# MRG Newsletter

Medical Reform Group of Ontario P.O. Box 366, Stn. J Toronto, Ontario M4J 4Y8

VOLUME 7, NUMBER 2 APRIL 1987

## Medical Reform Group Spring General Meeting

### Friday May 1, 1987, 8 p.m.

Discussion with Donald Cole, MRG member recently returned from 3 years in Nicaragua

**Topic:** Health and Politics in Nicaragua: Will the Revolution Survive?

**Place:** Catherine Oliver's, 121 Walmer Road, Toronto

Party to follow

### Saturday May 2, 1987

Place: South Riverdale Community Health Centre, 126 Pape Ave., Toronto

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|---|---|
| 9:30 - 10:00 | Coffee and Registration |
| 10:00 - 12:30 | Business Meeting<br>Steering Committee Report<br>Chapter Reports<br>Subcommittee Reports:<br>Extra charges<br>Drug Patent Act<br>Abortion<br>AIDS Working Group<br>Health coalitions<br>Report from Treasurer<br>Newsletter<br>Incorporation<br>Community Health Centres, HSO's |
| 12:30 - 2:00 | Lunch |
| 2:00 - 4:00 | Panel Discussion: Psychiatry and Current Issues of Patient Rights<br>Speakers: Carla McCague: Legislating on Patients' Rights<br>Tyrone Turner: Role of Patient Advocate<br>Sam Malcomsen: Professional Responsibility |
| 4:00 - | Resolutions<br>To be followed by a walk on the Leslie Street Spit |

### Contest

In keeping with tradition, there will be a contest at the Spring General Meeting. The topic this time is The Most Outrageous Extra Charge. There are two categories: Real, and Imagined. Prize to be announced.

## New MRG Phone Number

Effective April 20, the Medical Reform Group has a new telephone number. The new number is (416) 537-5877.

## Spring General Meeting Background Psychiatry and Current Issues of Patient Rights

The topic chosen for the educational forum is likely to engender considerable public debate. (See clipping from Globe and Mail in this issue.) Because it has become dressed in the judicial and legislative garb of two bills potential for confusion is high.

**Bill 7** was originally due to become law on April 1. A deferment to July has been effected because of controversy on when certain decisions should be referable to the Review Board. These decisions are in the following circumstances:

1) A competent patient refusing treatment

2) A relative of an incompetent patient, refusing treatment.

**Bill 190** Now in force allows the above two refusals of therapy to be overidden except where the treatment is ECT. In this case the Review Board becomes automatically involved if disagreement on 'need' for therapy arises. The table reprinted in this newsletter details some of the situations that may arise under Bill 7.

Our three panel speakers will be:

Ms Carla McCague on Legislating on Patients Rights

Dr. Tyrone Turner on The Role of the Patient Advocate

Dr. Sam Malcomson on Professional Responsibility as related to Patients Rights legislation.

All three have considerable experience in this area. Ms McCague is the head of the litigation section of the Advocate Resource Centre for the Handicapped. She is a co-author of the forthcoming *Mental Health Law in Canada*. She is a member of the Ministry of Health ECT Review Committee and a member of the evaluating committee for the Psychiatric Patient Advocate Office.

Dr. Tyrone Turner was the founding co-ordinator of the Psychiatric Patient Advocate Program of 1982-1986. He is currently a resident in psychiatry.

Dr. S.A. Malcomson has been a staff psychiatrist at the Clark Insititute in Toronto. He is a psychiatrist for the Family Courts. Previously he was the Director of Mental Health for Prince Edward Island. Currently he is Psychiatrist-in-chief and Director of the Queen Street Mental Health Centre.

Following the panel discussion there will be a discussion on the need for an MRG position and resolution.

#### Newsletter Deadlines

The publication date of the next MRG Newsletter is June 5, 1987. The deadline to submit items for the issue is May 18. Longer opinion and feature articles should be submitted earlier, by April 30.

The publication date for the subsequent issue is August 7. The deadline for that issue is July 20. Longer opinion and feature articles should be submitted earlier, by June 25.

# Background: Ontario government news release on Mental Health Act amendments Mental Health Amendment on Treatment of Psychiatric Patients

Toronto, January 28 -- An amendment to the Mental Health Act aimed at balancing patients' rights with their need for treatment was introduced today by Health Minister Murray Elston. It would replace an amendment in Ontario mental health legislation made last month.

In December, an amendment to the Mental Health Act was passed, as part of Bill 7, removing any means for a physician to treat an involuntary psychiatric patient when that patient had refused treatment, or, in the case of an incompetent, involuntary patient, when a relative refused.

"That amendment had been defeated earlier in committee but was later brought back to the House and passed in third reading without a great deal of discussion," Mr. Elston said. "It has raised many concerns in this province not only among health care professionals but among the families of many patients who should be treated."

The legislature agreed to delay implementing the amendment until April 1, this year, so that its impact on psychiatric care in the province could be assessed.

The Ontario Medical Association and the Ontario Psychiatric Association have both expressed strong reservations about the change in legislation. In addition, mental health experts from across Canada recommended last fall that the current Ontario provisions--which permit doctors to order treatment despite an involuntary patient's objections--be adopted in the Uniform Mental Health Act, which will be presented to the Uniform Law Commissioners of all provinces later this year.

In Ontario, when an involuntary patient or their relative refuses treatment, the current procedure is as follows:

– Three physicians, at least one of whom is a psychiatrist not on staff at the treating hospital, examine the patient and must agree that treatment should proceed.

– The attending physician then applies to the Psychiatric Review Board for a treatment order. The review board holds a hearing at which the patient has the right to be present and represented by counsel. If either the patient or the physician wish to challenge the board decision, both have the right to appeal to the courts.

"It is my conviction that, with a number of additional safeguards, this mechanism can be adapted to protect both the rights of involuntary patients and the need to treat major psychiatric disabilities," Mr. Elston said.

The proposed amendment would maintain the authority of the review board to authorize treatment for an involuntary psychiatric patient under certain conditions:

– During the first stage of seeking approval for treatment, the physicians who examine an involuntary patient will be required to give reasons why they believe the patient will not improve without treatment and why the review board should issue a treatment order.

– Second, in granting authority to proceed with treatment, the review board must specifiy the period of time for which the treatment order is effective. The board may also include terms and conditions under which treatment is to be provided.

– Third, during the course of any appeal by a patient or relative with regard to treatment, treatment will not proceed unless a judge of the court rules otherwise.

Electro-convulsive therapy will be excluded from review board authority. In order for ECT to be given, the consent of an involuntary patient or their representative **will** be required under the new amendment.

# Working Group on AIDS

AIDS has been and will continue to be a very controversial and emotionally charged issue. The solutions to the problems raised by AIDS are not arrived at via the same principles as those used to deal with most other medical problems. Rather than being based primarily on sound medical princples, the solutions are heavily influenced by the predominant social, moral and political climate of the day.

It is therefore very important that groups with enough political and medical sophistication to encourage solutions that are primarily based on sound medical principles enter the debate on AIDS related issues.

To do this effectively a group must recognize the quickly evolving nature of AIDS. This means that the group must often be able to work out positions quite quickly so that it can take a timely stand on an issue.

Because of this I am suggesting the formation of an MRG working group on AIDS, which would help the MRG Steering Committee address the pressing and challenging issue of AIDS.

Some of these issues are already demanding our attention, so anyone interested in becoming a member of this working group please contact me promptly so that we may have our first meeting as soon as possible.

Thanks
Steve Hirshfeld
(416) 925-7221 (H)
(416) 252-6475 (W)

# Community Health Centre seeks board members

West Central Community Health Centre is looking for new board members. West Central C.H.C. operates two non-profit clinics, in Alexandra Park and Niagara neighbourhoods, and offers a broad range of medical and dental programs to the individuals in the area, many of whom might otherwise not have access to them. We have an active community-based board and would love to have you join it if you are interested in this model of care provision and have the time. Please contact Fiona Chapman at 392-7912 for more information.

# Ministry of Health pamphlet

The Ontario Ministry of Health has published a short pamphlet: The Health Care Accessibility: What it means to you. The pamphlets are intended for waiting rooms and public information locations. They are available free, and in quantity, from Health Information Centre, Communications and Information Branch, 9th floor, Hepburn Block, Queen's Park, Toronto, Ontario M7A 1S2.

**1986 AMENDMENTS TO THE ONTARIO MENTAL HEALTH ACT**
By Way of Attorney General's
Equality Rights Statute Law Amendment Act, 1986 - Bill 7

**NOTE: AMENDMENTS TO SECTION 35(4)(a) OF THE MENTAL HEALTH ACT, WITH RESPECT TO THE REVIEW BOARD'S AUTHORITY TO MAKE TREATMENT ORDERS, WILL NOT BECOME LAW UNTIL APRIL 1, 1987.**

| ITEM | BEFORE | NOW |
|---|---|---|
| Reviewability of patient incompetency findings by physicians | There was no mechanism for challenging a physician's determination that an involuntary patient was mentally incompetent to make treatment decisions. In contrast, a determination of incompetence to manage one's estate could be challenged before the review board. | (1) An involuntary patient may now also challenge before the review board a physician's determination that the patient is mentally incompetent to make decisions regarding treatment.<br>(2) All patients may challenge a finding of mental incompetency to make decisions regarding disclosure of their clinical records.<br><br>Sections 29a(14) and 35(2a). |
| Age of consent | Eighteen years. | Sixteen years.<br><br>Sections 1(j), 29, 29a and 35. |
| Potential substitute decision-makers for an incompetent patient | List for determining "nearest relative" included legal spouse, children, parents, guardian, etc., but not common law spouse. | List broadened to include common law spouse, as defined in the Act.<br><br>Sections 1(j)(ii), 29(3a) and 35(7). |
| Maximum period of detention for assessing whether involuntary committal criteria are met (Form 1) | 5 days (120 Hours). | 3 days (72 hours).<br><br>Section 9(5)(b) and 14(3). |

| ITEM | BEFORE | NOW |
|---|---|---|
| Patient access to clinical records | Patients' access to their own clinical records was entirely at the discretion of the officer in charge of the psychiatric facility. The same was true in the case of a nearest relative acting on behalf of a minor or mentally incompetent patient. | A mentally competent patient sixteen years of age or over is entitled to examine or copy his/her clinical record, subject only to limited exceptions as follows: If the physician believes that disclosure of the record is likely to cause:<br>(1) serious harm to the treatment or recovery of the person while in treatment at the psychiatric facility, or<br>(2) serious physical or emotional harm to another person,<br>the officer in charge, on the advice of the physician, may apply to the review board for authority to withhold all or part of the record. The review board is the final arbiter.<br>For a child, or a mentally incompetent person, the nearest relative may access the clinical record, on the same terms as a competent person on his/her own behalf.<br>Section 29a. |
| | No statutory right for patients to request correction of information in their clinical record or noting of disagreement regarding the information. | A patient who is allowed to examine his/her record may request that information be corrected or require that a statement of disagreement be attached to the record.<br>Section 29a(13). |

