MRG NEWSLETTER

MEDICAL REFORM GROUP OF ONTARIO P.O. Box 366, STATION "J" TORONTO, ONTARIO M4J 4Y8

VOLUME 5, NUMBER 5 SEPTEMBER 1985

MRG Tackles Drug Advertising

Following the highly favourable Globe and Mail article about the MRG and pharmaceutical advertising (see P. 9 of this issue of the newsletter) the MRG Steering Committee has decided to start a campaign to test the adequacy of the regulations governing drug advertising.

At present, all the pharmaceutical companies marketing products in Canada and all the journals published in Canada have voluntarily agreed to abide by the rules and regulations in the Code of Advertising Acceptance of the Pharmaceutical Advertising Advisory Board (PAAB). The Steering Committee believes that a significant number of ads published violate even the rather loose and vague rules in this Code. To find out if this belief is valid the Steering Committee encourages all MRG members to send in complaints about advertisements to the PAAB Commissioner. Under the Code complaints submitted in writing must be investigated. If the Commissioner's ruling is not accepted by the complainant an appeal can be filed, again in writing.

The following sections of the Code seem to be the most frequently violated:

2.4 Advertising must reflect an attitude of caution with respect to drug usage, with emphasis on rational drug therapy. It should provide sufficient information to permit assessment of risk/benefit.

2.5 Advertising which is prejudicial to any sex, race, occupation or age group, or contravenes the ethical values of the health professions, is not acceptable.

3.1 Any advertisement containing therapeutic claims and/or quotations from the scientific literature must include a complete reference listing of the scientific source(s) of information.

3.5 The Board will not approve advertisements containing claims of quotations which emphasize only positive features of a pharmaceutical product while ignoring significant negative findings.

Examples of recent ads which seem to violate these rules are:

(continued on P.2)

General Meeting

The MRG's Fall General Meeting has been set for Saturday October 26. Among the topics to be discussed will be a proposed resolution on midwifery (see P. of this newsletter). Workshop and discussion topics being worked on are "How do you relate to drug companies and their marketing strategies?", "How do you manage a private practice which is also a small business?", and "Isolation and collegiality".

Further details about the meeting, including a complete agenda, will be mailed out in the first week of October.

CONTEST

The Fall General Meeting will feature a contest to see who can bring the worst drug ad. (See adjacent article, "MRG Tackles Drug Advertising") A door prize will be awarded for the worst ad.

MRG Tackles Drug Advertising

1) CMAJ Aug. 15/85 p. 264. Ad for Premarin --implies insomnia is a symptom of menopause. This is not supported by scientific evidence.

2) CMAJ Aug. 15/85 p.277. Ad for Vibramycin--implies most cases of sinusitis are bacterial in origin.

3) Can. Fam. Phys. Aug./85 p.1468. Ad for Proloprim. Doesn't mention that single dose therapy for UTIs is as effective as 10 day therapy.

4) Can. Fam. Phys. Aug./85 pp.1509-1512. Ad for Ansaid. Promises "rapid and sustained relief" and says it is "well tolerated". These claims are not supported with references.

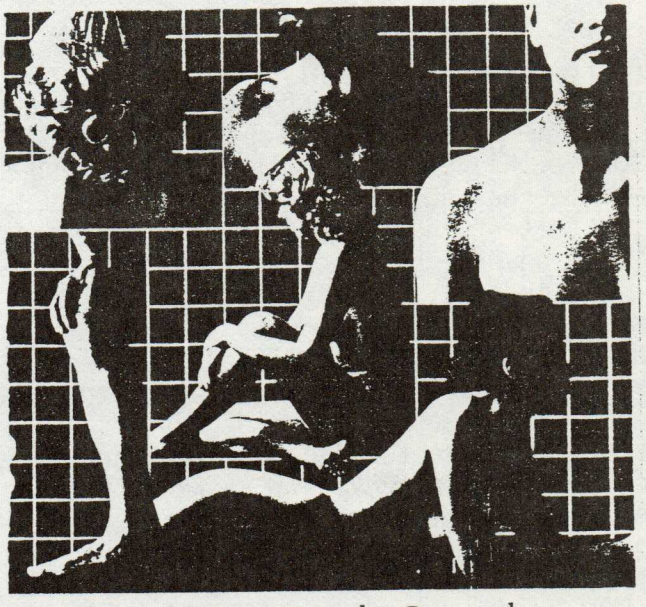
5) MD Aug./85 inside front cover. Ad for Lopressor SR. This ad is sexist.

The list could go on and on, but you can easily find your own examples. Complaints should be sent in writing to:

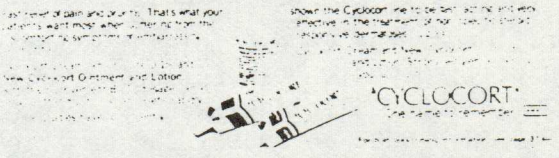
Commissioner, PAAB
345 Kingston Rd.
Pickering, Ontario L1V 1A1

If you send in a complaint please forward a photocopy of your initial letter and the Commissioner's response to the MRG at our mailing address. When we have compiled enough complaints and responses we will make the results public with the hope of strengthening the rules governing advertising.

AT THE MRG'S FALL GENERAL MEETING BRING A COPY OF THE WORST AD YOU CAN FIND. ENTRIES WILL BE JUDGED AND A DOOR PRIZE AWARDED FOR THE WORST AD.



A Strong Yet Gentle Steroid.
For Non-Specific Dermatoses



MRG Meets With Health Minister

MRG MEETS WITH NEW HEALTH MINISTER

An MRG delegation met with Murray Elston, the new Liberal Minister of Health, in late July.

The MRG was represented by Miriam Garfinkle, Gordon Guyatt, and Michael Rachlis.

The MRG delegation had two major agenda items going into the meeting: opting out, and a renewal of the consultative process initiated by Larry Grossman. This consultative process, which took place in 1983, involved a large number of groups with major interest in health care delivery (Ontario Hospital Association, MRG, OMA, nurses' associations, consumers' associations, etc.) and, remarkably enough, came to a consensus on a number of important issues.

The MRG delegation felt that if this consensus directed process could be renewed it would increase the chances of progressive movement in the health care field in Ontario.

Mr. Elston described some of the arguments the OMA was using in resisting an end to opting out but did not provide substantive information about government plans beyond what can be gleaned from the newspaper. He appeared interested in the idea of renewing the consultative process begun by Mr. Grossman.

What surprised the MRG delegation most was Mr. Elston's genuine interest in instituting progressive change and attempting to rationalize the health

MRG Meets With Health Minister

care system. He was very interested in exploring alternative ways of structuring health care delivery and alternative methods of funding physicians. We discussed Community Health Centres and Health Service Organizations at some length. The MRG delegation described the previous government's lack of support for either CHC's or HSO's and pointed out the potential advantages of these alternative ways of organizing health care. We also reviewed the present structure of the OHIP fee schedule, particularily the strong bias in favour of procedures. The possibility that the government might not leave the structure of the fee schedule entirely to the OMA was discussed. Throughout this part of the conversation Mr. Elston made evident his bias in favour of outpatient rather than institutional care. The MRG delegation made a plea that if expanded funding for CHC's and HSO's is instituted a well designed research program to evaluate the effects should be included. This led to a discussion of how research funding in Ontario might be expanded and rationalized.

In what were perhaps the strongest negative statements made by Mr. Elston during the interview, he expressed skepticism about birthing centres and told the MRG representatives that free standing abortion clinics were simply not on his government's agenda.

