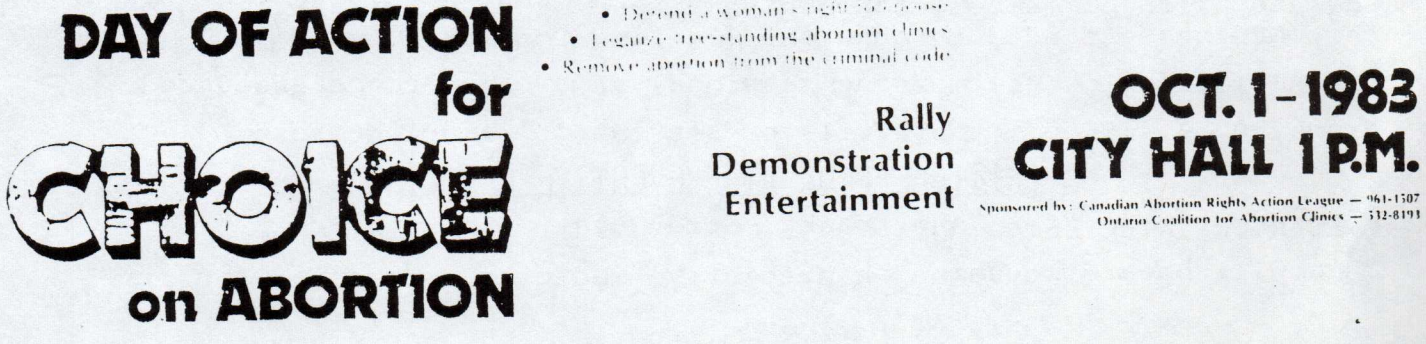
BE IT RESOLVED THAT the MRG calls on the Federal Government to abandon its plans to change the patent act as it applies to prescription drugs.

STATEMENT TO MINISTER OF HEALTH: with this NEWSletter we have included a statement of "Ontario physicians support for the establishment of medically insured free-standing abortion clinics", which is self explanatory. For signing and/or distribution, contact Miriam Garfinkle, (416) 531-2861 (h), or (416) 535-1958.

IT'S MEMBERSHIP DUES TIME: Yes! it is membership dues time and a form for your renewal membership is enclosed. Your early remittance will be most appreciated, along with the return of the form.

QUALITY OF CARE COMMITTEE: this committee has met twice during the summer. Several areas for study and action were discussed ranging from the current difficulties in the health care system to the quality of the doctor-patient interaction. Anyone interested in being associated with this committee should contact: Christine MacAdam, 8 Hector Ave., Toronto (416) 534-3045.

POSITION AVAILABLE: Klinic,Inc., requires a full time general practitioner to work in a community health centre in conjunction with two other physicians, nurse practitioners, and other professionals and paraprofessional social services staff. Resume to: Coordinator, Medical/Community Services, Klinic, Inc., 545 Broadway Ave., Winnipeg, Man., R3C 0W3.



Stephen Dale

Differing diagnoses on HEALTH CARE

MIDWAY through 1978, a young post-graduate doctor-in-training drifted dourly through the antiseptic glare of Toronto Western Hospital like some James Dean in intern's fatigues: weighed down with discontent at the medical mores he was supposed to be learning to love; alienated, frustrated and silently opposed to the powers that were overseeing his passage into doctorhood. Dr. Fred Freedman, now a physician in private practice, had certain notions as an intern that "the way the medical system was being run was wrong," but out of discretion and fear of the establishment he kept those ideas to himself.

One fateful afternoon, after a morning of crossed swords with the hospital bureaucracy, the dam burst, and Freedman confessed his "progressive" political soul to the intern who happened to be standing next to him, outside the hospital's radiology lab. The other's response, surprisingly, was one of recognition, and following on that was a revelation that thundered home with all the emotional velocity of a thousand final scenes from Marcus Welby, MD.

