MRG Newsletter

Medical Reform Group of Ontario P.O. Box 366, Stn. J Toronto, Ontario M4J 4Y8 (416) 920-4513

VOLUME 7, NUMBER 1 FEBRUARY 1987

MRG RESPONDS TO REQUEST FROM EVANS COMMISSION

The Medical Reform Group responded to a request by theOntario Health Review Panel for input into its deliberations. Premier Peterson appointed Dr. John Evans, former Dean of Medicine at McMaster and former President of the University of Toronto, to chair a task force to review the Ontario health care system in October. The other members of the panel include:

- John EVANS, M.D. (chairman) - associated with the University of Toronto and McMaster Medical School
- Mathilde BAZINET - former chairman of Health Sciences Division, Canadore College, North Bay
- A.S. (Sandy) MACPHERSON, M.D. - medical officer of health for the City of Toronto
- W. Murray McADAM, M.D. - former president of the Ontario Medical Association, Kitchener
- Sister Winnifred McLOUGHLIN - executive director of the Sudbury General Hospital, Sudbury
- Dorothy PRINGLE, R.N. - director of research of the Victorian Order of Nurses for Canada (representing the Registered Nurses Association of Ontario), Ottawa
- Rose A. RUBINO - chairperson of the National Health Committee, Consumers' Association of Canada, Toronto
- Hugh SCULLY, M.D. - vice president (and member of the fees negotiating team) of the Ontario Medical Association, Toronto
- Greg STODDARD, PhD - associate professor, department of clinical epidemiology and biostatistics, McMaster University, Hamilton
- W. Vickery SOUGHTON - president of Toronto General Hospital

There had been a suggestion from the Premier of the fall of 1985 that Dr. Evans would be asked to review the Ontario health care system. Informed sources said that the panel would in particular address issues relating to the autonomy of the medical profession to assuage the concerns of the Ontario Medical Association that the Health Care Accessibility Act was really an attack on "professional freedom". When the OMA did not go gently into that good night, the status of the task force became quite fuzzy. For months the OMA refused to talk to the government about any matters and there were rumours that the panel would be aborted. However, while the OMA leadership was in Winnipeg for the CMA annual meeting in August, they decided to resume relations with the government and finally the panel was selected. Clearly there is something aboutthe air in the prairies that makes people act more reasonably.

As the enclosed letter indicates, the MRG had stated to the Standing Committee on Social Development in the hearings on the Health Care Accessibility Act that there should be a Royal Commission to investigate the health care system. The group had suggested such a body of inquiry because Royal Commissions have lots of money and the clout to subpoena witnesses and other such fun. The steering committee also felt that this would be as good a forum as any to conduct some broad education of the public regarding the real issues facing the health care system. The panel, henceforth known as the Evans Commission, in fact has no plans for public hearings much less grass roots community development. We are hoping that at the very least we will be asked to meet formally with the commission.

We were sent a letter dated November 26, 1986 asking us to identify the three most important issues affecting the Ontario health care system. Gord Guyatt and Michael Rachlis drafted a letter to other members of the steering committee identifying six areas of longstanding and/or current MRG concern and asking for these (and any others) to be ranked. Six members of the steering commmittee participated in the process by which our items were selected. The first two items (ensuring equal accessibility and developing alternative payment systems) clearly were the highest priorities. The item on pharmaceuticals was scored somewhat ahead of developing a "healthy public policy", developing alternate systems of health care delivery, and improving access to abortion services.

The Steering Committee will continue to track this commission. Questions may be directed to Michael Rachlis at 466-0093.

Continued on page 2

Still time to join insurance plan

There is still time to join the MRG's group insurance plan at the discount rate. All MRG members (including associates), any M.D.'s spouse, and any M.D.'s office employee may join the plan. Options include first time coverage, extending your present coverage, or dropping your present coverage and going with the MRG plan. Any of the above options counts towards getting the required minimum number of insured members for the guaranteed issue bonus and an extra 5% discount on premiums. (Guaranteed issue is Great Weat Life's promise to pay $1500/month disability to any member disabled in the future regardless of their present state of health.

For information call Trudy Baker at 960-1736 before February 28.

MRG RESPONDS

Continued from page 1

Dr. John Evans
Ontario Health Review Panel
700 Bay Street, 14th Floor
Toronto M5G 1Z6

Dear Dr. Evans:

I would like to respond on behalf of the Medical Reform Group of Ontario to your request for input into your commission's deliberations. Our group would like to point out that there certainly are more than three priorities for Ontario's health care system. Indeed, one of the major problems with the health care system is the public's lack of understanding of the real issues which affect a sector which consumes over one-third of their tax dollars. This is why the Medical Reform Group has asked in its submission to the Social Development Committee regarding bill 94 that,

"The government should establislh a Royal Commission on financing of the health care system. It should provide facilities and funds for the public and non-profit organizations to become involved in the process. The commission should investigate alternatives to traditional delivery systems such as community health centres and health service organizations. It should also examine the distribution of physicians and resources."

The MRG still feels it is important to involve the public in any process of change. A task force such as yours offers an opportunity for education of the health care consumers of Ontario. We hope that you will see fit in your deliberations to plan public input and community education.

We find it somewhat difficult to respond to your request for the identification of three priority issues affecting the health care system. Some issues which might be suggested are long-term and process oriented (such as the place of the health care system within an overall health policy) whereas others are highly focused (such as the lack of access to high quality abortion services). Unfortunately, without a better understanding of your commission's overall objectives and process we fear our input might not be as useful as it might be otherwise. We hope that we will have a further opportunity to address the members of your commission on our detailed concerns about Ontario's health care system.

Having said the above, we would like to apprise you of the three priority issues which we think affect Ontario's health care system.

1. **Ensuring equal access to health care.** In particular, we feel that the government should find a mechanism to eliminate physician charges for fees not covered by OHIP. These fees act as deterrents to care for some people.
2. There is considerable evidence from other countries of the advantages of systems of physician payment other than fee for service and there is a significant number of physicians in Ontario who are interested in working under such alaternative systems of payment. We feel the Ontario government's support of such alternatives has been inadequate. **We would like the government to identify methods of facilitating the development of these alternative payment systems.**
3. The MRG is concerned about the marketing and prescribing of pharmaceutical products. **We feel the Ontario government should move to ensure ethical, informative, accurate, and helpful marketing of pharmaceuticals and at the same time protect the consumer from excessive prices for these products.**

We hope this input is useful to your commission's deliberations and we look forward to assisting you further with your task.

Sincerely yours,

Michael M. Rachlis, M.D.
For the steering committee of the
Medical Reform Group of Ontario

MRG Newsletter

The MRG Newsletter is published by the Medical Reform Group of Ontario, P.O. Box 366, Station J, Toronto, Ontario, M4J 4Y8; Phone (416) 920-4513. Members are invited to submit original articles, letters, announcements, and other items of interest. Publication of articles does not imply endorsement of the authors' analysis or opinions. The articles are meant to stimulate discussion on current issues and to provide an opportunity for members at large to express viewpoints on subjects of their particular interest.

Newsletter Deadlines

The publication date of the next MRG Newsletter is April 3, 1987. The deadline to submit items for that issue is March 16, 1987. Longer opinion and feature articles should be submitted earlier--by February 28.

