MRG NEWSLETTER

P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8 (416) 920-4513

Volume 4, Number 6 November 1984

MRG GENERAL MEETING

The Medical Reform Group held its general meeting, and celebrated its fifth anniversary, in Toronto on September 28 and 29. In this issue of the newsletter, we have several items relating to the meeting, including a summary of the main part of the meeting and of Stephen Lewis' speech on Friday night. We also have a summary of Carol Buck's presentation on Health Research in Canada, which she presented at the Saturday afternoon session. We would like to draw your attention to the fact that the publications which were available at the meeting, including a booklet containing all the MRG's basic position papers and policy resolutions, and including a major brief on the Pharmaceutical Industry in Canada, are available by mail. (Please see the last page of this Newsletter.)

REPORT ON THE MEETING
(An abridged version of the minutes)

1. Philip Berger presented a report from the Steering Committee. He noted that the Steering Committee found itself quite busy, a reflection of the number of issues with which the MRG was concerning itself and of the public profile which the MRG has achieved.

2. Joel Lexchin reported on the brief prepared for the Commission of Inquiry on the Pharmaceutical Industry in Canada. Praise was lavished on the brief, which it was noted is largely based on Joel's newly published book, "The Real Pushers: A Critical Analysis of the Canadian Drug Industry."

3. Gord Guyatt reported on the brief to the Senate Committee. He noted that the brief was an attempt to summarize all MRG positions and approaches. It develops the point that health has large economic and other dimensions' that poverty especially threatens the health of Canadians. He asked members to examine the brief, noting that while the authors felt confident that that what they had written was consistent with MRG positions in essence, it may go byond specific MRG policies in a few instances.

4. Don Woodside reported on the Health Disciplines Review, for which the MRG has prepared two briefs. He commented that in the view of those working on the issue for the MRG neither expanding nor restricting Colleges seemed to be a key issue in solving problems of the health care system. The question is how should the MRG proceed on this issue now? There are some really explosive issues which are being raised, for example, should the College of Physicians and Surgeons be abolished? The MRG is not ready to deal with some of these major issues and partly for this reason the briefs restricted themselves to a few specific concerns. Don Woodside agreed to co-ordinate a working group on the Health Disciplines Review and issues arising from it. More members for this working group are invited.

5. The Citizen's Guide to the Ontario Health Care System, a pamphlet being published by the MRG, is in the final stages of revision and will come out soon as a pamphlet.

6. Ontario Health Coalition. Michael Rachlis reported that a focus of activity now was to try to make sure that the Canada Health Act is actually implemented. The OHC has been following a lobbying strategy. There is some discussion in the OHC of taking a key health care issue such as care of the elderly, as the new focus of the coalition and concentrating work on it.

7. Canadian Health Coalition. Susan Stock, who has been the MRG's delegate to the CHC, has left Ottawa and so is no longer able to be the delegate. She was unable to attend the General Meeting, so Michael Rachlis reported.

8. The meeting passed the following two motion regarding the health coalitions.

Whereas it is stated Medical Reform Group policy that we should ally ourselves with other individuals and groups working for positive change in the health care system,

and whereas the Ontario Health Coalition is a group representing eighteen organizations striving for positive changes in our health care system,

Be it resolved that the MRG elect a delegate to the Ontario Health Coalition at each spring semi-annual meeting. The steering committee shall appoint a new delegate if the delegate resigns prior to a semi-annual meeting. The delegate shall take whatever action is consistent with MRG policy. Where the delegate is in doubt about a position he/she shall contact the steering committee. The delegate shall present the Ontario Health Coalition's annual report to the steering committee and a semi-annual meeting. The delegate shall also make reports to the steering committee as required from time to time.

Whereas it is stated Medical Reform Group policy that we should ally ourselves with other individuals and groups working for positive change in the health care system,
and whereas the Canadian Health Coalition is a group representing over forty organizations striving for positive change in our health care system,

Be it resolved that the MRG elect a delegate to the Canadian Health Coalition at each spring semi-annual meeting. The steering committee shall appoint a new delegate if the delegate resigns prior to a semi-annual meeting. The delegate shall take whatever action is consistent with MRG policy. Where the delegate is in doubt about a position sh/she shall contact the steering committee. The delegate shall present the Coalition's annual report to the steering committee and a semi-annual meeting. The delegate shall also make reports to the steering committee as required from time to time.

9. A financial report was presented which showed the MRG's financial performance for 1983-84 and made projections for 1984-85. The report was accepted, and the projections were adopted as a budget for 1984-85, with the proviso that some adjustments might be made later by the steering committee.

