MRG Newsletter

Medical Reform Group of Ontario, P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8 (416) 537-5877

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MRG General Meeting

The Medical Reform Group's Fall General Meeting will be held on Saturday October 24, 1987, at Community Centre 55 in Toronto. Community Centre 55 is at 97 Main Street. Details of the agenda will be published in the next MRG Newsletter.

Child Care at MRG Fall Meeting

Child Care will be available at the site of the MRG Fall meeting by pre-registration. To register, contact Catherine Oliver by October 1 at 964-7186 or 920-8738.

Disability Insurance

A considerable number of MRG members have taken advantage of the very favourable disability insurance Baker & Baker Employee Benefit Services has been able to obtain through Great West Life. The 15% discount is still in effect for all who apply.

To date however the per cent enrolment of the MRG membership is not yet suffficient to allow the insurance company to cover those members who have a medical history that precludes coverage under the plan. Several of the persons who have applied were declined by Great West Life for health reasons.

You may recall that one of the favourable items of the group coverage concerns insurability for all members without medical evidence if there is over 50 per cent participation of the group. Think about it! At this point there are no guarantees that Great West Life will honour, for the deadline has been passed. However, if a suffficient number of MRG members join we will go to bat for you and see if we can convince Great West Life to extend the option.

Trudy Baker
Baker & Baker Employee Benefit Services
1075 Bay Street, Suite 605
Toronto, Ontario
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Newsletter Deadlines

The publication date of the next MRG Newsletter is September 11, 1987. The deadline to submit items for the issue is August 24.

The publication date for the subsequent issue is November 6. The deadline for that issue is October 19. Longer opinion and feature articles should be submitted earlier, by September 24.

Steering Committee Update

The steering committee has met twice since the spring general meeting. Issues which have been discussed at the meeting include capital punishment, incorporation, and the Schwartz commission. The steering committee decided to present a brief about capital punishment to the government committees which would review the legislation. As it happened, with the good news of the vote against capital punishment that debate should be laid to rest. The steering committee met with a lawyer to discuss the details of incorporation and after lengthy consideration decided to proceed with incorporation. Final approval will go before the general membership at the fall general meeting.

The steering committee held discussions about the Schwartz commission on health legislation review. A draft of how the MRG sees the role of the College in discipline will be drafted for further discussion.

The steering committee continued its ongoing work: evaluating the past general meeting and planning the next one, the newsletter, reviewing correspondence, membership and financial information and chapter reports as well as dealing with issues as they come up.

The next meeting is August 13 at 8 p.m. in Hamilton. Any member of the MRG is welcome to attend steering committee meetings. Except in the summer, the meetings are scheduled to be on the last Thursday of each month. For more information call the MRG phone number, (416) 537-5877.

Fran Scott

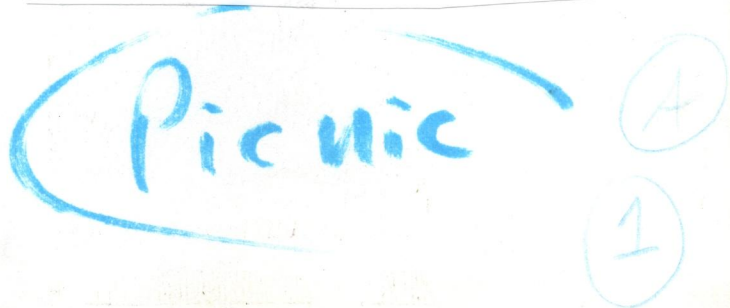
MRG Second Annual Picnic

The MRG will be holding its second annual picnic at Bronte Creek Provincial Park on Sunday September 13, from 2 to 6 p.m. Bronte Creek Park is west of Oakville, just north of the QEW. Exit at Burloak Drive and go north 2 km.

We will be eating at 4:30. Please bring your own barbeque, food, and drink.

Until 4 p.m., the mini-farm, fun barn, and probably tennis will be available. The pool will be closed. There is room for kites, frisbees, and baseball.

Bring your spouse, partner, kids.



Toronto chapter meeting

The June Toronto chapter meeting had as a topic "Preventive Health Procedures in General Practice". It was addressed by John Frank. The following is an outline:
John took basically two separate related tacks:

1. A narrow medical perspective of prevention of disease.

Firstly it is possible to classify preventive health procedures into those well done, e.g. BP checks and those not well done, e.g. Paps. Possible solutions included record linkages/reminder systems in offices/use of PHN's to follow "diffficult" patients/advertising campaign.

This classification of tasks well done and those poorly done was extended to the physician's explanation of screening tests to patients. Explanations that are well done, e.g. Prenatal screening for Down's/neural tube defects. By "well done" is meant: 1. Risks of screening test to patient; 2. Nature of therapeutic choices and implications of a positive test; 3. Possibilities of false positive/false negative.

In contrast is the situation with AIDS testing. The special situation with possible benefits accruing only to future sexual partners and offspring were the basis of some audience debate. The role of altruism in a patient at risk wanting to know the test results in order to benefit their partner/family was opposed to the present ineffectiveness of any therapy. The proponents of the latter view argued that since no therapy existed it would merely engender more fear and worry to have the test performed.

JF identified that a general problem in this area exists and suggested that informed consents and education of medical students/physicians was appropriate in order to facilitate patient information about pros and cons of screening tests.

John then reviewed some problems of new tests and took as a paradigm mammography. He identified pressures to use new technology ("disease lobby groups," experts wishing to utilize new technology.) and cautioned against them. The differing use of mammography by nations indicated the lack of objective standards.

E.g. U.S.A. too many mammograms used, Canada in middle, "about right", U.K. too anti-mammography.

He then went on to consider other screening tests that were available and demonstrated that these were being inappropriately used.

E.g. Hemoccult testing: 2% of all those tested go on to receive colonscopy and barium enema of whom only 0.2 have Carcinoma. Ref: Frank J. Can F. Physician January 1985.

E.g. Sputum cytology and radiotherapy for lung carcinoma. Basically the argument is that treatment is so ineffective what value is there in early detection? Ref: Provok P.C., Int. J. Cancer 34:1-4, 1984.

E.g. Breast cancer self examination.

J.F. suggested these anomolies arise due to an inadequate understanding of how to critically evaluate information about diagnostic tests. The solution is thus obvious; medical student training in critical evaluations and continuing physician education. One concrete way the latter could be performed was suggested: regular review of the Canadian Periodic Health Examination Task Force Group Findings published regularly. (1979, 1984, 1986 in CMAJ.)

He concluded part 1 with:

Advice to Primary Care Givers

1. Decide what screening tests are worthwhile for each age and sex group. The intellectual kick-start.
2. Offer the test to all at risk. Thus the Managerial Efffi-ciency Programme Step.
3. Inform patients of pros and cons of all tests. Finally the Hippocratic Step.