The publication date for the subsequent issue is June 5. The deadline to submit items for that issue is May 18. Again, longer opinion and feature articles should be submitted earlier, by April 30.

The mailing address for the MRG Newsletter is P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8.

Feature Articles:Withdrawal of services by doctors

DOCTORS AND STRIKES AND GOVERNMENTS

by Dr. Haresh Kirpalani

From Dr. Sutherland's recent article, I take his main messages to the medical profession to be:

1. The need for democratisation, by consumer/patient representation.
2. The desirability of Community Health councils
3. The need to recognise changes in the nature of medical practice over 30 years that has occurred.
4. Recognition of the likely continuation and extension of non-medical personnel into areas traditionally thought to be medical.

With these I have no opposition and personally would endorse. However he has one further point, and that is the need to extend and enforce the Public Hospitals Act in order to prevent 'the loss of services that are obviously essential'. I feel that some implications of his proposal for enforcement and strengthening of what is really anti-strike legislation should be considered.

DOCTORS AND STRIKES AND GOVERNMENTS

Were "essential services" to be enumerated they should properly include more jobs and services than those listed by the author; from policemen... to... garbage collectors. Who is prepared to deny that social workers, road maintenance crews, sewage workers, public civil servants of any ilk,... etc. ad infinitum... are "non-essential"? In short, the range of essential services can be extended to virtuallythe whole gamut of society that is forced to enter the labour market to sell their skills.

Any strike legislation worth its salt, is obviously used at times of conflict between the Labour principles of adequate renumeration, against the Employer principles of depression of what is considered adaequate renumeration. I would be concerned that the nature of monopoly employers (including Governments) leads them to designate as "essential services" those that present such a conflict at convenient times for the monopoly employer. This designation allows then, a convenient means to reject negotiations or recognition of grievances. This of course recently happened to the civil servants in Newfoundland. It can further be argued that neither legislation nor judiciary in recent times have been noted for their impartiality at such flash points. The 1981 struggle of the air traffic controllers in the USA illustrates this. The pretext of "essential services" can then be used as a battering ram against the genuinely low paid sections of health workers and indeed other low paid "essential service" workers.

1. NATURE OF DEMANDS RAISED

Unions involved in the dilemma - service to the public versus the necessity to muster what negotiating power they can, (including if need dictates, strikes) - recognise that actions that involve hitting at the public will in the long term and short term alienate the strikers from the public. That is *unless* the general public can be convinced of the fundamental "justice" of the demands being put, and the negotiating position into which the strikers have been placed. This then implies that there are progressive, just, "correct" strikes (here defined as being perceived by the public as not against the public interest) and reactionary "incorrect" strikes. That the public can appreciate these differences between various strikes in the hospital/health service arena is testified to by some examples.

Thus the general public in Great Britain openly and widely supported the Junior Hospital Doctors Strike of junior residents in 1975. They also supported the Ancilliary Workers and Nurse's strikes of 1980 and 1981. However they clearly rejected the strike demands of the Hospital Consultants in 1980, forcing them back to work very quickly indeed. In Ontario, the OMA found itself deemed as retrogressive,anti-democratic and unmindful of the election mandate placed upon the ruling party. Numerous examples of the necessity to include such tactics can be drawn from the non-medical arena: for example, very vividly, currently in the labour battles in France.

It is the case that Dr. Sutherland recognises the power (both moral and practical) that results from a public approval/disapproval. As he says: "The first issue was whether governments determine health policy, in this case a policy strongly endorsed by the public." In itself this last point is intimately bound up with the more general ones regarding practical democratisation and control of the health services (and governments) by the consumer/patient raised by Dr. Sutherland. I am in agreement with him on this issue. This is surely the fundamental area of struggle. The MRG should ensure that the OMA cannot borrow our clothes and misrepresent slogans of control of the health services by the consumer/patient.

2. MANNER OF IMPLEMENTATION OF THE STRIKE

If it is decided (for the moment, irrespective of the above considerations of correctness) that there is going to be a strike; then the manner in which it is implemented usually ensures a safety net. Thus the Junior Hospital Doctor's "Strike" could be interpreted as less of a strike than as a "work to rule"; with elaborate rotas and shifts to circumvent potential dangerous situations arising. Even though the political orientation of the OMA is considerably different from the Junior Hospital Doctors Committees of Great Britain, they also were not as far as I am aware, responsible in the strike for deaths or major morbidity.

Obviously for 1 and 2 to be safeguards, it is necessary for there to be an informed and aware public and democratically and representative trade union board. Pressure to enforce this latter change in the OMA is obviously required.

3. PROFESSIONAL LIABILITY

In the special case of physician strikes, this should be the last trench in which to ensure patient safety. Rather as actually happened during the strike, the College of Physicians and Surgeons should make clear that any loss of life or debility attributable to the action could lead to professional investigation. This should be attended by representatives of the physicians and their strike representatives also. This I think would be far more powerful and relevant a deterrent than that of legislation and judicial censure. This is currently the weakest trench, being the newest. Obviously, work needs to be done here to prevent surprises in an acute crisis situation. Operational rules must be explored prior to conflict situations.

IN CONCLUSION

My only disagreement with Dr. Sutherland regards legislation banning the right to strike. I oppose this on the grounds that this grants monopoly power against all health service workers. In addition it would be impossible to be exclusively aimed at health service workers, but is likely to be directed against far more vulnerable sections of the work force. At the present juncture, it would also unnecessarily inflame physicians with the spectacle of State Power. In any case, I suspect that in any crunch situation, legislation would be ignored. Solutions invoking the Colleges' mandate to safeguard professional standards should be explored.

Haresh Kirpalani is a member of the Medical Reform Group

Discussion paper of issues related to the physicians' job action against Bill 94

By Michael M. Rachlis

The recent Ontario Doctors strike highlighted the fact that there is no specific process for dealing with collective job actions by graduate physicians. Neither the government nor the College of Physicians and Surgeons seem to have the authority to deal with such a strategy by doctors. This of course does not rule out special legislation but that may well have made a tense situation much worse. To complement Ralph Sutherland's article in the previous newsletter and Haresh Kirpalani's article in this issue I would like to submit some of my thoughts on this matter. Particularly because most of the public looked to the College I start my analysis with that body. A previous version of this document was circulated to the board of directors of the Ontario Health Coalition.

History of the Ontario College of Physicians and Surgeons

Almost every society has some mechanism for determining who can and who cannot call themselves a "healer". The reason for this is basic: most lay people cannot determine for themselves whether or not a particular practitioner is competent. Although any regulatory system may be used for the healing profession's benefit and not the public's, the intent of the system is the protection of the public. This regulatory body specifies the education necessary for registration and determines what behaviour is considered "improper" by a registrant.

The first attempt to regulate the profession of medicine in Ontario was on September 24, 1792 when a committee of the Legislative Assembly of Upper Canada appointed a committee to consider means to prevent improperly qualified persons from practicing medicine. The committee reported the next day that in view of the primitive state of the Province there was no point in attempting to regulate the practice of medicine. However, in 1795 the Assembly did pass a bill which established a licensing board for medicine. The preamble justified the bill by saying:

"...inconveniences have arisen to His Majesty's subjects in this Province from unskilled persons practicing physic and surgery therein".

