TABLE OF CONTENTS

... Notice of General Meeting of MRG and basic agenda
... Resolution re generic drugs
... "Differing Diagnoses on Health Care" by Stephen Dale
... "The Ailing Credibility of doctors" by Jonathan Lomas (a MRG Member)
... Statement to the Minister of Health
... 1983-84 Membership Dues Notice and Form

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:

- Steering Committee
- Chapters
- Canada Health Act update
- Abortion Committee
- Quality of Care
- 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.

DAY OF ACTION for CHOICE on ABORTION

OCT. 1-1983
CITY HALL 1 P.M.
Rally
Demonstration
Entertainment

Sponsored by: Canadian Abortion Rights Action League — 416-1287
Ontario Coalition for Abortion Clinics — 519-8791
MIDWAY through 1978, a young post-graduate doctor-in-training drifted dourly through the antiseptic glare of Toronto Western Hospital. His name was James Dean in intern's fatigue: weighed down with discontent at the medical morass 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 of 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 popular 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-Ref orm 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 medics 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 fund 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 soft-spoken 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..."

Medical reformers see symptoms of a condition that may be terminal.

"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 that many doctors are burnt out by 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. That seems, 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 doctors into the community" is 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 perspective 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 MRCG to its "Health Care in the 80s and Beyond" conferences (the MRCG 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.

"I'm glad 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 does it function?赵'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?"

For the MRCG, which itself 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 over night, 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 student and low-key group operating mostly to provide self-support for "progressive" doctors who were "coming out.""

"I joined in December of '79, when it was still the stage of getting 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 MRCG went public, struck a constitution and began to partici- pate 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 MRCG members founded a store-front occupational health clinic in Hamilton (which has since folded due to financial problems). The group has also strengthened 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, Registered Nurses Associations 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 MRCG and the OHC have found their major battleground, predictably, to be the legal territory surrounding organizing and opting-out by doctors. Coincidentally, the MRCG 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 social 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 is hinted that the new act will lower the boom on doctors who have opted out of medical care, 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 2 to 10 per cent in Ontario to a high of 18 per cent, prompting many groups like MRCG to fear it's the thinning of a two-tiered medical 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 doctors' right to opt out and set their 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," havin simultaneously been a member of the MRCG 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 he 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 MRCG 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 he says it "calls me tremendously that they're spending a big part of my money fighting these people. 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. Most members of the MRCG, 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 a professional experience, Freed- man concludes "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 MRCG's stance a cynical one. He defends opting out as a "safety valve" against doctor strikes, and maintains that most doctors do 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 these people are a welfare case, or over 65, or a single mother, and they will respond to that. If I think the doctors in the Medical Reform Group could find agreeable doctors, but they want to box the doctor 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 the way I practice.' He's going to reserve the right to make judgment calls, just as he does in medicare."
Dr. John Smith, the well-known physician, has recently published his latest book, "The Modern Practice of Medicine," which has been widely acclaimed for its comprehensive approach to the field.

In his book, Dr. Smith discusses the importance of continued education and training for doctors. He emphasizes the need for doctors to stay up-to-date with the latest medical research and developments.

Dr. Smith also highlights the role of technology in modern medicine. He discusses the use of electronic health records and telemedicine in providing better care to patients. He suggests that these tools can help doctors make more informed decisions and provide more personalized care.

Moreover, Dr. Smith stresses the importance of ethical considerations in medical practice. He urges doctors to always put the patient's well-being first and to avoid conflicts of interest.

Overall, Dr. Smith's book is a valuable resource for both medical professionals and those interested in the field of medicine.
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 devastating 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 necessary 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 circumstances 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 is 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.