The Second Part dealt with

2. The World at Large Beyond Medicine in Prevention

Now John posed the question:
"Would the effective provision of effficacious preventive medical services to the entire population and their appropriate use really achieve prevention?" I.e. accept the ideal health care delivery system what then? John's a member of the MRG and it should not be surprising that his answer was No!

To justify this he reviewed familiar and depressing data on the "correctable" causes for morbidity and premature death today. The measure of death as an end point was considered inappropriate though convenient in the absence of definite data on "suffering".

Using this approach he built the following table:

Preventable Illness	Underlying Cause
1. Ischaemic heart disease Cancer Respiratory Tract	Smoking
2. Alcoholic liver disease Accidents	Alcohol
3. Accidents	Teenagers Bad driving Safety habits & poor enforcement of laws.
4. High Blood Pressure Stroke Heart Disease	Obesity Inadequate diets
5. Mental Illness Suicides Violence	Unemployment Social Isolation Inadequate Parenting
6. Occupational Diseases	Exposure to hazards

There can only be one type of solution to these problems and all are political, but some interesting little 'p' political solutions were cited.
E.g. Increased enforcement of drunken and unsafe driving legislation. Teenagers to receive driver licence for days only to accumulate three years safety record prior to early nighttime driving.
E.g. Emulation of Norway's coordinated food and agriculture policy to coordinate tobacco substitution of crops to relieve hardship of farmers etc.
E.g. Coordinated early detection, prevention of damage to disadvantaged children.

As a side issue, in response to some questioning J.F. pointed to the inadequate training of many physicians in simple counselling skills and his quotable quote was: "There is no rotation in happiness and fulfilment". Oxford Dictionary of Quotations please note.

In conclusion: "The real issues in prevention of disease are socio-political."

Thanks, John.

Back to the MRG's "Statement of Principles".

By Haresh Kirpalani (whose lack of speed writing ability is responsible for errors compounded by John's refusal to write a synopsis!)

Notices & Announcements

South Riverdale seeks MDs

New, energetic board, focussed on providing excellent working conditions to match excellent health care, requires full-time and part-time family physicians. Full range family practice with varied clientele including family planning clinic, visiting obstetrician, chiropody, housing service for mentally ill, and new program for elderly.

Three MD/NP teams; some evening hours; 1 in 4 on call; obstetrics not required; CCFP desirable; other languages, interest in gerentology or occupational health and community program development would be assets.

Salary $56,000 – $67,000 plus benefits. Send c.v. and covering letter immediately to Liz Feltes, Administrator, South Riverdale Community Health Centre, 126 Pape Ave., Toronto M4M 2V8. Phone (416) 461-3577.

Family Physician Required

Parkdale Community Health Centre has an opening for a full time physician. Applicants interested in part time hours may be considered for the position. Candidates should have experience/interest in community based primary health care with commitment to prevention, health promotion and community needs. Attractive salary and benefits package. Position available in November 1987. Applicants may contact the co-ordinator at (416) 537-2455 and should send a resume by September 30 to Co-ordinator, Parkdale Community Health Centre, 1257 Queen Street West, Toronto, Ontario M6K 1L5.

Inequities in Canadian health

The National Anti-Poverty Organization (NAPO) has received funding to review literature produced by community-based organizations referring to inequities in Canadian health. NAPO is asking for copies of materials (studies, policy motions, newsletters, briefs, etc.) which make any reference to health inequity. Please send to NAPO, 456 Rideau Street, Ottawa, Ontario K1N 5Z4. For further information please call (613) 234-3332.

Victims of psychiatry experiments

Anti-psychiatry activist Don Weitz is planning to present a petition to Parliament this fall asking for compensation payments to patients experimented on by Dr. Ewen Cameron in the 1950's and early 1960's. The experiments were co-funded by the CIA and Canada's Department of Health and Welfare, and were performed without patients' consent in Montreal's Allan Memorial Institute. Those interested in circulating the petition may contact Don Weitz at 100 Bain Ave., 27 the Maples, Toronto M4K 1E8.

Health News Briefs

Blind River clinic investigated

A clinic in Blind River, Ontario is being investigated by the Ontario College of Physicians and Surgeons because patients are being asked to sign a statement saying the doctor they see will remain their personal physician. Dr. I. G. M. Peer, who oversees the day-to-day operation of the clinic, said that he and one other doctor use the statement to provide an accurate patient register, which enables them to arrange for the necessary clerical help to handle paperwork. "This is not binding," he said. "The patient is free to change doctors as they wish, but the statement gives a register to work from."

Toronto Star, July 7, 1987

Scarborough to discontinue hospital grants

Scarborough Board of Control has voted not to contribute any more money toward hospital expansion. Over the past five years, Scarborough Council has given local hospitals $10 million in capital grants. Faced with provincial cutbacks in support, hospitals have been pressing local municipalities to come up with some of the money which formerly came from the province. Scarborough's decision reflects the borough's problems in finding money for its own capital spending.

Globe and Mail, June 26, 1987

Health News Briefs

Remembering Illegal Abortions

The Childbirth by Choice Trust has started a project to compile and publish Canadian women's stories about their illegal abortions. According to the Trust, "it is important that these stories be collected, particularly from older women and health care professionals, before they are lost to us. They are a significant part of our history and a reminder of the times we are fighting not to repeat."

Stories will be published anonymously and confidentiality will be respected. Those who are interested or would like more information are asked to contact Louise Daw, Childbirth by Choice Trust, 344 Bloor Street West, Suite 306, Toronto, Ontario M5S 1W9 or call 416-961-1507.

CARAL Newsletter, June 1987

AIDS groups criticize bill

The British Columbia government has introduced amendments to the provincial Health Act which would give the courts powers to order persons carrying communicable diseases to be confined to places other than hospitals, if the medical health offficer feels it necessary. Under current B.C. legislation, persons cannot be confined to a hospital against their will. Although B.C. Health Minister said that the legislation was primarily aimed at carriers of tuberculosis, he agreed that it could also be used to deal with AIDS carriers. AIDS groups believe that the legislation is really aimed at people with AIDS. They argue that the proposed legislation will arouse fears of quarantining, and will drive those at risk of infection underground.

Toronto Star, July 3, 1987

Judge orders prostitutes be tested for AIDS

An Ontario Provincial Court judge is refusing to sentence any convicted prostitutes or their clients until they have been tested for AIDS. Judge William Ross ordered two women who pleaded guilty to communicating for the purpose of prostitution to reappear in court in August with the test results or face arrest warrants. Ross said he would make the order for the tests in all future cases.