Responding to the fact that the budget projected a deficit in 1984-85, Philip Berger suggested raising the required extra money by encouraging members to take out Supporting Memberships, through speaker fees, and by sales of literature.
Michael Rachlis volunteered to co-ordinate a speakers' bureau on behalf of the MRG. It was suggested that there could be a little leaflet advertising the fact that the MRG has speakers available.

It was moved and carried, 14-11, that there be a subscription fee of $25 for non-members who wish to receive the MRG Newsletter.

It was moved and carried, 13-11, that the 1984-85 budget be accepted as is, ie., with no increase in membership fees, and that fees be reviewed in six months.

The financial report and budget are on page 3 of the Newsletter.

10. Steering Committee. Paul Rosenberg submitted his resignation from the Steering Committee. He was thanked for his contribution, especially for his work on the brochures and on the Health Disciplines Review committee.

The following people were selected as the 1984-85 MRG Steering Committee:

Philip Berger
John Frank
Fred Freedman
Gord Guyatt
Clyde Hertzman
Joel Lexchin
Michael Rachlis
Fran Scott
Don Woodside

It was suggested that there be regular mentions in the MRG Newsletter of the fact that Steering Committee meetings are open to members, as well as a contact number for finding out when and where they are.

11. Research funding. Drs. Carol Buck, John Frank, and Gord Guyatt participated in a panel discussion in the afternoon on research funding. A summary prepared by Carol Buck of her presentation appears in this issue of the Newsletter.

The meeting mandated the Steering Committee to initiate an educational process, possibly leading to resolutions, for the next general meeting, on the subject of research.

Medical Reform Group Financial Report and Budget

	Oct. 1, 1983 - Sept. 30, 1984	Projections for 1984-85
INCOME		
Membership fees	9,015	9,860
Donations from members	750	1,000
Conference fees	800	1,000
Special (speakers') fees	--	100
Sale of materials	70	200
Total Income	10,635	12,160
EXPENSES		
Administrative fees	7,932	8,320
Office expenses, printing, postage, phone, supplies	3,310	3,100
Ontario Health Coalition	150	150
Advertising	285	135
Speakers' fees	500	500
Travel expenses	269	270
Answering machine	226	--
Accumulated deficit	--	1,037
Total Expenses	12,672	13,512
Net Surplus (Deficit)	(2,037)*	(1,352)

*1,000 of the 1983-84 deficit was covered by an accumulated surplus from previous years in an MRG savings account.

STEPHEN LEWIS SPEAKS AT MRG GENERAL MEETING

For those who missed it, the following is a brief synopsis of the points made by Stephen Lewis in his talk on September 28:

There has been a consistent attack on the public sector, with calamitous consequences for the health care system. We may end up with selective social service programs instead of universality. But universality in certain programs is integral to a civilized society. There is an atmosphere of austerity and cutbacks, always directed at services for people, rarely if ever at the corporate sector.

There seems to be almost a moral imperative that Toronto needs a domed stadium, and the money for it is to be found regardless. Yet money for preventive services is "not available." Really it is a question of how society chooses to spend money, rather than money not being available. For example, the government was able to find $45 million for Minaki Lodge, but could not come up with $45 thousand for the Kenora Children's Aid.

There is an attack on workers in the public sector, with wage controls, take aways, and removal or bargaining rights.

Workers providing direct care for people, for example in nursing homes, receive $4.75, $5.00, $5.50 an hour, and they have to fight very hard to get even a minimal 5% raise. These are workers we consider indispensable.

There is never a peep from the medical profession on behalf of their poorly paid colleagues in hospitals, nursing homes, etc. This causes resentment towards doctors among such workers.

Perhaps some government (Manitoba) will take the opening offered by the Canada Health Act to allow other health care practitioners (nurses) to be an entry point into the health care system; to allow them equal status in performing certain health care functions.

A key danger to the health care sector is corporatization.

Some major corporations have decided to enter this inflation-proof sector of the economy. Speculation in health may be even more lucrative than speculation in real estate. One hospital in five in the U.S. is owned by a profit-making company. The five largest companies in the sector have increased profits by 30%-50%, indicating how attractive it is. These companies are huge multinationals. For example, AMI, the company which took over the hospital in Hawkesbury, controls 20,000 hospital beds, and it is not the biggest.

The way AMI balanced the books at Hawkesbury was by having the provincial government absorb the deficit. Any publicly owned hospital could do the same if it was given the same concessions by government.