| ITEM | BEFORE | NOW |
|---|---|---|
| Access to Clinical Records by Legal Counsel or Agent | For an incompetent patient or a minor, it was necessary for counsel to obtain consent from the nearest relative for access to the clinical record. In addition, it was necessary to receive approval of the hospital administrator. | For an incompetent patient or a minor, counsel may have access to their client's clinical record. In addition, counsel may disclose all or part of the record to the patient. The above is subject to harm provisions outlined in subsection 29(6),(7).<br><br>Section 33d(2). |
| Criteria for the use of restraint and documentation thereof | Restraint measures could be used to keep a patient under control. There were no legislated criteria as to when such control could be exercised.<br><br>There were no legislated requirements regarding the documentation of restraint. | Restraint measures can only be used to place a patient under control and only when necessary to prevent serious bodily harm to the patient or to another person. Section 1(r)<br><br>The use of any restraint measure must be precisely documented in the clinical record. Special documentation is required where chemical restraint is used. Section 35a(1) and (2). |
| Written notice to a patient and to the area director of Legal Aid | Written notice requirements applied only to involuntary certification (Form 3) and renewal of such certification (Form 4). | A physician must now also give written notice of the right to a review board hearing to a patient and to the area director of Legal Aid when he/she has determined that a patient is mentally incompetent (1) to consent to treatment, (2) to examine his/her clinical record, or (3) to manage his/her estate. (See new Forms 33 and 34 for written notice.)<br><br>Section 30a(1a),(2). |

| ITEM | BEFORE | NOW |
|---|---|---|
| Right to a hearing for a child between 12 and 15 years of age inclusive | A child under age 16 could be admitted to hospital as an informal patient on parent/ guardian authority, with no possibility of independent review of the placement. | Where a child age 12 to 15 inclusive is admitted as an informal patient (i.e., under parent/guardian authority), the officer in charge of the psychiatric facility must give written notice to the child and to the area director of Legal Aid concerning the child's right to a review board hearing. The review board automatically holds a hearing after 6 months if no application has been made in that period.<br><br>Sections 8a and 30a(1b), (2). |
| Ensuring that a committal certificate that comes before a review board or court is currently valid | The statute was unclear as to whether a hearing or an appeal froze an existing committal certificate until the tribunal rendered its decision. | Provision has been made for extension of committal certificates and appeal processing periods in order to allow an appeal or a hearing to proceed. If a certificate is allowed to expire before a hearing or appeal decision is rendered, the hearing or appeal is deemed to be abandoned.<br><br>Sections 32, 32a and 33f(1c)-(1i). |
| Timeliness of review board and court processes | The review board had one month in which to hold a hearing and render a decision.<br><br>No time requirements were set out relating to the appeal process. | The review board has seven days to convene a hearing. The decision must be given within one day of completion of the hearing, and written reasons must be given within two days thereafter. The statute also sets time limits for certain steps in the appeal process.<br><br>Sections 33b(2); 33c(1) and (3); and 33f(1a) and (1b). |

| ITEM | BEFORE | NOW |
|---|---|---|
| **NOTE: THE FOLLOWING AMENDMENTS HAVE BEEN INCLUDED IN BILL 7; HOWEVER, THEY WILL NOT BECOME LAW UNTIL APRIL 1, 1987.** | | |
| Ability to override a patient or a relative's decision with respect to treatment | An order could be made by a Review Board to provide psychiatric treatment to an involuntary psychiatric patient where:<br>(1) the patient is mentally competent and refuses the treatment;<br>(2) the patient is not mentally competent and a relative refuses the treatment; and<br>(3) the patient is not mentally competent and there is no relative available to make a substitute decision. | The Review Board now has authority to make treatment orders only for patients who are not mentally competent and there is no relative available to make a substitute decision.<br>Section 35(4)(a) |

# Learning Political Science With the MRG

Membership in the MRG can lead to unexpected forms of further education. The Patent Act has provided some delightful insights into the federal government under the Mulroney administration.

"The only (physician) group which has been opposed (to the changes in the Patent Act) are the Physicians for Social Responsibility. They're very left-wing, very hysterical in their approaches."

The above quotation appeared in the Medical Post from the distinguished non-hysterical right wing Minister of Consumer and Corporate Affairs Harvie Andre. Unfortunately for him, he mistook himself. Physicians for Social Responsibility (which in fact has been renamed and does not even exist) takes no position on the Act. He was doubtless intending to attack the MRG.

We have had the opportunity of meeting with the last two Ministers of Consumer and Corporate Affairs Michel Cote and Harvie Andre. Significantly we have not met with Health Minister Jake Epp, who is not involved with the legislation at all. Cote met with a delegation from the Canadian Health Coalition at an early stage, before it was certain the bill would even be introduced. As a politician he struck one as smooth. Most of the discussion from the government side was conducted by an aide, so that Cote did not have to reveal his thoughts.

Harvie Andre was a different proposition. He summoned a variety groups to consult with him on the Act (at their expense). We met with him alone except for a secretary taking notes. His approach was to try to give a patronising presentation about the need for the Act, in terms that might have been appropriate for a lunch meeting of the Calgary Rotary Club. Patents, we were assured were the basic foundation of industrial prosperity in the Western World in the past four hundred years. "Everything in this room is the product of Research and Development he proclaimed to us, as we looked at the potted plants and tried not to smirk.

It is impossible to know what goes on behind the scenes and who decides on which organisations are allowed to present their positions. Strangely, despite our apparently hysterical left wing views we seemed to have much less difficulty than such bodies as the Ontario Ministry of Health in getting to present our views.

We put ourselves down as requesting to make a presentation to the Parliamentary Committee looking at the draft legislation. Somewhat to our surprise, we were asked to appear; we had initially been told that only national organizations were going to be heard. We became aware of the strange politicking in the Committee regarding who was to be heard. At three days notice we were told that we had a hearing on February 3rd 1987 at 10:30 a.m. When we arrived, we discovered that the organization of the Committee was poor and we would have to appear at 3:00 p.m., necessitating a change in flights back to Toronto.

The Committee consisted of five Conservatives and one each from the Liberals and NDP. Naively one expected that a hearing on a proposed Act might be a chance for members to learn about a specialised field with a view to improving their legislation. But the Tory approach was to try to discredit unsympathetic witnesses. In the morning there was a delegation from the National Federation of Nurse Unions. The Conservative questioning was hostile and belittling. They also tried to take the same line with the MRG, asking about membership, but one notes that they tended to be more respectful and cautious towards practicing doctors.

The partisan approach was sufficient to be noted in a column by Joel Ruimy of the Toronto Star, which mentioned the MRG by name as a body worthy of greater respect.

To confirm the impression of poor organization, on Monday February 9th we received another phone call from the Committee Cleark asking us to appear the following day. Attractive as it would have been to come back for a rematch, we pointed out that we had already had our say and suggested that they check to see if there had been an oversight.

**Robert Frankford**

Robert Frankford is a member of the MRG Steering Committee.

# Report from the sub-committee on extra-billing

We have been working throughout the fall and winter, in touch via correspondence and delegation meetings; with the College, the Ministry, media (mostly newspapers), the NDP health critic David Cooke, in an attempt to gain information about the situation and assess our most appropriate role. It became clear that most of the focus centred on the "illegal" extra charges – discussion in the provincial legislature; reports in the Globe regarding the extent and amount of reimbursement that the general manager of OHIP has so far provided; the fact that no physician has yet been prosecuted in regards to the legislation. So we turned our own focus to the issue of the "legal" fees i.e. charges for items not covered in the OHIP schedule. Our task became increasingly frustrating – without our own resources to research the issue fully we were unsuccessful in trying to interest any of our 'network' groups in taking on the job (a big one) of canvassing or polling family physicians and/or specialists for this crucial information. We have some gathered evidence in our own files, but realize that we cannot yet confirm our impression that the levying of administrative fees is very widespread, perhaps even more so than before the passage of Bill 94. Responses from a few media outlets, regarding our request for more research/exposure of the issues, are still pending.

Please continue to inform your own patients of their recourse to either the general manager of OHIP (for reimbursement) or to the College, if they have been 'extra-billed'. And please continue to submit to us, confidentially of course, any letters or statements of extra charges that your patients are willing to contribute to our data.

**Mimi Divinsky**
**597 Parliament Street, # 203**
**Toronto, Ontario**
**M4X 1W3**

# Feature Articles

The following feature articles are intended to contribute to a discussion of issues. They do not necessarily represent MRG policy. Letters, rebuttals, and original articles are welcomed. Please send them to: MRG Newsletter, P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8.

## 'Alternative' Therapies—a challenge

I believe that the MRG must recognise a new menace to our health care system and the concept of rational medicine that we espouse. This is the alarming growth of the 'alternative' health delivery industry. I am speaking of the forms of quackery we see today—so-called naturopathy, homeopathy, clinical ecology, and their latest gimmicks: systemic candidiasis and total allergy syndrome (20th century disease).

This article is not a scientific repudiation of these practitioners—I will assume as rational people, MRG'ers already recognise the double-speak necessary to justify these therapies. Let me put some perhaps disjointed thoughts forward, however.

There are a number of different rationales these practitioners use to justify their approach:

...natural is better—while intuitively this sounds good, reality is a hard taskmaster. Many poisons and carcinogens are natural substances. While we would all oppose unnecessary additives and chemicals (and there are far too many) we must not assign to 'natural' a mystical connotation. Is 6 gms daily of Vit C natural? Is ascorbic acid manufactured by Swiss Herbal more natural than that by Roche Pharmaceuticals?

...old is better—traditional Western (or allopathic) medicine is definitely guilty of being close-minded and unwilling to investigate the possible benefits of certain alternative therapies. We in the MRG would chastise researchers and the medical establishment for not looking at all sources for medicinal agents including some of the traditonal herbs and techniques such as acupuncture. But just because there is a 1000 yr history of a treatment does not, unfortunately, attest to its merits. Pulse diagnosis was used in China for centuries because physicians were not permitted to undress and examine their patients. Whether or not it has any merit, pulse diagnosis arose out of a necessity based in irrationality—do we now elevate it to a virtue? Was bleeding used as a therapy for centuries because it worked? Do we assune that because all of recorded human history is patriarchical that women cannot be equal?