Toronto Star, July 4, 1987

Contaminated soil to be removed

The Ontario government has agreed to residents' demands to replace lead-contaminated soil from about 1,000 homes in Toronto's South Riverdale neighbourhood. The soil is to be replaced on all residential and publicly accessible lands to a depth of 30 centimetres. Environment Minister James Bradley said that the province will be asking Canada Metal Company, the company believed to be responsible for the lead buildup, to "make a meaningful contribution". Mr. Bradley said the project will be a model for similar soil-lead problems in the Niagara Street neighbourhood of Toronto. Tests have shown that some children in South Riverdale have blood lead levels several times higher than the acceptable limit of 20 micrograms per decilitre set by the Toronto health department.

Globe and Mail, June 26, 1987

CMA opposes employee drug tests

Dr. Jacob Dyck, the president of the Canadian Medical Association, says that the medical profession cannot endorse testing workers for drugs or alcohol when there is no suspicion of abuse. According to Dyck, mandatory testing for drug and alcohol abuse "is beyond what the profession can accept."

Dyck told the annual meeting of the Ontario Medical Association on May 25 that he is worried railway employees may have to undergo compulsory drug and alcohol spot tests when a new Railway Act is brought in. He fears that railway workers' personal physicians might be required to report to company doctors on health conditions of their patients. Dyck said that mandatory medical reporting and drug testing programs for railway employees, if written into legislation, could be the thin edge of the wedge" leading to similar tests for all sorts of workers.

Toronto Star, May 26, 1987

Number of residents to be cut

Ontario's teaching hospitals will lose almost 300 medical residents by 1992, in a series of cuts reducing the province's supply of doctors. The Ontario government believes that the province has a surplus of doctors. However, hospital offficials and deans of medicine are protesting the cuts. More than half the residency positions lost will be at Metro Toronto's ten teaching hospitals. "It's having enormous impact; it's got everybody convulsing," according to Dr. Kenneth Stuart, medical vice-president at University Hospital in London. To fill the gap, Dr. Stuart said, hospitals are considering alternatives such as hiring more salaried physicians or training nurses and operating room technicians to perform some of the tasks only residents are at present allowed to do.

Globe and Mail, June 11, 1987

Evans report released

The Ontario Health Review Panel, chaired by Dr. John Evans, released its report in late June, with a key recommendation being the creation of a Premier's Council on Health Strategies. The panel recommends the panel as a way of bringing about needed changes in Ontario's health care system. The report contends that the Ministry of Health is too entrenched and too concerned with day-to-day crisis management to be able to carry out needed long-term changes in the health care system. In addition, it sees a need to deal with overlapping responsibilities by the ministries of Health, Community and Social Services, and Labour. Dr. Evans said that his panel diagnosed many of the same problems as previous reports on the health system, and agreed with most of the proposed solutions. The proposed Premier's Health Council would have representatives from all the "stakeholders" in the health care system, including doctors, hospital offficials, patient advocates, and health experts.

The panel said that spending on health care in Ontario is not extravagant, and said that it "found no evidence that health-care costs in Ontario are out of control". The report did not tackle the question of whether there is an oversupply of doctors in Ontario.

Toronto Star and Globe and Mail, June 20, 24, 1987

Health News Briefs

Government changes stand on treatment refusal

Ontario's Liberal government has abruptly withdrawn support for its own proposed legislation that would have denied some psychiatric patients the right to refuse medical treatment. The Liberals proposed amendments to the Mental Health Act in December that would give a doctor the power to ask a review board to override a competent patient's decision to turn down medical treatment. Then on June 9, the government announced that it would be supporting NDP MPP David Reville's proposal to delete that part of the bill that allows a doctor to override a patient's right to refuse treatment.

Globe and Mail, June 10, 1987

CP's policy on diabetes ruled valid

A policy of Canadian Pacific Ltd. against employing diabetics as trackmen is a bona fide occupational requirement, the Federal Court of Appeal said in a ruling made public June 19. The court reversed a ruling by a human rights tribunal, saying the tribunal made "a fundamental error" in concluding that the policy was discriminatory and that there was only a slight risk of serious damage if stable diabetics were employed as trackmen.

Globe and Mail, June 20, 1987

AIDS policy for Metro Toronto employees

Metro Toronto Council has adopted a policy on AIDS which states that people with AIDS have the right to work, and that no one can refuse to work alongside someone who has AIDS. The policy stresses education of Metro's 25,000 employees, including police and ambulance workers.

Globe and Mail, June 24, 1987

Province, OMA agree on new fee deal

The provincial government and the Ontario Medical Association have agreed on a new medicare fee schedule which provides for a 4.8 per cent fee increase, including a 1.5 per cent increase to compensate doctors for no longer being able to extra-bill. The 1.5 per cent compensation for extra-billing translates to about $41 million. The government has also agreed to contribute $12 million to cover increases in doctors' malpractice insurance premiums. This is the first time the province has contributed to doctors' insurance costs. The extra-billing and insurance payments total $53 million over the one-year duration of the new schedule the same amount which the government started recovering from the federal government when it banned extra billing a year ago. This has led both opposition parties at Queen's Park to criticize the government for breaking its promise that the money recovered would go to hospitals and other parts of the health care system, not to doctors.

Globe and Mail, June 26, Toronto Start June 27, 1987

U of T gets $1.5 million for AIDS research

The University of Toronto has been given $1.5 million by the provincial government to establish an AIDS research laboratory. The money will help the university build the province's first isolation facility for AIDS and will be the reference centre for research into the diagnosis and treatment of the disease.

Toronto Star, May 26, 1987

Province will pay for AZT

The provincial government will pay so that AIDS patients can get the drug azidothymidine (AZT) for free. This became an issue after the manufacturer, Burroughs-Wellcome, suddenly announced in April, while the drug was in the middle of clinical trials, that it not accept new patients into the clinical trials and would charge those already enrolled $1000 a month, unless the federal government licensed the drug without requiring the company to submit to normal licensing requirements. In announcing that Ontario would pay the cost for patients, Ontario Health Minister Murray Elston said that the government was acting because most patients simply would not be able to afford the drug otherwise. But he expressed his displeasure at Burroughs-Wellcome's actions, noting that the procedure is that a company seeking to introduce a new drug pays for the cost of the clinical trials. Now that a precedent has been set, he said, "I don't know how many others will try this. If we do it for one company, do we do it for the next?" Asked if he agreed with one theory that AZT may prove disappointing over time so the company is hoping to recoup its development costs in the next two years, Elston said those suspicions had been advanced to him but that he had no evidence to prove them. Eight provinces have now agreed to pay for the drug.

Toronto Star, May 26, 1987

Hospitals insuring selves

Forty-nine Ontario hospitals have banded together to create their own liability insurance plan. The move is a response to drastic increases in insurance premiums over the last three years. Typical hospital insurance premiums jumped from $29,000 to $400,000 in three years. The newly created company, Hospital Insurance Reciprocal of Ontario, which began operation on July 1, has already signed up most of the larger provincial hospitals, representing 19,000 of Ontario's 27,000 hospital beds. George Speal, the chairman of HIRO, predicted that hospitals in other provinces will follow HIRO's example. HIRO has not yet decided whether it will invite about 100 smaller hospitals with fewer than 50 beds each to join the plan. Companies that previously insured hospitals will lose about $13 million in premiums this year as a result of the move.

