MRG Newsletter

Medical Reform Group of Ontario P.O. Box 366, Stn. J Toronto, Ontario M4J 4Y8 (416) 588-9167

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What Should the MRG Be Doing? A Special Meeting

The MRG Steering Committee has planned a special meeting for January to discuss directions and strategy. The purpose of the meeting is to review past activities and to explore priorities for the future. This won't be a decision-making meeting, but it will be an opportunity for talking about some of the broader philosophical and planning issues for which there often isn't time amidst the press of routine business at regular meetings.

While all Steering Committee meetings are open to all MRG members, the Steering Committee would like to extend a special invitation to members to come to this meeting and participate in the discussion.

The meeting has been scheduled for Friday January 29, 1988 at 7 p.m., and will be in Toronto. For more information, call (416) 588-9167

If enough interest is declared by the membership, a full day retreat could be arranged. Let the Steering Committee know.

Newsletter Deadlines

The publication date of the next MRG Newsletter is February 5, 1988. The deadline for that issue is January 18. Longer opinion and feature articles should be submitted earlier, by January 11.

The publication date for the subsequent issue is April 1, 1988. The deadline for that issue is March 14.

Longer opinion and feature articles should be submitted earlier, by February 25.

The Newsletter is always happy to involve anyone who wishes to play a part. This newsletter was put together by Haresh Kirpalani and Ulli Diemer. If you wish to play a role contact them at (416) 537-5877.

The Schwartz Commission and Discipline

I Part One: Background Paper on The Schwartz Commission, the CPSO, and the Discipline Process

The Schwartz Commission on Legislation for the Health Professions submitted its first report October 1986, and the College of Physicians and Surgeons of Ontario (CPSO) responded in January 1987. They make a number of far-reaching recommendations, including a Health Advisory Council, very much like the over-college we had suggested.

As well, they are in favour of 'scope of practice' legislation.

They appear to have responded to pressure for greater public participation and accountability, by asking that meetings of the council of CPSO be open to the public. They have also made a number of recommendations for changes in discipline hearings:

-that publication be allowed throughout

-that th ird parties can lay complaints

-that the minister of health can order a discipline committee hearing

-that panels be so constituted that there could be a majority of lay members.

Our Previous Response

When we first looked at the discipline process, about three years ago, at a general meeting, we were of the opinion that it focussed too narrowly on the errors of an individual physician, and not enough on the context in which s/he worked. However, college accountability for the competence and ethical practice of individual physicians is a major responsibility of the CPSO and warrants our attention.

Self Regulation

Recent theories justify self-regulation by the professions on two grounds:

-it would be costly and difficult for the government to attain the knowledge needed to set standards for practice--and perhaps impossible without the co-operation of the profession

-the professionals practice in many locations where they are not regulated by an employer

But at heart, the professions are performing the regulatory fucntion in the interest of the public, not of the profession. The problem which ar ises is that as one moves toward the public interest, at a certain point the support of the profession may be lost.

Publication of Discipline Hearings

The Commission recommended publication of hearings. It has been pointed out that this would lead to loss of privacy for the medical record of the complainant. The CPSO believes it would lead to fewer complaints or successful prosecutions of sexual impropriety. It would also undermine the reputation of the physician named in a way not easily repaired by a report of 'not guilty'.

On the other hand, publication would sharpen the sense of public responsbility in the process. We recommend the solution found under the Young Offenders Act: publication of evidence and events, but not names.

It is the same solution used in charges of sexual assault involving child victims, to protect the reputation of the child. After a guilty finding at the hearing, then names could be published as they are now.

Composition of the Discipline Committee

The membership of a discipline committee must satisfy three criteria:

-it must have sufficient expertise to make a credible judgment

-it must have credibility with the profession to make it enforceable.Doctors believe that doctors must set the rules for responsible practice

-it must have credibility with the public, that its interests and not the self-interest of the profession are being served.

In a review of discipline cases, Lomas found that 14% definitely required expert knowledge, 31% possibly, and 55% definitely did not, as for example, in sexual misconduct, fraud, advertising.

We recommend that in those cases which may require expert knowledge, that a majority (at least an equal number?) be physicians. Others may have lay or physician members but must have a physician representative.

Presence of Complainant

It has been the practice to exclude the complainant, justified on the grounds that the matter was between the college and its registrant. The CPSO proposes that complainants be present as observers. As the patient is the CPSO's main witness, we recommend both complainant and doctor be present. We need more information before we can judge what rights to counsel or cross examination the complainant or doctor should have, if any.