U.S. studies have shown that private facilities are no more efficient than public.

For-profit institutions are a major factor in care of the elderly. An entrepreneur who wants to make a profit in an old age home has to do it by cutting costs: either number of staff, or salaries, or food, or care. There is not enough money in it to make money any other way.

More care and services specifically for the elderly will be needed as the population ages. Care of the elderly is emerging as one of the most explosive issues.

Institutionalization of the elderly has to be decreased if costs are to be kept down. Care of the elderly should be the peg on which arguments for a wholesale revamping of the health care system is hung.

SUMMARY: BRIEF TO COMMISSION OF INQUIRY THE PHARMACEUTICAL INDUSTRY

The Canadian drug industry is almost totally foreign dominated. All of the top 21 companies in the industry are foreign owned and all are members of the Pharmaceutical Manufacturers Association of Canada

Price competition is almost non-exis in the prescription drug field. Of a tota of 1335 preparations listed in the July 1982 edition of Ontario's Drug Benefit Formulary there was significant price com petition in only 138 cases.

As a result of the lack of price com petition, there is a high degree of conce tration in the various therapeutic market i.e. antihypertensives, antibiotics, etc In 1982, in 28 out of 38 major therapeut markets, two companies accounted for more than 50 percent of sales.

Foreign control of the Canadian drug industry has dept manufacturing at a min level. Even before the Patent Act was ch in 1969, 85 percent of manufacturing was confined to the conversion of imported material into final-dosage form. Any fur decline in manufacturing in Canada since 1969 has occurred as a result of the mov ment of manufacturing operations to tax havens such as Puerto Rico.

Profits in the industry have always been considerably higher than those in manufacturing in general. In the 1970s, average pretax profit on capital employe for the drug makers was about 80 percent higher than for all manufacturing. Even these profit levels are likely an understatement of the true profitability of t industry due to factors such as transfer pricing.

While the Medical Reform Group beli that drugs are an essential component of modern medical care, we also feel that t Pharmaceutical Manufacturers Association Canada has over-emphasized the role of For instance, mortality figures for infe tious diseases such as tuberculosis or theria had dropped dramatically long be modern antibiotics or vaccinations were introduced.

Many of the products produced by drug industry research have little or no value. Of 2131 new products introduced into the American market from 1958 to 1967, more than two thirds were combination products, i.e. drugs with two or more active ingredients combined in fixed proportions. Most authoritative medical figures agree that combination products are generally poor therapeutic choices.

Research conducted by the drug industry is directed at those products which have the greatest profit potential. Many research projects, which tie up valuable scientific talent, are simply directed at producing "me-too" drugs i.e. drugs which are similar to ones which are enjoying healthy sales. Consider the case of the benzodiazepine class of minor tranquillizers: since the success of Hoffman La-Roche's Librium and Valium, we now have an additional ten other benzodiazepines on the market. Authoritative medical opinion is that there are few, if any, substantial clinical differences that distinguish one of these drugs from another.

Pharmaceutical research in Canada is very limited, but that was the case before the Patent Act was changed. According to a study from the Department of Industry, Trade and Commerce, in the period 1964-1971, research growth in the drug industry lagged behind research growth in all industries. The research that was done prior to 1969, and that continues to be done now, is undertaken largely to satisfy the requirements of the Health Protection Branch prior to marketing.

Strong foreign control of the industry is the main reason why more research is not done in Canada. People such as Donald Davies, chairman of Ayerst McKenna and Harrison, have admitted that drug research is concentrated in the home countries of the multinationals.

The multinational companies claim that they need patent protection in order to recover the costs of developing drugs. However, when they cite figures of $50 to $ million they are not just referring to Canadian costs, but world-wide costs, a distinction that they never point out. Since Canada represents about 2 percent of the world market, the Canadian share of development costs that needs to be recouped is $1.0 to $1.5 million. Estimates are that it takes 8.8 years to recoup development costs. Currently, the average time that a company has a monopoly on a new drug, before a compulsory licence is issued, is 8.5 years. Therefore, even with compulsory licensing the multinationals are able to recover development costs.

Immediately after the Patent Act was amended, the legislation was challenged by an American multinational, American Home Products Ltd. By 1971, of the 69 licences issued, there had been 43 appeals before the courts. The use of court appeals as a delaying tactic was recognized by some judges in their rulings. The multinationals also tried other tactics to undermine licensing including questioning the quality of the licensee's products and price cutting.