Globe and Mail, July 3, 1987;
Toronto Star July 5, 1987

Health News Briefs

Tobacco firms battle ad ban

Canadian tobacco manufacturers have launched an $800,000 advertising campaign to fight the proposed ban on tobacco advertising. The federal government plans to ban all tobacco advertising and forbid smoking in federal offfices in 1989. Under the legislation, tobacco advertising, already forbidden on television and radio, will be banned in newspapers as January 1, 1988, and on January 1, 1989, the ban is to be extended to billboards, magazines ads, and sponsorship of sports and cultural events. The Canadian Tobacco Manufacturers' Council is arguing that the ban won't achieve the desired effect of reducing the rate at which young people take up smoking. They also argue that the proposed legislation violates the Charter of Rights and Freedoms, in that it forbids the advertising of products and activities which themselves are perfectly legal.
Globe and Mail, July 9, 1987

Two dentists challenge ad rules

Two Toronto dentists are asking the Ontario Court of Appeal to strike down regulations that prevent dentists from engaging in promotional advertising. The two, Drs. Howard Rocket and Brian Price, are facing disciplinary action before the Royal College of Dental Surgeons of Ontario because of an advertisement which appeared in a number of magazines in 1985. The ad, promoting Holiday Inns, told how the two had founded Tridont Dental Centres and saw it grow into "North America's largest storefront dentistry group". College regulations restrict dentists' advertising to professional cards and announcements concerning the opening of new practices. Rocket and Price are maintaining that the rules are an infringement on guarantees of freedom of expression within the Charter of Rights and Freedoms. A lawyer for the College is arguing that the Charter's protection should not extend to commercial expression, and that the regulations are in the public interest.

Globe and Mail, June 26, 1987

Gays refused OHIP's family rate

The Canadian Union of Public Employees is taking the Ontario government to court for denying a lesbian couple the lower health insurance premiums paid by heterosexual couples and their families. Health Minister Murray Elston reaffirmed the government's refusal to recognize same-sex couples on July 8. Ontario Ombudsman Daniel Hill has criticized the government for its policy, saying he finds it inconsistent that the government can take away welfare assistance from a woman because she is being supported by a lesbian partner, but will not let the couple pay the family rate. "It seems reasonable that if a homosexual couple can be penalized for their 'dependent' relationship as far as one Government service is concerned, they should be able to benefit from another Government service offered to 'dependents."

NOW, July 16, 1987

Court rejects bid for secret hearing

The Supreme Court of Canada has rejected a request by 10 Toronto doctors for a closed hearing into the treatment they gave a Toronto boy who died at the Hospital for Sick Children seven years ago. A hearing open to the public and the media will now be scheduled. The case involves Steven Yuz, an eight-year-old boy who died in 1980 following surgery. The boys mother complained to the College of Physicians and Surgeons about the treatment he had received. The College said that it could see no grounds to launch discipline proceedings, so the mother appealed to the provincial Health Disciplines Board, a tribunal comprised on non-doctors. The board had always conducted its reviews into the disposition of complaints by the College in private. But in the spring of 1982 the Toronto Star newspaper, citing public interest in the case, asked that the review by held in public. The board agreed and the doctors spent the last five years trying to overturn the board's decision.

Toronto Star, June 5, 1987

U.S. to bar immigrants who test positive

All immigrants whose tests for the AIDS virus prove positive will be barred from entering the United States, U.S. Attorney-General Edwin Meese has announced. Meese also said that probation offfficers will be notified when prisoners with the virus are released from jail. He said the National Institute of Justice, a federal agency, will set up a data collection bank to assist police offficers who may have been exposed to the disease. Meese said he has directed the U.S. Immigration and Naturalization Service to develop a testing program that will deny entry to "all immigrants, refugees and legalization applicants" whose tests are positive. About 1.9 million people are expected to apply for legalization in the next 11 months in the U.S.

Globe and Mail, June 9, 1987

Elston criticized for fundraising

The Ontario Legislature's public accounts committee intends to question Health Minister Murray Elston to explain his methods of raising funds for the Liberal Party. Elston has been criticized for sending invitations to a $200-a-ticket fundraising event to hospital administrators, doctors, and others in the health field. Opposition MPP's charged that this put unfair pressure on people who depend on the Health Ministry for funds.

Globe and Mail, June 12, 1987

Feature Article

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.

Free Trade and Health Care in Canada

Our second principle in "Statement of Principles of the MRG" is that "Health is political and social in nature."

The very broad mandate of the MRG was to recognise "social, economic, occupational, environmental causes of diseases and be directly involved in their eradication."

We ought therefore to acknowledge some recent debates in Canadian society that inevitably affect health care. Or should we say a recent reprise of an old debate: Free Trade.

Obviously major effects from opening the border will be felt by all business sectors. In the U.S. such "business sectors" include health care and it would be naive to expect no push north from health care companies. We have taken the liberty of printing excerpts from the submission of the Ontario Public Service Employees Union (OPSEU) to the Select Committee on Economic Affairs in August 1986. The title "Free Trade and the Public Sector" gives one an indication of some wider issues in this debate than merely a narrow economic/business view.

We first summarize the argument in brief before quoting extensively from the document. Given "free trade", fierce competition from the U.S. will impel Canadian producers to be "competitive". The natural route to become more competitive will be to cut government spending, therefore cut public services and ultimately lower wages and working conditions even if it means destroying union bases.

A revealing comment by Laurent Thibault, President of the Canadian Manufacturers Association (a leading pro-Free Trade organisation) was made to a Senate Committee in 1980 (cited in C.A.W. Canada Pamphlet "Free Trade Could Cost Us Canada." 1987.)

"It is simply a fact that, as we ask our industries to compete toe to toe with American industry ... we in Canada are obviously forced to create the same conditions in Canada that exist in the U.S., whether it is the unemployment insurance scheme, Workmen's Compensation, the cost of government, the level of taxation or whatever."

The OPSEU analysis continues as follows under the banner: "Free trade is a Trojan horse with which to attack and cripple the public sector. We want none of it."

"In addition, those who are sceptical of free trade are committed to the belief expressed in Recommendation No. 10 of your Interim Report, namely:

'It is imperative that the Canadian Government guarantee that we do not compromise our social, cultural, regional and linguistic heritage in any trade discussions with the United States. This heritage includes, but is not limited to, government programs such as the Medicare system; pension and social security programs; the system of Workers' Compensation Boards; National Unemployment Insurance; regional development programs; and protection of Canadian content in the nation's media.'