In general, the MRG representatives found Mr. Elston friendly, relaxed, and attentive. Given the many problems the new government faces, they were pleasantly surprised at the extent of his desire to take an innovative approach as opposed to simply trying to deal in a reactive fashion with the exigencies with which he is faced. He obviously faces major constraints in the form of budgetary limitations, the political insecurity of an inexperienced minority government, and the intense opposition of the Ontario Medical Association. However he deals with these problems the MRG delegation had the impression of someone who was at least willing to consider alternative possibilities.

--Gord Guyatt

OFFICE SPACE AVAILABLE

Nikki Colodny, G.P. and Psychotherapist, is looking for a like-minded practitioner with whom to share offices at 425 Queen St. East, Toronto, beginning this fall. Call 364-3982.

MRG MEDIA CONTACTS

CBC Radio Noon phone-in program with David Shatsky.

Two CBC reporters from outside of Metro who heard the Radio Noon program and wanted further information about the Sault Ste. Marie Health Centre.

One Globe and one Star reporter in July regarding extra billing.

Successfully encouraged Linda McQuaig from the Globe to write a story on drug company advertising which appeared in August. Joel Lexchin and Michael Rachlis had a long meeting with her.

Two Canada AM programs. One vs. Dr. Bill Goodman of AIP about extra billing, and one vs. a former chairman of the Pharmaceutical Manufacturers Association of Canada regarding drug advertising and the Eastman Commission report.

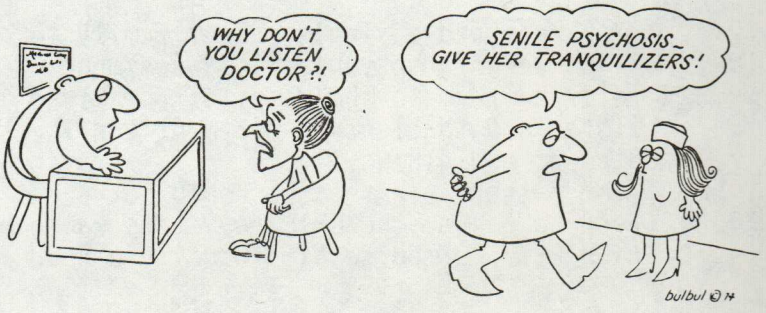
Interview with Judy Webb (CKFM) regarding drug advertising and the Eastman Commission.

Lunch with the publisher and the editorial board of the Star.

--Michael Rachlis

SIDE EFFECTS

"Side Effects", a play about pharmaceuticals which the MRG is co-sponsoring, will be playing in Toronto, probably for two nights during the last week of October. More details in the next newsletter.



Of Interest ...

HEALTH PROBE

Health Probe is a new organization of health professionals and other interested individuals whose purpose is to develop, advocate and have implemented public policies that result in health and well-being being promoted.

Health Probe owes its origins to the Beyond Health Care Conference on Healthy Public Policy held in Toronto in October 1984. As a result of the interest and enthusiasm generated by that conference, a group of people came together to establish Health Probe.

Health Probe will take on issues in public policy fields that impact upon health and that no other "health" group would be likely to tackle. Examples may include unemployment, housing, education policy, social income, agriculture, energy and transportation.

Health Probe will undertake action oriented research, prepare public statements and submissions, provide speakers, organize forums and work with a variety of community groups and health related organizations in action networks.

If you would like further information about Health Probe, or would like to be a member or attend a meeting contact:

Trevor Hancock
629 Manning Ave.
Toronto, Ontario
M6G 2W2
531-2889 (H) 485-2562 (W)

The next meeting will be Monday September 16, at 6:30 p.m., 64 Merton St. (Davisville & Yonge) (Potluck supper-no over available).

OPTING OUT EFFECTS

The following letter was received by a member of the MRG last month:

"Dear_____

You referred a single parent family to me last week for psychiatric assessment. I referred them to the Hospital for Sick Children's Outpatients Department and I wanted to explain why.

The father said that he could not afford to pay me the OHIP fee, then wait for OHIP to reimburse him (usually a four week delay. I gather that he is strapped financially. However, my being opted out of OHIP means that I bill patients directly. Though I do not extra-bill in cases where finances are limited, I do restrict my practice to clients who are willing and able to pay "upfront" and then get reimbursement. Too often in the past, I have consented to wait for the client to sign over his OHIP cheques to me, only for the client to withhold the money. In effect, I have ended up paying for the assessment.

That is my policy. I hope I can provide consultations to you in the future.

Sincerely,

_____

SOUTH AFRICAN MEDICAL GROUP

The MRG recently received a letter from the National Medical and Dental Association of South Africa, accompanied by a package of the group's publications. The letter states that "We are a group of concerned professionals who have come together to form NAMDA. We share similar objectives as the MRG and are interested in sharing publications. We would like to know how the MRG feels about such a relationship and whether it would be possible to exchange materials with each other." Enclosed with the letter are several of their publications, including their constitution, Papers and Policy Decisions of their first Annual General Meeting and conference, a pamphlet, "The Struggle for Health and Democracy in South Africa", and two copies of their newsletter (which mentions the MRG). They have been sent MRG materials in return.

The literature received from NAMDA is available for MRG members to peruse. Call Ulli Diemer at 920-4513 or 960-3903.

HEALTH COALITION SEEKS MEMBERS, SUPPORT

The Canadian Health Coalition, a coalition of organizations existing to preserve medicare, is now inviting individuals to become "friends" of the Canadian Health Coalition. Friends pay a fee of $15 (or more) and in turn receive the CHC's newletter and mailings. Contact CHC' 2841 Riverside Drive, Ottawa K1V 8X7.

Notices & Announcements

PATIENTS' RIGHTS SYMPOSIUM

The Patients' Rights Association is sponsoring a symposium on patients' rights on Saturday November 9, 1985, at Harbourfront, 235 Queen's Quay West, in Toronto. Workshop topics include Midwifery; The Health Disciplines Act; Women's Rights and Health Care; Doctor/Patient Relationships; and Health Rights in the Workplace. Registration fee is $25 for non-members, payble to 40 Homewood Ave., #315, Toronto M4Y 2K2. Call (416) 923-9629 for more information.

ONTARIO PUBLIC HEALTH ASSOCIATION MEETING

The Ontario Public Health Association is holding its annual Educational and Scientific Meeting in Toronto on September 22-25, 1985, at the Sheraton Centre. The theme is "Working Together: Building Coalitions for Public Health". Registration is $150 for members; $175 for non-members, payable to Laura Wood, OPHA Secretary, 1335 Carling Ave., Suite 210, Ottawa, Ontario, K1Z 8N8, phone (613) 725-1317.

HEALTHMATTERS

HEALTHMATTERS is a new quarterly publication by the Vancouver Women's Health Collective. They state that "we hope to provide Canadians with women's health information which is not accessible through the everyday media. Articles will include information gleaned from other sources throughout the English speaking world, book reviews, and original research. A one-year subscription is $15; address is 888 Burrard St., Vancouver, B.C. V6Z 1X9.

HEALTHSHARING

HEALTHSHARING magazine is a quarterly publication concerned with women's health and how women can take greater control of it. The current issue discusses reproductive hazards in the workplace, toxins in breast milk and Candidiasis.

Subscriptions: $8.00 individual, $15 organizations. Contact 101 Niagara St., Suite 200A, Toronto, Ont. M5V 1C3, 862-1791.

PHYSICIAN REQUIRED

A physician is required for a minimum of six months to work in a clinic for famine victims in rural Ethopia. Preferred qualifications background in public health or infectious disease or public health. Interested applicants should apply to Dr. Mark Doidge, Canadian Physicians for African Refugees, 72 Carlton St., second floor, Toronto, (416) 961-6786.

WORKPLACE REPRODUCTIVE HAZARDS CONFERENCE

This conference will be held at the Ontario Institute for Studies in Education 252 Bloor St. West, on September 6 and 7, 1985. It is billed as "a conference for labour, women, and community". Registration fee is $20, For more information call 484-8232.