A number of studies have shown that compulsory licensing has reduced the prices of those drugs against which licences have been issued, however the great majority of drug sales in 1981 were untouched by compulsory licensing. In 1981, total sales of drugs under compulsory licence were $170 million, of which only about $35 million represented sales of firms holding licences. That year, the total value of the Canadian human pharmaceutical market was $1.01 billion, meaning that drugs affected by compulsory licensing represented less than 17 percent of the market.

The Medical Reform Group believes that the Patent Act amendments proposed by Consumer and Corporate Affairs Canada would reduce the availability of generic drugs and result in an increase in the costs of drugs to the Canadian public. Therefore at its semiannual general meeting on October 27, 1983, the following resolution was passed: "Be it resolved that the Medical Reform Group call on the Federal Government to abandon its plans to change the Patent Act as it applies to prescription drugs."

COPIES OF THE FULL BRIEF WHICH WAS SUMMARIZED ABOVE ARE AVAILABLE FOR $10 FROM THE MRG, P.O. BOX 366, STATION J, TORONTO.

A BRIEF BRIEFING PAPER TO THE MEDICAL REFORM GROUP ON THE SUPPORT OF HEALTH RESEARCH IN CANADA

From Carol Buck

1. THE PROBLEM:

In Canada at the federal level, there is a large discrepancy between the funds available for laboratory research in comparison with other kinds of health research. Although a few provinces, of which Ontario is an example, provide funds to redress this imbalance the national problem is great enough that corrective measures are required.

In 1983-84 the budget of the Medical Research Council (MRC) was $141 million, compared to a budget of $16 million for the National Health Research and Development Program (NHRDP). The MRC supports what it calls "basic, applied and clinical research", most of which is directed toward molecular and cell biology, biochemistry, physiology, immunology and pathology. The clinical element of the MRC program is directed mainly toward clinical trials of drugs used at the tertiary level of health care. Support of research into health services is specifically excluded from the MRC's terms of reference on the grounds that NHRDP takes care of this aspect of research. It is ludicrous to believe that health care research, a very difficult and complex activity, can share a budget of $16 million with the other demands made upon the budget of NHRDP.

It is clear from documents emanating from the MRC* that it believes the solutions to our health problems lie in what John Frank so aptly calls "the technological fix". The beliefs of the MRC are readily accepted by a society that is in love with technology and whose most powerful leaders are in an age-group for whom technological solutions seem particularly attractive. An affluent 50-year old leader of the business community is unlikely to be inflamed by the idea of research into the environmental or personal antecedents of disease. Realizing that a myocardial infarct, stroke or cancer are the likeliest causes of his premature (however defined) demise, he will opt for heroic adventures in surgery, preceded by the full panoply of diagnostic aids, relevant or otherwise.

2. WHY DO WE NEED A MUCH BIGGER BUDGET FOR RESEARCH OUTSIDE THE SPHERE OF THE M.R.C.?

2.1. Research into environmental causes of disease, ranging from the physical to the social has reached the stage where many important questions await answers from experimental intervention against putative causal factors whose role has been strongly suggested by descriptive and analytic studies. I will give only one example: experimental interventions to prevent the consequences of childhood exposure to slum housing, family disruption, and inappropriate education. (If more on this subject is needed, contact Dr. Dan Offord in the Department of Psychiatry at McMaster).

2.2. Research into the natural history of common symptoms is urgently needed so that we can find out what is meant by "serious".

2.3. Research is needed into the most effective treatment for commonly occurring symptoms. There is nothing wrong with clinical trials of cyclosporin, but a comparable effort should be directed toward remedies for migraine and back pain or toward the factors contributing to the occurrence of migraine and back pain.

2.4. There is a widely accepted fallacy that the cost of research must be proportional to the technological complexity of the methods employed. What this fallacy leads to is the notion that research into the causes and natural history of common diseases and into the efficacy of various forms of health care can be carried out with very modest funds because the research methods do not require expensive laboratory equipment. The truth is otherwise. Following large numbers of people in a search for causes is a very expensive endeavour. Recording the intracacies of health care and its outcomes is equally expensive. Experimental interventions against presumed physical, psycho-

---

* MRC Brief to the Task Force on Allocation of Health Care Resources, 1984.

logical or social causes of disease are extremely costly if they are to be carried out correctly in accordance with the principles of science.