"free trade with the United States threatens the public sector in Canada and Ontario just as much as it threatens the private sector ...

First of all, Canada is a trading nation, and in order to hold their own in international trade, Canadian producers must be competitive. most of our trade is with the United States, and since ... this is above all true of Ontario, costs in Canada must be at least as low and preferably lower than costs in the United States. As the advocates of free trade never tire of telling us, free trade will be good for us because it will require Canadian producers to be more competitive than ever.

Many government services are of course essential in facilitating production. But they also involve costs. When competition intensifies, business clamours for government restraint, lower taxes, and suitable incentives.

Business has been saying, and with free trade would say even louder:

- Cut business taxes and government spending so that we can be competitive.
- Lower wages and working conditions, forget about pay equity, so that we can be competitive.
- Follow Reagan's example, slash public services and smash unions so that we can be competitive.

That is why our study examines what the Reagan administration has done to the public sector in the United States. It looks at labour, health care, social security, and welfare, women, and taxes and spending. The overall result of the Reagan administration's policies has been to redistribute income the wrong way, up instead of down. The government has been taking money from the poor and giving it to the rich.

... Not a few of our free traders would like to imitate Reagan's policies in Canada. They think that free trade would help them.

As you know, any U.S. producers who are up against stiff competition from Canadian exports can complain to the Department of Commerce that the Canadian producers are being subsidized by the Canadian or provincial government. In its investigation, the Department of Commerce examines all federal and provincial government programs which could conceivably provide a subsidy. If it concludes that subsidies are being given, and if it also concludes that U.S. producers are suffering 'material injury' because of Canadian exports, a countervailing duty equal to the alleged subsidy is imposed. Every possible government program is investigated, and the percentage subsidy which each program supposedly provides is calculated to three decimal places!

... No government program which might conceivably provide a subsidy escapes its scrutiny.

President Reagan has said that the United States would never give up its right to impose duties against foreign subsidies. To protect our exports against these duties, the federal government and the provinces would have to promise never to have any programs that provide subsidies or even the appearance of subsidies.

... Finally, free trade threatens the public sector by way of contracting out, privatization and the invasion of U.S. service companies in competition with Canadian firms.

Free Trade and Health Care

Free trade would increase the pressure for privatization. It's hard to believe, but it is now being suggested in the United States that private enterprise be allowed to operate the prisons, at a profit of course. No doubt the prisons operators would demand a large fee each time an inmate on death row was executed – extra billing with a vengeance!

OPSEU has briefly summarized four ways in which free trade will attack and pervert the public sector directly:

- by forcing the federal and provincial governments to imitate U.S. tax and spending policies;
- by forcing government programs to be based entirely on so-called commercial considerations, so as to avoid contervailing duties against Canadian exports on the ground that they are subsidized;
- by prohibiting preference to local, provincial or national suppliers in government purchases of goods and services, and
- by increasing contracting out and privatization, in which U.S. companies will be invited to compete with Canadian companies.

"This is the 'hidden agenda' of free trade."

OPSEU reminds us that once upon a time our illustrious Prime Minister himself said in 1983: "Free Trade affects Canadian sovereignity, and we will have none of it, not during leadership campaigns or at any other time . . . sleeping with an elephant is terrific until the elephant twitches, and if it ever rolls over . . . you're a dead man."

Finally, why is the United States interested in even negotiating?

George Ball then of the U.S. State Department is quoted as saying in 1968:

"The issue will inevitably be economic integration, which will require, an expanding area of common political decision." (CAW 1986)

This agenda is unchanged as the chairman of the U.S. Senate's subcommittee on trade told the economic affairs committee of the Ontario legislature:

"The sooner your culture and ours can blend together the better it will be for both countries." (CAW ibid 1987)

The chimera of the Canadian beaver and the U.S. eagle will certainly have as its meat accessible health care.

Haresh Kirpalani

Health & Safety Committees need more teeth

The Steelworkers in District 6, along with other unions in Ontario, are supporting New Democrat amendments to legislation that would give workers more rights in health and safety.

Steelworkers were out in force to attend a massive news conference at Queen's Park on health and safety the day before the bill was given first reading.

The private member's bill, introduced by Sudbury East MPP Elie Martel, gives workers control of health and safety committees. It would give the committees power to identify a hazard to health and safety and require employers to remove it. As well, environmental tests could be carried out on the order of the committees at the employer's expense. New machinery and chemicals would have to be approved by the committee before they are introduced into the workplace.

Martel cited 248 deaths in the workplace as well as 138,000 lost-time injuries last year. In reference to the deaths and injuries Martel said: "If they were policemen we'd be turning this country upside down."

Members from other political parties broke ranks to vote with the NDP on the bill. It is now scheduled to go to committee for debate.

Within weeks of the vote, Ontario labour minister Bill Wrye introduced a much-watered-down version of the bill that, in the words of District 6 Health and Safety Co-ordinator Norm Carriere, "does nothing to achieve the kinds of things we need to make our workplaces safer."

The government bill continues the "internal responsibility" system, which sees health and safety committees dominated by the employers. The bill also fails to give the committees or a health and safety representative any power to stop unsafe work. The committees would only be able to do what they do now – recommend changes without the power to back them up. The issue of a full time health and safety worker representative is also completely ignored by the government bill.

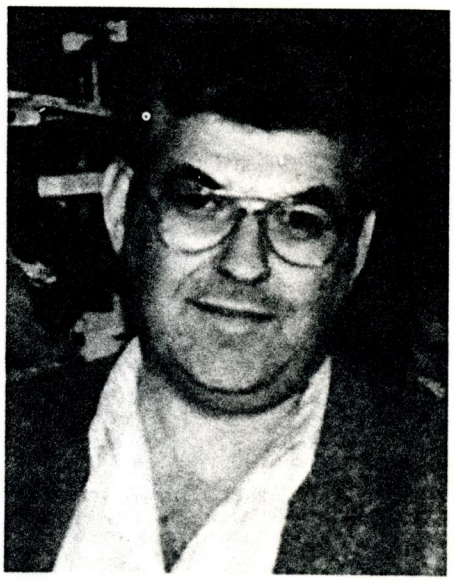
Meantime, a report given to the minister a year ago but kept secret until now shows that many of the 8,000 labour-management committees in Ontario are employer controlled and unable to provide any real protection for workers.

The report, by SPR Associates Inc., says health and safety committees exist only on paper or not at all in hundreds of workplaces. Many of the most effective committees, however, are where the worker representatives drop the idea of "co-operating" with the employer, and take on an adversarial role instead, demanding protection for themselves.

It also says that without proper enforcement by labour ministry inspectors, the committees turn into vehicles of self-deception.

This, in essence, has been the main criticism the Steelworkers have made of the government's bill – it continues to rely on a faulty "internal responsibility" system (depending on employers to clean up the workplaces themselves) rather than to force them to do so by enforcing the law.