SULLIVAN-LEMAY LEGAL ACTION FUND

On July 12, 1985, two BC midwives were charged with criminal negligence and practicing medicine without a licence. Funds are being sought to cover their legal fees. Cheques may be made payable to Maternal Health Society, P.O. Box 46563, Station G, Vancouver, B.C., V6R 4G8

Proposed Resolution on Maternal Health Care

The MRG's Working Group on Health Disciplines Legislation Review has drafted a proposed resolution on midwifery which it is presentingfor consideration by the membership at the Fall General Meeting on October 26. The working group is still working on the resolution so the following text may still undergo some revisions. If so, the revised text will be mailed out before the general meeting. The following, however, certainly represents the basic thrust of the working group's thinking:

STATEMENT ON MATERNAL HEALTH CARE

1. Appropriately trained, certified and publicly accountable midwives and family physicians/general practitioners are both capable of providing unsupervised primary obstetrical care.
2. A clear distinction should be drawn between primary care obstetrics which is most appropriately provided by midwives and family physicians and secondary/tertiary care obstetrics which is the domain of consultant obstetricians. An important implication of this dichotomy is that midwives should not be based in hospital units oriented toward the provision of secondary/tertiary care.
3. Existing hospital obstetrical units, oriented in terms of attitudes, staffing and equipment toward technological approaches and the management of obstetrical complications, offer an inhospitable and potentially hazardous environment for incomplicated low-risk birthing. The likelihood of unnecessary amniotomy, anaesthesia, forceps delivery and episiotomy is substantial. Imperfect diagnostic procedures, such as electronic fetal monitoring, applied in low risk situations result in significant numbers of normal labours being erroneously labelled as pathological. The rising rate of Caesarian sections may in part reflect this phenomenon.
4. Women have the right to low technology birthing alternatives which could be provided by midwives and/or family physicians at home, in free-standing birthing centres or in special low-risk obstetrical units in hospitals. These alternative models of care should be evaluated in relation to safety, patient acceptability, effectiveness and cost.
5. Ease of patient movement and professional communication between primary and secondary/tertiary care sectors must be assured.
6. Midwifery must be seen as one component of an integrated primary health care system providing continuity and comprehensiveness of care.
   Since family physicians/general practitioners are the principal primary health care providers in the existing system, strong linkages between midwives and family physicians sharing care of patients must be developed. Two general models for this linkage can be identified:
   1) family physicians and midwives working together in community health centres or health service organizations.
   2) negotiated linkages between midwives and family physicians practicing independently either individually or in formal or informal groups.

   The first of these models is preferable and incentives should be developed to promote such arrangements. To ensure a minimum level of integration and communication, regulations should provide that any person receiving care from a midwife have an identified primary care physician and require formal communication at appropriate intervals.

   The division of tasks between midwives and family physicians would form a spectrum with total care by midwives at one end, total care by family physicians at the other end and a variety of negotiated shared care arrangements in between. Specific arrangements would be determined by local conditions and the personal

Maternal Health Care

preferences of providers, and, especially, recipients of care.

As previously suggested, midwives should be fully responsible for their own professional actions. Neither family physicians nor obstetricians should have a supervisory relationship to midwives.

7. Midwifery should be viewed as an alternative mode of primary obstetrical care rather than as a supplement or add-on to existing services.
8. Care provided by midwives in keeping with the above principles should be fully publicly funded.
9. Existing hospital obstetrical units cannot in themselves, provide adequate training for family physicians and midwives in primary care obstetrics. Clinical settings developed expressly to accommodate uncomplicated low-risk birthing are needed as primary care training sites.
10. Midwives and family physicians can make a significant contribution to each other's education.

Brian Hutchison
August 6, 1985

MRG MEMBERSHIP

Do you know of someone who ought to be an MRG member, but isn't? Let them know about the MRG, or ask Ulli Diemer (416-920-4513; 416-960-3903) to send them a basic information kit about the Medical Reform Group.

MRG NEWSLETTER

If you have information or opinions which you think would be of interest to other MRGers, then put them in the Newsletter. Write to P.O. Box 366, Station J, Toronto M4J 4Y8 or call Ulli Diemer at 416-920-4513 or 416-960-3903. Book reviews and other short, readable submissions are particularily welcomed. The fact that items are published in the MRG Newsletter does not necessarily imply MRG endorsement of any particular group, activity, or opinion.

CANADIAN MEDICINE: A STUDY IN RESTRICTED ENTRY

By Ronald Hamowy. 394 pp. Vancouver, B.C., The Fraser Institute, 1984. $14.95.

FIRST AND FOREMOST IN COMMUNITY HEALTH CENTRES: THE CENTRE IN SAULT STE MARIE AND THE CHC ALTERNATIVE

By Jonathan Lomas. 224 pp. Toronto, University of Toronto Press, 1985. $27.50 (hardcover); $12.95 (paperback).

The social history of Canadian medicine is poorly documented. Hamowy notes that most of the source material has been written by physicians reflecting an establishment position. Here are two books written by nonphysicians, both of them authoritative historians of their subjects. Each author advocates alternatives in the provision of medical care in Canada.

Hamowy's study is ostensibly limited in its scope, being an account of the development of medical licensing legislation in British North America from the earliest days to the early years of this century. It is not a narrow historical study, however. The Fraser Institute is a Canadian body advocating free-market economics; the book's introduction makes it clear that the study has been published to raise questions about the economic consequences of restrictive legislation.

There are pressures in Canada against the medically dominant model of licensing. As in the United States, there are growing demands for professional recognition for other health providers, such as nurses and midwives. There is some pressure from bodies (such as the Fraser Institute) that favor competitive free enterprise. The complexities of federal–provincial legislation and the essentially similar philosophies of the major political parties make imminent change unlikely.

The book by Lomas deals with the history of contemporary Canadian institutions. His book should be valuable to physicians as well as to students and administrators of health care systems. The Group Health Centre in Sault Ste. Marie, Ontario, is an interesting hybrid. It was founded as a union-sponsored prepaid plan before the institution of universal medical care in Canada. Lomas documents its integration into the universal system, which now guarantees funding. Unlike American health maintenance organizations, health service organisations (HSOs) — the Canadian equivalent — are obliged to accept any residents as enrollees. Initially, this center was a closed plan for steelworkers. The negative reaction of the established local doctors was a predictable and familiar one. At present, about half the population of Sault Ste. Marie (a middle-sized town in Northern Ontario) is enrolled in the plan and enjoys a wider range of services than would be anticipated.

The Sault center was inspired largely by union-sponsored HMOs in the United States. Conversely, if some form of universal medical care financing develops in the United States, the Canadian experience should have important lessons based in part on the Sault Ste. Marie experience. HSOs exist in Ontario, operated by community boards or by physician groups alone. None are run by private businesses. Critics of the commercialization of American health care will find it interesting to analyze why there has been minimal penetration of the system in Canada.

Comprehensive community-based primary health care is a threat to the established, physician-dominated system. Although Lomas favors the establishment of alternative systems of this type, Hamowy would appear to have a different idea. The two seem in agreement on the need to change legislation.

Lomas concludes with pessimism about the prospects for further development of community-based health centers in Ontario. It is possible to take a very different view, on the basis of what is occurring in Canada as much as in other countries. This includes the increased expectation of other providers for recognition, constraints by paying agencies (in this case, government), a developing oversupply of physicians, and computerization (with its manifold implications).

ROBERT FRANKFORD, M.B., B.S.
2615 Danforth Ave.
Toronto, ON M4C 1L6, Canada

THE NEW ENGLAND JOURNAL OF MEDICINE Aug. 8, 1985

Robert Frankford and Jonathan Lomas are members of the Medical Reform Group.