In the nineteenth century various Medical Acts were passed and amended by the Provincial legislature. During this time in North America there was considerable strife between different groups of healers. There were regular physicians, eclectics, homeopaths, naturopaths, osteopaths, and towards the end of the century, chiropractors. These professions to a lesser or greater extent, took over the practice of health care from the traditional healers in the eighteenth and nineteenth centuries. Most of these traditional healers were women whereas most of the new health professions were male dominated.

The Act of 1869 established the College of Physicians and Surgeons of Ontario. Provincial legislation recognized homeopaths and a group called "eclectics" but these physicians had minority representation on the College Council. The homeopaths retained some representation until the 1930's.

During the twentieth century, the College of Physicians and Surgeons gradually took the form it has at present. The most important change in the regulation of the medical profession since the second world war was the Health Disciplines Act which was passed in 1974. (It has been amended since.) The new Act covered physicians, dentists, pharmacists, optometrists, amd nurses. The Act provided for lay representation on the College of Physicians and Surgeons Council. Larry Grossman, while he was Minister of Health in 1983, appointed Mr. Allan Schwartz to review the Health Disciplines Act. This review is proceeding and is expected to be completed by later this year.

The present composition of the Council of the College of Physicians and Surgeons of Ontario

The governing council of the College is composed of 27 people. Sixteen are physicians who are elected from the ten electoral districts of the College. Five members come from the five Ontario faculties of medicine in Ottawa, Kingston, Toronto, London, and Hamilton and are also physicians. Six members are appointed by the Lieutenant Governor in Council (the cabinet). These members must not be doctors, dentists, optometrists, pharmacists, or nurses.

The problems associated with the discipline of physicians during collective job actions

Physicians are specifically excluded from the Ontario Labour Relations Act. They are further omitted from the Ontario Hospital Labour Disputes Arbitration Act. This law was passed after a Royal Commission report of a hospital strike in Trenton in 1965. Ironically, the Commission recommended that strikes be permitted if patients' health were not endangered but the Robarts' government enacted a law which applied a total strike ban on all hospital employees except doctors. Therefore, the government does not appear to have any specific recourse to collective action by physicians. This does not prevent the government from passing other legislation forcing doctors to work. The Province of Quebec passed such legislation in 1982 which provided for large fines if physicians did not return to their regular duties whether in clinics or private offices. However, this legislation is difficult to draft and cumbersome to enforce if physicians were to continue their actions.

Unfortunately the College of Physicians and Surgeons primary mandate is to deal with individual problems and not collective job action. The College however, does have considerable potential power in this situation. Ontario Regulation 448 (under the Health Disciplines Act) section 27 defines what is improper conduct of a physician. This is referred to as "professional misconduct" and has 32 definitions. Three of these may be relevant to job actions by physicians.

Section 27, subsection 20,

"contravening while in the practice of medicine any federal, provincial or municipal law, regulation or rule or by-law of a hospital designed to protect the public health;"

subsection 23,

"failing to continue to provide professional services to a patient until the services are no longer required or until the patient has had a reasonable opportunity to arrange for the services of another member."(of the College)

subsection 32

"conduct or an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional."

The penalties for professional misconduct include the suspension of a doctor's license for life, although he/she can appeal this after one year. Other penalties include reprimands and fines of up to $5000.

Subsection 23 is what is commonly referred to as "abandonment of patients." The definition of abandonment can be problematic. Clearly it is not abandonment if a physician has not seen someone for two years and the person breaks her leg and cannot find the doctor. Clearly it is abandonment if a home-bound elderly person has pneumonia, is being treated at home, deteriorates, and the doctor is unavailable. However, it is not so clear if a person has high blood pressure, is seeing his doctor every three months, cannot find his doctor because of a job action, does not contact a pharmacist or emergency department, misses his prescription, and has a stroke. During the collective action by physicians in 1986, many people did not realize that they had other options available for treatment when their regular doctor was on strike. They perceived they were abandoned by their doctors.

During the recent physicians' job action in Ontario, it is quite likely many physicians were in breach of this subsection. Any physician who had patients on the Provincial Homecare program had continuing responsibility for those patients. If he/she were unavailable and had made no provision for another physician then they were probably guilty of professional misconduct.

Subsection 32 is purposefully vague but there are some actions and statements of physicians which leave room for such charges. A doctor was shown on CBC television saying that it might be better for there to be one death now (because of the strike) than ten or a hundred deaths in the future because of more government control of health care. Another doctor who supported a total withdrawal of medical services said to the Oshawa Times and CBC television that she defined such withdrawal as:

"What that means to me is sitting on the curb watching ambulances pull in the front door, and watching the funeral directors pulling out the back door."

While there should be no legal censure on freedom of speech in this regard it would not be surprising if at least some physicians felt these public statements were disgraceful, dishonourable, or unprofessional.

Subsection 20 probably is the most important one in defining professional misconduct in this dispute. Firstly, if a doctor extra bills a patient now that the Health care Accessibilty Act is law, she/he is breaking a Provincial law and clearly in violation of this section. Secondly, many physicians have likely been breaking a regulation of the Public Hospitals Act. Regulation 865, section 27 of the Public Hospitals Act states:

"When a member of the medical staff is unable to perform his duties in the hospital he shall arrange for another member to perform his duties and notify the administrator."

The ten doctors of internal medicine at York County Hospital who were planning to withdraw all services including to the emergency department were clearly in breach of this section. The College did respond to this situation and the doctors resumed the provision of essential services. However, it seems certain that the doctors who reduced services in emergency departments were also breaching this section.

The College's actions in the doctors' strike

At first the College took no particular stand on the strike. The Concil issued a two paragraph statement to the media on June 12, 1986. It said that the College could not specify how long a particular treatment or procedure could be delayed and the College left this decision to individual doctors.

After, the first emergency departments announced the restriction of services, the Council released a further statement to the media and the medical profession on June 16. It said that the Council was monitoring the situation at the Northwestern Hospital in Toronto and had determined that all patients who sought care were being assessed and seriously ill patients were being treated. The Council said further that the complete closure of emergency departments was unacceptable but that the scaling down of emergency departments could also be unacceptable depending upon the alternate services available in the area. The College did not detail the specific regulations which might be breached during the job action or the penalties which could be imposed upon physicians guilty of such breaches.

On June 19, the College sent a letter to all physicians which indicated its actions taken during the strike up until that point. The letter from Dr. Michael Dixon, the registrar of the College warned the profession that it was in a privileged position in Ontario society and that the right of self regulation was a trust to be exercised in the best interests of the citizens of Ontario.

The College said further that it recognized the right of all citizens including physicians to protest by withdrawal of services if such withdrawals did not endanger patient life or health. Interestingly this is identical to the MRG position. This statement did not outline the specific responsibilities of physicians during collective job action or the specific regulations which might be breached during such actions. However, the College did try to indicate to the profession that professional self regulation might be at stake if physicians continued their actions.

On June 26, the College issued a strong statement to physicians and the public. It said that such actions as were taken by the internal medicine specialists at the York County Hospital was unacceptable. The College noted that because of efforts by the College and others these doctors had resumed the provision of essential services. Dr. Dixon warned physicians that similar action taken by others would result in an immediate investigation and possibly professional misconduct charges. The statement did not outline the specific responsibilities of doctors during job actions or the specific regulations which might be breached. Neither did the statement outline the possible penalties for professional misconduct.