3. WHAT SHOULD WE DO?

3.1. First, we must get our terminology cleaned up to avoid acquiescing in some of the aforementioned fallacies. The terms "basic" and "applied" research must be given up because their connotations are pejorative. This issue has been forcefully addressed by the H.B.G. Casimir, quoted in Science Vol. 224, p. 708, 1984: "I always say that applied research does not exist and that it is sloppy thinking and sloppy grammar. I can distil whiskey, I can distil drinkable whisky. I cannot distil consumed whisky. And so, I cannot do applied research. I can apply research, certainly. I can do applicable research. I cannot occupy myself with applied research". Rather, we must use terms that refer to the nature of the work done rather than to the value judgements implied by such terms as "basic" and "applied" or "wet lab" and "dry lab". Parenthetically, I deplore the division of the relatively new discipline of epidemiology into Big E (search for causes of disease) and Clinical E (study of natural history, diagnosis and treatment). Life is tough enough for epidemiology without laying upon it the potential trauma of a civil war.

3.2 The MRG clearly recognizes that issues pertaining to health extend beyond the sphere of doctors, nurses and other health professionals. Therefore the MRG should advocate and participate in interdisciplinary research with behavioural scientists, political scientists and members of other relevant disciplines.

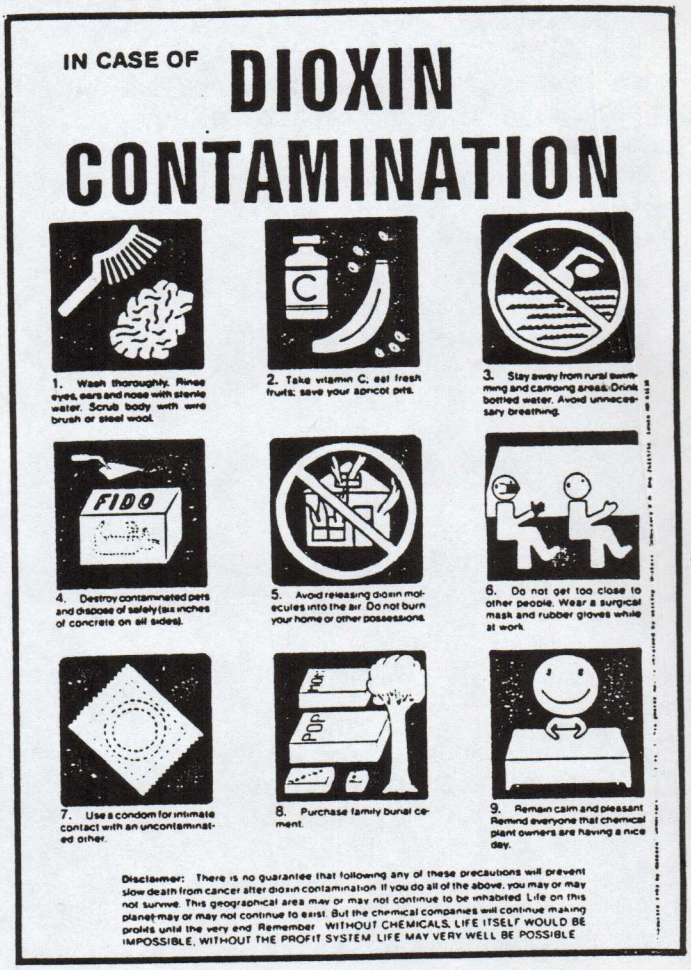
3.3. To foster the kinds of research that are so desparately needed and presently so under-funded, the MRG should be vocal about the money required to conduct research of high quality into the problems of disease causation, prevention and care.

3.4. The MRG should take a stance against the mystification that glorifies reductionist research in comparison with other kinds of health research. The following quotation, whose source I have lost, might be useful:

> "One never hears complaints from administrators or legislators that research in immunology is worthless because they cannot understand it. But one frequently hears that health services research funding is being wasted on 'incomprehensible regression equations' ".

Whoever wrote this understood the bigotry shared equally by many scientists and consumers of science in contemporary society.

3.5. I believe that the MRG's consideration of research funding must be continuous, but that its expressions of concern should be carefully timed. When alerted by news reports of by information from colleagues, it should respond quickly with a well reasoned brief based upon its continuous consideration of research priorities and strategies.



CAPITAL PUNISHMENT

The Steering Committee is going to propose at the Spring General meeting that the MRG take a stand opposing capital punishment.

The MRG passed a motion in May 1980 opposing any participation by physicians in the administration of the death penalty. The Steering Committee suggests that that position be broadened to explicit opposition to the death penalty. This would enable the MRG to publicly add its voice to those opposing current moves to restore capital punishment in Canada.

Members who have any comment on this issue before it comes to the general meeting are asked to write or to contact a steering committee member.

