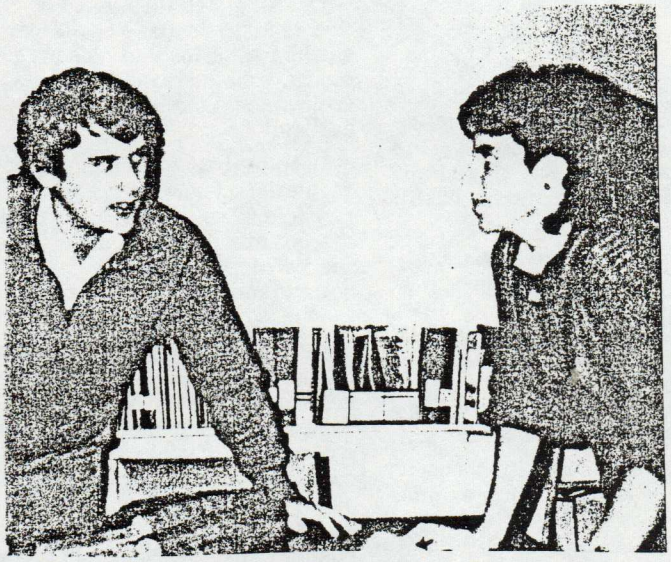
MRG NEWSLETTER

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

VOLUME 5, NUMBER 7 DECEMBER 1985

General Meeting Report



Gord Guyatt and Shawna Perlin at October 26 MRG General Meeting.

STEERING COMMITTEE REPORT

Philip Berger delivered the Steering Committee report. The Steering Committee activities which he described included:

Pointing out a seeming contradiction in Premier Frank Miller's statements about extra billing during the recent provincial election campaign, with resultant front-page coverage of the issue.

A meeting between MRG representatives and the new Liberal Health Minister, Murray Elston.

A speech by Fran Scott to the NDP Provincial Council meeting.

A meeting between MRG representatives and the Toronto Star Editorial Board.

Consideration of participating in the upcoming court case on extra billing.

Involvement in the pharmaceuticals issue, with resulting "bursts of publicity".

STEERING COMMITTEE ELECTIONS

Three new members were elected to the MRG Steering Committee at the October 26 general meeting. They are Shawna Perlin, Bob Frankford, and Mimi Divinsky. Shawna is a resident at McMaster doing her residency in emergency. Bob is in family practice in Toronto, and is involved in consumer health advocacy organizations. Mimi is in private practice in Toronto and has been active in the Toronto chapter of the MRG.

They join the other members of the Steering Committee: Gord Guyatt, Michael Rachlis, John Frank, Fran Scott, Clare Pain, Philip Berger, and Don Woodside.

Two long-serving members of the Steering Committee stepped down at the annual meeting: Joel Lexchin and Fred Freedman. Fred plans to be active in the Toronto chapter, while Joel is off to New Zealand.

Debby Copes and Ellen Buchman at October 26 MRG General Meeting.

General Meeting

STEERING COMMITTEE REPORT (Continued)

Co-sponsorship of the play "Side Effects" about pharmaceuticals.

Involvement in the working group on responsible use of pharmaceuticals.

A working group on the midwifery issue, with a resolution to be proposed to this general meeting.

The idea of an MRG-sponsored insurance plan for member physicians.

MRG representatives debating drug industry officials on national TV.

The publication of The Real Pushers on the pharmaceuticals issue by steering committee member Joel Lexchin.

On-going work on the newsletter and planning for the general meeting.

The steering committee reviews correspondence. A sampling of groups from whom correspondence includes the Canadian Health Coalition, the Childbirth Education Association, INFACT, the National Medical and Dental Association of South Africa, and Dying with Dignity.

The Steering Committee has appointed official media representatives, Michael Rachlis for Toronto and Gord Guyatt for Hamilton.

The Steering Committee has continued to examine its internal functioning, role, and direction.

MRG NEWSLETTER

If you are involved in activities which other MRG members would be interested in, or if you have information or opinions which you think would be of interest to other MRGers, then put them in the Newsletter. Write to MRG Newsletter, 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 particularly welcomed. The fact that items are published in the MRG Newsletter does not necessarily imply MRG endorsement of any particular group, activity, or opinion.

Clippings

Globe and Mail
November 20, 1985

Higher limits proposed for work-place toxins

Canadian Press

VANCOUVER

Any proposal by the B.C. Workers Compensation Board to decrease standards on toxic substances in the work place will be opposed by the medical profession, say physicians specializing in occupational health and safety.