Issues raised by the doctors' "strike"

1. Physicians are the only workers within hospitals who are permitted to withdraw their services. It is unfair for dietary workers to be prevented from any withdrawal of service when physicians seem to have the right to withdraw a considerable number of services.

2. The College of Physicians of Surgeons of Ontario has responsibility for individual physicians not groups. Dr. Michael Dixon, the registrar of the College, said on June 26 that the Health Disciplines Act did not authorize the College to act against groups. He noted they would focus their investigation and possible prosecution on individual doctors. However, Dr. Dixon also said that the College had dismissed the need for further regulations to strengthen their authority during withdrawals of services. He observed that the current regualtions under the Health Disciplines Act were sufficient in the present circumstances.

3. The Council of the College has an essential conflict of interest in any collective job action. Twenty-one of the 27 members of the College's Council are physicians. Sixteen of these are elected by physicians in the ten electoral districts in the Province. Many of present members of the Council have been involved with the Ontario Medical Association in the past. By disciplining other doctors they not only run the risk of retaliation through decreased referrals and the "cold shoulder", but they also may be acting against the interests of the profession.

There are a number of suggestions that might be made to remedy these problems. I would like to make the following two to stimulate discussion.

1. Bring physicians under the Ontario Labour Relations Act and/or the Hospital Labour Disputes Arbitration Act. It is hard to imagine how the government could place physicians in private practice under the Labour Realtions Act. However, it could outline essential services in the Hospital Labour Disputes Act and then allow all workers and doctors to withdraw all but essential services. This is virtually identical to the resolution passed at the October, 1982 MRG semi-annual meeting. This position has the advantage of protecting the public's health while allowing some right to withdraw service. It seems obvious that some of the services which physicians provide are essential and that some of the services which other health workers provide are non-essential.

If physicians were included it would add some fairness to the current situation where the highest paid workers are allowed to withdraw service while all others are not. It would also remove the responsibility of policing the profession during collective actions from the College of Physicians and Surgeons.

2. Give government appointees a majority on the College Council. At present only six of 27 members are lay appointees of the Lieutenant Governor in Council (the cabinet). If they had a majority then the Council of the College would not find itself in as much of a conflict of interest situation during physician job actions. This may be seen by some as the end of self-government but committees of the College dealing specifically with the areas of professional competence could continue to have physician majorities.

Michael Rachlis is a member of the Medical Reform Group.

JOB OPENING

The Lakeshore Area Multi-Service Project (LAMP) Occupational Health Program requires a physician to work on salary in a community health centre up to 17½ hours per week. Will be required to do individual health assessments, Worker's Compensation Board claims assessments and group assessments for medical monitoring programs.

Training and/or experience in occupational medicine is essential. Knowledge or experience of community based service delivery an asset.

Remuneration in keeping with salaries paid in other community health centres.

Starting date: immediately.

Apply to: LAMP Occupational Health Program
185 Fifth Street
Toronto, Ont.
M8V 2Z5
(416) 252-6471
Attention: Bonnie Heath, Co-ordinator

Health News Briefs

Court upholds B.C. practise restrictions

The British Columbia Supreme Court has upheld legislation which allows the provincial government to restrict the supply of billing numbers given to doctors. Without a billing number, a physician cannot charge the provincial medical insurance plan for services. Dr. Robert Conn, president of the Canadian Association of Interns and Residents, which launched the court challenge of the legislation, called the court decision "the most significant threat to medicare to date." He predicted that the B.C. policy will force doctors to operate outside of medicare and that that would create a two-tiered system. On the other hand, Robert Evans, a health economist at the University of British Columbia, said he doubted that doctors would practise outside the provincial medicare scheme in significant numbers because "who will pay their bills?" Under the system affirmed by the court decision, a graduating doctor would not be allowed to open a general practice in Vancouver and bill the provincial health insurance plan for his or her services, for example, if the provincial government decided that there were already enough general practitioners in the city. Some physicians in British Columbia are limited to practising in a particular geographical area. Others are limited to billing only up to a set percentage of other doctors in that area, which effectively limits them to practise only 20 to 50 per cent of the year.

-Globe and Mail and Toronto Star, January 7, 1987

Controversial Health and Safety report released

An internal inquiry into the Ontario Labour Ministry's controversial health and safety division has found negligence, errors in judgment, unreasonable delays and inconsistencies, but no misconduct by senior officials. The two-volume report has been branded a whitewash by the two opposition parties in Queen's Park and by labour groups. The report, by management consultant Geoffrey McKenzie and lawyer John Laskin, says health and safety has become a highly politicized issue which some groups with "a socialist agenda" are using to seek "control of the workplace, the right to stop an operation." Mr. McKenzie told reporters that if groups such as the Ontario Public Service Employees Union (which represents health and safety inspectors) had their way, "the balance between workers and employers would be significantly affected" and business would be "reluctant to invest in Ontario." The report says that the ministry's workplace inspectors are over-worked and undertrained. Complaints of violations of the safety act increased to 1,525 last year compared to 98 five years ago, while the number of inspectors has actually been decreased. In the industrial branch, there is a backlog of 8,000 inspections. The report calls for more inspectors and more training--goals OPSEU agrees with--but Keith Rothney, an inspector and union activist-- said the report is "an insult to the intelligence of inspectors" because it fails to hold senior management responsible for causing the problems.

-Globe and Mail, January 13, 1987

WCB to study cancer claims of miners

The Ontario Workers Compensation Board is studying the compensation claims of 434 cancer-stricken miners who worked in gold and mixed ore mines in Northern Ontario from 1955 to 1977. Richard Murzins, director of public affairs for the WCB, said yesterday that the vast majority of these miners have already died from lung or stomach cancer. "Very few are alive." Earlier in 1986, the provincial government confirmed in a major study on the mortality of Ontario miners from 1955 to 1977 that "Ontario gold miners have a significantly increased lung cancer risk as compared to the age and period matched male population..."

-Globe and Mail, November 15, 1986

Court rules injured workers can sue employer

The Newfoundland Supreme Court has ruled that the Workmen's Compensation Act violates the Charter of Rights and Freedoms by prohibiting an injured worker from suing his employer. The Newfoundland cabinet is seeking to appeal the decision, arguing that it would "gut" workers' compensation boards across Canada and create a liability crisis for employers. "It would be a nightmare for industry," said Leslie Thoms, a lawyer for Newfoundland's Attorney-General. The decision by Supreme Court Judge T. Alexander Hickman found that the act (which is similar to acts in every other province) discriminates against injured workers by rendering them the only Canadian citizens without the right to sue. The case was brought to court by Shirley Piercey, whose husband was electrocuted in the bakery where he worked. She was awarded $37,000 from the WCC. Her lawyer, Malcolm MacKillop, called it "an amazing victory". "A lot of Canadians have always thought you can sue your employer if there's an accident. It comes as a shock to them. We have had terrible accidents here where there was clear negligence."