PHYSICIAN WANTED

The Women's Health Clinic in Winnipeg has an opening for physicians, both full and part-time.

Benefits include salary, flexible time, some evening and Saturday work, and an opportunity to participate in a health care team.

Physicians must be cognizant of women's health issues, caring and non-judgmental. Please contact by phone or mail:

Executive Director
Women's Health Clinic
304 - 414 Graham Ave.
Winnipeg, Manitoba
R3C 0L8

LOCUM AVAILABLE

A locum is available for two weeks in February at York Community Services. Contact Catherine Oliver at 653-5400.

MEMBERS SPEAK

Two MRG members, Doug Sider and John Frank, gave a talk on October 18 in Toronto on "The Politics of Health in Southern Africa". Doug Sider returned to Canada recently after working with CUSO in Mozambique for four years, while John Frank was in Zimbabwe recently.

MRG OTTAWA CONTACT

Frances Kilbertus is the new MRG contact person in Ottawa, which means that she receives Steering Committee minutes and is the MRG's contact person with the Canadian Health Coalition, which is based in Ottawa.

SUBSCRIPTIONS TO NEWSLETTER

The September general meeting established a subscription price of $25 a year for non-MRG members who wish to receive the MRG Newsletter.

BE A SUPPORTING MEMBER

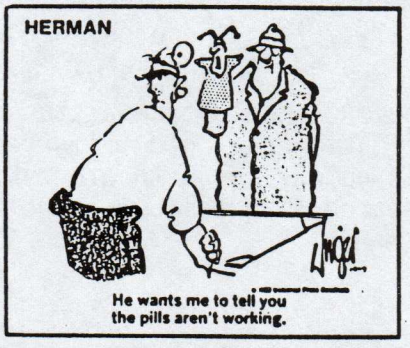
Membership fees fall short of covering all of the MRG's expenses. The fall general meeting decided, however, not to raise fees because there are members who could not afford the higher fees. Instead members are urged to become Supporting Members if they can, by renewing at a Supporting Member rate rather than the standard. Please see the membership form on page 12.

MRG NEWSLETTER

Members are invited to submit information to this newsletter which they think would be of interest to other members. Send material to P.O. Box 366, Station J, Toronto M4J 4Y8, or call Ulli Diemer at (416) 920-4513.

THE REAL PUSHERS

Joel Lexchin's book, The Real Pushers: A Critical Analysis of the Canadian Drug Industry has now been published by New Star press. Joel is a member of the MRG Steering Committee, and co-author of the MRG brief to the Commission of Inquiry on the Pharmaceutical Industry in Canada.



NO WORD ON HELP FOR PATIENTS

The Ontario Government has abandoned its commitment to the urgent recommendations of a Toronto task force report released a year ago urging the province to spend $1.6 million to improve housing conditions for discharged psychiatric patients, Toronto alderman David Reville has charged. The cabinet received the report positively in 1983, but since then has been silent about its intentions, according to Reville. The city would like to get started on housing projects for 2,000 discharged patients but can't until funding comes through.

B.C. DOCTORS CHALLENGE RESTRICTIONS

The B.C. Medical Association has said that it will no longer participate in committees set up to ration billing numbers for new doctors. The idea behind the rationing is to push doctors to practice in areas that are under-doctored while keeping the numbers down in urban areas that are considered to have enough doctors. The B.C.M.A. says that the program violates doctors rights and is ineffective in attracting doctors to isolated areas.

PROVINCES CONSIDER COST LIMITS

Alberta Health Minister David Russell has said that provincial health ministers are thinking about limiting the money available for health care. He was speaking after a meeting of the ministers in Calgary. He said that a "capping" proposal was under consideration, under which only a fixed amou nt would be available for health expenses. If spending ran ahead of projections, doctors would only receive a portion of the payments they ordinarily would.

Mr. Russell assured reporters that the quality of health care would not suffer under his proposal.

ONTARIO CONSERVATIVES WANT MEDICARE DEAL?

Ontario NDP leader Bob Rae has charged that the Ontario Conservative government is hoping to make a deal with the Mulroney government to allow them to evade the penalty provisions of the Canada Health Act regarding extra-billing. Rae's comments came after the B.C. Health Minister said after a meeting of provincial health ministers that they would be asking to meet with Mr. Mulroney and "asking him to reflect on the damage the Canada Health Act has done to the system."

Ontario currently pays $4.4 million a month in penalties because it allows extra-billing.