Breadth of Review

Maintaining physician competency is a challenging task, and the CPSO is a leader in North America in peer review. It would appear that a valuable potential indicator of substandard practice is being lost in the discipline process, which is an examination only of the incident in question. We recommend that a review be set in motion by a complaint which evaluates the physician's general quality of care in a standardized way, such as is done in peer review. Although it is not an examination of the context of care as the MRG had originally suggested, it does move the hearing toward maintaining the quality of practice rather than just judging a particular act.

Corrective Action

A broader review may turn up evidence of incompetence. The college will need to be able to prescribe remedial education. The physician may need financial support to undertake it, and educational institutions and clinical settings will need to be prepared to accept such referrals.

Why Bother?

It may appear that we are re-inventing courts of law at physician expense as the discipline process is made more public.

However, one of the benefits to patients and physicians alike of a credible system is that patients have not resorted en masse to the courts to address their grievances. It is also a great benefit to the public if the outcome of a complaint is upgrading of the physician rather than an adversarial court procedure and a financial settlement.

Strikes

The CPSO is not set up to deal with a strike, and will lose its credibility with either the profession or the public or both if it is forced to be the arbiter of adequate care during an organized withdrawal of services. A withdrawal of services in such a fashion is entirely different from the inadequate or improper provision of services under normal conditions. An acceptable level of emergency care needs to be defined ahead of time, and monitored during a strike. Enforcement efforts would then properly be directed towards the organizing body, as they are in other labour disputes.

Don Woodside, Sept. 29, 1987

Part II Discussion of CPSO Discipline at Fall General Meeting, October 24, 1987

1. There was general agreement with publication of evidence but withholding of names until a guilty verdict.

2. There was less support for a majority of physician members on panels, but one recommendation was for 60% physicians, 40% lay, which would be 3:2 on a panel of 5. It was noted that physicians have come down hard on sexual misconduct, more than on technical incompetence.

3. The presence of the complainant at a hearing was supported but we were reminded s/he often feels intimidated. It was suggested s/he be offered protection under the Canada Evidence Act.

4. Regarding the suggestion that each discipline hearing include a 'peer review' type of practice audit, it was felt to be unnecessary in cases involving ethical misconduct, and should be worded in a permissive way.

5. There was a strong concern that the discipline process not ignore the contextual issues of quality and integration of care. If this is not within the mandate of the CPSO, then it could be taken up by the Health Advisory Council, the new 'over-college' recommended by the Commission.

6. Patients sometimes need help to draft a complaint. A mechanism should be readily available and well-publicised. Patients may also need legal aid.

7. Interest was expressed in the difference between cases coming to the discipline committee and those going to civil suit.

Implementation of Midwifery

November 2, 1987
Ms Elinor Caplan
Minister of Health
Queen's Park
Toronto, Ontario

Dear Ms Caplan:

I am writing on behalf of the Medical Reform Group of Ontario to urge to government to bring in legislation implementing the recommendations of the Task Force on the Implementation of MIdwifery in Ontario. While we appreciate your wish to have full consultation with all affected parties before acting, it is our position that full consultation has already taken place. The Task Force held full hearings across Ontario and received briefs from consumer organizations, health care professionals, institutions and many individuals.

We would particularily like to emphasize the importance of including in the legislationthe following recommendations of the Task Force:

1. Scope of practice to be consistent with the international definition of midwife.

2. Midwives should practice in hospitals, birthing centres and other institutions and in the home.

3. There should be multiple routes of entry to midwifery education.

4. Midwifery should be regulated through a system of licensure under an independent College of Midwives.

It is time--in fact, well past time--that midwifery services be available in Ontario as they are in most of the rest of the world. We urge the government to *act* on the recommendations of the Task Force as soon as possible.

Yours truly,

Catherine Oliver, M.D.
for the Steering Committee of the Medical Reform Group of Ontario

General Practitioner

General Practitioner with obstetrics experience and familiarity with women's health issues is required for a group practice situated in multi-diciplinary health care setting. X-ray, ultrasound, physiotherapy, laboratory, minor surgery and pharmacy within clinic. Additional services of Counsellor, Dietitian, Home Visiting Nurses and a wheelchair equipped van. Health eduation is an integral part of the Health Centre's program. Full privileges available, commensurate with training, in two local hospitals. On call rota. Starting salary guaranteed. Reply in confidence to: Prince Albert Community Clinic, 110 - 8th Street East, Prince Albert, Saskatchewan S6V 0V7.