-Globe and Mail, November 15, 1986

Dental Association battles capitation

The Ontario Dental Association is engaged in a major campaign to halt the spread of prepaid dental plans in which dentists are paid a fixed payment per patient instead of a fee for each service. Association president Dr. Bernard Dolansky referred to capitation plans as a threat to dentists' freedom to practise the way they want. Under capitation schemes, dentists get an annual flat fee for each patient regardless of the number of visits or work performed. At present, two large insurance companies, London Life and Metropolitan Life are involved in capitation plans. "We have to relegate capitation to where it belongs...practised by second-class dentists" for a dwindling population of patients receiving second-class treatment, said Dolansky.

-Toronto Star, October 22, 1986

NOW DECEMBER 11-17, 1986

A prescription for profits

Toronto doctor Joel Lexchin, author of The Real Pushers, a book on Canada's drug industry, argues that the new federal drug bill is robbing consumers to offer free trade mega-profits to U.S.-based corporations.

By JOEL LEXCHIN

Brian Mulroney and his Conservatives want a free trade deal with the U.S.; the multinational drug companies want even bigger profits for their Canadian subsidiaries. In order to help everybody else get what they want, Canadians are going to get stuck with huge increases in the cost of prescription drugs, and the Canadian-owned generic drug industry may go belly-up. It's a tradeoff that sends Canada backwards in time.

Before 1969, drug prices in Canada were among the highest in the world. Three major federal reports all pointed to one thing as the source of that distinction — the patent system. Once a company took out a patent on a drug, it had a monopoly on sales for 17 years, until the patent expired. With no competition, the multinational drug companies were free to charge whatever they liked for their products — and they did.

By 1969, the situation was becoming intolerable. With the advent of medicare, people were now universally able to see doctors, but they couldn't afford the medications they were being prescribed.

The solution was a bill allowing compulsory licensing. Even if a drug was still covered by a patent, a company (a so-called generic company) could go to the Commissioner of Patents in Ottawa and get a license to import and sell the drug in Canada.

Naturally, the multinational companies were none too happy about the proposal and they let it be known. Their association, the Pharmaceutical Manufacturers Association of Canada (PMAC), spent over $250,000 lobbying against the legislation. Canadians were warned that in the event of an epidemic the necessary drugs might not be available, and that people would die in any event because of the poor quality of drugs that the generic companies would supply. All of this was to no avail and the legislation passed on March 28, 1969.

The multinationals and the PMAC did not give up their opposition, however. They have been lobbying intensively ever since to get compulsory licensing repealed. Over the years they have mobilized support from provincial governments in Quebec and Alberta, numerous scientific and medical research organizations and leading Canadian physicians.

By 1984, all the pressuring started to have its effect. The question of compulsory licensing had been making headlines for a couple of years as various Liberal ministers of consumer and corporate affairs came out with promises of action of one sort or another; but with an election on the horizon, the entire affair was finally sloughed off onto a commission headed by University of Toronto economist Harry Eastman.

Eastman held hearings during the fall of 1984 and issued his report in May 1985. What Eastman found was that, contrary to the companies' claims, the multinationals had been doing very well under compulsory licensing. Profit levels in Canada were better than in almost all other Western industrialized countries; growth in the pharmaceutical industry, from 1969 to 1984, was better in Canada than in the United States; and the multinationals had lost an insignificant 3.1 per cent of the Canadian market to the generic companies.

Little research

True, the multinationals were not doing much research in Canada, but then they never had, even before 1969. The reason for the lack of research in Canada was quite simple, according to Donald Davies, chairman of the Canadian subsidiary of Ayerst: "Virtually all companies do most of their research in their home country ... That's just the way it is." There are no multinationals based in Canada and so Canada gets little pharmaceutical research. Eastman was also quite clear that it would be a waste of time and money for the government to try to make Canada into a major pharmaceutical research centre.

Finally, what Eastman found was that compulsory licensing was doing exactly what it had been set up to do: it was saving Canadians money on their drug bills. Eastman conservatively estimated those savings at $211 million a year. On a natural drug bill of about $1,300 million annually, compulsory licensing was shaving 16 per cent off the cost of prescriptions. So Eastman concluded that apart from some minor modifications compulsory licensing should be left alone.

By the time the Eastman report came out, Brian Mulroney was in office, with a promise to "open up Canada for foreign investment." During the 1984 election campaign Mulroney had made statements favourable to the multinational drug companies, and had sent the PMAC a letter strongly supporting patent protection. And of course, the Conservatives wanted a free trade agreement with the Americans.

Now the multinationals had another way to exert pressure; not only could they lobby the government directly but they could also use their considerable influence in Washington to press their case.

Rumours denied

The Washington connection proved very powerful. Ronald Reagan raised the matter of compulsory licensing with Mulroney as a major item at the "Shamrock Summit" in Quebec City in March of 1985. Vice-president George Bush said publicly that Canada had given a commitment to change the Patent Act. U.S. trade representative Clayton Yeutter rebuked Canada for failing to make long-promised changes in its drug patent law, saying that "We've been exercising uncommon patience. But even our patience ultimately begins to wear thin." Yeutter issued a veiled threat of trade action against Canada if the issue was not settled soon.

All during the fall of 1985 and the spring of 1986 there were sudden predictions of the imminent introduction of new patent legislation. Those rumours were just as quickly denied. Finally, on June 27, the last day the house was sitting before the summer recess, the Conservatives tried to introduce their bill. But through a series of blunders that probably only the Conservatives could have managed, the bill didn't reach the house in time to be tabled.

Once again things went on hold publicly, while behind the scenes the pace of the lobbying intensified as the opposition to the bill mounted. Arrayed against the Conservatives' plans were senior citizen groups, the National Anti-Poverty Organization, the Consumers Association of Canada, the Canadian Health Coalition, the Medical Reform Group of Ontario, the Canadian Drug Manufacturers Association (representing the generic companies), the NDP and the Liberals (although there may have been second thoughts on the part of leader John Turner, a former member of the board of the Canadian subsidiary of the Swiss multinational Sandoz).

None of this lobbying had any effect, and early last month consumer and corporate affairs minister Harvie Andre finally succeeded in getting Bill C-22 tabled in the House. Basically, the bill will give multinationals a 10-year monopoly on any new drug they introduce; that means 10 years without any competition from cheaper generics. In return the multinationals are supposed to invest $1.4 billion in research and development in Canada over the next 10 years and create 3,000 new "high tech" jobs. An information paper from consumer and corporate affairs speaks of creating "a world-class industry" here in Canada, a goal that the Eastman report warned was virtually impossible.

There is nothing in the bill that actually commits the multinationals to do anything. All the bill says is that there will be a review of the legislation after four years and again after 10 years.

"Me-too" drugs

A lot of scientists have supported the bill because of the new investment in research, but what kind of research can Canada hope to get? Most of the money that the multinationals invest in research worldwide goes into developing what are

called "me too" drugs, drugs that are slightly different, but no better, than ones already on the market. These drugs are developed not because they are going to serve any major medical need, but because they have the potential for major sales.

There are more than a dozen arthritis medications on the Canadian market, not because that many are needed but because they account for $100 million in sales annually.

Only about 5 per cent of the new drugs introduced in any year offer a major therapeutic advance; 85 per cent represent little or no therapeutic gain. The pattern of investment in Canada is not going to be any different.