PLAN TO CLOSE RETARDED CENTRES

A national research centre on mental retardation has published a strongly worded critique of the Ontario government's effort to close several institutions for the mentally retarded. The report by the National Institute on Mental Retardation says the Community and Social Services Ministry is seeking to save money with the closings without regard to the effects. The ministry plan calls for closing down six institutions and sending about 1000 residents into group homes and other living alternatives. The report strongly questions whether the proposed alternatives will be real alternatives, charging that people will be pushed out of institutions without being given the support needed for them to cope on their own.

MORGENTALER WINS

A Toronto jury acquitted Dr. Henry Morgentaler and two associates on charges of breaking the abortion law by performing abortions at a clinic, rather than at a hospital with a committee. Dr. Morgentaler announced after the verdict was announced that the clinic would re-open. He also offered the clinic to the Ontario government as a training project in teaching doctors abortion techniques.

BILL WANTS OPEN FILES

NDP MPP Tony Grande has introduced a private members bill in the Ontario legislature which would give patients the right to see their medical records within 10 days of a request. The measure was proposed by the Krever Commission into the confidentiality of health records.

None of the commission's recommendations have been acted on. Private member's bills have virtually no chance of being passed.

CHEMICAL SPRAYS HURT HYDRO CREWS

Workers who sprayed herbicides for Ontario Hyrdo in 1983 experienced a large number of acute health effects, according to a study done for the Hydro Employees Union. The study, by two doctors in the department of occupational and environmental health at St. Michael's Hospital, found that foresters who handled the herbicides suffered more from acne, headaches, weakness, eye irritations, sore throats, chest pain, and nasal congestion that a group of Hydro linemen who were not exposed. The authors note that the study did not deal with long-term health effects. The study was based on 1,321 employees.

FAMILY WINS ACCESS TO RECORDS

For the first time, the Ontario Court of Appeal has ordered a patient's medical records released to enable his family to determine the quality of medical care he received before he died.

MIDWIFE BILL DEFEATED

A bill introduced by an NDP MPP that would have legalized midwifery in Ontario was defeated in the Legislature by Conservative members who refused to let the measure come to a vote. The bill, sponsored by David Cooke, would have established legal standards for the training and practice of widwives.

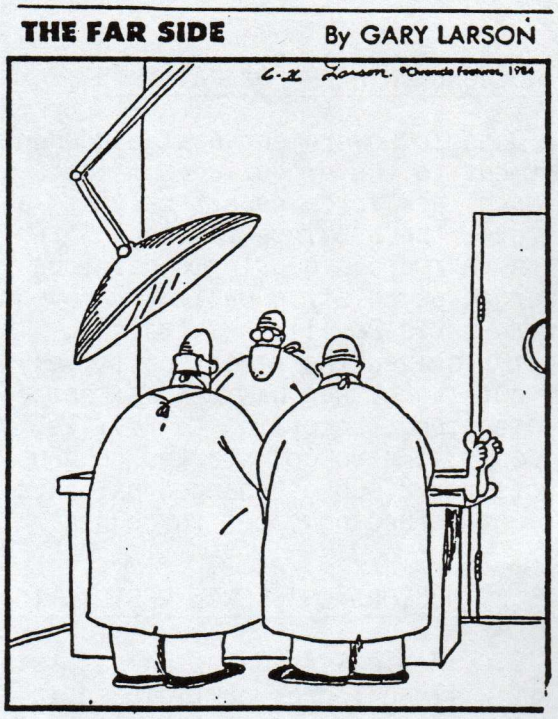
NO PUBLIC SHOCK HEARINGS

The Ministry of Health has refused to call public hearings by the committee it established to review the use of electric shock on psychiatric patients. Opponents of electroschock had been demanding public hearings, partly because they charge the committee is biased.