...holistic is good—here I agree entirely. We in the MRG have by self education around socio-economic and occupational isssues tried to become more holistic. We try to do complete social and physical histories and examinations. I have seen many patients who have seen 'holistic' practitioners and have never had a proper personal and family history done. Is pulling out a strand of hair and subjecting it to chemical analysis holistic (or 'natural' for that matter)? Why do we allow these practitioners to usurp the title 'holistic'?

Why do people seek the services of these practitioners? One very important reason is obvious. We live in a difficult and complex time. People feel out of control. My patients are unhappy when I tell them 'I don't know' or 'I'm sorry but there is no treatment'. Although these people profess that they want honesty from their doctor—they really don't, they want answers. Although progressive people rail against control of our society by arrogant experts—they place themselves obediently in the hands of practitioners who claim answers for everything, who ask them to believe so much in them that the patient would be willing to make draconian changes in their lives to comply with therapy. And this they do devoid of any criticism and with little real explanation.

If I prescribe Penicillin I am asked for a detailed list of possible side effects and questioned as to the necessity of the medication. But these same people take on faith dozens of pills from a 'drugless' practitioner and when I ask them, have no idea what side effects there may be—after all, it's all natural (of course Penicillin never really came from moulds). If these people were this uncritical of politics we would live in a fascist state.

And arrogance! I am humbled by the complexity of the biological ecosystem in which we live. Not so our brave alternative practitioner! Go on a starvation diet, flush your system with mineral water, rid your body of 'toxins' and unwanted bacteria. Then take bacteria in oral tablets to replenish your system the right (?natural) way. I am astounded by the arrogance with which these practitioners blunder ahead. Do you know so much medicine that you would attempt to reconstruct a human's flora?

What is a drug? Is not any chemical taken internally to affect a physiological change a drug? If zinc or Vit C is taken under the promise of curing acne or a URI, are they not drugs? Healthsharing, a feminist health magazine once ran an issue on 'drugless' practitioners. They documented the case of a woman with menstrual cramps who was put on naproxen for dysmenorrhea (bad) and compared this to the 'drugless' approach of 6 megavitamins, 2 megaminerals, and 2 herbal medications (good). The latter woman took 10 different pills daily and was a testament to the effectiveness of a drugless approach.

There are real political dilemmas that arise from 'alternative' medicine.

In as much as it mystifies normal human physiology and

misinforms its customers it is anti-human. If we equate knowledge with a first step to power then it is oppressive.

In as much as most of its customers are female, it is anti-women. This is a whole area of further research which I, personally, am interested in. It is not coincidental that women are preyed upon by these people.

In as much as most of it pursues almost exclusively individual solutions to social issues and phenomena, it enhances alienation and moves people out of the political forum and into the personal arena.

In as much as it seems to encourage blind faith in it methods, it stifles rational thought and therefore retards progressive action.

But why should the MRG enter the fray? To date "alternative" practitioners have been under attack exclusively by the medical establishment. The public, partly correctly, perceive this as simply a turf issue. But a progressive group with our history could enter the arena with clean hands. Our mandate is to further peoples' control over their lives by demystifying right wing medical propaganda.

I hope I have demonstrated how 'alternative' practitioners mystify and how much of their ideology lies within the framework of historically regressive ideologies—albeit temporarily formally espousing 'progressive' language.

How we are going to reach people is very problematic. How not to sound too conservative while carrying the progressive torch? 'Alternative' therapies rely on a belief system and the converted are therefore not subject to the usual rational argument. Believing that baked bread, with no demonstrably viable yeast, can cause 'chronic candidiasis' is not something that we can easily counter.

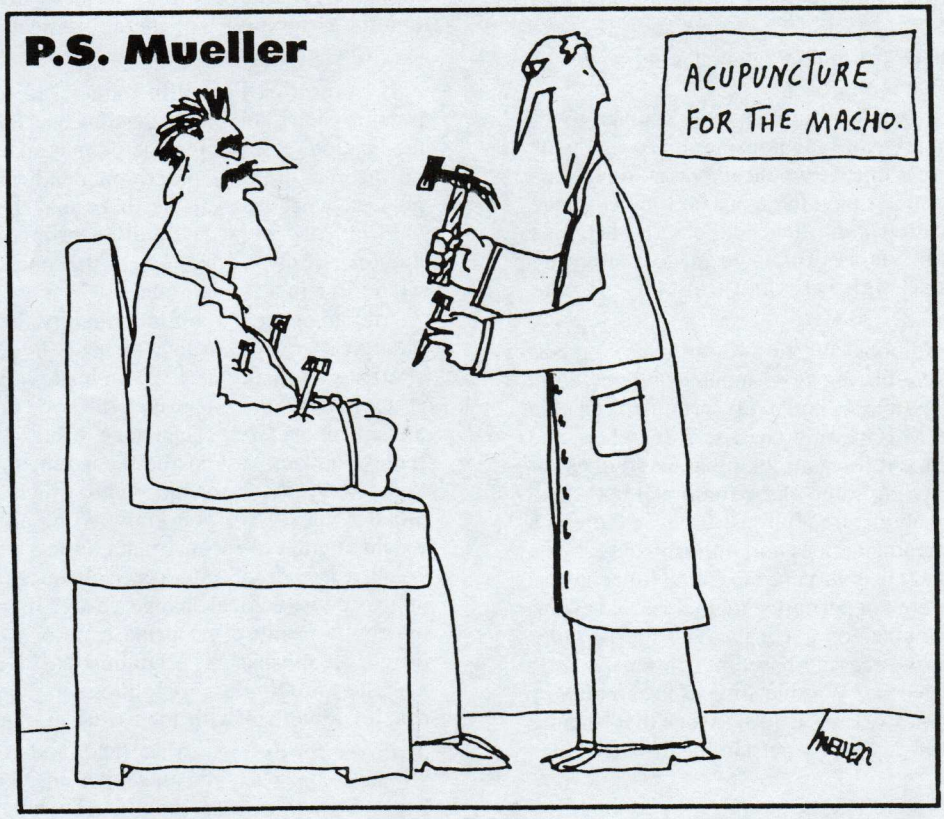
We may hope, however, to catch those people who are flirting with these ideas or perhaps those otherwise sane people who in the honest mistrust of the medical system and their need for personal security would ignorantly run from knowledge and understanding into the arena of doublespeak, blind faith, and an escape from freedom and ultimately into further self denial.

I really don't think all this can be dismissed as middle-class mishigas*. These ideas are increasingly finding an audience in the media and are becoming symptomatic of a growing individualism in our society.

*Mishigas: craziness

**Fred Freedman**

Fred Freedman is a member of the Medical Reform Group.



# The British Columbia Billing Numbers Dispute

**The recent attempts by the British Columbia government to restrict billing numbers has been defended on two principal grounds – that of rising medical costs and of inappropriate distribution of physicians through the province. Adequate discussion of the narrow issue of the dispute then demands some consideration of wider problems. The following tries to briefly:**

**1. review some of the suggested causes and solutions for rising costs.**
**2. discuss some political background**
**3. then discuss the recent B.C. billing dispute.**

### Suggested causes and solutions
### A. Cures versus prevention

Two *distortions* of the line "prevention is better than cure" are current. A *distortion from history* follows McKeown's argument(1): "Clearing of slums, provisions of running water, adequate sewage, decent nutrition eliminated TB in the 1920's, not new technology...Simple, cheap, non-technical solutions can be adopted to eliminate modern day diseases."

But this reasoning may not apply to all present day diseases. Argument continues about the exact contribution of diet to Ischaemic Heart Disease. In other areas the situation is even less clear. Respiratory Distress Syndrome in prematures is an important cause of morbidity and mortality in childhood.(2). Effective prevention of premature labour (thereby preventing RDS and other adverse perinatal events) is not yet possible. The most radical "prevention" could be argued to be eradication of gross poverty. However such a "Maximalist" solution is currently unlikely. Preventive interventions, often praised as cheap and simple are sometimes technical and expensive e.g. prevention of newborn metabolic diseases. It is not that prevention is undesirable, but it may not be enough or cheap. There is also an ethical issue for the physician faced with an individual patient; prevention for such an individual becomes academic.

The second *distortion is the shift of responsibility from governments to individuals.*

This happened in the National Health Service (NHS) in Great Britain after many decades of underfinancing. Suddenly if one does not "prevent" ill health by running, attacking squash balls or otherwise throwing oneself into paroxysms of exercise myoglobinuria then "it is your responsibility". This is an example of a reactionary government's adoption of a pseduo-radical slogan: "Health – everybody's business". This line in effect blames the victim. What implementation has there been of preventive measures that touch company profits – such as smoking or unemployment or accidents at work? All these issues induce a strange neglect by governments.

### B. Physicians are useless – The Ivan Illich Effect

It is said that the physician does little true "medical" work, defined as diagnosing and treating, etc. However the physician who identifies the 40 of truly physical ailments (?more ?less) is still socially useful. Areas of work traditionally those of the physician may ultimately be performed by a different individual. But neither the scale nor limit nor training of such replacements has been defined. Further isn't the "caring" function of physicians relevant any longer?

Extending the argument into cutting physician numbers assumes: -that "unnecessary" physician costs are the real culprit for rising medical costs. "Physicians order new expensive tests leading to new and expensive treatments, which may or may not work, but which gratify the egos and salaries of physicians". But some would argue that the major reasons for inflation of costs were new medical procedures. (3) Many treatments do work, and cabinet ministers and economists interested in cutting back "unnecessary" items of health care often receive them

Rooted in rejection of a very common, real arrogance of power in the medical profession the Illich Effect usually ends up throwing out the baby with the bathwater. Abuses of power have to be curbed but this is a separate issue.

### "Rising, Unreal" expectations of health

Should something good enough for one generation serve as the standard for future generations? If this is *not* true of technology in other areas of life: transport, writing, photography, cinema, agriculture – why should it be true of medicine? Can one prevent technological change? The last 40 years or so have certainly dampened enthusiasm for the goddess "Progress". But abuses of technology for political/economic motives often explain misuse of technical innovations. Luddites vainly opposed technological changes in the 18th century. *Medical Ludditism* may be a real danger of some cost containment strategies. Parents of premature infants have radically different notions of care from ten years ago. Can we now retreat from therapy of such infants? Renal dialysis and transplantation is a new technology now part of health expectation. In Great Britain racked by "economic crisis", renal dialysis is now marketed. This is because National Health Service access to diaysis for the under 12's and over 60's is limited on grounds of cost reduction.(4) Elsewhere a forceful view on the general implications of health rationing for the "non-productive elderly" has been put.(5) Before I am accused of thoughtless technocracy ("a CT scanner in every practice") scientific debate about the merits of new therapies must continue. But with full understanding of the political forces that impel cost-cutting.