As Carriere says, the toughest law in the world will do nothing if it's not enforced.



Norm Carriere

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United Steelworkers of
America, District 6.

A16 THE GLOBE AND MAIL, FRIDAY, MAY 1, 1987

Patient rights 'lost in shuffle' in health-care power struggle

BY NINA APRILE
Special to The Globe and Mail

WATERLOO, Ont.

Patients are being shut out of a struggle for control of Canada's multi-billion-dollar health-care system, a conference was told yesterday.

While doctors, nurses and other health-care workers jockey for power, patients' rights are being lost in the shuffle, about 200 delegates at the two-day conference at Wilfrid Laurier University were told.

Every group says it is entering the fray on behalf of patients, but health-care needs are being ignored, said David Coburn, a representative of the Patients Rights Association.

Health care in Ontario is "a welfare system for health professionals," Mr. Coburn said.

"Lots of people are making a lot of money from it," he said, citing certain industries, including drug suppliers.

Medical dominance is being challenged by other professional groups, including nurses, midwives and sociologists, each group saying it represents patients, said Mr. Coburn, a sociologist at the University of Toronto's faculty of medicine.

"Everybody has the patients' rights at heart. We know that when doctors went on strike in Ontario, it was to protect the patients," he said.

The battle over extra-billing in Ontario was a demonstration of doctors' power, he said.

Mr. Coburn cited a number of instances of medical malpractice and bureaucratic bungling. Lack of response on the part of medical authorities and hospital administrations demonstrates the need for greater patients' rights, he said.

Health care in this country is "not really as good as we're always told," he said. Laws are broken every day and little is done about it, he said.

A review of the Health Disciplines Act has prompted a number of associations to fight for "exclusive rights" over various parts of the human body, he said. "If you blow your nose in Ontario, you could be fined for practicing medicine without a licence."

Dr. Michael Rachlis, a member of the Medical Reform Group of Ontario, said he is very pessimistic about patients' rights.

"I think we may be seeing the tunnel at the end of the light," he said.

Dr. Rachlis predicted that taxpayers will start demanding that politicians cut health-care expenses.

The current system is extremely inefficient and expensive, he said.

Specialists do the jobs of general practitioners, general practitioners do the work of nurses and patients are lodged in expensive acute-care beds instead of nursing homes, he said.

"In Canada, we love to lock people up in institutions," he said.

Dr. Rachlis said the focus on individual health problems in this country works to the detriment of patients.

Hospital administrators are enmeshed in power struggles with communities and government for the bigger institutions, he said, and hospital board members are the economic elite of communities.

"It's not in these people's interest to have community-based health systems," he said. "Whose interests are really being served by making people think that health care is liver transplants rather than the kids who die in poor areas from car accidents?"

Consumers are "brainwashed" into believing that only large and expensive, highly technical institutions can deliver proper health care, he said.

Dorothy Pringle, director of research for the Victorian Order of Nurses in Ottawa, said doctors control who has access to patients.

Government has colluded with physicians to maintain the status quo, she said, though there is no evidence it is in patients' interests.

"Doctors have used their dominance to protect their employment and income. But frankly, I think if nurses were in the same position, we'd do the same thing. We just didn't get in there first," Ms Pringle said.

The New York Times
Sunday, May 10, 1987

Hospitals Pitch Harder for Patients

More are turning to Madison Avenue to fill their beds. But ad campaigns leave many doctors feeling queasy.

By TAMAR LEWIN

IT worked for Tupperware. So now hospitals are using the same idea: getting a group of women to gather in a home for games, prizes, refreshments and a sales pitch. But at the BodyCues women's home health care parties sponsored by the St. Elizabeth Medical Center in Dayton, Ohio, the pitch comes from doctors and nurses — and what is being sold is nothing less than the hospital itself.

It is a soft sell: The icebreaker is a game in which a doctor's black bag full of medical instruments and supplies is passed around and each woman takes a turn pulling something out of the bag and telling the group what she thinks it is used for. And the womer are never asked to sign up for hospital services.

"The concept behind it is to create good word of mouth," said Joan Thomas, the senior vice president of marketing at St. Elizabeth. "It's a very good solid community service, but it also gives us a chance to showcase what we're good at. The women who come to the parties are well, so we don't expect them to show up at the hospital the next day, but the physicians who give the parties definitely do get new patients as a result, and eventually, a lot of those women are going to turn up as hospital patients."

But if it is a soft sell, it is a serious one, and one that is being repeated in various ways by hospitals around the country. Faced with empty beds, hospitals are using marketing campaigns to fill them. Their spending on ads alone has increased fivefold in the last three years; overall, hospitals now spend more than $1 billion to sell themselves to patients.

During the last five years, hospital occupancy rates nationwide have dropped from more than 75 percent — where they had hovered for a decade — to the 1986 average of 63 percent. In good part, the falling rates were prompted by the Federal Government's shift to a Medicare reimbursement plan that makes it more profitable for hospitals to discharge patients quickly. But since hospitals with very low occupancy rates run the risk of being closed, they are competing ever more desperately for patients — and dreaming up increasingly elaborate marketing campaigns to woo them.

The marketing efforts have their share of critics. Some health policy experts say the new emphasis on marketing is unnecessarily driving up health costs. And as hospitals evolve into more aggressive advertisers, they say, the ads may become misleading. Many doctors are worried that a hospital's success may come to depend more on the quality of its marketing efforts than the quality of the health care.

"The whole thing turns my stomach," said one doctor at a New York hospital with an active marketing department. "I cringe every time I see one of our ads. The administrators here tell me it's important, but I think hospitals ought to be striving for clinical excellence, not publicity."

Despite the misgivings, hospitals — like other formerly low-profile institutions such as universities and law firms — have begun advertising with a vengeance, on television and radio, on buses, subways and billboards.

They are offering new amenities, too: candlelight dinners for new parents, and concierge services, gourmet menus and more stylish furniture for private patients.

Some hospitals are now creating clubs, like HealthExpress at Lee Memorial Hospital in Fort Myers, Fla., whose 10,000 members get a membership card, a discount on certain outpatient services — and a steady stream of mail from the hospital, which uses the club to build up, and refine, its mailing list.

OTHER hospitals have created trademarked brand-name "product lines." At hospitals owned by the Republic Health Corporation, these include "You're Becoming" (cosmetic surgery), "Gift of Sight" (cataract surgery) and "Step Lively" (podiatric surgery).

Many hospitals now have neighborhood centers — known as "Doc in a Box" — for cash customers who want quick, cheap medical advice on cuts, colds and other problems not serious enough to warrant an emergency room visit. Many also have free physician referral services, to attract new patients to specialists affiliated with the hospital.

A few hospitals are even turning to the most basic marketing technique of all, price cuts, most commonly by waiving the Medicare deductible for in-patient care of senior citizens.