If most of the high tech jobs are going to involve developing drugs of little or no value, what does that say about how well the talents of the Canadian researchers are going to be used? The United States Task Force on Drugs concluded that research on redundant drugs may lead to "a waste of skilled research manpower and research facilities, a waste of clinical facilities needed to test products, a further confusing proliferation of drug products promoted to physicians, and a further burden on the patient-consumer who, in the long run, must pay the costs."

Sales decline

The key word in that quotation is "costs." What is the price of the government's generosity towards the multinationals? The first cost may be the demise of the Canadian-owned generic companies. Andre points to the United States, where the generic industry is thriving even without compulsory licensing. But the U.S. has a market for prescription drugs more than 10 times the size of Canada's. There, companies can wait for patents to expire before they start to make a drug, but in Canada the generic companies don't have the luxury of waiting 10 years to start marketing a drug. By the time a drug has been on the market 10 years its sales are already starting to decline. Capturing a share of a shrinking Canadian market just won't be good enough to allow some of the generic companies to survive.

The second cost is that of the new drugs. The price of drugs already around won't change and the bill contains provisions for the creation of a Drug Prices Review Board, which Andre promises will ensure that prices on new drugs will not be too high. But the person appointed to head the board, Harry Eastman, is quite blunt about the fact that without competition for 10 years those new drugs are going to be more expensive than if there was competition. Andre refuses to release the studies his department did to predict what will happen to drug prices, but according to a study done by the accounting firm of Coopers and Lybrand, Canadians could be paying an extra $650 million a year by 1995.

For those Canadians who pay for drugs out of pocket, that extra money will come from the same place; those covered by an insurance plan will be paying increased premiums.

Ontarians have the Drug Benefit Plan, which covers drug costs for everybody on welfare or over 65. Currently the plan costs over $400 million a year. It's anybody's guess how much the cost of the plan may go up without generic competition. The money to pay for the increase will come from tax money or, if the government doesn't want to raise taxes, perhaps from other social programs like medicare. Or the government may just decide to leave off some of the new drugs from the plan altogether because they are too expensive.

All of these arguments, and others, have been made to the Conservatives time and time again. Their latest response has been to choke off debate on Bill C-22 in the House of Commons. The bill, which received second reading — approval in principle — early this week, will now be going to committee stage, but there is no indication that the Tories will be any more receptive to reason at that point than they have been until now. Alongside the interests of the U.S. and the multinational drug companies, the interests of ordinary Canadians don't count for much.

Abortions at Morgentaler clinic doubled because MDs refuse referrals

By Paula Adamick
Special to The Star

LONDON — The number of abortions performed at Dr. Henry Morgentaler's clinic in Toronto has more than doubled in the past year because Canadian doctors are refusing to refer their patients for hospital abortions, Morgentaler's assistant says.

Dr. Nikki Colodny said yesterday that about 3,500 abortions were performed at the clinic last year, compared with 1,600 in 1985.

Most were performed on Ontario women, Colodny told a National Action Committee on the Status of Women conference here.

However, patients came from all over the country to the free-standing clinic because many doctors will not refer their patients to a therapeutic abortion committee at a nearby hospital.

"It's my impression that one-third to one-half of women come to our clinic because they feel their doctors won't help them," Colodny said. "Or if they approach them, they refuse to help and would not refer them on."

Colodny, who along with Dr. Robert Scott was charged last September with procuring an abortion, called the practice of refusing referrals "outrageous," adding that "doctors cannot hold women hostage in this way."

And she advised about 300 women attending the weekend conference not to wait for the Supreme Court of Canada ruling on the constitutionality of the abortion laws, but to continue to work hard for the pro-choice movement.

The courts will not provide the answer to the problem, Colodny said, so pro-choice activists must continue to lobby everywhere possible for easier access to safe abortion.

"They can repeal this law and give us something not much better," she said of the upcoming Supreme Court decision. "We have to build a national, visible, pro-choice movement and not wait for the courts."

Part of the plan is to involve pro-choice doctors across the country in supporting easier abortion and to establish more abortion clinics.

Colodny said that a Vancouver coalition is planning to set up a free-standing abortion clinic somewhere in southern B.C. in the next year.

Diane Mossman, of the Canadian Abortion Rights Action League, told the workshop that the difficulty in procuring an abortion last year was the worst since 1969.

Thirty-six hospitals across Canada performed 74 per cent of all abortions, Mossman said, and more than 2,000 Canadian women crossed the border to procure abortions in the United States.

"It's the worst crisis in access to abortion since 1969. On all fronts, we are under attack."

Workers' health and safety checkup

Armed with case by case exposés, unionists are blowing the whistle on what they call ministry-corporate collusion.

By ELLIE KIRZNER

Somewhere in the icy towers of Commerce Court, a series of closed-door hearings is going to decide the way the ministry of labour carries out the business of occupational health and safety in this province. Here, a ministry-conjured inquiry headed by lawyer John Laskin and management consultant Geoff McKenzie is being treated to the verbal lashings of some unusual bedfellows making common cause against the province's system of safeguarding employee health.

And as they blow the whistle on the ministry's tip-toe investigation, they are hoping to explode the entire workings of a government service which they say is quietly complicit in the deaths of workers throughout the province.

Stan Gray — the worker's movement maverick who heads the Ontario Workers Health Centre — and the ministry's own inspectors organized in the Ontario Public Service Employees Union (OPSEU) decided to whip up this minor storm last week by leaking copies of their briefs to the press.

It wasn't something they were supposed to do. But then it wasn't this kind of in-house scrutiny that OPSEU members in particular were dreaming about when they called for a massive overhaul of ministry operations. They were thinking rather more grandly about a wide-open commission.

Now unsure whether this inquiry is headed for a whitewash, wrist slapping or wholesale censure, they are making sure they get to say their piece. What both ministry inspectors and Gray think the public ought to know is that senior ministry officials are protecting companies at the expense of workers' health.

They say they are tired of having to use the press as leverage to wheedle enforcement of safety regulations from bureaucrats reluctant to live within their own laws. And they want a lot of apples to fall up there at the top of the ministry tree and they are naming names and times and places to make sure some of that happens.

It's a timely conjuncture for appraisal. Events and eventualities have been falling all over each other. Just as workers at de Havilland Aircraft of Canada staged their massive work refusal over exposure to deadly chemicals this summer, figures were released showing that the numbers of workers injured on the job are soaring skywards. In the first six months of this year, nearly 90,000 workers were injured, topping by almost 7,000 the 1985 record, a figure that doesn't include thousands of others who develop cancers 10 or 20 years after exposure to toxic substances.

Labour minister William Wrye hasn't exactly been slouching at the post either. In a mixture of NDP accord pressure and his own stated intention to undo the bad habits of complacent Toryism, he's been active on the legislative front. Last year, he introduced Bill 101, right to know legislation designed to give workers and communities access to information on toxic substances and amendments to section 145 of the Occupational Health and Safety Act to provide greater protection to workers from toxic exposure.

Neither are yet law. But he also issued a new set of procedures to increase the possibility of laying charges against employers ignoring inspectors' orders and he's forked over $1.7 million for a new health and safety education centre to be run by the Ontario Federation of Labour (OFL).