"It seems they have definitely increased the allowable levels of arsenic and vinyl chloride," Dr. Henry King, chairman of the B.C. Medical Association's committee on occupational health, said of the draft of new health and safety regulations proposed by the board.

In the list of permissible concentrations of airborne contaminants, the draft shows the levels of arsenic going to 0.2 milligrams a cubic metre from 0.05 milligrams and vinyl chloride to five parts per million from 2.5.

"Any relaxation of permissible levels of toxic substances in the work place we deplore," Dr. King said Monday.

Dr. King and Dr. Clyde Hertzman, director of occupational and environmental health in the University of B.C.'s department of health care and epidemiology, said that, contrary to union claims, arsenic and vinyl chloride are still properly designated as carcinogens.

Dr. King said the proposed changes "must be subject to open hearings to clarify these points" at which time the medical profession would present briefs against decreasing the standards.

Dr. King, Dr. Hertzmann and Dr. Terry Anderson, vice-chairman of the association's committee of occupational health, studied and discussed the proposed board changes during the weekend.

Dr. King said they found no effective change to the regulations regarding asbestos and noise requirements, claims made by union spokesmen who viewed the draft earlier.

Despite their criticism of relaxed regulations for toxic chemicals, the physicians expressed approval of the board's proposed inclusion of a section dealing with the establishment of medical health programs.

The section details that employers must establish and maintain medical programs with qualified medical staff wherever workers are exposed to lead, mercury, arsenic, cadmium, fluorine, or compounds containing those substances, as well as organophosphates, silica dust, asbestos, environmental pressure changes, heat, noise or tuberculosis.

"We have been asking for this inclusion for some time," Dr. King said. "It was proposed in 1978 but it has never been promulgated."

Dr. King said doctors also are pleased that qualified medical officials would determine whether an employee is able to perform his job safely.

Dr. Eric Young, chairman of the association's environmental health committee, also praised the board's proposal for long-awaited pesticide regulations.

Dr. Young, who spearheaded the association's lobby to have pesticide regulations included in board policy in 1982, said all 12 regulations suggested by the association have been included in the draft.

But the proposed regulations would require pesticide warning signs be posted in English only, Dr. Young said, and "we recommended that signs be posted both in English and in the language understood by the majority."

Dr. Clyde Hertzman is a member and former Steering Committee member of the MRG.

Notices & Announcements

MRG MEETING ON COMMUNITY HEALTH CENTRES?

Michael Rachlis is interested in knowing how many MRG members would be interested in a special one-day conference on community health centres. If you might be interested, contact Dr. Michael Rachlis, 305 Rhodes Ave., Toronto, M4L 3A4, (416) 466-0093.

INFORMAL MEETING TO DISCUSS FUTURE DIRECTIONS FOR MRG

An informal potluck supper meeting is being organized by the MRG Steering Committeein order to discuss ideas for future directions for the MRG with non-Steering Committee members. This evening get-together is being planned for January 10 at 7 p.m. at John Frank's, 536 Euclid Ave., Toronto. Members are invited to attend; however, to help planning, you are asked to contact MRG Secretary Ulli Diemer by January 5 if you plan to attend. Call 920-4513 and leave a message if you will be coming.

MRG SPOKESPERSON ON RADIO NOON

On November 14 Gord Guyatt was interviewed, as a member of the MRG, on the version of CBC Radio Noon which is broadcast to all of Ontario except Metro Toronto. The issue was the appropriateness of Hawkesbury Hospital enlisting an American consulting firm (at a tab of $300,000 each year) to make their hospital more efficient. Gord made two major points: first, that the American evidence suggests that privatly run hospitals are actually more expensive than their public sector counterparts; second, that considerations of efficiency may take precedence over considerations of quality of care when private consulting firms are recruited for running medical facilities.

HAVE YOU PAID YOUR MEMBERSHIP?

MRG members who have not yet renewed their membership for 1985-86 are asked to do so as soon as possible. (The membership year runs from October 1 to September 30.)

The MRG has been very busy over the past year, playing a prominent role in the extra-billing controversy, the pharmaceutical issue and the abortion debate. At the October 26, 1986 semi-annual meeting resolutions were passed on AIDS antibody testing and midwifery. All these activities promise to keep the MRG on the front lines of health care issues.

In order to maintain the quality of our newsletter and continue work in all areas we have increased the number of paid hours of the MRG executive secretary, Ulli Diemer. Our increased budget depends on your support.