"We were both feeling acute frustration with the system," recalls Freedman, whose youthful good looks would make him a star candidate for General Hospital. "In effect, we turn to each other for comfort and, my God, we find it and we're both stunned. The feeling was 'Where have you been?' We almost put our arms around each other."

They had lunch together the following day, at which time the pair poured over the plight of isolated "progressives" within the gold-plated world of medicine, and exchanged visions of what health care in Canada should be like. Shortly after that emotional union, the Medical Reform Group of Ontario (MRG) was born.

Today the MRG boasts a membership of more than 200 — about half doctors and half medical students, based mainly in Toronto and Hamilton — a puny platoon when compared with the Ontario Medical Association's army of 15,800 doctors but still, a growing voice from the fringes where before there was only silent compliance. The renegade medics of the MRG insist they aren't really radicals; that many of their key tenets for reform were the same ones stressed in Federal Health Minister Monique Begin's first (though aborted) draft of the impending Canada Health Act. Still, up against what some characterize as the extreme ideology and enormous influence of Canada's official medical associations, these kamikaze medicos appear to be dive-bombing conventional wisdom.

The ferocity of their disagreement can be seen in the MRG's founding statement, in which it delivers a stinging rebuke to the Ontario Medical Association. Calling the association "a powerful force for retarding progressive development in the health care system," they chide it for being "too conservative and overly self-interested." Between David and Goliath there comes an entire philosophy of medicine. With health care in Canada plunged deep in crisis (basically because there isn't enough money to feed the system), the feeling is that something's got to give — and the medical lobby is determined that it won't be doctors' salaries or status. Enter the progressive medics with their "small is beautiful" heresies. They are against large salaries, against lots of high-tech medicine, and for more accessible "primary" health care delivered through community facilities. They also feel it's high time to "democratize" the health system, to scrap the "archaic hierarchy" of doctordom and to invite other health care workers and involved citizen groups into the limelight of medical policy-making.

Dr. Michael Rachlis, a salaried doctor at the South Riverdale Community Health Centre and the MRG's resident expert on medicare, attributes the current health care conundrum directly to the preponderance of fancy surgery and the new and expensive high-tech medicine that many doctors consider "sexy". Rachlis says the return on those things is not high enough; that a doctors' collective might and individual expertise would, in general, be better directed toward environmental, occupational and preventive health care.

"What we're seeing now," says Rachlis, a balding softspoken man with a passion for statistics and a penchant for subtle sarcasm, "is that we're spending all this money on health care, and it's not really doing anything for health, that it's making no real difference in terms of morbidity and mortality rates. The major determinants of health in our society are related to housing, nutrition, occupation and that type of thing. Those ideas were radical 10 years ago, but now they get front-page coverage in The Wall Street Journal. It's becoming clear that preventive medicine is what gives you the big bang for your buck."

What does not make economic sense, says Rachlis, is paying an increasing portion of health budgets to doctors, at the expense of other health care workers. "If the trends continue," says Rachlis, "with

Medical reformers see symptoms of a condition that may be terminal

doctors getting more and more of the pie, and less and less available for other health workers and for innovations such as community medicine, we're going to be facing a tremendous squeeze, where your grandmother and my grandmother will be able to get coronary artery by-pass surgery, but she's not going to be able to get a $5-an-hour home-care aid to keep her in her home."

Rachlis also takes a shot at medical education, not because it represents poor economy, but because, claims Rachlis, it is socializing doctors inappropriately for a profession demanding of mercy and imagination. The MRG believes that modern medical training fosters an aristocratic attitude on behalf of doctors, isolating them from the concerns of average people, and confining them to the inbred hierarchical world of fellow physicians.

"Doctors undergo what is without a doubt the harshest of any professional training," says Rachlis. "And if you look at the hospital environment, where most doctors are still trained, it is the closest thing in our society to the military. You have several different classes of workers, and within each of those six or so professional groups, you have at least four or five different levels. For doctors there are about ten links in the chain of command from the chief of medicine to clinical clerks who are just med students . . . Everyone has uniforms, and the nurses have different stripes to denote their rank. They don't salute each other, but there are certain informal salutes.