### A Political Framework
### 1. Health of the larger economy

From government figures, Canadian spending at present is not far off line from that of other governments, when calculated as a ratio between Gross National Product per head of population and total health care expenditure per head. That is considering that the nation at the moment is "relatively wealthy", the amount spent on health is *not* astoundingly large.(6)

It has to be asked: "whose problem is this anyway, and why has it surfaced with such apparent urgency?" I would deny that it is the *whole* of society's problem. A society where individual profits are made at current levels(7) does not make decisions impartially for (FIall of society. Furthermore government which make decisions on relative expenditures (e.g. defense dollars versus health dollars) without explicit debate cannot be fully representative. There has been no large scale debate about the implications of renal diaysis, liver transplantation policies; or the health cutback

implications of continued missile testing. I suggest that this should be a prerequisite for major policy decisions, though admittedly difficult to implement. I do not accept the arrogance of policy planners and politicians who deny the ability of the population.

The increasing urgency perceived by governments in current health costs reflect current and likely turmoils in their economies. Current U.S. policy debates are dominated by the budget deficit and awareness of impending trade war. The implications are not lost on Canadian politicians, who wish to clear their economic decks. But it is increasingly politically dangerous for governments to be seen to cut health services. Rhetoric about "tightening our belts" faces limits. The objective value (irrespective of their own desires) of theorists who attack medical spending as A. Cochrane and R. Evans, is to allow the cloak of scientific respectability to be donned by cutting politicians.

### How Will Doctors Respond, and Should We Care?

Before tactics in an individual struggle can be discussed, I think it is helpful to consider how individuals of the affected group are likely to respond. Is the group homogenous or are there different interest groups within the group? Can factions be drawn to a progressive stance? Some progressive doctors deny that there is any vestige of Hippocraticism in the profession. Often they feel that doctors are so mercenary and powerful, that they are automatically on "the other side". Is this the case? What social group can they be part of anyway?

Physicians mostly do not employ a large number of individuals. By current definitions then they are not capitalists. Even the richest physician (??earning $300,000/year) is not in the league of those capitalists who often determine state responses. Yet most physicians are not totally employed/salaried, and do not fit perceptions of a "working class"—least of all to themselves! They are in a peculiar midway stage, subject to the whims and pressures of those above and those below themselves. They share many essential detials with the individuals shop keepers, who are labelled petit-bourgeois.

A fundamental belief/illusion of this class is in "individual freedom". If only they can be liberated from the directives of the capitalist class and the imperative needs of a labouring class (the overwhelming mass of people who work as employees) then they could "be their own boss" and achieve optimal living conditions for themselves.

By this light the frantic desire of the petit-bourgeois physician for "independence" is understandable. To them the alternative is submission of conditions of work to monopoly employers—including the state. Doctors in Great Britain who worked for the Poor Law Commission felt this for instance(8), as did doctors in the U.S.A. who worked for private companies.(9) Presently U.S. physicians are again being put into this position, working for efficiency minded corporations. A comparison can be made of the corner shop owner being taken over by the monopoly chain Loblaw's.

Such a desire for "independence" is unrealistic and false, e.g. drug decisions are subject to pressures from multinational companies. This unrealistic desire may lead the petit bourgeois into confrontation with reality. We saw this recently with the Ontario strike. The usual ideology of the petit bourgeois—independence, self reliance, material reward orientation—makes them peculiarily susceptible to demagogic reactionary movements. Because of the associated beliefs of the petit bourgeois they are vulnerable prey to specious and high sounding but eventually meaningless phrases such as: "freedom in medicine", "independence for physicians" etc.

However this class is not homogenous. *Possibly,* at least a large minority of physicians could be won to a progressive viewpoint. The poor support of physicians for the recent strike in Ontario illustrates this. In Canada, probably at least a significant minority of physicians believe in an open and accessible health service funded by central taxation. It is often forgotten that at the time of the NHS inauguration in Great Britian, a significant number of pro-NHS physicians were actually recorded by the British Medical Association (BMA) polls. In the main these were hospital based consultants, young GP's, and many had vivid recollections of the Poor Law Commission. The BMA of course were disappointed by these results.(8)

### B.C. Billing Dispute

Progressive objectives in this dispute should be to ensure democratic and effective delivery of health care whilst neutralising reactionary demands of the traditional leadership of physicians. This is best done by an appeal to the best interests of the population. I would hope in the process to convince the best elements of physicians that ultimately any possibility of actually achieving "independence" lies in allying with the progressive sections of society. I would therefore argue:

Any state has a mandate to ensure medical coverage of remote areas whilst maintaining fiscal solvency. Furthermore the state already intervenes in the supply of physicians by creation of hospitals, funding of staff physicians, etc. and by medical school funding. Any centralised state is mandated to control sources, funding and location of any industry or services. This has to be achieved considering a demonstrated need, efficiency, geography and supply of raw materials. Obviously modern day Canadian society does not operate as a traditional laissez-faire capitalism.

In principle therefore the B.C. legislature and judiciary are correct to impose billing number restrictions on physicians.

However it is tactically clumsy, provcative, and ultimately counter-productive, to legislate on restriction of billing numbers.

**Without first**

i) Clearly demonstrating the "need" to do so.

Almost invariably in capitalist states, "rationalisation" is in the direction of cost-cutting. This exercise is often performed amidst demagoguery, without clear demonstration of necessity for "rationalisation". Academic economists may be convinced of the need, I am talking of a more accessible demonstration.

ii) Obtaining an electoral mandate from the population following: Full discussion of the priority of public expenditures; the division of the total tax revenue between competing choices of welfare, health, housing, defence, industry, etc.

This discussion should entail justification of profit margins of health related industries—drugs, chemicals, hospital supplies, industrial pollution, hospital equipment, hospital contractors, etc.

iii) If then it is accepted that a genuine crisis exists, this has to be carefully explained and possible alternatives discussed with physicians e.g.

a) depression of salary scales of insurance coverage
b) other cost cutting in ways that impact on the physician but not the patient, e.g. ceilings on number of patients that could be enrolled by one physician's list. This is any case is totally defensible on grounds of patient care standards.
c) financial incentives to settle and work in under-doctored areas, compulsory physician rotations through under-doctored areas etc.
d) cuts in number of medical school enrollments
e) restriction of billing numbers to all medical graduates from a fixed future date. Thus future medical students should be aware of limitations they would face. This avoids penalising individuals who trained under different expectations.

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THE GLOBE AND MAIL, WEDNESDAY, MARCH 25, 1987

# Challenges to hospitals under Charter are predicted

**BY ANN SILVERSIDES**
The Globe and Mail

Hospitals and provincial governments will face a rash of legal challenges from patients under the Charter of Rights and Freedoms, constitutional lawyer Morris Manning predicted yesterday.

The right to refuse treatment will probably emerge as one of the most important issues, Mr. Manning told an Ontario Hospital Association conference.

But the challenges will also involve issues such as which patients receive organ transplants and whether hospitals can justify physically restraining patients, the lawyer said. He acknowledged that he was engaging in "crystal-ball gazing."

The refusal, or termination, of doctors' hospital privileges will probably also be on the agenda, he said.

Mr. Manning told the Toronto meeting that, in his view, there is no question that the courts will ultimately decide that hospitals, which have a close relationship with government, are subject to the provisions of the Charter.

Those who run hospitals must, therefore, "acquaint themselves with the notion" that individual rights are sometimes in conflict with the way hospitals are run, he said. In order to protect themselves, hospitals must draw up procedures for instances where there is a conflict, he advised.

"Real problems" will emerge when, for instance, a Charter case revolves around the right of a person, who is not a danger to others, to refuse treatment, Mr. Manning said.

He cited the example of a schizophrenic who may behave in a bizarre manner and may be out of touch with reality but who poses no threat to others. "I don't think that today . . . you can force such a person to have treatment for their own good."

The difficult question is what to do with such people, he said. Does a hospital become a custodian, allowing the person to occupy a bed in an institution and take up valuable resources, or does it run the risk of treating the patient and leaving the matter to be settled in the courts? Mr. Manning asked.

Such cases pose serious dilemmas because of the financial pressures on hospitals and the health care system, he said.

If a challenge involving patient restraints is launched, administrative convenience would not be accepted as justification for the action, he said. "If patients are being restrained so that staff can go off on a coffee break, I think that would be held to be unreasonable. . . . Hospitals will have to demonstrate that it is not for mere convenience that patients spend their days (tied into chairs) and staring at the walls."

## Novel law enforcement

Your article Extra-Billed Patients Given $7,000: No Action Taken Against Doctors (Jan. 29) gives us insight into advances in law enforcement and crime prevention.

We are informed that although many Ontario doctors are acting illegally in extra-billing patients, "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."

What a novel approach. Perhaps police departments should consider its merits in dealing with offences such as drug trafficking, drunken driving, convenience-store robberies and so on. Or are there two approaches to law enforcement and crime prevention — one for the doctors and one for the rest of us?


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Globe + Mail
Feb. 16, 1987

# The MRG Brief to the Parliamentary Committee on Bill C-22 January 1987

INTRODUCTION

The Medical Reform Group believes that the question of patent protection for pharmaceuticals cannot be viewed in isolation from other issues surrounding prescription drugs. Patent protection is not an absolute right. Granting patent protection for inventions, pharmaceutical or otherwise, is a decision taken as part of a country's social policy. Other aspects of social policy may take precedence over patent protection as we saw in 1969. At that time three major federal reports from the Restrictive Trade Practices Commission, the Hall Royal Commission on Health Services and the Harley Committee had all found that Canadian drug prices were among the highest in the world. All of these reports identified patent protection as one of the major causes of those high prices and recommended substantial changes to the Patent Act as it pertained to prescription drugs. The Restrictive Trade Practices Commission had, in fact, advocated the complete abolition of patent protection for pharmaceuticals. These recommendations on patent policy were made on the assumption that it was more important for Canadians to be able to afford drugs than for companies to have full patent protection on their products. The government of the day agreed with that conclusion resulting in Section 41(4) of the Patent Act allowing compulsory licensing to import.

In proposing to substantially limit compulsory licensing, the current government has to be able to show that the social benefits from those changes will outweigh the costs. Before we examine the costs and benefits of the proposed legislation, Bill C-22, we would like to review the effects of compulsory licensing over the past 17 years.

THE EFFECTS OF COMPULSORY LICENSING.