A Letter to MRG Members From Nicaragua

Apartado 4074
Managua, Nicaragua

Dear Fellow Members,

Saludos!

As two members of the MRG working in Nicaragua we would like to ask your assistance and update you on the current situation of health care in Nicaragua.

The Reagan administration's war on Nicaragua has had horrible effects on health care. The "contras" backed by the CIA and using tactics of pure terror, have systematically attacked the infrastructure of the health care system. In the last 3 years, 22 health posts have been completely destroyed, 9 others have been partially destroyed and 32 health posts and centres have been forced to close.

The "Contras" have also consistently threatened, kidnapped and killed health care workers. Between 1981 and 1984, 74 health workers workers have been killed while carrying out their work. Among those killed were 2 internationalist doctors, one French and one German.

Even these grizzly statistics can't convey all the opportunities lost or all the costs to health care that result from the war. The Ministry of Health, for example, has a program to upgrade the training of traditional midwives. One of the graduates of this program in the north of the country, was threatened by the "Contras" and told not to continue attending births or receiving upgrading. As a mother herself, she felt an obligation to other mothers and decided to continue. Two months later, her throat was slit by the "Contra".

The aggression against Nicaragua has expanded with the formal imposition of an economic blockade by the U.S. government. This blockade will be especially hard felt in the health sector where 25% of materials and medicines have come from the U.S.

Despite the physical and economic aggression, the Nicaraguan health care system and its workers have achieved some incredible results. Polio has been eliminated through a nation wide vaccination campaign and this year alone 4 times as many vaccines have been given as during the best year of the Samoza dictatorship. Visits to physicians have tripled when compared to the years before the triumph of the revolution, testimony to the desire to provide health care to the most marginalized sectors of society.

Reaching the poorest and most isolated villages has required the dedication of many volunteers. One of us, working in a rural area, has seen 2 students and a farmer walk 17 kms. over rugged mountain terrain to reach one village. They vaccinated 50 children and retraced their steps in the hot sun. These "brigadistas" as they are called, express the commitment of a people in transition, facing incredibly difficult challenges to construct their new society.

We are asking you to express the same dedication as that of those brigadistas and help the continued development of the health of the Nicaraguan people in their time of need. You can contribute through Medical Aid to Nicaragua or MATN at 947 Queen St. E.
Toronto, Ont.
M4N 1J9
You can also collect primary care equipment and supplies for the Tools For Peace project (connect through MATN). Finally one of us is going to be in Ontario in July and will entertain questions on the situation and other suggestions for help.

We look forward to seeing your contribution!

Fraternally,

Donald Cole M.D.
Benjamin Loevinsohn M.D.

MRG STEERING COMMITTEE MEETINGS

MRG members are welcome to attend Steering Committee meetings. Meetings are usually held the last Thursday of each month. If you are interested in attending, call Ulli Diemer at 416-920-4513 or 416-960-3903 for information about where the meeting will be. Meetings alternate between Hamilton and Toronto.

THE GLOBE AND MAIL, TUESDAY, AUGUST 13, 1985

Some MDs expressing alarm over drug sales campaigns

By LINDA McQUAIG

About once a week, a clean-cut man arrives in the small town of Powell River, B.C., and chances are he will be offering a free lunch.

Like any travelling salesman, this representative of one of the multinational drug companies knows that making an appealing presentation helps sell prescription drugs as much as vacuum cleaners.

So whether he is a "detail man" making a door-to-door sales pitch to doctors or a "professional" representative bringing in a medical speaker for a company-sponsored luncheon at a local hotel, he has something for the doctors he is visiting.

With the multinational drug companies in Canada spending more than $200-million a year on various forms of advertising and promotion — from glossy ads in medical publications to cocktail parties at medical seminars — some doctors are expressing alarm at the impact of all this advertising.

Dr. Michael Rachlis, a Toronto physician and spokesman for the Medical Reform Group, argues that the massive sales-promotion budgets drive up drug prices and encourage doctors to prescribe more expensive drugs. It also encourages them to prescribe drugs in cases where non-drug therapy might be more appropriate, he says.

Dr. Rachlis argues that the friendly relationships the drug companies try to cultivate with doctors have a tendency to "make doctors less critical in their judgment" when it comes to prescribing.

Dr. Jerry Avorn, director of the Drug Information Program at Harvard Medical School in Boston, says this is more of a problem than doctors care to admit.

He says that while most doctors deny they pay much attention to drug company advertising, studies have shown that their knowledge of drugs is more consistent with drug company literature than information in scientific journals.

Dr. Avorn says that the advertising and promotion campaigns of drug companies are so extensive that there is a need for a network of "counter-detail men" to give doctors strictly scientific information about drugs.

Concern about the cost of drug advertising comes at a time when federal policy affecting drug prices is under review.

The multinational drug companies are waging an intense campaign to strike down a section of Canada's patent laws which is credited with saving consumers $211-million in 1983. The section permits the sale of no-name generic drugs, which are cheaper copies of the brand-name drugs produced by the multinational firms.

Consumer savings on drugs could have been even higher if the drug industry had not spent so much on advertising and promotion, says Robert Kerton, a University of Waterloo economist who heads the economics-issues committee of the Consumers Association of Canada.

The consumers association has been trying unsuccessfully since the mid-1970s to have drug advertising banned.

Prohibit advertising, CAC says

The drug industry spent about as much on promotion and advertising in 1983 — $209-million — as it lost because of generic competitors — $211-million — according to calculations based on figures from the recently released Eastman commission into the pharmaceutical industry.

"If the international drug companies are so concerned about the $211-million that went to the generics, all they have to do is get rid of their advertising, which most doctors say doesn't add anything anyway," Dr. Rachlis argues.

Last year, the multinational drug industry in Canada spent about $240-million — $4,501 per doctor — on advertising and promotion to woo Canadian doctors to prescribe their products, according to figures provided by the Pharmaceutical Manufacturers Association of Canada.

This includes glossy, full-color advertising in dozens of journals and giveaway magazines for doctors and pharmacists, promotional literature sent to doctors, and the army of 2,500 detail men who make personal calls on doctors across Canada.

Not included are the additional funds that drug companies spend sponsoring medical seminars and providing free hospitality at medical events. (These costs are counted as part of medical education, not promotion.)

Many of the large multinational drug companies have entire departments which organize medical seminars across the country. Frank Round, manager of professional relations at the pharmaceutical firm Syntex Inc., said that last year his company put on 93 seminars, which often began with a cocktail party and ended with a dinner.

"If you give them a couple of drinks, it softens things up," says Mr. Round.

Doctors like the seminars, he explains, because they can build up credits for continuing education which they need to keep up their membership in medical colleges. Some doctors tend to doze off during the seminars, however, Mr. Round said.

Syntex spent about $300,000 last year on its seminars and special medical videotapes for Canadian doctors, he said.

One recent revelation suggests that some drug companies also resort to more innovative ways to interest doctors in their products. Dr. Patrick Murphy, of Johns Hopkins University in Baltimore, recently made public a drug company sales manual mistakenly left behind in his office by a detail man. Among the gimmicks the drug company suggested its detail men use were: cookies with shapes and colours of drug capsules; pizzas with drug initials picked out in pepperoni; and Easter baskets with eggs resembling drug capsules.

Gordon Postlewaite, spokesman for the manufacturers' association, argues that drug advertising is cost-effective because it provides information to doctors that helps prevent adverse drug reactions.

But doctors like Dr. Avorn from Harvard and Toronto geriatrician Dr. Cyril Gryfe say that much drug advertising is promotional rather than strictly informative and that the extensive sales campaigns encourage doctors to rely too heavily on drugs for treatment.