"The training itself is not unlike marine boot camp: there's extremely long hours, you step out of line and you're subject to degradation; and it's not surprising when many doctors are through they tend to function with this extremely rigid frame of mind. It breaks you down; One of the over-all effects of this is that it removes people from the real world so that they can no longer relate to day to day problems that people face. The other, I think, is that it really removes analytic capabilities. Many doctors have lost the capacity to think."

Dr. Debbie Copes, another physician in private practice and a member of the MRG steering committee, feels the trials of "getting doctored" are reflected in current physicians' economic demands. "I really think it leads to the belief that once you get out you deserve whatever you can get — like, 'I've suffered, I've done my time, all those hours on call, why shouldn't I be paid well for it now?' "

Which brings us back to the subject of money, a threat to many relationships at the best of times, and something which hasn't won medical reformers much respect among their peers.

"Generally we disagree with the financial preoccupation of the OMA and are on the side of the public," says Freedman, "which I think feels that doctors are generally making a fair piece of the cake, and that it's time to say 'wait a minute, how much of our health care budget is going towards paying doctors' bills' . . . We get a lot of resentment from the medical profession because they tend to see themselves as under attack, so when we stand up on the public's side, they take it personally. There seems to be some degree of discord and anger."

Those types of responses — anger, and perhaps disdain — are what one might expect would greet such uninhibited critics of an almost sacrosanct profession. Yet the official reaction has been almost conciliatory. The provincial ministry of health, which has jurisdiction over administration of health services has invited the MRG to its "Health Care in the 80s and Beyond" conferences (the MRG has accepted). One ministry official indicated the group's ideas are given "due consideration along with those of the OMA." The OMA's response has been cool.

Eugene O'Keefe, director of communications for the OMA, refers to the leftist doctors and their barbs more with amusement than anger. O'Keefe contends that the OMA promotes a balanced health care system — and has paid ample attention to preventive medicine. "How far does it go?" O'Keefe asks, "Do you have a nutritionist on every block? . . . A lot of preventive medicine is also education, but there the compliance factor enters in. What if people refuse to act on the education — do you force them to change their lifestyles?" As for the MRG itself, O'Keefe notes the high proportion of its membership in medical school, and suggests that "because they are young they like to take on specific causes, as one always does in university . . . A lot of people want to change the world overnight, which I suspect is the case with many members of the Medical Reform Group."

How does a tiny band of idealists go about trying to change the world? At first it started small: beginning as a mostly covert and low-key group operating mostly to provide self-support for "progressive" doctors who were "coming out."

"I joined in December of '78 when it was still in the stage of meeting in Fred's house," says Copes. "At that first meeting what I found was some old friends whom I hadn't seen since medical school, whose politics I really hadn't been aware of. I also found a sense of relief that the people I was mainly surrounded by, the doctors I worked with every day, were not the only kind of doctors there were: that there were doctors who shared my views."

Shortly after that the MRG went public, struck a constitution and began to participate in various issues. During the hospital workers' strike of 1979, the group voiced its support for the CUPE strikers and organized against using interns for so-called "scab" labor. Later, several MRG members founded a store-front occupational health clinic in Hamilton (which has since folded due to financing problems). The group has also broadened its influence considerably by hooking up with the Ontario Health Coalition, an amalgamation of 17 like-minded special interest groups including labor unions, seniors, church and native peoples' groups, the Registered Nurses Association of Ontario and the Social Planning Council of Metro Toronto. The leadership of those organizations is said to collectively represent three million Ontarians.

Yet both the MRG and the OHC have found their major battleground, predictably, to be the troubled territory surrounding extra-billing and opting-out by doctors. Coincidentally, the MRG went public around the same time the current epidemic of opt-outs began to sweep the country, and it's this phenomenon which has bestowed upon the group much of its momentum and membership.