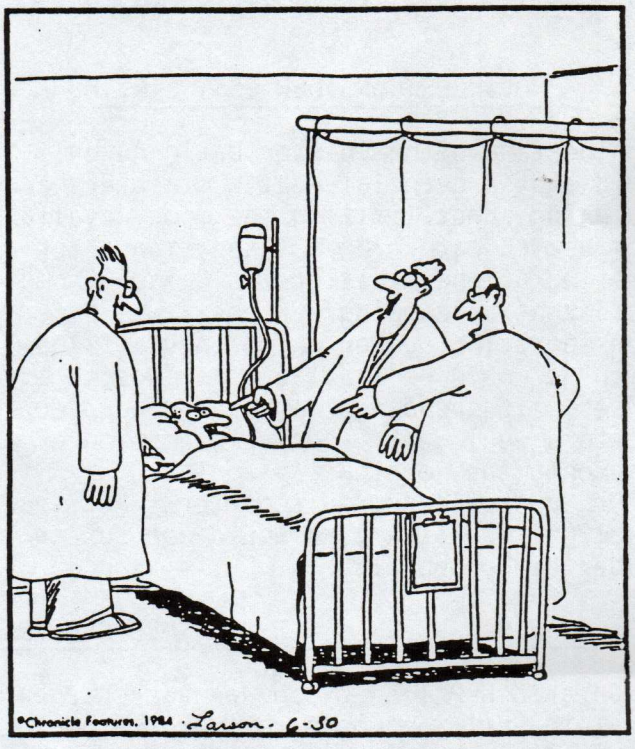
QUOTABLE QUOTE

"I like to consider myself an entrepreneur. When I was a resident, I sold jewellry on the side to nurses and patients."

--Dr. Douglas Phillips, founder of National Medplex Corporation, which operates free-standing emergency centres in Long Island, New York.



"Okay, Wellington. I'm comfortable with my grip if you are . . . Have you made a wish?"



Testing whether laughter IS the best medicine.

MEDICAL REFORM GROUP OF ONTARIO

* * * * * MEMBERSHIP FORM * * * * *

Please print or type

NAME _____

ADDRESS _____

_____

_____

PHONE _____

SIGNED _____ DATE _____

MEMBERSHIP FEES:

Supporting Member	$150 and up
Physician	$100*
Affiliate	$ 50*
Organizations	$ 50
Associate	$ 25
Medical Student	$ 20

*Members joining for the first time may pay only half the annual fees for this category.
Physicians and medical students in other provinces may become Affiliate Members. Non-physicians may become Associate Members.

Enclosed please find remittance of _____ Please register me as a member of the Medical Reform Group of Ontario. (State category) _____

My areas of interest are: _____

_____

_____

Educational events I would like to see are: _____

_____

_____

Areas I would like to work on are: _____

_____

_____

I would be available to speak on behalf of the MRG YES____ NO_____ MAYBE____

Subjects on which I could speak _____

_____

PLEASE SEND THIS FORM TOGETHER WITH YOUR CHEQUE OR MONEY ORDER TO THE MEDICAL REFORM GROUP, P.O. Box 366, STATION J, TORONTO, ONTARIO M4J 4Y8.

IF YOU WOULD LIKE A RECEIPT, PLEASE CHECK HERE _____

P.O. BOX 366, STATION 'J', TORONTO, ONTARIO M4J 4Y8

MEDICAL REFORM GROUP OF ONTARIO

MRG DOCUMENTS AND PUBLICATIONS

The Medical Reform Group has produced a number of briefs, position papers, analyses and other documents. These publications are available at the following prices:

		# of Copies
BASIC DOCUMENTS (1979-1984) *Includes a Brief History of the MRG, MRG Resolutions, the Constitution, and the MRG's Brief to the Senate Sub-Committee on Health Policy (contains a synopsis of the MRG's approach to health issues)*	$6.00	_____
BRIEF TO THE COMMISSION OF INQUIRY ON THE PHARMACEUTICAL INDUSTRY (1984)	$10.00	_____
THE CRISIS IN HEALTH CARE: BRIEF TO THE HALL COMMISSION (1980)	$3.50	_____
A CITIZEN'S GUIDE TO THE ONTARIO HEALTH CARE SYSTEM	In preparation	_____
COMMUNITY CLINICS STUDY (1980)	$3.50	_____
CONSOLIDATING THE GAINS OF THE 1970's: DO OR DIE FOR ONTARIO'S HEALTH CARE SYSTEM (1983)	$2.00	_____
BRIEF ON THE CANADA HEALTH ACT (1983)	$1.00	_____
TRANSCRIPT OF MRG PRESENTATION TO THE HOUSE OF COMMONS STANDING COMMITTEE ON HEALTH, WELFARE AND SOCIAL AFFAIRS (1984)	$3.75	_____
SUBMISSION FOR THE ONTARIO HEALTH PROFESSION LEGISLATION REVIEW (1984)	$1.50	_____
COMPLETE EDITION OF MRG NEWSLETTERS AND POLITICALETTERS, 1979-1984	$16.00	_____
YEARLY SUBSCRIPTION TO MRG NEWSLETTER	$25.00	_____

Please send me the publications indicated above. I enclose a cheque for _____

NAME _____

ADDRESS _____

_____

P.O. BOX 366, STATION 'J', TORONTO, ONTARIO M4J 4Y8