Compulsory licensing has not had any substantial negative effects on the Canadian subsidiaries of the multinational drug companies. Based on figures in the Eastman Report, in 1983, patent holding companies, that is the multinationals, had lost only 3.1 percent of the Canadian market to generic competition.[1] The accompanying table (Table 1) shows that since 1970 pharmaceutical manufacturing has been extremely profitable in Canada. In an international context, Eastman found that, with the exception of the United States, profit levels in Canada were generally higher than in most other well-developed countries in the world.[2] Comparing overall growth and development in the pharmaceutical industry in Canada relative to that in the United States yields, according to Eastman, "the straightforward conclusion that growth has been more buoyant in Canada than it has been in the United States since 1967."[3]

Although compulsory licensing has not adversely affected the pharmaceutical industry it has had a profoundly positive effect on Canadian consumers of prescription drugs. Eastman calculated 1983 savings due to compulsory licensing as at least $211 million.[4]

Based on this brief analysis, the Medical Reform Group concludes that the 1969 decision to introduce compulsory licensing to import has had an overall positive social benefit. The question thus becomes: will the suggested benefits from the new law be even greater than those presently received?

THE PROPOSED LEGISLATION

I The Benefits

According to an information paper issued by the Department of Consumer and Corporate Affairs,[5] the proposed amendments to the Patent Act incorporated in Bill C-22 have five principal objectives. In sumary these are:

(l) To bring Canadian patent policy in line with that in other developed countries.

(2) To maintain opportunities for growth for generic companies in Canada.

(3) To guarantee, through governmental and Parliamentary reviews, that the pharmaceutical industry's commitments for research and development are met.

(4) To ensure fair-priced drugs for Canadians through the creation of an independent Drug Prices Review Board.

(5) To encourage new investment in research and development and thereby "transform Canada's pharmaceutical sector into a world-class, innovative industry."

These then can fairly be termed the putative benefits of the legislation. We will now examine these five points in detail.

(l) As we pointed out earlier patent protection has to be viewed as part of a country's overall policy with respect to drugs. Comparing just the length of patent protection in Canada with that in other countries is extremely short-sighted. However, that is all the government appears to have done. We have not seen any evidence that the Conservative government has attempted a comprehensive analysis of how patent legislation in other countries fits in with the rest of their policies regarding pharmaceuticals. Changing Canada's patent legislation to conform to that of other countries, without also examining how the rest of our prescription drug policies compare to those in other countries, is merely change for the sake of change.

Virtually all countries except the United States regulate the price of drugs using a combination of policy instruments, one of which is patent legislation.

Presumably, one of the major reasons why the Conservatives wish to extend patent protection is because they, like the multinational drug companies, believe that companies should enjoy the fruits of their labours. It is widely claimed that it costs $50 to $100 million to develop and bring to market a new drug. However, it should be noted that these are world-wide costs. Canada represents about 1.5 percent of the world pharmaceutical market and as such our share of those expenses range from $750,000 to $1,500,000. We can find no evidence to suggest that multinational subsidiaries in Canada are not presently recovering these costs.

Finally, we find it ironic that after so many years of the multinationals accusing the generic companies of getting a "free ride" due to compulsory licensing that some of these

same multinationals will be getting a "free ride" under Bill C-22 because of the efforts of other multinationals. Extended patent protection is being offered to all companies. As long as the overall goals of increased investment and job creation are met all the companies will benefit regardless of their individual contributions to these goals.

(2) The growth of generic companies is supposed to be maintained under the new legislation by allowing them to apply for a compulsory licence after seven years if they agree to manufacture the fine chemical ingredients in Canada. Generic companies are unlikely to start manufacturing fine chemicals. The Canadian experience with compulsory licences to manufacture from 1923 to 1969 shows that only a handful were issued. Part of the explanation for the dearth of compulsory licence applications was related to the costs involved in manufacturing fine chemicals for the Canadian market only. As Eastman pointed out, production of the active ingredients of drugs is characterized by moderate economies of scale. For most drugs, the entire world supply of its active ingredient can be produced in a single plant.[6]

Consumer and Corporate Affairs adds that the generic industry in the United States is experiencing vigorous growth without the benefit of compulsory licensing.[7] American generic firms are prospering by selling drugs on which the patents have already expired. Economics of scale in the Canadian case make this a scarcely viable for our generic firms.

(3) There are no direct provisions in the legislation for holding the multinational companies to their promises about either research and development investment or job creation. The Cabinet review after four years and the Parliamentary review in the tenth year of the legislation are supposed to ensure that the companies have complied with their promises. There are, of course, no guarantees that the new patent policies will be revised whatever the outcome of these reviews.

(4) The Medical Reform Group has no objection to the creation of a Drug Prices Review Board to monitor drug prices, but we foresee problems in its operations. The Board is supposed to use the Consumer Price Index to help it follow price trends. The Royal Commission on Health Services concluded that: "any examination of drug prices requires more intensive inquiry than reliance on the general purpose price index on drugs."[8]

Another factor that the Board is allowed to take into consideration is the cost of making medications. These costs may prove to be difficult to determine because of the possibility of the distortion of costs by transfer pricing.[9]

The Board is also instructed to examine the Canadian portion of world costs related to research on drugs. But research costs, the Canadian portion or otherwise, are very difficult, if not impossible, to ascertain. According to a study prepared for the Pharmaceutical Manufacturers Association of Canada:

> The unusually high proportion of unallocable common costs in the total structure of pharmaceutical costs makes it impossible for prices charged for individual drugs to be directly related to costs of producing those specific drugs. Common costs, such as outlays for research and development or similar overhead activities, are applicable to all products in their totality but not traceable to any product individually and can not be allocated to individual products except in the most arbitrary manner.[10]

The Medical Reform Group is worried about the length of time that it may take the Board to consider the price being charged for a given medication. Although the Board could terminate the exemption from compulsory licensing or order a roll-back in the drug's price, knowing that there would be a lengthy review could give companies an incentive to charge excessive prices. An excessive price before the review coupled to a long review process may allow the company to earn more than a reasonable price over a ten year exemption from compulsory licensing.

We are also concerned that merely terminating the exemption from compulsory licensing may not be a sufficient penalty for charging excessive prices. There is no guarantee that a generic company will apply for a compulsory licence on the product. Furthermore, even if that occurs the information paper from Consumer and Corporate Affairs states that it takes, on average, 2.4 years for the Health Protection Branch to issue a Notice of Compliance for a generic drug.[11] Presumably, during that time the patent holding company would go on charging its excessive price.

Finally, we note that the wording of the legislation does not give the Board any power to control the price at which a new drug is initially marketed.

(5) The Consumer and Corporate Affairs information paper speaks of creating "a world-class, innovative industry" here in Canada.[12] According to Garry McDole, president of Astra Pharmaceuticals Canada Ltd. and vice-president of PMAC, even with that transformation the multinationals would still not start manufacturing fine chemicals in Canada, nor would they engage in exporting.[13] Mr. McDole's statement correlates with a finding by the Department of Industry, Trade and Commerce that Canadian subsidiaries are usually "not encourage or permitted by the head office to assume responsibility for exports of their products."[14]

Large, innovative, research intensive pharmaceutical industries have developed in certain countries for very specific historical reasons. A study by the Organisation for Economic Co-operation and Development goes into considerable detail in analyzing these reasons.[15] The large European companies grew out of firms that began as manufacturers of dyestuffs and organic chemicals and were well established by the mid 1930s. Although the U.S. based companies were relatively small until the beginning of the second World War, the advent of the Hitler regime in Germany caused an exodus of German scientists to other countries particularly the U.S. During the war the demand for anti-infective agents was immense and the United States was the only country in a position to manufacture such materials on a large scale. By the end of the war the American industry was highly prosperous, uniquely experienced in antibiotic production and fully aware of the potential of research. Since the 1950s those countries with a strong indigenous pharmaceutical industry--the U.S., the

U.K., Germany, Switzerland and France--have consolidated their position as the world's major pharmaceutical nations. With the exception of Japan no other country has broken into this elite group. Expecting a simple change in the length of patent protection to substitute for all of these factors shows extremely naive thinking on the part of the government.

The same OECD study also concluded that those countries where the pharmaceutical industry was dominated by multinational subsidiaries were highly unlikely to develop a strong domestic industry. Commenting directly on the Canadian situation the study said:

> An additional factor which must be considered in assessing the relatively low proportion of funds directed to pharmaceutical R & D in Canada is that technology and the results of innovation from parent corporations have been so readily available and so economically attractive in the short term, that the growth of national innovative technological capacity has been severely inhibited.[16]

The Conservatives believe that extended patent protection is necessary to promote increased investment in the Canadian pharmaceutical industry. Member companies of the American Pharmaceutical Manufacturers Association were surveyed regarding the reasons for establishing foreign affiliates. The leading considerations were given as tariff and trade restrictions (listed by 95 percent of respondents as "important"), legal requirement for local production (85 percent) and "better servicing of existing work" (81 percent).[17] Apparently patent protection was not a major factor.

The Conservatives place considerable emphasis on the huge increases in research and development expenditures that will supposedly result from the new legislation.[18] But, it is not even clear that patent protection is the best way to encourage research. Some studies suggest that directly contracting for research services is a superior method for generating research.[19]

The multinational drug companies have consistently maintained since 1969 that they have not been investing in research and development in Canada because compulsory licensing has severely curtailed the lifespan of pharmaceutical patents. The inference is always that research and development spending was growing by leaps and bounds in the pre-1969 era. This inference is not borne out by the facts; total expenditures on research and development in 1967 represented only 3.5 percent of the value of factory shipments and this figure had actually grown to 3.8 percent in 1982.[20]

Any new spending is not going to result in Canada becoming a centre for basic pharmaceutical research. The Eastman Report concluded:

> Canada does not now possess either the scientific manpower or the physical infrastructure that would make it a major world centre for basic pharmaceutical research. Nor, in the opinion of the Commission, would it be wise for governments to seek to create such an environment in competition with heavily supported long-established centres in other countries.[21]

Eastman's opinion is echoed by Astra president Gerry McDole.[22]

For a final comment on the possibility of Canada developing an innovative pharmaceutical industry, the Medical Reform Group would like to refer back to the OECD study we cited earlier. The decision to try and persuade foreign companies to establish research facilities in Canada is termed by the OECD study a **low control** option. According to this study this type of strategy would have a tendency to make drugs more expensive and perhaps rather less safe. The overall assessment of this option is that it is not "particularly attractive."[23] The authors of the OECD study also note that whenever governments have deliberately tried to encourage pharmaceutical innovation, in countries where it only exists on a low level, "the results have been disappointing."[24]

Consumer and Corporate Affairs Minister Harvie Andre believes that more research automatically means better drugs.[25] Any evidence for this belief is lacking. An analysis of important new drugs introduced onto the U.S. market from 1955 to 1973 showed that from year to year there was little change in their absolute number despite a large increase in the overall amount of money being spent on research.[26]

Only 14.3 and 9.1 percent of new chemical entities approved for use in the United States in 1982 and 1984 respectively, represented drugs with significant therapeutic gain. Of 922 new molecular entities under study in the United States at the end of 1982 only 2.5 percent were felt to have the potential for significant therapeutic gain and 87.0 percent were of little or no therapeutic gain.[27] The Medical Reform Group believes that most of the promised investment in research and development will go towards producing drugs in the latter category.