Like the official medical associations, the reformist doctors are awaiting the release of Begin's new Canada Health Act (and trying to influence its content in advance), as that document should provide the definitive word on extra-billing. The minister has hinted that the new act will lower the boom on doctors who have opted out of medicare, in order to bill patients directly and at their own rates. In the late '70s the level of opted-out doctors increased from a traditional level of 8- to 10 per cent in Ontario to a high of 18 per cent, prompting many groups like MRG to fear the rise of a two-tiered medicare system, where only those who could afford it would receive superior health care. The medical associations, however, feeling that doctors had dropped in status during the years of the anti-inflation board, began to lobby in favor of a doctor's right to opt out and set his own prices.

For a few doctors, like occupational-health physician Dr. Brian Gibson, to be a part of a doctor's organization that campaigns against medicare is an unbearable contradiction. Gibson, on staff at St. Michael's Hospital, department of environmental and occupational health, and a teacher at the University of Toronto's faculty of medicine, quit the OMA in 1982 "when they raised membership fees $100 to build up the war chest," having simultaneously been a member of the MRG for two years before that. Gibson chose medicine as a second career in 1970 (with an MA in near-Eastern studies, he had previously been a Biblical scholar) because "I wanted to be involved in something of direct use to people." Gibson is opposed to the OMA's stance on opting out because he feels medical care is too important and too central a service to peddle privately. "If medicine is something offered on the market just like any other commodity," says Gibson, "then of course doctors should be able to set the price. But if it's a social good which everybody has equal access to, then doctors really have to be in dialogue with society in determining what they should be paid for it. They have to take on the responsibility of providing it for a reasonable price to everyone."

Other MRG members remain part of the OMA, though they oppose extra-billing. Rachlis, for one, is tied to the official body through his insurance policy, although "it galls me tremendously that they're spending so much of my money fighting medicare. It's estimated that the medical associations in Canada will spend $2-million fighting medicare this year."

Just where you stand on extra billing is pretty much representative of how you feel about doctors. To members of the MRG, most mainstream doctors have shown themselves to be more concerned about their pocketbooks than the public they serve. They cite studies of the experience in Saskatchewan, where hospital user fees were implemented between 1968 and 1971, to indicate that use of medical service by low-income people is drastically curtailed by additional fees. They also look with horror to Australia and New Zealand, where comprehensive medicare systems have been virtually dismantled, and wonder if it will happen here.

From professional experience, Freedman complains "I can't send my patients to get things done without paying unless I plead with the specialist, saying 'This person is really poor.' I shouldn't have to do that."

Yet O'Keefe at the OMA finds the MRG's stance a cynical one. He defends opting out as "a safety valve" against doctor strikes, and maintains that most doctors have the discretion not to charge poor patients. "A doctor may be individually recalcitrant," says O'Keefe, "but the majority will recognize on a referral that 'This person is on welfare,' or over 65, or a single mother, and they will respond to that . . . I think the doctors in the Medical Reform Group could find agreeable doctors, but they want to box the doctor in and have all of their patients get free care because that's their philosophical bent. There comes a time when a physician might say 'That's not going to work. That's not the way I practice.' He's going to reserve the right to make judgment calls, just as he does in medicine."

The orthodox view is that a doctor deserves that power; that, with his special knowledge and power over life and death, the modern medicine man should have licence to make those critical "judgment

(contined Page 6 "calls

PUBLIC INTEREST FORGOTTEN?

The ailing credibility of doctors

BY JONATHAN LOMAS

Mr. Lomas is health policy analyst at McMaster University.

FOR THE FIRST time in the history of the medical profession in Ontario, Health Minister Larry Grossman has been forced to impose upon it a regulation governing conduct. The imposition is the culmination of events that have called into question the credibility of the profession's disciplinary and licencing body — the College of Physicians and Surgeons — in protecting the public interest and being seen as independent of the Ontario Medical Association.

The current issue revolves around the request that physicians notify patients in advance if they are going to charge additional money beyond the benefit from the health insurance plan.