Dynamite indictments

Wrye has said publicly that he's awaiting the inquiry's report and is willing to "let the chips fall where they may" in terms of uncovering mismanagement in the ministry. But his detractors say the whole occupational health and safety system reeks of employer bias, and misconduct has become a thoroughly normalized procedure.

It's noon Monday and Stan Gray swings out of the Commerce Court elevator, two briefcases in hand. He's taking time out from presenting his dynamite series of anti-ministry indictments to the inquiry and he settles his large frame onto a bench in the caverns of profit-rich Bay Street. His white T-shirt puts him outside the stream of suits and ties but he's a black sheep in any attire.

Gray's unrelenting independence has also placed him beyond the pale of mainstream labour politics. While the more militant union locals tap into his resources and experience, the OFL leadership has kept its distance.

Gray's document is a scandal sheet of ministerial wrongdoing, a panorama of names, dates and places where senior officials allegedly neglected to enforce safety standards or refused to prosecute companies who were clearly guilty of unlawful conduct. And running through it is the force of his conclusions from the front lines — that the Occupational Health and Safety Act itself is a lever for management negligence.

In August 1985, for example, two workers at Stelco in Hamilton charged that the company's medical department had hidden from them records of workplace health damage. For over 10 years, Stelco had documented their medical deterioration — lung disease in one case, hearing loss in another. But the company told the affected workers nothing.

The ministry found that for six years Stelco failed to provide these reports to the workers' representatives on the health and safety committee. When the ministry finally forced the company to turn over their documents, hundreds of reports on previous health damage were produced. But, says Gray, no charges ever were laid.

This was also the case at Westinghouse in Hamilton, where high levels of PCBs on the floor area were documented by ministry personnel from 1984 to 1986. A recommendation for prosecution was issued by an inspector this year but it wasn't followed through. And Gray has a roster of 15 similar atrocities where ministry seniors gave the nod to company infractions.

General contempt

"What would happen if the police apprehended a ring of car thieves and just told them to give the cars back and forget about it?" Gray asks. "And the police authorities then told the media that prosecution was inappropriate since the matter was settled? It would breed

a general contempt for the law and its police, and encourage robbers to try their luck since they would face no penalty if caught."

Workers pay with their blood, tissues, lungs and sometimes their lives when employers are given a free hand on safety issues. And the Occupational Health and Safety Act itself encourages this spirit of laissez faire. At the heart of the problem, Gray says, is the concept of "internal responsibility," where employees and management are expected to work out safety problems themselves through joint committees and rely on ministry intervention when they are deadlocked. But the symmetry assumed by the act is fictive, Gray says, because employers have most of the power and workers have little.

"What would one think of police called into an assault situation who told the victim (to) work it out with the rapist? The situation is analagous here because not only is it a victim/victimizer relationship — but the cop is called only because one side is stronger than the other. This is exactly what you have in health and safety since the law gives labour and the committees only consultative and no real power. Like the sexual assault situation, one side can unilaterally impose its wishes."

The internal responsibility system is, he says, a licence for companies to violate the law. "The policy itself is misconduct, devised by the senior levels of the ministry who use it as a code word or public relations justification for a go-soft-on-the-corporations policy."

It's time, says Gray, to call a spade a spade. "All these things are high-level white collar crime. It's a particular kind of misconduct that creates victims. Are these officials not to be treated as murderers and to be prosecuted for criminal negligence?"

Public face

OPSEU's ministry inspectors have arrived at similar conclusions through quite a different route. To most workers, they're the public face of the ministry and some will admit that unionists often perceive them as management pawns. But they say their failures are the failures of ministry policy and that they can't protect fellow workers without more clout for themselves.

In this particular weave of OPSEU-style social unionism, inspectors see a relationship between their own integrity as workers and the service they are providing to the public. "Our members are tired of being portrayed as the fall guys for politicians' errors," says union president James Clancy.

Inspectors, he says, are "flying on one wing." There are simply not enough of them to prevent employers from subjugating worker health to profits and pragmatism. There are, the union points out, only 205 inspectors in the health and safety division. "Workplace inspection and accident prevention don't even rate with wildlife preservation, where 239 conservation officers and 530 deputies protect birds and animals," the OPSEU brief says.

At least 80,000 workplaces haven't even been registered, let alone inspected, while 37 per cent of unionized workplaces and 68 per cent of small or non-union workplaces have no health and safety committees. "A small inspectorate virtually guarantees employers the right to defy the law," says OPSEU.

Little training

Instead of bringing the staffing crisis to public attention, managers "arranged a bureaucratic burial of the problem: it's called code 99. It's a wastebasket." The code means inspections will only take place in the event of serious accidents and work refusals — a situation which leaves thousands of workers unprotected. "Code 99," says OPSEU, "literally undoes the law of the land."

Then there is the way inspectors are thrown into the workplace without systematic training and without a background in toxicology, ventilation and hygiene monitoring. "In an age when health and safety problems are often invisible to the naked eye, inspectors are sent out half-blind.

"The conscious denial of training is part of a profoundly political decision to downplay the role of enforcement under the act. Instead, management places a premium on the inspectors' role as facilitators of the 'internal responsibility system.' This means that inspectors hop from breakdown to breakdown and try to patch up differences rather than lay down the law."

The powers of the inspector in the act, OPSEU says, read like fiction. Theoretically, they can drop in unannounced, demand information, order that material be posted, that improvements be made and that machines or worksites be shut down. If disobeyed, they can order prosecution.

"In real life, however, the inspector has almost no power." This is because inspectors' recommendations to prosecute must rise through the ministry bureaucracy until they are co-signed by the manager, area administrator, director and the legal branch. These are the points at which charges and prosecutions get blocked. "The ministry has announced a get tough policy but it can't get tough on employers until it gets tough with itself," the union says.

OPSEU, too, offers its own galaxy of bureaucratic terrors — diligently documented cases where political intervention or personal influence hinder prosecution, where inspectors are discouraged by their supervisors from enforcing the act, where ministry officials collude with companies to circumvent inspectors' orders and where ministry prosecutors fail to appear in court.

New variable

Where the Laskin-Mackenzie inquiry is going to go with the mind-bending they've had to listen to is anyone's guess. But one thing is certain; there's a new variable in the health and safety worker-management equation — a blossoming consciousness among workers that while their labour may be for sale their health isn't.

And the 600 de Havilland workers who folded arms and refused to work for over a week in August learned that changes come to those who walk. From 1983 to 1985, ministry inspectors had issued the same compliance order six times for regulating dangerous isocynate. Workers were also being exposed to a host of other chemical carcinogens and neurotoxins. When doctors from Gray's clinic visited the plant in May, they found swollen eyes, respiratory sensitization, constricted airways, skin depigmentation, dermatitis, cancers and neurological damage.

Under ministry scrutiny, it turned out that there were widespread abuses and irregularities in de Havilland's medical division and that the union and government were not being informed of health hazards. And when the company stalled on implementing changes, the workers headed out and didn't go back until the company agreed to ventilation controls.

"A lot of what happened didn't come through the health and safety committee — it wasn't functioning right," says John Bettes, the presi-

dent of local 112 of the Canadian Auto Workers (CAW). "The union is learning methods of forcing implementation of the act. The problem is always getting into a position where you can enforce it.