Dr. Gryfe, medical director of Baycrest Centre for Geriatric Care, said that doctors are trained at universities to think of drugs as the primary method of helping people, and this training is reinforced by the industry's heavy sales promotion. As a result, older patients are "literally snowed with drugs" at a time in their lives when their kidneys and liver may not be able to handle the medicine.

Elderly 'snowed' with drugs

He points to advertisements for diuretics, drugs which cause the patient to excrete excess water, thereby reducing the danger of heart failure. Excess water might not accumulate in the first place if the patient ate less salt, Dr. Gryfe says, but the ads for diuretic drugs do not point out this non-drug alternative.

Similarly, the drug companies are heavily promoting the use of expensive new arthritis drugs called non-steroidal anti-inflammatories, even though for many patients these drugs are no more effective than simple low-priced Aspirin, Dr. Avorn said.

Mr. Postlewaite agrees that drug advertising emphasizes a drug approach to treating patients. "That's because that's what the industry is all about. We're not in the business of giving group therapy." He added, however, that he is in favor of non-drug treatments where appropriate.

But some doctors, like Dr. Lilli Kopala of Powell River, argue that as a result of the heavy promotions by drug companies, some drugs are prescribed too freely and in the wrong circumstances entirely.

Dr. Kopala did a survey at the local hospital in 1981 and found that the popular anti-ulcer drug Tagamet was prescribed inappropriately 80 to 90 per cent of the time. In 10 per cent of the cases she studied, there was no apparent reason at all for the drug to be prescribed.

She suggested that the situation reflected a "terrific sales campaign by Smith Kline & French," the drug's manufacturer.

Dr. Avorn argues that his system of counter-detail men can help counteract the highly effective sales campaigns of drug companies. A four-year experiment of the counter-detailing system in the United States found that when provided with strictly scientific information, doctors prescribed fewer and less costly drugs, he said. The resulting savings were larger than the costs of hiring the counter-detail men.

The potential savings have caught the attention of the Ontario Government, which last year spent about $390-million paying for drugs for senior citizens and welfare recipients.

"He (Dr. Avorn) is identifying some positive changes that could be made in terms of physicians' prescribing habits — how to get them to prescribe less and more astutely. Can you counter-attack the propaganda from the industry? That's interesting," said Michael McRae, co-ordinator of Ontario's Drugs and Therapeutics Advisory Service.

Mr. McRae said that although the Health Ministry has not officially shown any support for such an idea, "there has to be interest."

Dr. Avorn points out that both in Canada and the United States, where drug advertising is screened by specially appointed bodies before publication, advertising does not misrepresent the characteristics of a drug.

"The problem is not one of misrepresentation; it's one of emphasis. The persuasion is not necessarily in the direction of optimal care, or at least cost-effective care."

However, in other countries that do not have rigorous control over the content of drug advertisements, some drug companies do indeed resort to "downright misrepresentation," he says.

Globe and Mail, Nancy Ackerman

Dr. Michael Rachlis: Medical ads set alarm bells ringing.

Critique of multinationals rejected by journal's editor

Globe and Mail, August13, 1985

Dr. Joel Lexchin is convinced that he has been censored by the Canadian Pharmaceutical Journal because of critical comments he made about the multinational drug industry.

The pharmaceutical journal, like dozens of others aimed at doctors and pharmacists, relies heavily on advertising by the multinational drug companies.

Of all the speakers at a June conference on drugs and geriatrics, Dr. Lexchin is the only one whose speech was rejected for publication by the journal. The journal published a special issue containing 10 other conference speeches.

Dr. Lexchin, a Toronto physician, said that his critical slant against the industry was one of the reasons given by the publication's editor in rejecting the speech, which dealt with the portrayal of elderly people in drug advertising.

But editor Jean-Guy Cyr said yesterday that this was not one of the reasons for rejecting Dr. Lexchin's speech. He said the other speeches all dealt with therapeutic issues, whereas Dr. Lexchin's was more of an opinion piece.

Mr. Cyr criticized Dr. Lexchin's speech for "looking at one side of the issue and one side only."

Asked whether the journal had ever published an article critical of the multinational drug industry, Mr. Cyr said he did not believe so. He added that as far as he remembered, no critical article had ever been submitted in the two years since he has been editor.

Dr. Lexchin believes the journal's rejection of his speech indicates how closely the medical and pharmaceutical journals are tied to the drug industry, and how this affects their content.

"What that means is that journals are overly dependent on pharmaceutical advertising, and willing to compromise their editorial integrity," says Dr. Lexchin, author of the book The Real Pushers: A Critical Analysis of the Canadian Drug Industry.

With the multinational drug companies spending tens of millions of dollars a year on advertising, dozens of new journals have started to catch some of these ad dollars.

Dr. Lexchin points to examples of how these publications have tended to take editorial stands which support the multinational drug industry on controversial political issues, such as whether Canada should abolish its system of licencing low-priced generic drugs.

He says that while some publications do not take editorial stands on the issue, those which do have heavily supported the position of the multinational drug industry.

Dr. Gordon Guyatt, a specialist in internal medicine at St. Joseph's Hospital in Hamilton, also argues that the vast array of publications aimed at doctors — many of which are sent out free in the mail — can have a negative impact on medical practice.

The problem with this, says Dr. Guyatt, is that they present evidence in an unscientific way and most doctors have little knowledge of how to evaluate the evidence they are reading.

Some of the give-away magazines simply cater to doctors' leisure-time interests, with articles such as "The Middle Class MD's Guide to Buying a Yacht."

Doctors' rights

The Canadian Medical Association is mocking the notion of rights in relying on the Charter of Rights and Freedoms for support in the fight for extra-billing (CMA Challenges Extra-Billing Law — July 18). This is not an issue of professional, civil or economic rights.

Prohibiting extra-billing does not mean doctors will be told where to work, what time to show up for work, how many patients to see in a day, what treatment to use, what conferences to attend and how many holidays to take. They will not be told how to dress or be required to provide sick notes when absent from work. Doctors will not resemble in any way employees, civil servants or chattels of the state.

Doctors will still be able to affect their incomes within medicare by the usual determinants of successful entrepreneurship: organization, efficiency, competence and cost-effective management. Limiting the price of their commodity (medical services) places the medical profession in line with other regulated and competitive industries such as communications and energy.

The issue of extra-billing is the conflict between the unfettered freedom of doctors to bill as much as the market will bear and the right of Canadians to medical services unimpeded by personal financial considerations.

Banning extra-billing is an insignificant infringement on professional independence and a major step forward in securing the right of access to medical services for all Canadians. It affirms the Government's duty to protect the public interest without compromising the freedom of independent business — in this case, the medical profession.

Philip B. Berger, MD
Toronto

Globe + Mail, July 7, 1985

Case for midwifery gets boost from obstetrician

By LINDA HOSSIE

The medical and political case for midwifery got unexpected and thorough support yesterday during a dramatic day of inquest testimony that left two midwives in tears.

Testifying at an inquest into the death of Daniel McLaughlin-Harris, McMaster University obstetrician Murray Enkin said "maternity care in this province would be improved by a well-developed home birth program" with medical backup.

He also said that nothing in the physical condition or the labor of Daniel's mother, Alix McLaughlin, indicated she was in a high-risk category for delivery of her baby.

Daniel McLaughlin-Harris was born last October with the help of two midwives at his parents' Wards Island home. He was not breathing at birth and was rushed to the Hospital for Sick Children where he died two days later.

Dr. Enkin, a faculty member at McMaster University and an obstetrician at McMaster's trail-blazing maternity centre, was the first expert medical witness who did not imply that fault for the baby's death lay in inadequate care for the mother and child during risk assessment, labor and delivery.