Your membership fees will help ensure an MRG voice on the health care issues of today.

MRG RESOLUTIONS

At the back of this newsletter are four pages of recent MRG resolutions. MRG Members who have purchased the "black booklet" (Basic Documents of the MRG) may add these pages to Resolutions section of the booklet to keep it up to date. Three of the four pages contain the resolutions, on AIDS Antibody Testing and on Maternal Health Care, which were passed at the October 26, 1985 General Meeting. Earlier versions of these resolutions appeared in the previous MRG Newsletters. The resolutions were amended at the meeting, however, so the current versions are now the accurate ones.

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.

Of Interest...

The following comments are replies to the enquiry on the Medical Reform Group Membership form asking which issues members would like the MRG to concentrate on:

* Abolition of extra billing; economics of health care -- cost/benefit; ethics of allocation of health care resources; environmental determinants of health related to above.
* Choice; Women in medicine; Community Clinics
* Extra billing; Canada Health Act; Occupational Health/Safety; Reproductive Rights, eg. midwifery, abortion clinics, hazards, etc.
* How to survive in OHIP; quality of care
* Ambulatory Psychiatric Services -- de-institutional: abolition of mental hospitals
* Workmen's Compensation Board; role of RNA's; supporting choice in abortion
* Women's health -- choices; Midwifery/ out of hospital birth & abortion
* Extra Billing; printed information sheets to educate patients on their illnesses or how to prevent illness
* Increasing home care; the tobacco issue; enforcing the Canada Health Act
* Extra billing; investigation of the catastrophic increase in hosipital insurance costs (from 100,000 to $1 million) not being picked up by government, means a decrease in grants to hospitals de facto, and represents a significant amount of most hospitals' capital investment (facilities, equipment)
* Issues relating to the funding of health care
* Alternatives in provision of health care; pharmaceutical issues; health disciplines legislation
* Women's health, abortion, medical education
* Changes in the drug industry
* Extra billing; lack of OHIP coverage for alternative, ie non-medical practitioners
* rational health care funding; midwifery; Women's health care issues
* Cost-cutting in the system; support for alternatives in maternity care (midwifery, birthing centres, etc.)

MRG members, replying the the MRG Membership form questionnaire would like to see the following educational events:

* Discussion re: implications of the Canada Health Act
* On the Workmen's Compensation Board, the Role of RNA's, and supporting choice in abortion
* How to work with other health care professionals
* Medical Ethics -- there are people teaching ethics to medical students at U of T
* Health economics; health care funding; and the privatization issue
* Pharmaceutical propaganda
* Politics of AIDS; gay and lesbian health care issues; more topics related to primary care practice
* A focus on mannerisms which improve habits of motion as applied to routine activity -- body awareness, self acceptance
* Personal support -- practice concerns

OMA has taken a fringe position on extra billing, says Reform Group

Ontario Medicine
November 25, 1985

Most physicians accept the inevitability of the government's planned ban on extra billing and the majority would never walk out over the issue, says Dr. Philip Berger, a member of the steering committee of the Medical Reform Group of Ontario.

"We think our group is headed to an inevitable victory on the issue," he said in an interview. "It's (extra billing) going to go."

Dr. Berger says the Ontario Medical Association has taken a fringe position on extra billing, considering 85 per cent of the public is opposed to it. And while most physicians agree with the right to extra bill, few would take drastic action to oppose government plans.

The Medical Reform Group opposes extra-billing because members don't believe in "two-tiered medicine," Dr. Berger says.

"It has a direct effect on poor people. It's not a theoretical issue for us. It's a very practical one."

However, Dr. Berger adds that there are physicians who opt out but don't extra-bill and they're competent, sensitive people who do it out of principle, not out of greed.

"I'm not against them personally," he says. "They're very sensitive to the needs of poor people — but I don't think they're in the majority."

Caters to the wealthy

Dr. Berger points out that his patients, most of whom live in the lower income Regent's Park area of Toronto, can't see an opted out psychiatrist unless they pay.

Some psychiatrists will see people who can't pay and not extra bill them, but few do this, he says.

"People who cannot afford extra billing do not have as wide a choice, particularly with consultants, as people who can afford it," Dr. Berger maintains.

The Medical Reform Group also argues that it's simply too expensive for Ontario to have extra billing. Federal penalties for the practice cut into the province's health care allocations, something Dr. Berger feels we can ill-afford.

And doctors will not become like civil servants, as some proponents of extra billing say, he adds.