Last June the Health Minister made this request to the college and asked it to designate absence of such advance warning as professional misconduct. This would have placed the action in a category of some 32 other misdemeanors ranging from the specific — having an entry in the yellow pages in bold type or failing to complete forms requested by a patient — to the general — failing to "maintain the standard of practice of the profession". These 32 regulations make up the "professional misconduct" clause for physicians under the Health Disciplines legislation. As a self-regulating profession, the physician members of the College of Physicians and Surgeons administer the legislation and are made responsible for ensuring that the profession operates in the public interest.

It would have seemed reasonable, therefore, for the college to agree to the minister's request for prior notification of the public by physicians who extra-bill. It did not. After the minister's request, the college is allowed 60 days to respond and last August the college, in a letter to its membership, stated that it would "refuse the request of the Minister of Health to add the proposed regulation".

Discussions on the issue continued behind closed doors, with no public reason given for the college's refusal. Presumably the search could produce no private reason either, because in March of this year the minister exercised his prerogative to impose the regulation on the college.

At this point the OMA — the "trade union" for doctors — decided to enter the discussion, beyond whatever communication it already had with the college. The OMA wrote Premier William Davis expressing dismay at this "unnecessary and restrictive action", and complaining that the effect of the regulation was "to elevate a minor indiscretion to the level of a major breach of professionalism". A difficult argument to maintain when the physicians had already elevated failure to fill out forms for a patient to professional misconduct status.

The OMA also maintained that "the number of cases in which lack of prior notification has created any burden for patients is infinitesimally small". This position would seem to contradict the college's opinion, which (despite the fact it refused to pass the regulation) noted in 1981 that physician failure to inform patients of excess fees beyond OHIP was "the second commonest issue dealt with by the Complaints Department".

However, the likely real concern of the OMA was captured by the statement that "this is the first time in its 102-year history that the Minister of Health . . . has unilaterally forced a regulation upon the College of Physicians and Surgeons of Ontario and, by definition, on the profession".

As a self-regulating profession physicians must walk a fine line between advancing their own interests and protecting the public interest. If they are seen to favor their members' interest over the public's interest, their credibility is eroded and their right to self-regulation questioned. Hence two distinct organizations exist: the OMA — the profession's interests — and the college — the public's interest exercised on its behalf by physicians.

The college's refusal to accede to the Government's request for a regulation, and, most important, its failure to provide any good reason for the refusal, would appear to place it closer to the interests of the profession than those of the public. The necessary dividing line between college and OMA seems to be getting hazy.

Mr. Grossman's precedent-setting imposition of the prior notification regulation should be read by the profession as a signal that he considers it to be losing credibility. Instead, Ontario physicians have most recently chosen to complain about the threat to their "status as independent businessmen".

What has precipitated the increasing lack of credibility in the college's ability to "protect the public interest"? Clearly, it is difficult for the college to defend its refusal to pass the prior notification regulation on any public interest grounds, especially given the long-standing existence of an identical advance-warning requirement for charges above the OMA's own fee schedule. What's sauce for the goose does not appear to be sauce for the gander.

This is not, however, an isolated and rare lapse in the college's vigilance over the public interest. Consider the following selection of college actions in the recent past.

In an Ottawa court in May, 1980, a physician pleaded guilty of sexually assaulting a 23-year-old woman who, only weeks before, had been told by the college that her complaint against the doctor was unfounded. The college had unquestioningly accepted the Ottawa physician's version of events.

During the OMA's withdrawal of service in April last year the objectivity of the college was once again called into question when it was revealed that some of the 21-member board, entrusted with protecting the public from any over-zealous withdrawals of service by physicians, were taking part in walkouts themselves. More recently the college, acting in its licencing capacity for Ontario, decided arbitrarily to exclude from practice any doctors trained outside the six main English-speaking countries. Physicians trained in France, or other mainland European countries, would be effectively excluded from practicing in Ontario. Justifications for this on grounds of protecting the public interest are difficult to unearth. Another blow to credibility.