Hassle Free Clinic

Hassle Free Clinic is looking for doctors to work regular or fill-in shifts. The clinic focuses on family planning and sexually transmitted diseases, including AIDS. The clinic is collectively run and staff work closely with doctors. We believe in involving women in their own health care and we take a pro-choice stand concerning abortion. Clinic hours are: Monday, Wednesday and Friday 10 - 3, Tuesday and Thursday 4 - 8. Call Laura Cowan at 922-3549.

Discussions in Bioethics

The National Film Board has produced **Discussions in Bioethics**, a series of 8 open-ended dramas, each no longer than 15 minutes, concerning a number of subjects in bioethics. The subjects covered are: prenatal diagnosis; quality of care; compulsory sterilization; the right to refuse treatment; allocation of scarce resources; death through benigh neglect; the defective newborn; chemical warfare. The dramas, each based on documented cases, are designed for workshops, seminars, and training sessions. The series is available on U-matic, VHS, and Beta. For more information contact Discussions in Bioethics, National Film Board of Canada, P.O. Box 6100, Montreal, Quebec H3C 3H5.

Professional and Social Responsibility

The Centre for Society, Technology and Values is holding a major conference at the University of Waterloo March 16 - 18, 1988 on **Professional and Social Responsibility**: Conflict or Congruence?

Subjects to be addressed include Ethical Codesfor the Professions; Global Peace and Human Rights, and Beyond Professional Ethics: Issues and Agenda. The conference fee is $120. For more information contact the University of Waterloo Centre for Society, Technology, and Values, PAS 2061, Waterloo, Ontario N2L 3G1, (519) 885-1211 ext 6215.

Have you renewed your membership?

Some of you have not yet renewed your membership for 1987-88. Now is the time to do so: our new membership year started on October 1.

As you know, working for the principles to which we are committed often entails an uphill battle, especially in the current political and economic climate. Over the past number of years, the existence of the MRG as an organized and credible alternative voice within the medical profession has at times made a significant difference to how government and media have handled health-related issues.

The MRG and its members are working on a number of important issues, including an end to extra billing in its new guises, support for free standing abortion clinics, and support for a greater degree of choice in maternal health care. Over the past year, the Medical Reform Group has also participated in efforts to block the new federal pharmaceuticals legislation and to oppose the re-establishment of capital punishment.

The effectiveness and credibility of the MRG in working for our common goals and principles are directly based on having a committed membership. We need you to stay with us inf we are to continue to be heard. And we need your financial support if we are to maintain the organizational resources to make ourselves heard.

Please send in the form below together with your cheque as soon as possible.

To join, or for more information, please fill in the form below:

Name_____
Address_____
Membership category_____
Enclosed is: Basic membership fee_____
Additional Supporting member donation_____
Total Amount enclosed_____

Publications

The Medical Reform Group and its various working groups have produced a number of informative and valuable briefs, position papers, analyses, and other documents. These publications are avaiable at the following prices:

Basic Documents.....$6.00
(includes a Brief History of the MRG, MRG Resolutions, the constitution, and a synopsis of the MRG's approach to health issues)

Brief to the Commission of Inquiry on the Pharmaceutical Industry.....$10.00

The Crisis in Health Care: Brief to the Hall Commission.....$3.50

Community Clinics Study.....$3.50

Consolidating the Gains of the 1970's: Do or Die for Ontario's Health Care System.....$2.00

Brief on the Canada Health Act.....$1.00

Transcript of MRG Presentation to the House of Commons Standing Committee on Health, Welfare, and Social Affairs.....$3.75

Submission for the Ontario Health Profession Legislation Review.....$1.50

Complete Editon of MRG Newsletters 1979-1986.....$25.00

Yearly Subscription to MRG Newsletter.....**$25.00**
(applies to non-members; membership includes Newsletter subscription)

Please send me the publications indicated above. I enclose a cheque for _____
Name_____
Address_____
Send your order to MRG, P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8.

Disability Insurance for New MRG Members

The MRG provides the opportunity to all new members to obtain disability insurance that is very favourable as far as rates and options is concerned. For full details call or write Trudy Baker, Baker & Baker Employee Benefit Services, 1075 Bay Street, Suite 605, Toronto, Ontario M5S 2B1, (416) 960-1736.

Letter

Dear people:

I was given your name by someone who thought you might be able to be of some assistance in our search for a pro-choice physician to practice in Fort McMurray.