"They'll be like any other regulated industry."

Dr. Berger says businesses from the trucking industry to telecommunications groups have to follow government regulations and physicians, who are business people, "are no different."

"If they have to be constrained, in my personal opinion, by a very generous fee schedule, then they have to accept that very minor infringement on their rights."

Photo: Pauline Anderson

Dr. Philip Berger

Doctors aren't told when to show up for work, when to take holidays, what time to go home, how much sick time they're allowed, or any such stipulations, he points out.

"They are absolutely not civil servants. It is true they won't have a choice to bill higher, but they have a lot of liberties most other people don't have."

There is no room for monopolies, he adds, where the public is held at the mercy of a certain group of people or cartel.

Kathleen Harford

MDs 'just want full fee'

Globe and Mail, Nov. 25, 1985

Doctors denounce as unfair proposed extra-billing ban

BY ANN SILVERSIDES
The Globe and Mail

A doctor can tell by the way patients walk and talk whether they can afford to pay more than the insured rate for medical services, Dr. Garry Willard told a weekend public forum on extra-billing in Ontario.

Dr. Willard, chief of surgery at Etobicoke General Hospital, was one of a number of doctors who took to the microphones to denounce the Ontario Government's plan to introduce legislation next month banning the practice of extra-billing.

The Saturday forum, the last of nine held in Ontario, was advertised as a meeting to solicit the public's views on different ways of ending the practice of extra-billing.

But it was doctors, most of whom said they extra-billed — but only those patients who could afford it, who dominated the public part of the forum.

Many of the doctors said the term extra-billing is inflammatory and that the practice of charging patients more than the Ontario Health Insurance Plan rate should be called market-place billing, balance billing or full billing.

"Extra-billing implies greed and that doctors want more. But they don't want more, they just want their full fee," said Dr. Howard Eisenberg, identifying himself as chairman of the Ontario Medical Association's section of independent physicians.

In Ontario, 12 per cent of doctors — 4.6 per cent of general practitioners and 19.9 per cent of specialists — bill patients above the OHIP rate.

Dr. Eisenberg called "communistic" a comment by Dr. Philip Berger, one of the panelists, that "if there is an apparent conflict between the economic rights of physicians and the right of Ontario citizens to unimpeded access to insured services, we believe that any model for ending extra-billing should fall on the side of Ontario citizens."

Dr. Berger was speaking as a member of the Medical Reform Group.

Dr. Keith Meloff, a neurologist, told the group that the plan to ban extra-billing "is a political charade. Doctors will be enslaved."

He complained that nurses get overtime pay if they work on a Sunday "while a doctor is lucky to get 10 per cent more."

Another panelist, Joan Charboneau of the Association of Independent Physicians of Ontario, referred to doctors who do not extra-bill their patients as "Government doctors."

Dr. Willard said those doctors, whom he called "the 88 per cent of the great unwashed not represented here today," have subsidized the provincial health insurance plan by 30 per cent of their gross income. (The OMA fee schedule is 25 to 30 per cent higher than the OHIP schedule.)

Health Minister Murray Elston, who spoke at the end of the forum, noted that some speakers dismissed the ban on extra-billing as political "as if political was some sort of game that was not real.

"I have to advise them political means people, and overwhelmingly people want an end to extra-billing."

Mr. Elston said the idea that extra-billing should not be dealt with until the the health-care system's other problems have been addressed is false.

"We have to deal with this before we get down to dealing with other problems. . . . They can only be solved against the backdrop of accessibility" to health care.

In an apparent reference to the OMA, Mr. Elston said "none of us can afford to withhold our ideas about solutions" to the problem of how best to end extra-billing.

Dr. Berger was the only one of the four panelists to discuss different extra-billing options. He said that, in anticipation of large numbers of doctors leaving OHIP after extra-billing is banned, the Minister of Health should define which services by physicians are essential.

"If physicians in a particular specialty or geographic area do not participate . . . then the minister should be empowered through regulation or legislation to take such action as is necessary to ensure provision of those essential services."

*In response, Philip Berger in part told Dr. Eisenberg to "bring some manners with (him) when (he) comes to meetings." Dr. Eisenberg then apologized for his comment, saying that he meant it to apply to the MRG as a whole, not Dr. Berger personally.