During afternoon testimony, the midwives' lawyer, Marlys Edwardh, gave the doctor Ms McLaughlin's pre-natal and labor record to examine. Dr. Enkin said the record showed no signs of a high-risk factor in Ms McLaughlin's health.

When asked by Ms Edwardh to evaluate the labor record kept by the midwives and to consider that Ms McLaughlin's child died after birth, Dr. Enkin said: "From everything I've been told, I don't think I would have done anything different."

The remark dissolved the tension of days of critical testimony and Ms McLaughlin as well as midwives Vicki Van Wagner and Sue Rose broke into tears of relief.

In earlier testimony, Dr. Enkin said doctors' arguments that hospital births are safer than home births are based on "crude statistics."

Figures showing higher mortality rates for home births, he said, often include births that happened inadvertently at home. Many of those cases would involve premature deliveries, he said, and many of those would be high-risk cases.

The best available data seem to indicate that home births are safer than hospital births, Dr. Enkin said.

He cited a 1977 study showing a series of problems in 1,046 home births, and an equal number of hospital births, where the mothers in both groups were matched for risk assessment, age, educational level, and income status.

Twenty of the home births produced fetal distress during birth, he said, compared with 119 cases of distress in hospital deliveries. Home births produced nine cases of post-partum hemorrhage, compared with 25 in hospital.

There were no birth injuries in the home births, he said, while there were 30 in the hospital births.

The same study showed dramatically increased use of intervention in labor, Dr. Enkin said, particularly in the use of forceps (1.5 per cent at home births and 30.5 per cent in hospital) and surgical openings of the vagina (9.8 per cent in home births and 87.4 per cent in hospital).

"The available statistics do not give us the right to coerce women into hospital for birth," he said.

Asked by Ms Edwardh about a medical style called the "aggressive management of labor," Dr. Enkin said he recognized the term.

A previous witness, Mount Sinai Hospital obstetrician Knox Ritchie, told the inquest he had written papers on the active management of labor.

Dr. Ritchie said that a woman's cervix should dilate at a rate of one centimetre an hour, and that if it didn't, he would break the membrane holding the amniotic fluid, or use drugs to hurry the labor.

Dr. Ritchie also testified that the two midwives should not have let Ms McLaughlin's second stage of labor go for 2½ hours without transporting her to hospital.

But Dr. Enkin said using drugs to speed labor carries risks for the mother and child. All labors are different, he said, agreeing with previous testimony from the midwives that the crucial things to watch for are the well-being of the mother and the baby, and that steady progress is being made in the labor.

"Any time a person sets a rigid time limit on second stage, you're asking for trouble," he said. "The major problems with second stage come from intervention to hasten second stage. That's when birth injuries happen."

Half-way through the day's testimony, about 300 men, women and children gathered in front of the coroner's court to demonstrate their support for the midwives and midwifery. Many of the placard-carrying demonstrators were parents who had help from midwives during births, either at home or in hospital.

THE GLOBE AND MAIL, THURSDAY, JULY 18, 1985

Challenge of Health Act is criticized

"Dr. Michael Rachlis, spokesman for the 150-member Medical Reform Group of Ontario, said the court action is a waste of both the CMA's and the provincial and federal government's time and money.

'I'm concerned that the main physicians' organization is still fighting this issue when they should have given it up a long time ago as a lost battle,' he said.

Dr. Rachlis said the number of doctors who have opted out of provincial medicare programs who hold leadership positions in medical associations is disproportionate to their actual numbers.

Most who choose to opt out are surgical specialists, anesthesiologists, obstetricians and psychiatrists, he said."

Globe and Mail, July 18

PETERSON HOLDS BACK ON INJUNCTION

Ontario Premier David Peterson has backed away from his election campaign promise to seek a civil injunction against further abortions at the Morgentaler Clinic in Toronto. Responding to a question in the Legislature, Mr. Peterson said that he had received legal advice not to seek the injunction while the case is before the courts.

CATHOLIC AGENCIES CAN'T DENY ABORTIONS

Starting in October, Roman Catholic children's aid societies will no longer have the power to prevent pregnant girls in their care from having abortions. Ontario's new child welfare laws will permit a court to vest in a parent who has lost legal guardianship the right to consent to medical treatment, including abortion, for a child in agency custody. The new amendment was drafted primarily to deal with the issue of a pregnant teenager who is a ward of the agency and is being prevented from having an abortion. In these situations, the courts will direct the Roman Catholic Agency to place pregnant girls in the care of a non-sectarian CAS, which can authorize abortions.

TOXIC FLOW IMPERILS GREAT LAKES

Toxic substances flowing into the Great Lakes from contaminated ground water and falling from the atmosphere are major threats to the world's largest supply of fresh water, says a report by the Great Lakes Water Quality Board, which reports to the International Joint Commission. The report says that serious water pollution is a problem all around the Great Lakes basin, with 42 Canadian and U.S. centres showing heavy to moderate contamination. Almost all of these areas have contaminated sediments, and many also have problems with bacteria, suspended solids, oil, and grease.

PESTICIDE FOUND IN WELL WATER

Alachlor, a widely used and controversial herbicide, has been found in higher than "acceptable" levels in a number of Southern Ontario rural wells. All affected well owners have been told not to drink or cook with the water, and at least one nursing mother has been told to stop breast feeding her baby. In tests on wells, the Ontario Ministry of the Environment has found unacceptable concentrations of the chemical in wells in Middlesex, Essex, Lambton, Simcoe, and Prince Edward counties. Scientists in the Department of Health and Welfare in Ottawa recommended last year that alachlor be banned, but instead, Agriculture Canada opted for a new warning label, a ban on aerial spraying, and a ban on the use of alachlor on potatoes.

CLEAN-UP OF DUMP SITE SHELVED, COTTAGERS TOLD

Promises made by Ontario Premier David Peterson during the spring election campaign to close and clean up a leaking liquid industrial waste site near Balm Beach, Ontario are being shelved. According to Environment Minister James Bradley, "in Opposition, you can make many promises, but you don't have to carry them out. Now, we cannot make the extended statements and promises of Opposition, but we must make the real statements of Government."

HEALTH CENTRE URGES LEAD BAN FOR GAS

High levels of lead contamination in the South Riverdale area of Toronto have prompted the South Riverdale Community Health Centre to call on Ottawa to ban the use of lead in gasoline. A ban on leaded fuel would result in a 5 per cent drop in the levels of lead in the blood of area residents, according to Dr. Michael Rachlis, an MRG member who is a consultant for the Health Centre. Failing a total ban, he said, the centre would like to

Health News Briefs

LEAD BAN CALLED FOR (continued)

see the use of leaded fuel restricted to heavy trucks and machinery. The health centre also asked Ottawa to use taxes to dissuade motorists from using leaded gasoline by equalizing the price of the two types of fuel as an interim measure. Citing gasoline lead as a source for about 35 per cent of the lead in humans, the health centre said surveys in the U.S. and Canada show motorists are using leaded gasoline in cars designed for unleaded because it is cheaper. The brief comes 12 years after lead contamination became an issue in the area.

LOBBY FIGHTS SALES PUSH FOR TOBACCO

A group of Canadian doctors and scientists has called on the government to reject a proposal for a federal tobacco marketing agency, saying tobacco is a deadly crop and that it would be irresponsible for Canada to push sales, especially in Third World countries. Spokespersons for five public health and medical associations told a news conference that they would fight the creation of any body to promote tobacco sales. The five organizations, Physicians for a Smoke-free Canada, the Canadian Cancer Society, the Canadian Lung Association, the Canadian Public Health Association, and the Non-Smokers Rights Association, have come together to form the Committee for Responsible Public Policy on Tobacco.