Sunset Hospital in Las Vegas, probably the first in the nation to advertise, at one point years ago even tried to increase its weekend occupancy by holding a prize drawing for patients who checked in on Friday or Satur-

New York's Doctors Hospital stresses fast service in its ad, left; Mount Sinai explains a new way for cancer patients to avoid amputation.

day night and stayed until Monday morning. The weekly prize: a round-trip "recuperative cruise" to the destination of the patient's choice.

St. Elizabeth, which spends a bit less than 1 percent of its $93 million budget on marketing, did so well with BodyCues — it has sponsored more than 60 parties a year for three years, and won glowing press coverage — that it decided to market its own marketing device. For $18,000, other hospitals can buy the BodyCues package, and give their own home health parties. So far, 13 hospitals have bought the package, for a total of nearly a quarter of a million dollars.

Although the marketing budgets for individual hospitals still seem small, the proliferation of programs has made the total figures soar. Last year, hospitals nationwide spent $1.1 billion on marketing, $500 million of it for advertising, according to Chicago's SRI Gallup Hospital Market Research. In 1985, total marketing costs were $700 million, with $313 million for advertising. In 1984, advertising expenditures were only $104 million, but the field was so new that no one tallied total marketing costs.

Now, though, hospital advertising has become all but universal. SRI Gallup says 91 percent of the nation's hospitals advertised last year, up from 64 percent a year earlier. The average hospital spent $102,000 on advertising last year — but some of the larger ones had advertising budgets of more than $1 million.

It is clear that marketing can help attract business — in some cases, tripling or quadrupling the number of patients coming to the hospital for an advertised service. And some hospitals say their campaigns help to prompt bigger charitable donations. Marketing can also be used to offset negative publicity from high-profile malpractice suits or other problems.

What is still debatable is whether the increasing emphasis on marketing is good as a matter of social policy. Supporters say that the more competitive environment will lead to cheaper, more accessible and better-quality services.

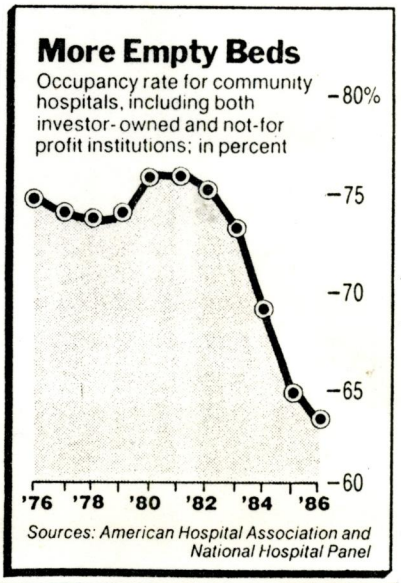
"We used to be pretty paternalistic, but now we ask consumers what they want and we try to give it to them, whether it's shorter-stay maternity care or a guarantee that they'll be seen within 15 minutes when they come to the radiology department," said Anne Doll, senior vice president for marketing at Dayton's Miami Valley Hospital. "We used to have the highest prices in town, and we've worked very hard to get them down into the middle range. In my view, all the competition and the marketing has been good for the industry and the consumers."

Others disagree, arguing that marketing simply adds to the high costs of health care.

"It's going to drive up costs, no doubt about that," said Uwe E. Reinhardt, a health economist at Princeton University's Woodrow Wilson Institute. "Whether we're talking about ice cream or health care, marketing creates demand. We probably eat more ice cream than we should, and all the hospital advertising may lead people to seek out health care they really don't need."

"But it's essentially a zero-sum game," Mr. Reinhardt added. "So we are going to be paying for billions of dollars' worth of wrestling for market share. There is some benefit in marketing, in that it may give people useful information. But it can also be misleading, and there is a danger that there will be some tradeoff of clinical quality for amenities."

Good or bad, hospital marketing seems to be here to stay — and evolving into more sophisticated forms.



Hospitals

"When hospitals started advertising on a regular basis, about five years ago, it was almost all image advertising, designed to boost the general image of the hospitals, and make consumers feel good about the institution," said Lauren Barnett of the Chicago-based American Hospital Association. "But as competition heightened and advertising expenditures increased, hospitals tended to market specific products."

HOSPITALS face a tough obstacle, however, when they develop consumer marketing — for it is usually the doctor and not the patient who chooses which hospital to use. But with the increasing trend to consumerism in health care, patients are making more active choices about their medical care and many hospitals see marketing as a way to give the public information that will make them smarter consumers.

"Physicians are still the primary gatekeeper, but consumers make more of the choices in obstetrics, cosmetic surgery, emergency room admissions and sports medicine," said Ms. Barnett.

So those, along with a smattering of back-pain programs, sleep disorder clinics and wellness programs, are the ones many hospitals are advertising — with dramatic effects.

For example, St. Elizabeth, the Dayton hospital that developed BodyCues, began advertising its sports medicine center in December. The center had been averaging 20 percent growth a year since it opened in 1982, but in the first quarter of 1987, it had 100 percent growth over the same quarter in 1986.

"The results are overwhelming," said Dena Michaelson, St. Elizabeth's director of public relations. "So we'll be doing a lot more."

But hospitals are also looking for ways to increase their overall business.

"Right now, the marketing money is all going to consumer advertising, but consumer sales are small potatoes," said Todd Darche, vice president of planning and marketing at Lee Memorial Hospital, which has more than 5 percent of the population in Fort Myers signed up as members of either HealthExpress or a new senior citizens' club called SHARE.

"It's really the physicians and the employers that are driving the train," said Mr. Darche. "And we're going to be doing more marketing to them. We've hired one nurse as a physician's rep, who goes around to the doctors to see how the hospital can help with their practice and solve any problems they're having with the hospital. Down the road, there are going to be a lot of sales-trained people doing that, and getting paid on an incentive basis."

The soft-edged image advertising that most hospitals start with — "we care" ads, market researchers call them — may be fading away.

"I think we've finished with the warm fuzzies in 1986," said Paul Keckley, whose Chicago-based market research company, the Keckley Group, works for Mr. Darche's hospital and others. "The 'we care' ads are worthless. We've studied it up, down and sideways, and there's no relationship between image ads and market-share movement. What we're moving toward now is full-blown product differentiation, ads that say, 'Our infection rate is 1 percent, theirs is 3 percent. Come here and lower your risks.' That will be effective."

Maybe, but many hospital administrators worry about that approach.