The Bancroft Times

And North Hastings Advertiser

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WEDNESDAY, SEPTEMBER 11, 1985

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EMERGENCY NUMBERS	
Telecare	332-2000
Fire	332-2222
Fire (Maynooth)	338-2223
Fire (Wollaston Twp.)	332-2222
Police	332-2111
Ambulance	332-2121
Hospital	332-2825

Dr. Michael Rachlis Addresses Poverty Meeting

The fourth meeting of the people Against Poverty association, held in Bancroft on Friday evening, September 6, was so well attended that there was difficultly fitting everyone into the room booked for the occasion.

The speaker was Dr. Michael Rachlis, of the Medical Reform Group of Toronto. Also attending was Michele Leering, Barrister and Solicitor, from the Hastings and Prince Edward Legal Services.

Dr. Michael Rachlis has worked for eight years as a General Practitioner in Toronto. This past year he has been attending a Community Medicine Training Program. He represented a group, the Medical Reform Group, which has some 150 doctor members in the Toronto and Hamilton area, and has been growing steadily since its 1979 founding.

Dr. Rachlis defines health as, "A complete state of social and mental well-being." He regards hospital care as Illness Care, or Sickness Care. Health is not an absence of illness, but a complete state of well-being, a positive thing. Such a state of health is closely related to how a person lives: housing, food and job.

Dr. Rachlis cited the example of TB, the dreaded killer of a century ago. Modern medicine has accepted the credit for greatly reducing the incidence of tuberculosis. But, notes Dr. Rachlis, "TB was already a disease that was on the way out." It was defeated more by better nutrition, and better housing than it was by medication. "It wasn't doctors, it wasn't hospitals, it wasn't drugs." When people no longer slept five to eight in a room, the incidence of this contagious disease was reduced.

"TB is a poor people's disease," Dr. Michael Rachlis continued, drawing a relation between poverty and ill health. "You live in a society where you see goods, food, and pleasant things, knowing that you cannot have them." This leads to a conditioned sense of worthlessness, and a sense of lack of control over one's self and one's life.

"You don't have control over the basic things in your live," Dr. Rachlis reminded his audience: "This causes a real stress on people's life."

Stress related disease, while associated with the high-powered executive, is much more common among the poor. Heart disease is twice as common among the poorest 1/5 of Canada's population as it is among the wealthiest 1/5. The poorest 1/5 live on an average 7 years less, and suffer disability 14 years more. Only alcohol consumption is greater among the wealthiest (35% take 7 or more drinks a week) than among the poorest (16.5% take 7 or more drinks a week).

Specifically, the Medical Reform Group would like to see three actions taken in Ontario.

Cont'd on Page 4

Dr. Michael Rachlis, centre, speaks to a room crowded with people, at the People Against Poverty meeting on Friday, September 6. With him are two of the leaders of the People Against Poverty group in Bancroft, Dee Dwire (left), and Stuart Maier (right).

Poverty Meeting

Cont'd from Page 1

1. A removal of all financial barriers to medical care. The Group is opposed to extra billing to doctors, and also the OHIP premiums. The poorest people are supposed to be exempt from paying OHIP premiums - provided they have the training and patience to fill out the Premium Assistance application forms.
2. Medical services should be more responsible. Decisions should be made not just by doctors and governments, but by a group containing nurses, orderlies, and consumers.
3. A recognition of the strong relation between good health and good housing, food and employment.

Legal Services

Michele Leering briefly described Legal Services, which presently operates in Belleville, Picton, and Madoc with two lawyers. This is not a Legal Aid office, but is a non-profit service funded by the Clinical Funding Committee of the Ontario Legal Aid Plan an organization of the Law Society of Upper Canada.

She describes their work: "We give FREE summary legal advice in most areas of law. If you meet our financial criteria, we can represent you in Small Claims Court, as well as before a Tribunal, such as the Unemployment Insurance Commission, Workmen's Compensation Board, and the Rent Review Board. We can also represent you in appeals against decisions by Community and Social Services or your Welfare office."

Michael Rachlis is a member of the MRG Steering Committee.

Labor groups fight medical monitoring

By VIRGINIA GALT
The Globe and Mail

Governments and companies that require medical monitoring as a condition of employment are facing growing pressure to justify the use of such tests.

Medical monitoring encompasses procedures ranging from physical and psychological examinations to specific tests designed to measure the effects of on-the-job exposure to dangerous substances.

Labor spokesmen say the information collected during pre-employment medical examinations often goes far beyond the essentials needed to determine whether a person is fit to do a job.

The pre-employment or pre-placement medical screening process is often "a direct invasion of privacy and it is used to deny workers jobs," the Ontario Federation of Labor says in a report on medical monitoring.