Mr. Andre spoke glowingly of the "3,000 new, high-quality jobs" that have been promised by the pharmaceutical companies.[28] We are extremely sceptical about this promise. In 1980 the entire Canadian pharmaceutical industry employed only 930 people in all of its research and development activities.[29] We find it hard to believe that employment in this area will be increased more than fourfold. Whatever the number of jobs that will be created most of them will be concerned with developing drugs of little new medical value. How well are the talents of the Canadian researchers and scientists going to be utilized? Haskell Weinstein, former acting medical director of the J.B. Roerig Division of Pfizer, deplored what he regarded as a waste of scientific talent:

> A great many extremely fine scientists are employed by these manufacturers. Their talents should not be expended on patent by-passing chemical manipulations, on ridiculous mixtures of drugs, or inconsequential additives to established drugs. Since the number of well-trained capable scientists is severely limited, their potential should not be wasted.[30]

In the same vein, the U.S. Task Force on Prescription Drugs concluded:

> To the extent that an industry devotes a considerable

share of its research program to the development of what have been termed duplicative and noncontributory products, there may be a waste of skilled research manpower and research facilities, a waste of clinical facilities needed to test the products.[31]

Based on our analysis, the Medical Reform Group feels that whatever new investment that is generated will mostly result in unnecessary drugs and a misallocation of Canadian research talent.

In summary, looking at all the proposed benefits from Bill C-22, the Medical Reform Group concludes that their value ranges from nil to minimal.

II The Costs

Although Mr. Andre maintains that the proposed legislation will not cause any rise in the price of existing drugs, he offers no guarantees about the costs of drugs introduced in the future. The Drug Prices Review Board is supposed to ensure that prices charged for these drugs are not excessive, but we have already outlined the problems that the Medical Reform Group sees in the Board's operations.

What is certain is that for most new drugs there will not be any generic competition for the first ten years that they are on the market. As Table 2 demonstrates, the more the number of companies selling a drug, the greater the potential savings to the consumer. Using figures from the Eastman Report, the Medical Reform Group has identified a group of three drugs which had generic competition by 1982 although they had been available for less than ten years. Sales for these drugs in 1982 were $76,435,000. Under the proposed legislation these drugs would not have had any generic competitors. Our estimate of sales of the three drugs in the absence of generic competition, based upon Eastman's research, is $149,873,000. Therefore, on these three drugs alone, generic competition resulted in a savings of $73,438,000 in one year (See Table 3).

There can be no doubt that if the proposed bill is passed that new drugs will be more expensive than they would be under the current system of compulsory licensing. Besides the additional costs to individual consumers and the provincial drug plans, the Medical Reform Group is seriously concerned that higher costs will deter patients from filling prescriptions and thereby adversely affect their health. A follow-up study was done on patients who were taking "essential medication" upon discharge from a hospital in London, Ontario. It was found that almost one third of the time the cost of the drugs was a significant factor in explaining why medications were not taken properly.[32] In a second study, this time of patients discharged from hospital in Halifax, 31 out of 199 did not fill their prescriptions because of the high cost of the drugs.[33]

The Medical Reform Group concludes that there would be significant negative economic and health care costs if Bill C-22 is passed.

CONCLUSION

The current legislation is doing the job it was intended to do, saving Canadians money, while doing little harm to the multinational drug companies. The proposed revisions to the Patent Act contained in Bill C-22 would confer a great benefit on the multinationals, without any reciprocal benefits for Canada or Canadians. Most new research done would be of little medical value; the number of new research jobs promised is highly unrealistic and most of the jobs created would result in a misallocation of Canadian talent; the cost of new drugs would be signficantly elevated; and people's health could suffer. For all these reasons, the Medical Reform Group believes that the greatest social good would result from leaving the Patent Act as it is and we therefore stand by our resolution of October 1983 and call on the government to abandon its plans to change the Patent Act.

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[1]Commission of Inquiry on the Pharmaceutical Industry, *Report* , Supply and Services Canada, Ottawa, 1985, p.158.

[2]*Ibid*, p.277.

[3]*Ibid*, p.68.

[4]*Ibid* ,p.315.

[5]Consumer and Corporate Affairs Canada, *Patent Act Reform: Pharmaceutical Policy*, undated.

[6]Commission of Inquiry, *op. cit.*, p.155.

[7]Consumer and Corporate Affairs, *op. cit.*, p.14.

[8]Canada, Royal Commission on Health Services, *Report*, Volume 1, Queen's Printer, Ottawa, 1964, p.693.

[9]Commission of Inquiry, *op. cit.*, pp.431-9.

[10]J.J. Friedman & Associates, *Pharmaceutical Prices in Canada: Guiding Principles for Government Policy*, Pharmaceutical Manufacturers Association of Canada, Ottawa, 1981, p.90.

[11]Consumer and Corporate Affairs, *op. cit.*, p.4.

[12]*Ibid*, p.2.

[13]D. Westell, "New Drug Law May Not Mean Much Change," *Globe and Mail*, November 11, 1986, pp.B1-2.

[14]Department of Industry, Trade and Commerce, *The Health Care Products Industry in Canada*, Ottawa, 1980, p.5.

[15]M.L. Burstall, J.H. Dunning and A. Lake, *Multinational Enterprises, Governments and Technology--The Pharmaceutical Industry*, OECD, Paris, 1981.

[16]*Ibid*, p.173.

[17]Pharmaceutical Manufacturers Association, *Survey of Potential Effects on U.S. Pharmaceutical Industry of Barke-Hartke Bill S.2592, 92nd Congress*, Washington D.C., 1972.

[18]*Notes for Remarks by the Honourable Harvie Andre*, November 6, 1986, p.1.

[19]B.D. Wright, "The Economics of Invention Incentives: Patents, Prizes, and Research Contracts," *American Economic Review*, 73:691-707, 1983.

[20]Commission of Inquiry, *op. cit.*, p.62.

[21]*Ibid*. p.423.

[22]D. Westell, *op. cit.*, p.B2.

[23]M.L. Burstall, *op. cit.* p.234.

[24]*Ibid*, p.232.

[25]Notes, *op. cit.*,p.3.

[26]B. Teso, *Technical Change and Economic Policy. Sector Report: The Pharmaceutical Industry*, OECD, Paris, 1980, p.36.

[27]Commission of Inquiry, *op. cit.*, p.242.

[28]Notes, *op. cit.*, p.3.

[29]Canadian Drug Manufacturers Association, *Pharmaceutical Patents: Compulsory Licensing. A Case for the Retention of Section 41(4) of the Patent Act*, Toronto, 1983, p.29.

[30]U.S. Senate, Committee on the Judiciary, Subcommittee on Antitrust and Monopoly, *Hearings on Administered Prices in the Drug Industry*, U.S. Government Printing Office, Washington, D.C., Part 18, 1960, p.10254.

[31]Task Force on Prescription Drugs, *The Drug Makers and the Drug Distributors*, U.S. Government Printing Office, Washington, D.C., 1968, p.21.

[32]"Cost Factor in Misuse of Drug Medication," *Drug Merchandising*, 55:12, April 1974.

[33]F.N. Brand, R.T. Smith and P.A. Brand, "Effect of Economic Barriers to Medical Care on Patients' Compliance," *Public Health Reports*, 92:72-8, 1977.

Table 1: Rate of Return on Capital Employed, Before Taxes, 1970-1982

| Year | Pharmaceutical Manufacturing (%) | All Manufacturing (%) | Rank of pharmaceutical industry out of 87 manufacturing industries |
|---|---|---|---|
| 1970 | 20.9 | 8.2 | 3 |
| 1971 | 23.8 | 9.5 | 2 |
| 1972 | 23.8 | 10.8 | 3 |
| 1973 | 22.3 | 15.2 | 11 |
| 1974 | 25.0 | 17.3 | 8 |
| 1975 | 22.6 | 13.4 | 10 |
| 1976 | 19.4 | 11.7 | 13 |
| 1977 | 18.7 | 10.8 | 13 |
| 1978 | 20.4 | 12.8 | 12 |
| 1979 | 24.9 | 16.2 | 10 |
| 1980 | 27.1 | 14.7 | 4 |
| 1981 | 27.8 | 11.9 | 1 |
| 1982(prelim.) | 26.1 | 3.3 | 2 |
| Average | 23.3 | 12.0 | 7 |

Source: Statistics Canada, *Corporation Financial Statistics--Detailed Income and Retained Earning Statistics for 182 Industries*, Ottawa, various years.

Table 2: Effect of Competition on Drug Prices

Ontario 1985

| No. of suppliers of drug | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 10 |
|---|---|---|---|---|---|---|---|---|
| Price of least expensive brand as a percent of most expensive brand | 81.3 | 71.6 | 60.4 | 55.2 | 42.3 | 26.1 | 36.3 | 27.5 |

Calculated from: *Ontario Drug Benefit Formulary*, January 1985.

Manitoba 1985

| No. of suppliers of drug | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Price of least expensive brand as a percent of most expensive brand | 73.5 | 49.2 | 48.0 | 29.4 | 17.4 |

Calculated from: *Manitoba Drug Standards and Therapeutics Formulary*, January 1985.