"When it came to this local union, we're a little more militant than some others and we said we're going to do it. The employers have now learned that when you are faced with people such as us that you're better to just capitulate and get on with the job rather than trying to fight — 'cause you're going to lose. We've developed a procedure that works now."

And other members of the local tried it out at Woodbridge Foam the following month with the same results. It's a long way from the Bay Street hearings to Highway 7, where a low red brick building which 25 years ago was a textile plant churns out foam for car seats. A corn field backs on to the factory and it feels a lot like the country, except for those loads of green, yellow and purple rolls of foam that come streaming from the plant in big trucks.

There's a sign in the parking lot that cautions drivers, "do not back in against building, car exhaust gases are hazardous to health." But workers are all wearing respirators for the first time and groups of them are being pulled off the shop floor to receive health and safety training from other specially trained CAW members who, too, have been pulled from their own workplaces.

All this has happened since September, when Woodbridge workers staged their own work refusal after the deadly chemical TDI (toluene diisocyanate) spilled.

"I was sleeping when I received a call at 5 o'clock in the morning that the people have refused to work," says plant chair Nana Agyemang. "The problem has been there for a long time but because of the weakness of the union we had we couldn't do anything about it. So last year we switched to the CAW and we decided to tackle it.

"We went through the plant and it was very, very terrible. There were so many places with no ventilation. Our situation is very, very bad. The doctors are coming to test the people. We don't know how many people are being affected with this chemical because some people have been here 25 years. People have been dying like hell.

"That very Sunday we got the news that one of our ladies working in the office died of cancer. The next day, we had more news that a lady we were working with is being operated on with breast cancer. So many people — I've been there almost 10 years and I know at least six or seven people died of cancer. If it weren't for the CAW, people will die."

According to Agyemang, it took a call to the CBC to get the ministry to the plant. And while the company refuses to comment on what they obviously consider a most delicate matter, the union says that without its own health and safety know-how, the plant would at this moment be shut down.

"There are a lot of companies who pay lip service to health and safety committees and Woodbridge has been one of them," says union staffer Moe Kuzyk. "We are helping the company meet their obligations under the act so they don't get closed down. This is what happened at de Havilland and the same here. The company doesn't have the people trained to put a program on or the resources. If they can't meet those legal obligations, they would be closed down by the ministry."

"The key thing," says Bettes, "is that the workers turned around and refused to work. If that were to spread province wide, what would they do? So the political pressure has to come from the workers themselves. We've taken the government further than they wanted to go."

CANADIAN CENTRE FOR INVESTIGATION AND PREVENTION OF TORTURE (CCIPT)
—Doctors Needed—

The CCIPT is a voluntary non-profit organization which provides support services to torture victims. It is funded by the Settlement Branch of the Federal Department of Immigration and by a grant from the United Nations Special Fund for torture victims. A Board of directors, including three physicians who are also MRG members, is responsible for administering the Centre. The CCIPT operates from a west Toronto house owned by Doctors Hospital.

The CCIPT has an associate physician membership of about 40 doctors, mostly family physicians and psychiatrists. The physicians' role is twofold:

1) to examine torture victims and provide medical reports regarding the victims allegations to lawyers; lawyers might use the medicolegal report in support of the victims' applications for refugee status in Canada.
2) to provide ongoing medical care to the victims in an empathetic and informed manner.

The physicians' work within the CCIPT is a continuation of the services voluntarily provided in Toronto since 1978 through the Amnesty International Medical Group. The CCIPT was formed because treatment of victims is not within Amnesty's mandate. Clients sent to the CCIPT (from lawyers, immigrant agencies, church groups and others) are referred to the physicians association with the CCIPT.

In the first year of service since the CCIPT opened in April, 1985, the Centre took on about 120 referrals. In the last few months the number of new referrals has tripled to almost 30 per month. Many of the victims are from African coutries as well as from South America.

Because of the increased case load there are not enough physicians to meet the needs of torture victims referred to the CCIPT. Victims are now placed on a two months waiting list. The CCIPT is seeking physicians who would be prepared to see one patient per month. There is a teaching kit for new physicians which includes published articles and an outline on how to examine torture victims.

In 1980 the MRG adopted a set of resolutions in support of medical work with torture victims and the work of the Amnesty International Medical Group. Becoming an associate physician of the CCIPT is a practical and useful way of acting on the MRG resolutions — especially in a time of need.

Physicians interested in becoming associated with the CCIPT can contact Philip Berger at 926-1800 or phone the CCIPT directly at 928-9137 and ask for Joanne or Anne.

No action taken against doctors

Jan 21/87

Extra-billed patients given $7,000

BY ANN SILVERSIDES
The Globe and Mail

Ontario has reimbursed more than $7,000 to patients who complained about charges by doctors, but the Medical Reform Group says only a small percentage of those affected by charges are formally complaining.

"We believe the province should do a survey to find out the extent of problem," said Dr. Michael Rachlis, a spokesman for the 150-member group.

Since June, it has been illegal for Ontario doctors to charge patients more than the Ontario Health Insurance Plan rate for medical services.

Patients who complain about the practice are eligible for refunds and, as of last week, the province had reimbursed 113 patients a total of $7,058. In total, 305 patients have requested declaration forms to register their complaints.

But so far, the province has taken no action against the doctors who charged patients the extra money.

"We're concerned because since no one has been charged, doctors who extra-bill rightly feel that it is all right to continue this practice," Dr. Rachlis said in an interview.

Health Minister Murray Elston has said the province is holding back from laying charges because it wants to see what patterns of illegal charges develop.

Also, the "whole issue is being tackled in (financial) negotiations," now going on between the Ontario Medical Association and the province, Robert Stephens, special assistant to Mr. Elston, said yesterday.

About one-third of the money reimbursed to patients has been for charges that "presented a barrier to insured services, for instance, charges for abortion referral letters," a Ministry of Health spokesman said.

(Some Ontario gynecologists are charging patients $40 to $75 to write a letter of referral to a hospital abortion committee.)

In other words, the province is reimbursing patients not just for charges above OHIP-insured services, but also for charges for services not covered by OHIP. These charges are not illegal.

(The OMA and the College of Physicians and Surgeons of Ontario have taken the position that the abortion referral letters are medical-legal documents and hence not insured by OHIP. Ontario has not disagreed. In Alberta, the provincial medical association is awaiting a court decision on its challenge of that province's ruling that such letters are insured services.)

Dr. Rachlis said that if the Ontario Government acknowledges that charges for abortion referral letters create a barrier to care, it should tackle the problem faced by all women seeking abortions, instead of "quietly reimbursing the few who complain."

Health and Safety at Work

The Protection of workers' health and safety has become a major industrial, social, and political issue in Australia.

Through their unions workers have been demanding a new approach to the design and organization of work and technology in order to reduce the appalling toll of occupational injuries and diseases.

This handbook is directed to the needs of health and safety reps, union staff people and to those of workers generally. Health and Safety at Work provides a wealth or essential information for training and on-the-job reference. It covers in detail: the social context of injury and disease prevention; hazards, diseases, and their control; techniques of monitoring, measurement and control; organizing on the job.

John Mathews was the head of the ACTU-VTHC Occupational Health and Safety Unit from its inception inn 1981 to 1984.

$27.95. Available from DEC Book Distribution, 229 College St., Toronto M5T 1R4. (416) 597-0328.