Even the specific, government-legislated tests to monitor the effects of exposure to dangerous substances are now being subjected to more skeptical scrutiny by workers who initially thought such tests would lead to improved working conditions.

"The labor movement is becoming increasingly suspicious that medical surveillance programs are being used as a substitute to cleaning up the workplaces," David Bennett, director of health and safety for the Canadian Labor Congress, said in an interview.

Instead of removing the hazards, employers tend to remove the workers who have built up unacceptably high levels of dangerous substances in their bodies, Mr. Bennett said.

Dr. Gordon Atherley, president of the Canadian Centre for Occupational Health and Safety, has long crusaded for safeguards to ensure that medical monitoring programs are medically and socially beneficial.

"We have to assure ourselves that the positives really do outweigh the negatives — that biomedical surveillance not only monitors exposure but leads to progress; that early detection not only detects disease but improves prognosis; that data are not only gathered but are also devoted to action to improve conditions at the workplace," Dr. Atherley wrote in a recent issue of the American Journal of Industrial Medicine.

"Biomedical surveillance is controversial . . . and it faces a troubled future unless something is done to address the ethical concerns as well as the scientific questions. Human rights legislation may well have to be invoked to protect individuals against harmful consequences of biomedical surveillance."

The Energy and Chemical Workers Union has played a leading role in promoting labor-management discussion of medical monitoring and it wants a role in designing and overseeing any such programs that apply to its members.

"One of the most important features is that it has to be established for the benefit of the workers. It cannot be established simply as a cost-saving device for the company," Reg Basken, national director of the union, said in an interview. Any monitoring of employees must be tied to a related monitoring of the workplace.

"The biggest concerns most of our members have are about confidentiality and employment security." Breaches of confidentiality constitute "the single most difficult area," Mr. Basken said. "Some personnel departments believe it is their right to have medical records."

Mr. Basken and other union spokesmen said the standard rules of doctor-patient confidentiality should apply, with the employer entitled to know only whether a person is fit to work or whether there is evidence of a workplace danger that should be corrected.

John Calvert, a senior research officer with the Canadian Union of Public Employees, said employer access to personal medical histories can lead to serious discrimination against employees.

For example, a supervisor who knows that an employee once had a nervous breakdown might decide that he or she has a "nut" on staff and will treat the employee accordingly.

Dr. Atherley agreed in an interview that an employer's knowledge about personal medical conditions can result in discrimination that is difficult to prove.

While some situations inspire sympathy, conditions such as acquired immune deficiency syndrome (AIDS) — a disease primarily affecting homosexuals — are generally viewed with repugnance.

Although medical evidence indicates that the disease can be spread only by exchange of blood or intimate sexual contact, AIDs victims in Canada and the United States have reported losing their jobs as soon as their condition has become known.

"I can't be convinced that basic human attitudes do not influence recruitment policies and that is where discrimination starts to come up," Dr. Atherley said. "That is why human rights (guarantees) are so important."

None of the critics of medical monitoring deny that there are some bona fide job requirements that cannot be overlooked. There is general agreement, for instance, that firemen and airline pilots must be fit.

"The acid test is whether you can do the work you are asked to do," Dr. Atherley said.

Civil liberties groups in the United States have mounted a campaign against the growing practice among employers of testing the blood and urine of job applicants to determine drug and alcohol use.

While such a practice appears to be uncommon in Canada, "I don't think it is fair to say it is absent here," Dr. Atherley said. "Such massive screenings — testing everyone for everything — make me profoundly uncomfortable."

Globe and Mail
October 7, 1985

MORGENTALER ACQUITTAL OVERTURNED

The Ontario Court of Appeal has set aside a jury's acquittal of Dr. Henry Morgentaler and two others on abortion charges and has ordered a new trial. The court unanimously ruled that there were fundamental errors of law in the original trial. In particular, the court rejected the defense of necessity on which the defense had based itself in the trial.

The Montreal doctor quickly announced an appeal of the decision. Attorney General Ian Scott said that the government looked forward to a retrial, but that in the meantime no new charges would be laid against Dr. Morgentaler's Toronto clinic.