INCREASE IN BIRTH DEFECTS

A disease surveillance report published last month by the Ontario Ministry of Health identifies increased rates of cleft lip/palate, hypospadias, Down's syndrome and missing limbs among babies born in certain parts of southern Ontario between 1973 and 1983. The report also notes a "significantly high" incidence of stillbirths in northwestern Ontario. While advising caution in interpreting the data, the report said that "pesticides may have contaminated the soil or drinking water, or steel industry tailings may have contaminated the air and/or soil" in the most affected areas, which include the counties of Dufferin, Wellington, Brant, Halton, Niagara, Hamilton-Wentworth, Haldimand-Norfolk, and Waterloo. Further studies are planned.

ONUS PUT ON MDs IN FORCED COMMITTALS

A recent Ontario court decision could pave the way for involuntary psychiatric patients to successfully appeal their committal to hospital, mental health advocates say. A decision by District Court Judge High Locke places the onus on a physician to show that a patient is a danger to himself or others and must remain in a psychiatric hospital. In his decision, Judge Locke said that the burden of proving that the involuntary admission and the subsequent certificate of renewal "was lawfully appropriate, falls upon a physician who signs the specific forms in question and upon the hospital in to whose custody the patient is taken." The case before the judge involved a man who challenged a regional review board decision in court. He is the first to do so.

MDs CHALLENGE RETIREMENT CLAUSE

Ten British Columbia doctors have succeeded in -- at least temporarily -- getting the B.C. Supreme Court to temporarily restrain a hospital from cutting off their admitting privileges because they are 65 or over. The doctors challenged Vancouver General Hospital's retirement rules under the new equality-rights section of the Charter of Rights and Freedoms, which prohibits discrimination on the basis of age. The court victory is only tentative because the hospital is appealing the ruling, but in the meantime the doctors have had their privileges restored. The case is being seen as a test case on compulsory-retirement rules.

VOTE SOUGHT FOR PSYCHIATRIC PATIENTS

The Psychiatric Patient Advocate Office, with the backing of the Canadian Mental Health Association, is pressing for patients in psychiatric hospitals to be given the vote in Ontario municipal elections this November. About 4,000 patients are affected. According to Dr. Tyrone Turner, the provincial co-ordinator of the PPAO, a quasi-independent agency financed by the Ontario Ministry of Health, the current system effectively disenfranchises most institutionalized psychiatric patients. Only patients declared incompetent are legally barred from voting, but most are effectively prevented from voting because their hospitals are never enumerated.

GOVERNMENT PROMISES EXTRA-BILLING ACTION

Ontario Premier David Peterson says that he hopes to introduce legislation banning extra billing this fall. Mr. Peterson says that he favours the "Quebec model" whereby physicians must be either fully opted in or fully opted out. Opted out doctors are not allowed to bill the medicare plan, and doctors in the plan are not allowed to charge above medicare rates. At present, the federal government withholds about $50 million a year from Ontario in transfer payments as a penalty for allowing its doctors to extra-bill patients.

MANITOBA ACCEPTS ARBITRATION

The Manitoba Medical Association has signed an agreement with the provincial government which provides for arbitration to settle fee disputes in the next two years if a mutual agreement on fees is not reached. The government has initially resisted arbitration, but agreed to it after the Canada Health Act led it to ban extra billing by doctors. The agreement also provides for a 2% fee increase this year.

CMA CHALLENGES EXTRA-BILLING LAW

The Canadian Medical Association has filed a court challenge to the Canada Health Act's provision that penalizes provinces that allow extra-billing. The suit, filed in the Supreme Court of Ontario, seeks a declaration that the federal law is outside the constitutional jurisdiction of the federal government, and that it violates the Charter of Rights. The CMA contends that health matters are exclusively within the domain of the provinces. It also maintains that the provinces are prevented by the constitution from enacting legislation to meet the requirements of the federal law. Ontario is named as a respondent in the suit along with the federal government because of its stated intention to ban extra-billing.

GROUPS DECRY NEW DRUG TAX

Anti-poverty and consumer protection groups are mounting a campaign against federal plans to tax health-care products, saying that the levy will turn some already costly life-sustaining medical supplies into luxuries. The groups charge that the 10 per cent tax on the products--announced in the May 23 federal budget--will hit the poor the hardest. The tax will affect thousands of non-prescription items such as cough syrups, pain relief pills, laxatives, denture cream, bandages and anti-histamines, as well as syringes and sugar testers for diabetics.

MAKE MIDWIFERY LEGAL, INQUEST JURY URGES

A controversial inquest into the death of a baby delivered by two midwives at the parents' home on Toronto Island ended with a recommendation from the jury that midwives be allowed to deliver babies in Ontario. The jury also noted, however, that in its opinion the child's life could have been saved if it had been taken to hospital earlier. The father of the baby said after the inquest that he and his wife were "extremely disappointed with the inquest proceedings that (allowed) our son's death to be used as a political battleground for obstetricians, doctors, and the medical model to maintain control over maternity care."

VANCOUVER MIDWIVES CHARGED

Two midwives have been charged with criminal negligence in connection with the death of a baby born May 8. The charges follow a police investigation made at the request of the provincial College of Physicians and Surgeons. Gloria Lemay and Mary Sullivan are also charged with two counts of unlawfully practising medicine while acting as midwives.

Health News Briefs

PATIENTS' INSURANCE CLAIMS UP

The Canadian Medical Protective Association, which insures most Canadians doctors, paid almost $13.8 million in settlements last year to patients who successfully sued. The amount is up considerably from $10.9 million the previous year, and is sure to mean substantial premium increases.

ONTARIO CONSIDERS DRUG PLAN OVERHAUL

The Ontario Government is still paying inflated prices for drugs provided free to groups such as senior citizens and is considering a major orverhaul of the province's drug delivery system, Health Minister Murray Elston has said. More than 1.3 million people, including senior citizens, welfare recipients and the disabled, used the Ontario Drug Benefit Plan last year, with the result that the plan represents about 40 per cent of theprovince's drug market. In the 1984 annual report, the provincial auditor estimated that inflated drug prices listed in Ontario's Drug Benefit Formulary meant that the Government paid $14.5 million more than necessary in a one-year period. The prices listed in the formulary were "higher, in some cases much higher than the prices at which drug manufacturers were actually selling to pharmacies," Mr. Elston said.

CMA OPPOSES HOME BIRTHS

The Canadian Medical Association took a strong stand against home births at its August annual meeting. A resolution approved at the meeting maintained that home births increase the risk of complications for both mothers and newborns, and that exposing patients to higher risks is "retrogressive and irresponsible."

NEW REGISTRY WILL TRACK DES PATIENTS

Ontario has started the first registry to locate the estimated 35,000 women and their children in the province who were exposed to DES, now banned because of links to cancer and other health problems. The registry is at Wellesley Hospital in Toronto and is the first concerted effort in Canada to find individuals with known or suspected exposure to the drug and alert them to medical problems linked to its use.

PHARMACISTS' GROUP ACQUITTED

Some Metro Toronto and area pharmacists conspired to lessen competition by attempting to boycott the health insurance firm of Green Shield Prepaid Services Inc., but the conspiracy did not affect enough people to be illegal, a Supreme Court of Ontario judge has ruled. The Metro Toronto Pharmacists Association conspired to boycott Green Shiled because the firm wanted to pay less than other drug insurers for some prescriptions, thus reducing pharmacists' profits, Justice Mabel Van Camp said. However, the boycott plan did not lessen competition "unduly", the judge said. William Wilkinson, retired board chairman of Green Shield, said he found the judge's reasoning "unusual". The attempt to reduce competition "didn't count because we didn't have a big enough share of the market."

HERMAN

"I never have any luck with living things."