Table 3: Saving in Drug Costs Due to Generic Competition

| Drug | Notice of Compliance | Actual 1982 Sales ($000) | Estimated 1982 sales in absence of generic competition* ($000) | Savings due due to generic competition ($000) |
|---|---|---|---|---|
| Cimetidine | May 1977 | 44,250 | 86,765 | 42,515 |
| Naproxen | June 1974 | 29,078 | 57,016 | 27,938 |
| Trimetoprim | Aug 1973 | 3,107 | 6,092 | 2,985 |
| Total | | 76,435 | 149,873 | 73,438 |

*Eastman estimated that, in 1982, without generic competition, drugs would have been 49 percent more expensive. (Commission of Inquiry, *op. cit.*, p.317)

# HEALTH NEWS BRIEFS

## Powell Report urges improved access

Dr. Marion Powell, commissioned by the Ontario Ministry of Health to report on abortion access, released her report at the end of January, calling for improved access to abortion services in the province. Powell's report recommended setting up regional abortion centres, expanding services at women's clinics, and sending doctors trained in the procedure to smaller communities. Women seeking an abortion would no longer have to see their own family doctor first, but would be able to go directly to a hospital-affiliated clinic. Pro-choice groups welcomed Dr. Powell's recognition of severe problems in access, but criticized the continuation of therapeutic abortion committees under the propsed new model. The committees are required by the present federal law. In her report, Dr. Powell also noted that while 27,274 therapeutic abortions were done in Ontario in 1985, at least another 5,000 were obtained by Ontario women in freestanding clinics in Canada and the United States. In addition, in some areas women are forced to pay extra charges of up to $500 for administrative fees and equipment.
*Globe and Mail and Toronto Star, January 29, 1987*

## Vander Zalm seeks abortion cutbacks

British Columbia Premier William Vander Zalm has announced his government's intention to introduce measures which he says will reduce the abortion rate in the province. Vander Zalm, a strong anti-abortionist, said that the B.C. government will improve support programs for single mothers, increase day care fundings, increase welfare rates, crack down on spouses who fall behind on support payments and make it easier to adopt. He also said that he might consider reducing the fees doctors are paid to perform abortions.
*Toronto Star, March 10, 1987*

## Elston says women's health services to be improved

Ontario Health Minister Murray Elston announced plans for improved health services for women while rejecting a recommendation by Dr. Marion Powell for regional abortion centres. The new services being planned include more family planning programs, more treatment centres for rape victims, the establishment of a Women's Health Bureau, and three new birthing centres in Toronto, Ottawa, and Northern Ontario. Elston had little specific to say on the question of improving abortion access. He said that therapeutic abortion committees, called useless by 95% of the doctors interviewed by Powell, would be continued and expressed doubt that abortions could be carried out in hospital-affiliated women's centres as recommended by Powell.
*Toronto Star and Globe and Mail, March 14, 1987*

## Nursing Homes Bill of Rights

The Ontario government has introduced legislation to ensure that commercial nursing homes provide proper care and tend to the basic medical and nursing needs of their residents. One of the major features of the legislation was a ten-point bill of rights for residents. The charter of rights would contain principles governing the dignity, privacy and respect of patients, plus attempts to ensure that they are properly sheltered, fed, clothed and groomed. The proposed amendments include beefing up licensing regulations, more comprehensive financial accountability for both non-profit and private nursing homes, mandatory reporting by residents and staff of instances of abuse or neglect.
*ONA Newsletter, Vol. 14, No. 2*

## Immigrant doctors protest policies

Foreign medical graduates have been protesting Ontario governnment policies which block their access to internship positions. Under the policy, only 24 immigrant doctors will be granted internships next year. There are about 500 foreign-trained doctors in the province. Before the new policy was announced, 63 to 70 (unpaid) internship positions were open in Ontario to foreign-trained doctors. All physicians must intern at a Canadian hospital before they can be licensed to practise in Ontario. The forieng-trained doctors have been lobbying for permission to take positions in northern and remote communities which are currently under-serviced.
*Toronto Star, December 24, 1986*

## OFL seeks ban on drug tests

The Ontario Federation of Labour has called for legislation banning compulsory drug testing in the workplace. OFL Gordon Wilson said corporations are attempting to take advantage of high unemployment rates by screening workers. He accused employers who are concerned about drugs being taken by workers "don't seem the least concerned about the poisons they inject into our bodies in the workplace." OFL delegate Red Wilson said unions have been begging companies for years to get involved in drug- and alcohol-abuse programs. Instead, he said, they; came up with drug testing. Michael Lyons, president of the Labour Council of Metro Toronto, told the convetion that "as often as not it's the workplace that forces workers to turn to alcohol and drugs in the first place." He called drug testing "nothing more than a management tool to better control the workplace." William Reno of the United Food and Commercial Workers suggested that unions agree to drug testing if politicians agree to lie detector tests and company managers agree to breath tests after their lunch breaks.
*Globe and Mail, November 26, 1986*

## Arbitration award in Manitoba

A three-member arbitration board gave Manitoba's 2,000 doctors a one-year fee increase of 6.55 per cent in late December, to the dismay of Manitoba's NDP government, which was the first province to adopt a system of binding arbitration in fee disputes. Health Minister Laurent Disjardins said the government is extremely concerned about the size of the award. "We just haven't got the damn money," he said. "We're certainly not happy with it. I don't think it's reasonable." Earlier in the fee negotiations the government has been offering 1.6 per cent plus an amount to cover the increase in the volume of medical services, which the Manitoba Medical Association had been seeking 12.7 per cent. The Manitoba government, facing a budget deficit this year of $587 million,has asked all government departments to put a two per cent limit on their spending increases.

In late January, Mr. Desjardins announced that the government is terminating its agreement with the MDs to submit disputes to binding arbitration. He also sent back the fee increase to the arbitration, saying he wanted clarification and discussion on the volume of medical services for which the province is being billed. Acording to Mr. Desjardins, quoting an adjudicator's report, Manitoba doctors increased their billings by three per cent last year, of which only 0.8 per cent could be justified.

The Manitoba Medical Association has since responded by taking the government to court to force it to pay the arbitrated increase.

*Globe and Mail and Toronto Star, January 1987*

## Private insurance in Alberta

The Alberta government has introduced legislation to allow private firms to insure items not on the provincial health care plan. The legislation originally would have allowed some items covered by the plan to be insured, but this was withdrawn after extensive criticism. The government has suggested that abortion may be one procedure which will no longer be covered by provincial medicare.

*Globe and Mail, March 12, 18, 1987*

## 16-year-old has abortion after court OK

An Alberta teenager was finally able to go through with the abortion she had decided to have after the Alberta Court of Appeal ruled that she was competent to make the decision. The young woman had been opposed in court by her parents. After undergoing a 16-hour procedure in her 19th week of pregnancy, the young woman expressed anger that she had had to struggle against her parents, local doctors, and red tape for two months before being able to carry out her decision.

*-Globe and Mail, January 3, 1987*

**The Bhopal Tragedy: One Year After**

This report contains reports, interviews, actions taken by various organisations on the Bhopal disaster, legal documents and photos. It was prepared by The Asia-Pacific Peoples' Environment Network (APPEN). It is available from S.A.M., 37, Lorong Birch, 10250 Penang, Malaysia for $8 seamail, $16 airmail.

## Alberta MDs asked to take cut in pay

Alberta Hospitals Minister Marvin Moore has asked the provinces doctors to accept a pay cut of ten per cent to help reduce health costs. The province's doctors are the highest paid in Canada, said Mr. Moore, and should take a share of the burden at a time when other sectors of Alberta society are taking massive cuts in their income.

An arbitration board turned down his proposal to reduce doctors' salaries in mid-February, but did impose a freeze on doctors incomes. Mr. Moore then announced that the government will be looking at the possibility of restricting the number of doctors allowed to practice medicine and taking action to decrease enrolment in provincial medical schools.

*Globe and Mail, January 27, 1987, February 13, 1987*

## Hospitals called "bottomless pits"

The Toronto Board of Health has turned down a request from the Hospital Council of Metro Toronto for financing of capital projects. Board members said hospitals are like "bottomless pits" because they have been chronically underfinanced by the provincial government. Board members said the money can be better spent on growing community-based health programs.

*Globe and Mail, February 3, 1987*

## Vander Zalm may sell B.C. hospitals

British Columbia Premier William Vander Zalm has said that every crown corporation the government operates will be considered if the price is right. Asked if this included hospitals, he affirmed that the government is "not drawing the line anywhere."

*Toronto Star, March 7, 1987*

# A nasty replica of Question Period

By Joel Ruimy Toronto Star

OTTAWA — Forget the daily Question Period, longtime Parliament Hill watchers tell Ottawa rookies. The real place to assess the performance of backbench MPs is in committee hearings of the House of Commons.

That's where MPs, free of the constraints imposed by television and by party discipline, get the real work done. That's where they are free to ask whatever questions they want and to look at the details.

The advice has been sound: One committee last week looking into AIDS revealed MPs at their compelling best as they quizzed Health Minister Jake Epp about government actions against the killer disease.

## Patent protection

But another committee last week turned into a nasty little replica of Question Period, complete with Conservative MPs assailing the credentials of the very witnesses they had summoned to appear.

At issue was the government's proposed legislation giving 10-year patent protection to the name-brand companies that develop new prescription drugs. The government says the law will spur drug research and create jobs.

But critics maintain the bill will lead to higher prices for medicines because it will curb the ability of generic drugmakers to turn out low-cost copies of name-brand drugs, a practice that saves consumers $200 million a year.

The debate, understandably, has aroused passions on both sides of the issue. Consumer groups, most provincial governments and many physicians see no need for the legislative change to an 18-year-old system that has kept prices low.

**JOEL RUIMY**

**Analysis**

But medical researchers, other physicians and the name-brand drug companies themselves say the bill would restore fairness to the system that protects inventors of everything except prescription drugs.

The bill is before a committee of MPs for examination, the usual process before the legislation returns to the Commons for third and final reading, a vote which turns the proposed legislation into law.

The committee hearings into the bill, known as C-22, should have been a place where MPs could find out the thoughts of the various groups they had invited to testify.

Instead of testimony, however, there was testiness as the Tories showed they were more interested in toeing the party line than they were in hearing the opinions of Canadians.

When the president of the National Federation of Nurses' Unions read a brief to the committee warning that there would be higher drug costs, and that these increased costs would siphon money away from other health care services, Tory MPs grew angry.

Jim Hawkes (PC-Calgary West) took a swipe at the credentials of the 24,000-member union by saying angrily that "your brief sets you up against people with PhDs . . . who say this patent protection is absolutely essential."

Monique Tardif (PC-Charlesbourg) added angrily that the nurses had "got my blood pressure up.

"I have a feeling that what you presented . . . turns the debate away from the health care of Canadians and to the way nurses are treated."

The Ontario Medical Reform Group, which also opposes the bill, was next up and it fared little better. Hawkes pointedly asked how many members the group had and whether they were all licensed physicians.

Representatives of the group replied that they had between 150 and 175 members — either doctors or medical students — leaving the impression the group is of little account.

## Deserved hearing

But the group established its credibility during the doctors' strike in Ontario, when it served as the only organized voice of physicians opposed to the walkout. And it deserved a better hearing than it got.

Earlier, the Tories on the committee also took the unusual step of voting to bar witnesses from the United States — and of holding that vote only after the two opposition MPs on the committee had left.

The opposition had wanted to hear witnesses from the U.S. generic drug industry and from an association representing millions of American retirees who, as a group, constitute one of the biggest markets for medicines.

Toronto Star, Feb. 8, 1987

# Politicians moving cautiously on abortion

**ROSEMARY SPEIRS**
**Queen's Park**

Before he went before the cameras, Ontario Health Minister Murray Elston was carefully coached not to stir up the anti-abortionists.

The health minister was so low-key, at a news conference where he was supposedly announcing improvements in abortion services, that five days later there has been no sign of furor . . . and considerable doubt about what he meant.