MORGENTALER DENIED LICENCE FOR CLINIC

The Manitoba College of Physicians and Surgeons has denied a request by Dr. Henry Morgentaler that it licence his Winnipeg clinic to do abortions. The College gave no reason for its decision in making the announcement. Dr. Morgentaler's licence to practice in Manitoba was suspended in March on the grounds he failed to get College approval of the clinic, which was closed after police seized equipment in 1983, reopened this year and then closed after two further police seizures this spring.
[Canadian Press, Oct. 22, 1985]

OTTAWA PLANS ADS TO BATTLE SMOKING

Health Minister Jake Epp announced a $1.5 million advertising campaign to combat smoking this fall. The campaign is aimed mainly at young people in a bid to counter a controversial trend among tobacco companies toward pitching advertising at youth. The ad campaign was announced one week after the federal government committed $90 million to help Ontario tobacco growers. "All of us recognize that there are inconsistencies," said Mr. Epp, who also acknowledged that the government's spending is tiny compared to the advertising budgets of the tobacco companies. The new campaign is a joint effort by Ottawa, the 10 provinces and 2 territories, and 7 non-governmental organizations such as the Canadian Cancer Society and the Canadian Medical Association.
[Globe and Mail, Oct. 23, 1985]

B.C. COURT RULES REGULATORS CANNOT SEIZE PHYSICIANS' FILES

A ruling by the British Columbia Supreme Court that it is unconstitutional for investigators from the College of Physicians and Surgeons to remove doctors' files will make it tougher to investigate complaints against physicians, the college registrar says. Dr. Craig Arnold said investigators frequently request a doctor's files to check suspected violations of the college's regulations. The court ruled that a New Westminster doctor did not have to turn over his files because "the seizure involved in this case was unreasonable and contravened the provisions ... of the Charter." The judge said legislation empowering investigators to inspect and copy files is an unwarranted invasion of patients' rights to privacy and could endanger a patient's health if he or she requires medical treatment while the college has the files.
[Globe and Mail, September 9, 1985]

ELECTRONIC TAGS TRIED IN TORONTO HOSPITAL

A Toronto hospital is being used to test an electronic monitoring system designed to keep track of patients who might try to escape from unlocked wards. The device consists of an electronic tag that would be worn by a patient. If s/he goes into a restricted area, an alarm is triggered. The system is aimed at institutions such as nursing homes and psychiatric wards. The system is being tried at Riverdale hospital in Toronto, a 784-bed chronic care institution, initially with nurses wearing the tags to test the technology. The technology has come under severe attack from civil liberties and patients rights advocates
[Globe and Mail, November 1, 1985]

Health News Briefs

INSURANCE COMPANY TESTING FOR AIDS

At least one major life insurance company in Canada has required some applicants to take an AIDS antibody test as a condition of being considered for insurance, according to Dr. Paul Kordish, the company's medical director. [Globe and Mail, Nov. 25, 1985]

ONTARIO WILL BAN EXTRA BILLING

The provincial government will introduce legislation in December to end extra billing by Ontario doctors, Health Minister Murray Elston has announced. The announcement comes despite the opposition of the Ontario Medical Association, which has refused to meet Mr. Elston to negotiate an end to the practice.
[Globe and Mail, Nov. 25, 1985]

NURSING HOME CHARGING RESIDENTS EXTRA

A private nursing home charged residents for extra services, including a $150 fee for leaving the home, the provincial auditor said in a report released November 28. Auditor Douglas Archer recommended in his report that nursing homes be required to demonstrate the "reasonableness of charges" for services not covered by public health insurance. He cited the example of one home which charged fees for maintaining residents' trust accounts or helping residents fill out applications for public assistance, or for making purchases from a store.
[Globe and Mail, Nov. 29, 1985]

DRUG PRICING SYSTEM BEING CHANGED

Ontario Health Minister Murray Elston has announced what he says is the first step in a reform of the province's prescription drug retailing system. Mr. Elston said the province will no longer accept prices cited by drug companies for listing in its formulary, the price guide for the Ontario Drug Benefit program. The formulary is also the basis for all retail prescription drug prices in the province. Under the ODB, the province provides free prescription drugs to senior citizens, welfare recipients, and the disabled. Purchases under the ODB account for about 45 per cent of the Ontario prescription drug market. As well, Mr. Elston said he intends to introduce legislation to give the Minister of Health more control over the retail drug system. In legislation introduced in November, the government would be able for the first time to set the prices it will pay under the ODB plan. Under the second proposal, a new prescription drug regulation act, pharmacists would be required to post their professional dispensing fee, which has no formal ceiling. As well, they would be required to provide drug cost and dispensing information on receipts or labels, and to inform consumers if there is a less expensive substitute for the drug named on their prescription.
[Globe and Mail, Nov. 8, 1985]

MRG General Meeting, October 26, 1985

Photos by Mimi Divinsky.