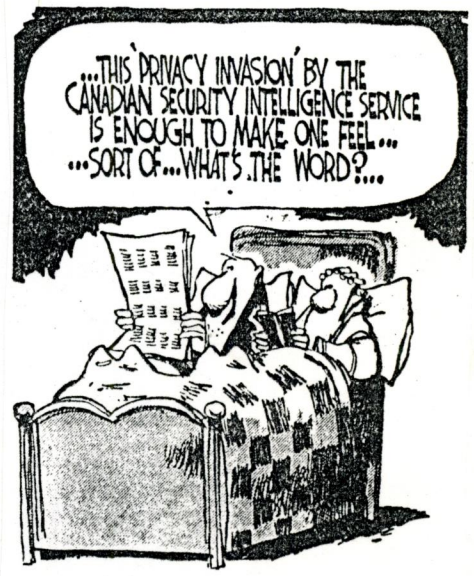
"If the data are valid and accurately assess the care that's offered, the public has a right to know," said Dennis Crimi, vice president for marketing at St. Luke's-Roosevelt Hospital Center in New York. "But unfortunately, it's very easy to use misleading or confusing data."

Mr. Crimi's hospital is putting much of its marketing effort into one of the least controversial and most effective techniques: a doctor referral service through which callers can get the name of a nearby doctor who meets their specific needs.

Such services are proliferating. Some New York City buses now carry advertisements for both St. Luke's New York Doctor Line (876-5432) and Mount Sinai's Doctor Referral Service (1-800-MD-SINAI).

"Finding a physician in New York is like working through a maze," said Mr. Crimi, adding that the service has made 10,000 referrals in four months. "If we can help people find the right doctor, ultimately it will provide patients for us."

"We're in a competitive environment, and we need to react," continued Mr. Crimi, who came to St. Luke's-Roosevelt in 1985 to set up a marketing department and now has a staff of 16. "The reality is that hospitals that don't compete effectively will either go out of business or have to curtail the services they offer." ■



GABLE
Regina
Leader-Post

THE NEW YORK EXPERIENCE: **MARKETING BLITZ**

Minneapolis, Dayton, Memphis and other cities have led the way in hospital marketing, but now New York is catching up. The $1.5 million barrage of television, radio and print ads describing the medical advances pioneered by doctors at the Mount Sinai Medical Center is one of the most ambitious in the nation.

"This whole marketing strategy is designed to establish, as a fundamental image, the quality of the doctors at this institution," said Natel Matschulat, the 43-year-old Greek-born whirlwind hired by Mount Sinai last year to be its first vice president for marketing, public affairs and development.

Ms. Matschulat had a reason for choosing that image: her research for the campaign showed that "excellent doctors" were what consumers called most important in choosing a hospital.

"Our marketing has been extremely effective," Ms. Matschulat said. "From the day the first ad appeared in February, calls to our physician referral service increased fourfold."

Ms. Matschulat, who formerly ran the "I Love New York" campaign for the state, has a marketing strategy that goes far beyond advertising.

Mount Sinai, located at 100th Street and Fifth Avenue, now has a concierge, who greets private patients upon admission and helps the patient who, say, wants a business meeting catered in his hospital room. Private patients get newspapers delivered to their room, courtesy flowers, a restaurant-style menu, terrycloth slippers, reclining chairs, a choice of art for their room, and soon, the option of renting a VCR and movies.

Some Mount Sinai doctors say the marketing campaign is an embarrassment. Both staff morale and patient care would be better served, they say, by spending the marketing budget — Ms. Matschulat won't disclose that figure, but it is widely thought to be more than $3 million — on basics such as higher salaries for support staff.

Ms. Matschulat's ideas about boosting staff morale are based on image, not money. She has tried such gimmicks as a "Winter Festival" for hospital employees and Nurses' Recognition Day, when the Times Square Spectacolor sign announced "Mount Sinai Nurses — New York's Finest."

"To have a marketing success, for health care or anything else, you have to have a good product and high awareness," Ms. Matschulat said. "That isn't just advertising. It's the seminar we held on in vitro fertilization, which was a public service that also made many people aware of our in vitro program. Or our program to help screen people for early signs of colon cancer. Since our doctors were on Channel 5 to publicize it, we've processed something like 90,000 tests."

Mount Sinai needs all the good publicity it can get. It got a spate of unwanted publicity in February when it was fined $8,000 for performing an unauthorized heart transplant. The advertising campaign began just two weeks after the fine was imposed, but Frederick Klingenstein, chairman of the board of trustees, said that was coincidental.

Marketing departments have become almost obligatory at all the big hospitals — but most aren't aping Mount Sinai's razzle-dazzle.

"We don't take a bells-and-whistles approach," said Peter Ghiorse, vice president for external affairs at St. Vincent's Hospital and Medical Center of New York, at Seventh Avenue and 11th Street. "That just ain't us."

Last January, the hospital began a series of newspaper advertisements, each telling the poignant story of a St. Vincent's patient.

St. Vincent's has also started a physician referral service. And in the last three years, Mr. Ghiorse said, the number of births it handled has almost doubled, in part because of "very focused" marketing through the Archdiocese of New York's Office of Family and Christian Development. The hospital, co-sponsored by the archdiocese, even enlisted John Cardinal O'Connor to get all the priests in the archdiocese to mention the hospital.

Most researchers say it is just a matter of time before New York hospitals become as aggressive in their marketing tactics as those elsewhere.

"New York is still five years behind, but it will only take it 18 months to catch up," said Paul Keckley of the Keckley Group in Chicago.

Others disagree, pointing out that occupancy rates at New York hospitals are always higher than the national average. "Many of the major university hospitals are completely full," said Kenneth E. Raske, president of the Greater New York Hospital Association. "Generally, when occupancy rates are high, there's not much impetus for marketing."

You Have Views! . . .

Write

Editors Lamenting Doggrell

We are in the MRG.
Who rant and rave about fees.
We do have other views
But on these we must muse.
Because members to us don't write
in order to set the OMA right.
Instead they will plunge
into daily life with a lunge.
Thus our pleas please hear
From daily fray retire with no fear.
Pick up pen and paper
Or modern processor.
We editors do not, intend,
to wield razor to rend
Your offspring to tatters.
No, we'll print them in this paper.

In a more serious vein the editors remind members that the newsletter depends on active participation. There would be the possibility of continuing to reprint the Globe and Mail's analysis of health. If one agrees totally with that interpretation I guess there's no problem. If not we could print views, news, tentative gestating thoughts, etc. The size of the organization is such that it is most unlikely the membership is familiar with each other's daily political-clinical problems. Even less likely are we to know one another's political solutions.

If recent events prompt agreement with Gable of Regina (cartoon P. 13) we will print anonymously!

The curre editorial board consists of Robert Frankford, Haresh Kirpalani, Fran Scott and Don Woodside. If any of you wish to partake in this activity, fine! All of us are in Hamilton-Toronto. Are there others out there who have time to write regularly?

We are exploring what the role of the newsletter should be. These presumably include:

1) Informing members of current policy M.R.G.
2) Disseminating beyond the immediate MRG circles our analyses.
3) Constructive debate to actually form our analyses.
4) Preparation for the general meetings.