Finally, the college appears to have grown so unaware of its function of protecting the public interest that in its recent brief to the Ontario Council of Health's Policy Conference it spent considerable time recommending the introduction of user fees on patients, stating that "shifting health policy away from total comprehensive coverage to some degree of user participation for some services is fundamental". It is difficult to

appreciate up[illegible] what grounds the college feels user fe[illegible] ill contribute to protection of the public interest. And one is left asking whether it is purely coincidental that the introduction of user fees has long been a favorite policy proposal of the OMA.

Such suggested links between college policy and OMA policy erode the profession's credibility, given the supposed independence of the two organizations. It is no more reassuring to discover that many of the college's senior staff have received their initial training at the OMA. The college's registrar, Dr. Michael Dixon, spent seven years on the staff of the OMA prior to taking up his current appointment in 1979.

The Minister of Health recently instituted a review of all the professions. Perhaps particular attention in this review should be paid to the College of Physicians and Surgeons.

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calls". On the other hand, the Medical Reform Group represents another viewpoint — committed to "de-mystifying" the profession, to stripping the doctor of his near-priestly status and making him instead a public servant. And that, for many doctors, is the worst demotion of all.

ORLAND FRENCH

GLOBE + MAIL JULY 21/83

First things first

An anesthetist who demanded immediate payment from a woman lying drugged on an operating table will not be disciplined by the College of Physicians and Surgeons. The College said the doctor's conduct was "just short of professional misconduct". —news item, July 19, 1983.

AROUND A table in The Gall Bladder, the 19th hole lounge of a golf club favored by medical practitioners, a group of professional men mull over the antics of a colleague. The doctor, regrettably absent from this group, had recently been politely interviewed by the College of Fishes and Sturgeons over a complaint by a patient.

The patient had complained that while he was lying paralyzed on the shoulder of a highway in July, 1981, following a traffic accident, he had been attended to by a doctor who, with his lawyer at his side, had demanded cash in advance. The helpless accident victim had nodded assent. The doctor removed $90 from the man's wallet. The lawyer counted it and took $20. The doctor had then attended to the wounded man.

The college ruled that the doctor would not be disciplined because the action "fell just short of professional misconduct". A spokesman for the college said, "Actually, the doctor's normal fee was $100. He was extremely generous in that he left $10 in the man's pocket."

The group in The Gall Bladder chuckled with glee. "What a character!" said one man. "Wasn't that the week he pitched his golf clubs into the water hazard on the 15th hole?"

"Sure was. Remember? I can still hear him shouting at the water troll. He had hit five balls in a row into the water and he was furious. 'You want to play golf?' he said. 'Here, play golf.' "

Even heaved bag

"Right, right. And he took his clubs, one at a time, and pitched them all into the water. He got his best distance with the nine-iron, I remember. Then he threw the bag too."

"Yeah. We stopped him from running the cart in after them."

"Remember when he got back to the clubhouse, without his clubs, and the first thing he saw was the notice for the Medical Tournament on the weekend? Jeez, was he mad. He had to buy new clubs and he was broke. First thing he says was, 'I gotta make sure I collect before I patch 'em up.' "

"First things first. I guess he was pretty steamed up. Well, can't blame him. That was the fourth set of clubs he'd thrown away that summer. He'd have been better off spending money on lessons to get rid of his hook, in[illegible] all those clubs."

"Do you know, he was going to write to that fellow later, and ask for the other $10? I think it was George who talked him out of it."

"Yeah. I told him to use cheaper balls and he'd save that much on a Wednesday."

"Hey, guys, this really could have been serious. I mean, what if the fellow had refused to pay in advance? Ever since Grossman slipped through that rule requiring advance notification, I've worried about that."

"Ah, you'd take care of the guy."

"Yeah, but I'd feel so stupid. I mean, a man who thinks he's dying isn't going to argue. Then when he finds out he isn't going to die, he might forget that you asked him for more money. And if I don't ask him while he's all bloody and his bones are sticking through his skin, I can be found guilty of professional misconduct."