RESOLUTIONS AT FALL GENERAL MEETING

SEPTEMBER 29, 1984

MRG Delegate to Ontario Health Coalition

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.

MRG Delegate to Canadian Health Coalition

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 he/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.

Subscription fee for Newsletter

There shall be a subscription fee of $25 for non-MRG members who wish to receive the MRG Newsletter.

Membership Fees for 1984-85

The 1984-85 budget shall be accepted as is, ie., with no increase in membership fees. Membership fees shall be reviewed in six months, at the spring general meeting.

RESOLUTIONS AT SPRING GENERAL MEETING
April 27, 1985

Membership Fees

MRG Membership fees for physician members shall be $125 per year. Fees for other categories of membership shall remain as they are now.

Capital Punishment

Be it resolved that the MRG opposes the restoration of the death penalty.

RESOLUTIONS AT FALL GENERAL MEETING
October 26, 1985

AIDS

1. Whereas it is important that a patient be able to freely discuss all aspects of his/her physical, emotional and sexual life with his/her health care provider; and, whereas the exclusion of sexual orientation from the grounds on which discrimination is prohibited in the Ontario Human Rights Code may add to the health problems of an individual particularily if the absense of protection under the Code inhibits the patient from being honest with his/her physician;
    Be it resolved that the MRG supports the principle that sexual orientation be a grounds on which discrimination is prohibited in the Ontario Human Rights Code.

2. Whereas the medical implications of a positive AIDS virus antibody test are presently unknown;
    Be it resolved that all tests (excluding their use for blood and sperm donations) should be done only with informed consent and that results of tests be shared only between laboratory, doctor of patient's choice, and the patient, and that any other agency eg. government, insurance company, employer, etc. not be allowed to have access to individual identifier data.

3. Whereas current medical knowledge believes that AIDS cannot be passsed by casual contact;
    Be it resolved that the MRG believes that in keeping with usual public health principles for the prevention of infectious diseases, persons in high risk groups, with AIDS, AIDS Related Complex or who test antibody positive should not be discriminated against in employment, housing, or provision of services; where there is clear scientific evidence showing that transmission of the causative agent will occur in such circumstances appropriate standard public health measures should apply.

4. Whereas the AIDS epidemic is growing and whereas misinformation about the spread of the disease has at times created a public hysteria;
    Be it resolved that the MRG calls on the government to increase funding into education and further research into AIDS.

RESOLUTIONS AT THE FALL GENERAL MEETING
October 26, 1985

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 primarily 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, frequently offer an inhospitable environment for uncomplicated low-risk birthing. The likelihood of unnecessary amniotomy, anaethesia, forceps delivery and episiotomy is substantial. Imperfect diagnostic procedures, such as electronic fetal monitoring, applied in low risk situations may 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 physicains 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. The division between primary and secondary/tertiary care should not be rigid. Clearly midwives and family physicians have an important collaborative and supportive role to play in secondary/tertiary care obstetrics. Obstetricians with a special interest in primary care obstetrics should not be excluded from that field. 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 health care system providing continuity and comprehensiveness of care.

Since family physicians/general practitioners are the principal 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 on 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 preferences of providers and especially, recipients of care.

STATEMENT ON MATERNAL HEALTH CARE (Continued)

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 accomodate low-risk birthing are needed as primary care training sites.

10. Midwives, family physicians, and obstetricians can made a significant contribution to each other's education.

RESOLUTION ON MIDWIFERY

In view of the foregoing statement of principles on Maternal Health Care, the Medical Reform Group of Ontario resolves that:

1. Midwifery be legalized in Ontario to be performed by personnel certified clinically competent by a formal assessment process. This certification process should be supervised by a regulatory body to be established with representation of and accountability to the public, but which should be specific to the regulation of midwifery.

2. Care provided by midwives in keeping with the above principles should be fully publicly funded under Provincial Medical Care Insurance.

3. Although there is still some scientific doubt regarding the relative safety of home-births (even with good emergency support), it is clear that many well-informed women in Ontario are currently deciding to give birth at home and that that choice is their right. Unfortunately, the College of Physicians and Surgeons of Ontario has responded to this situation by actively discouraging physicians from providing the necessary clinical back-up to such women. The MRG calls on the College to abandon this punitive approach, which is placing the health of such mothers and their infants in jeopardy unnecessarily. The MRG further suggests that they develop appropriate standards for physicians' attendance at home births.