Letter to Michel Cote

The Hon Michel Cote
Minister of Consumer and Corporate Affairs
Place du Portage, Phase 1
50 Victoria St.
Hull, Quebec K1A 0C9

4th July 1985

Dear Mr. Cote,

I am very glad to have had the opportunity of discussing pharmaceutical questions as a representative of the Medical Reform Group on June 11th. I hope that is was of value to hear the views of a practicing physician. I trust that I was able to elucidate some of the current practices of the pharmaceutical industry and the needs of doctors in the best interests of their patients. In this letter I would like to clarify some of the concerns I expressed.

My reading of the Eastman report is that it is a very inadequate document, written from the narrow perspective of an economist. There is a simplistic belief that the development of new pharmaceuticals is good per se and that health benefits to the consumer inevitably result. The section of the Eastman report on the role of drugs in the decline of diseases (pages 243-244) are superficial and not in accordance with the accepted opinions of authorities in the field. One wonders where Dr. Eastman went to find his authorities if he chooses salvasan (sic) and hexamthonium (also sic) to support his case. His claim that the decline in tuberculosis is associated with the introduction of drugs is also at complete variance with accepted opinion. His views on the place of drugs in mental illness are similarly eccentric. It is highly doubtful that reserpine (yet another obsolete and hazardous drug he chooses as an example) has been of any great benefit. Amazingly he totally ignores the considerable medical and social costs of the overmarketing of 'minor' benzodiazepine tranquillizers--something that has been sufficient of a problem for the Department of Health and Welfare to publish a warning booklet.

Even in the question of saving costs by price competition, Eastman fails to give simple and intelligent suggestions. He acknowledges that at least 65% of Canadians have third party drug payment plans but then makes proposals to increase price competition at the retail level. This is obviously an absurdity in a market where there is no consumer incentive to reduce costs. You will recall that in our discussions I stated that there is an urgent need for price to be stated in the drug advertising to physicians. Is not drug advertising intended to be informative to the prescriber? Any legislation that you bring in should include this much needed requirement.

It is distressing to read in the Eastman report that Canada should aim to produce a favorable environment to the transnational corporations by not limiting the profits of the companies, not limiting advertising expenditures and not encouraging generic substitution. All these programs have developed in other countries for good reasons, that exist here too. There is no question that the government will have to address these problems sooner or later. There is a growing world-wide consumer movement responding to the marketing excesses and failure to develop products in relation to real health needs. Any concessions that you make should be made in cooperation with the Department of Health and Welfare and only at the price of severe restrictions on marketing practices.

The views in this letter are not necessarily those of the Medical Reform Group, which may later clarify its position on legislation when it is proposed.

Yours sincerely
Robert Frankford M.D.

MEMBERSHIP RENEWAL

Dear fellow MRG Member:

The approach of fall marks the end of one very active year for the MRG, the beginning of another -- and membership renewal time.

The past year has been an active one for the MRG. Local chapter meetings have looked at a whole range of important issues, and working groups and the Steering Committee have produced briefs and public statements on a number of these issues.

Over the past year, the MRG has:

- Presented a major brief on the pharmaceutucals/patent law issue to the federal Eastman Commission on the pharmaceuticals industry. The issue is continuing to attract significant media attention in which the contributions of MRG spokespersons are being prominently featured.
- Been active in supporting choice on abortion and in supporting medically insured free standing abortion clinics.
- Continued lobbying on extra billing, which is again very much a "hot" issue. Recent MRG actions have included press statements during the Ontario election and a meeting with the new Minister of Health.
- Participated in discussing possible changes to the Health Disciplines Act. Among the initiatives being proposed by the MRG working group on this issue is a resolution on midwifery to be considered by the membership at the Fall General Meeting.
- Sent representatives or liaison people to several other organizations, including the Canadian and Ontario Health Coalitions, the Coalition Against the Death Penalty, Physicians for Choice, and the Committee for Responsible Marketing of Pharmaceuticals.

Naturally, this degree of activity places increased demands on our group resources, both of time and money. As a result, a fee increase for full members was discussed and unanimously adopted at the Spring General Meeting. Associate and affiliate membership rates have not been changed. The increase, from $100 to $125, is the first since 1981. The increased revenue will enable us to meet the continuing demands on the MRG's resources and collective expertise, and to continue producing the MRG Newsletter -- our main means of communication among our membership -- in its expanded and more frequent format.

We would like to strongly urge those members who can afford to do so to consider being a Supporting Member by renewing above the required rate. Supporting Memberships have been a crucial ingredient in the MRG's finances in the past year especially and will continue to be very important to us.

A membership form is attached on the next page. We would appreciate your sending it, and a cheque, to the MRG, P.O. Box 366, Station J, Toronto M4J 4Y8, as soon as possible. The MRG's membership year -- and budget -- run from October 1 to September 30. We depend on the membership renewing promptly in developing a realistic budget for the following fiscal year.

The effectiveness and credibility of the MRG in working for our common goals and principles are directly based on having a committed membership. We hope to hear from you soon.

Yours sincerely,

Philip Berger
for the Steering Committee
Medical Reform Group

P.S. With the exception of one part-time executive secretary, the MRG is a voluntary organization. You as a member are strongly encouraged to consider whether you can help in promoting the MRG's goals by, for example, joining a working group, or becoming part of our speakers' list on which the Steering Committee can draw in responding to increasingly frequent requests for speakers from the MRG.

P.P.S. Recognizing that there might be members who can not afford the increased fees, the spring general meeting authorized the Steering Committee to accept reduced fees in such cases.

Medical Reform Group

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

Please print or type

NAME _____

ADDRESS _____

_____

_____

PHONE _____ CATEGORY _____

BASIC MEMBERSHIP FEE _____

ADDITIONAL SUPPORTING MEMBER DONATION _____

TOTAL AMOUNT ENCLOSED _____

MEMBERSHIP FEES:

Supporting Member	Over $125
Physician	$125*
Affiliate	$ 50*
Organization	$ 50
Associate	$ 25
Medical Student	$ 25
Newsletter subscriber	$ 25

*Members joining for the first time may pay only half the annual fees in this category.

Physicians in other provinces may become Affiliate Members. Non-physicians may become Associates.

My areas of interest/expertise: _____

_____

_____

Issues I would like the MRG to concentrate on: _____

_____

_____

Educational events I would like to see are: _____

_____

_____

Areas I would be willing to work on/Ways I would be willing to be involved: _____

_____

_____

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

Subject(s) on which I could speak _____

_____

Comments (Use back if necessary): _____

_____

_____

_____

Names & Addresses of people who should be sent information about the Medical Reform Group: (Use back if necessary)

_____

_____

_____

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 WISH A RECEIPT, CHECK HERE_____

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 *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	$10.00	
THE CRISIS IN HEALTH CARE: BRIEF TO THE HALL COMMISSION	$3.50	
A CITIZEN'S GUIDE TO THE ONTARIO HEALTH CARE SYSTEM	In preparation	
COMMUNITY CLINICS STUDY	$3.50	
CONSOLIDATING THE GAINS OF THE 1970's: DO OR DIE FOR ONTARIO'S HEALTH CARE SYSTEM	$2.00	
BRIEF ON THE CANADA HEALTH ACT	$1.00	
TRANSCRIPT OF MRG PRESENTATION TO THE HOUSE OF COMMONS STANDING COMMITTEE ON HEALTH, WELFARE AND SOCIAL AFFAIRS	$3.75	
SUBMISSION FOR THE ONTARIO HEALTH PROFESSION LEGISLATION REVIEW	$1.50	
COMPLETE EDITION OF MRG NEWSLETTERS AND POLITICALETTERS, 1979-1985	$20.00	
YEARLY SUBSCRIPTION TO MRG NEWSLETTER (Applies to non-members; membership includes Newsletter subscription)	$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