Elston's caution is understandable in political terms. In three different cabinet discussions of the abortion issue, Liberal cabinet ministers were divided over whether to act fast on Dr. Marion Powell's damning report on abortion services in Ontario or to postpone the whole emotional issue until after the next election.

The cabinet majority (20 men and one woman) decided to proceed rather than break Premier David Peterson's two-year-old promise to remove the barriers that restrict access to abortions for Ontario women.

But the Liberals also decided to hedge. They fear the power of the right-to-lifers to create nasty public scenes. Attorney-General Ian Scott has been a target of anti-abortionists for refusing to send the police to close the Toronto clinics of abortionist Dr. Henry Morgentaler (even though Scott is at the same time prosecuting Ontario's case against Morgentaler in the Supreme Court of Canada).

The Liberals don't want right-to-lifers picketing them at every election stop. So Elston talked at length about discouraging the need for abortion, through education and counselling, and about more timely abortion services. He said nothing about better access to abortions — until, pushed very hard by reporters, he reluctantly conceded he'd "like to think" that the 5,000 Ontario women who annually seek abortions outside Ontario, or at illegal clinics, could get the service performed legally in this province.

Representatives of pro-choice groups who attended the conference were dismayed. Cherie MacDonald of the Ontario Coalition for Abortion Clinics said afterward that Elston "used a lot of words to say nothing about improving access." Only Norma Scarborough of the Canadian Abortion Rights Action League was even cautiously hopeful; she noted that in the final minutes Elston had finally appeared to pledge better service.

The real reason for Scarborough's hope, however, is her confidence in Powell. Director of the Bay Centre for Birth Control, Powell has been asked by Elston to work with the hospitals to restructure pregnancy counselling and abortion services. "If it is possible to do it, Dr. Powell will get it done," said Scarborough.

In January, Powell's report told the government what many women know but politicians don't want to hear: Contraceptive failure, not carelessness, is the foremost reason for unwelcome pregnancy, so no amount of birth control counselling will eliminate the need for abortion services.

Although 27,000 abortions were performed in Ontario in 1986, 5,000 women had to go to free-standing clinics in the United States and Canada. Women were referred from all over the province to the Morgentaler clinics because, out of 176 accredited hospitals in the province, 104 either did no abortions or very few. Women faced extra referral fees of up to $500, plus the expense of repeated travel and accommodation before they could get approvals from hospital therapeutic abortion committees. Delays caused a high incidence in Ontario of less safe abortions in the second trimester of pregnancy.

Although Powell noted that the physicians and health care professionals she interviewed felt strongly that abortion should be removed from the Criminal Code, she was constrained by the existing law in making her recommendations.

She called for: adding abortion to the services provided by women's clinics in hospitals; regional clinics specializing in abortion counselling and procedures; permitting general practitioners to perform abortions, not just gynecologists; allowing abortions in out-patient clinics instead of expensive operating rooms; paying doctors "sessional fees" for abortion services because the fee-for-service system pays inadequately; re-organizing therapeutic abortion committees to provide swifter decisions; and travelling abortion services to look after smaller communities.

Elston's response was to dispatch Powell to talk to the hospitals about developing proposals for more timely and sensitive abortion services. He also promised to study the question of allowing general practitioners to perform abortions and of new funding methods to encourage hospitals and physicians to offer abortion services.

Just how actively these goals will be pursued isn't clear. Powell wasn't at the news conference (perhaps Elston feared her strong views would be too controversial), but she said in later interviews that the health ministry is committed to implementing her recommendation for hospital-affiliated women's centres, which would include abortion services.

Perhaps she's right, and Elston really is prepared to move behind-the-scenes, if not to say so publicly. But he gave no timetable, and no clear commitments on which the government can be held to account.

It may be good politics. But the 5,000 women who will be forced to seek abortions elsewhere this year, and next, deserved a clearer, and stronger, answer.

Addendum: MRG Newsletter, April 1987 Issue (Volume 7, Number 2)

## Mental Health Act Amendments: Review for the Spring 1987 Meeting of the MRG

By Don Woodside

A number of amendments were passed in Bill 7 to bring Ontario's Mental Health Act (MHA) into line with the Charter of Rights and Freedoms, and in line with a uniform MHA for all provinces. A summary of Bill 7's changes is on pages 3 - 7 of the Newsletter.

Shortly after it was passed, the lawmakers and mental health professionals realized they had written in an absolute right to refuse treatment on the part of certified patients who were competent to make that judgment. Bill 190 was brought forward. It re-instates the option of a review board making a treatment order against the wishes of 1) a competent refuser, or 2) the relatives of an incompetent refuser. Bill 190 retains an absolute right of refusal only for ECT. It accepts the distinction between certification leading to detention, and three kinds of competency:a)to manage one's own affairs; b) to make a will; and c) to consent to treatment. It also alters the list of substitute decision-makers for the incompetent patient somewhat, the point of dispute being the rank order of relatives.

### The Main Issues

1. Should commitment and competency to consent to treatment be separated?
2. Should a civil judicial process take over in a) detaining people for examination? b) certifying the person as an involuntary patient? c) deciding if they can be treated?

### In My Opinion

A single judicial process after the three day assessment should determine committal and treatability, and the former should imply the latter. It doesn't seem reasonable to me that a person be deprived of freedom on the grounds of a mental illness and the imminence of dangerousness to self or others on that account, and then be considered competent to consent to or refuse treatment. If they are that competent they probably shouldn't be held; if they are held it is not for a crime but for treatment. Certainly that is the only reason for holding them in a hospital.

Separating committal and treatment sets in motion a process which will lead to 'patients of indeterminate status' -- who must be held but can't be treated. They will not be welcome in either general or psychiatric hospitals. One may assume there will be administrative pressures to create separate holding units at psychiatric hosptials which will have some qualities of a 'snakepit'. There will be no function for clinical staff where treatment is forbidden. But then, what legal justification can there be for incarcerating people who have committed no crime? Rights to fundamental justice would be really trampled by such an outcome -- perhaps even by such a category as indeterminate status.

It will be important that decertification be relatively simply. It is not easy to prove sanity or harmlessness to a court, but it is important for the patient to reassume responsibility in treatment.

Most psychiatrists would like to get out of the committal business. I heard several say, "call me when you want me to treat someone".

I don't think either Bill 190 or Bill 7 adequately deal with these issues. I would recommend a commission to investigate the options and the facts behind the functioning of such options where they exist. There are legal, administrative and financial issues to be addressed. Enclosed (pp 25-26) are notes of a symposium which looked at some of them.

April 1987

## Mental Health Act Changes: Right to Refuse Treatment

At a recent symposium in Hamilton on the subject of the changes in the Mental Health Act incorporated in Bill 190 and the Human Rights Code, a range of opinion was expressed by: David Reville, NDP Housing Critic at Queen's Park; Gilbert Sharpe, lawyer with the Ministry of Health who drafted Bill 190; Jo Peterson, directory of the Friends of Schizophrenia; and Wayne Fyfe, administrator of the Hamilton Psychiatric Hospital. Most of them issued disclaimers that their position was unofficial.

### Reville

The mental health provisions of Bill 7 were overshadowed by the sexual orientation issues. The concern over rights to refuse treatment are federally inspired, by the Charter. Changes to the MHA were made in an empty house before Christmas, leading to tearing of various hair and a deal not to introduce the changes until April. Then Bill 190 was brought in to deal with consent and substitute decision making. The NDP doesn't believe in an override by relatives. There will be public hearings later in the spring. There is majority support for 190 but a large network of opposition by rights groups. If the opposition is successful, we revert to Bill 7. The lawmakers are ignorant and confused about this issue. Psychatrists have not told them what it means in practical terms, and need to do so. Psychiatrists are terrified over the conflict between absolute consent to treatment, and their statutory obligation to keep a committed patient safe. The real needs of patients are not these, but adequate housing, work, and family support. The hospital sector of care is over resourced already and the community under. $400 million to institutions, $20 million to community, despite having shut 75% of the beds in 20 or 30 years.

### Peterson (FOS)

The patient needs a supportive family, safe affordable housing, and meaningful employment, and access to good care when ill. Someone with schizophrenia is very ill. Withholding meds hurts them. She made a plea for psychiatrists to be more involved with the family. Asked for a mobile pysch team to come to the home for committal. Her organization has organized letters to MPs. Reville says they outnumber opposing letters. There are lots of horror stories. She made a plea for a right to treatment under the Charter. Sharpe later disputed this most strongly; inviolability of the person is one of the most basic rights.

### Sharpe

He says as a professor of law prior to getting involved in Mental Health he was very naive about the issues, they are complex, and some tension is inevitable. There is no compromise that will suit everyone. Most democratic countries have narrow committal criteria. Due process over committal with a tribunal and right to see evidence is the minimal Charter protection. But is only responsible to treat as well if the patient is in hospital against his will for an illness. The fundamental deprivation of freedom is at committal. Bill 190 is an appropriate compromise.

### Fyfe

Legislation is being used to produce change. Better administration could solve some of the problems the legislation seeks to solve. Patients have responsibilities as well as rights. Informing patients of their rights is not very effective as they aren't in a position to enforce them, so the focus should be on informing the public. If physicians could cure mental illness, there would be less opposition.

Medical staff in Ontario Hospitals are confused, anxious, and angry. Clinical staff are affected. Administration is overworked. All of the procedural duties have fallen on existing clinical and administrative staff. General hospital units, where psychiatrists get no pay for review board hearings, are transferring such patients to psychiatric hospitals. It is a further step toward two-tiered care. He recommends: accept the law; become the best advocate

possible for your patient; divest provincial ownership of hospitals.

Size of the problem at HPH before this legislation:

About 450 beds
285 review boards in 1986
Certification rescinded - 10/285
Consent to treatment - 4
Only 2 of 10 decertifications felt challengable by the hospital
Time: 264 hours for the board; 207 hours by psychiatrists, not including preparation time or recovery.

Reville cited a study from Mass of treatment refusers. Only 2% were consistent refusers. Other proportions were single dose, consistent or inconsistent refusers, or particular drug refusers.

Discussion

Reville requested practical recommendations from professionals that would make the law work. One such as for non-clinical staff to act as functionaries for the clinical team, preparing the case, so that the physician would only come in as a witness. As well, review board staff should be the bearer or bad news to the patient. The law must provide funds.

Some thought that one hearing should encompass both committal and treatment. I believe that this is true of some provinces.

We could move to civil committal, such as they apparently have in some U.S. states. The patient waits in jail until the hearing, or it occurs, as an emergency, in hospital. It takes the process out of medical hands entirely. But it sounds to me like a return to pre-Charcot --or was it Janet--when mental patients were kept in jails.

Another was for psychitrists to offer patients more treatment options.