Have a choice

A shaggy-haired old doctor in the corner spoke up. "Well, you don't always have to extra-bill."

Silence struck the room. Disapproving looks shot toward the corner. "Bill," said one golfer, "You're a disgrace to the profession. You stick to the Government's fee schedule, you write love letters to Monique Begin, and you haven't broken a hundred all summer. What do you know about extra-billing?"

"Lots. I get the union bulletins from the OMA," said the old doctor. "Of course, I'm just a GP, so I'm not really part of your gang. Besides, I paid off my mortgage long ago, I haven't bought any condominiums, and I haven't thrown my golf clubs into the water for years. Matter of fact, my car is nearly two years old. Still runs like a charm, too."

The other golfers looked at each other, shrugged, then turned back to their table. One of them said, "Tomorrow, first thing, I'm going to ask my lawyer to find what 'just short of professional misconduct' means. I've gotta know my legal limits."

September, 1983

Hon. Keith Norton
Minister of Health
Queens Park, Ontario

We, the undersigned medical practitioners in the province of Ontario, wish to state our support for the establishment of medically-insured, free-standing abortion clinics in Ontario.

As physicians we know that there is no completely reliable method of birth control and that not every method is suitable for every woman. We have seen the devestating results of unwanted pregnancy- to the child and the mother. Until birth control techniques and the dissemination of birth control information greatly improve, we face an undesirable but nesessary choice- that of abortion.

As physicians, we are all too familiar with the obstacles confronting many women seeking abortion in Ontario. Accessibility to abortion has been compromised by several factors. Section 251 of the Criminal Code of Canada states that all abortion requests must be screened by a Therapeutic Abortion Committee in an accredited or approved hospital. Many hospitals, particularly in rural and smaller urban centres, in response to minority but powerful anti-choice pressure, have not established such committees.

In larger centres, the number of abortions being performed has been severely limited by quotas limiting the operating space allocated to the abortion procedure. For example, the clinic in the Toronto General Hospital receives approximately 75 calls daily from women requesting abortions and only six are booked daily. Calls are accepted only during certain restricted hours, with that single line being busy for hours on end.

Finally, many private gynecologists levy a fee to the patient of over two hundred dollars in addition to the OHIP rate. This has recreated a two-tiered system of selection whereby wealthier patients are able to obtain abortions earlier and more easily through private services.

These circumstanes conspire to force many women to wait unnecessarily long periods of time to obtain procedures (often three weeks or more). The result is an increased medical risk to women. In addition, many women must travel long distances from all areas of the province, from smaller centres to larger centres for a simple procedure, and increasingly to Quebec to the Morgantaler Clinic or across the border to Buffalo or New York (often from Toronto, itself).

We believe as well, that as a result of these delays and obstacles, an unnecessary number of second trimester abortions are being performed.

As physicians, we feel that the present lack of guidelines governing therapeutic abortion committees often leads to humiliation for women already facing a crisis in their lives. Whereas one committee may utilise the broad definition of health given by the World Health Organisation, another may grant abortion only on the strict grounds of serious impairment of health.

Ontario women need access to early, medically safe and medically-insured abortions. This access in not guaranteed by present legislation and practice. We believe that free-standing abortion clinics could serve this purpose. The safety of these clinics has been demonstrated already in Quebec and the United States. They can also offer a supportive environment for women which hospitals seem unable to do. Clinics have the potential to make the procedure more humane and offer more comprehensive care in the form of birth control counselling and psychological support and thus have a more preventive role.

In order to combat the resurgence of the two-tiered system of medical care delivery we must ensure that these clinics will be fully covered under medicare. We suspect that in the end such clinics would be much less expensive than the hospital situation and certainly decrease the number of second trimester abortions being performed.

To reiterate, as physicians concerned with the health care of women in this province, we support the establishment of free-standing abortion clinics that are medically insured.