Here's a bit of history:

-Oct/86 municipal election--57% of people voted in favour of establishing a TAC at our hospital in the first-ever plebescite to be held on this issue

-the hospital board (to which I was elected) took until April 1987 to finally establish the committee

-May 1987. Obstetrician/gynecologist leaves the community citing economic pressure (no referrals from a particular group of family practice anti-choice physicians) leaving no one who was willing to perform abortions.

-there is only 1 obs/gyn now in the community (pop 35,000) and this summer he was so overworked that women were being air-lifted to Edmonton for C-sections. (Average age of the population is 27--lots of babies!)

-the hospital is currently trying to attract another obs/gyn to town but their intention is not to specifically recruit someone who is pro-choice.

-the danger of a specialist who is pro-choice locating here is the dependency on referrals.

-however a general practitioner would not have this dependency

-there are a number of doctors (10-12) who are very supportive of having a functioning TAC

-currently, women must travel to Grande Prairie (a 9 hour drive) or out of the province to obtain an abortion

-there are probably around 200 women/year leaving the community

And that, in a nutshell, is the situation we are in.

The community, although somewhat isolated (430 km north of Edmonton) is a great place to live. The make-up of the population is very cosmopolitan. The facilities for recreation are boundless--sports, theatre--and the great outdoors with lots of fishing, skiing (downhill and cross-country) canoeing, etc.

If any member is the MRG is interested, please call me at (403) 791-4395.

Sincerely,
Judy Moynihan
Co-ordinator, Ft. McMurray CARAL

Minutes of MRG General Meeting

October 24, 1987

The meeting was called to order by Don Woodside at approximately 9:30 a.m. at Community Centre 55 on Main Street in Toronto. Approximately 25 members registered for the meeting.

Reports from MRG representatives:

Michael Rachlis reported on the **Ontario Health Coalition.** Michael announced his intention of resigning from the OHC Board of Directors, on which he has represented the MRG for the past several years. A call was put out for a volunteer to replace Michael on this body. Carole Cohen will continue to be the MRG's representative at the OHC's general memberhip meetings.

Michael Rachlis also reported on the **Canadian Health Coalition** on behalf of Frances Kilbertus, the MRG's representative on the CHC. She reports that the CHC has a new board of directors with new energy, and that it is considering future directions.

Mimi Divinsky reported on recent developments around the abortion issue. On Sunday October 18 there was a cross-Canada series of rallies in favour of choice on abortion. An estimated 300 to 400 people attended the Toronto rally. The Supreme Court's decision on the Morgentaler case is expected soon.

Philip Berger reported on the MRG's involvement in the **capital punishment** issue. He traced the MRG's stand on the death penalty. In 1980, the MRG passed a resolution opposing the participation of doctors in the death penalty. In 1985, it passed another resolution which opposed the death penalty per se. The MRG participated in the Coalition Against the Death Penalty together with a broad range of other organizations--it was the only medical organization to take part. Philip noted that the Canadian Medical Association had declined to take a stand on capital punishment on the grounds that it was a hypothetical questions as long as the death penalty had not yet been passed into law. The defeat of the capital punishment resolution in the House of Commons seems to have laid the issue to rest.

Midwifery Task Force: Bob James reported on behalf of Brian Hutchison. The Task Force Report has just been released, and it contains many of the recommendations which the MRG had favoured. These include a community-based, non-fee-for-service model with globally based budgeting. Midwives do not have to be nurses, although credits will be given for nursing training. The MRG was quoted extensively in the report. (Copies of the report are available from the Communications branch of the Ministry of Health, on the ninth floor of the Hepburn Block in Toronto.)

It is not clear, however, how, when, and if the report will be implemented. The report was released with comment by the government; i.e. without any indication of how it regards the report. The midwives association is urging the Minister to take action on the report, rather than do yet more study. The MRG will also send a letter to the Minister asking her to implement the report. It was also decided to invite the MRG members who have been most active in following the issue--Brian Hutchsion, Catherine Oliver, and Pat Smith--to come to the next Steering Committee meeting for a discussion.

Steering Committee Report: Don Woodside presented the Steering Committee report, which appears below:

When I agreed to write the Steering Committee report I thought it would be a brief task; after all we have not been involved in a strike, and it has been a long hot summer. But we are involved in a wide range of activities. Some will be addressed separately in greater detail later in the morning.

We started early to prepare for this fall meeting, shifted location to provide daycare (but no kids were enrolled) and shortlisted three topics for the afternoon discussion: the Evans Report on the Health Care System, Healthy Public Policy, and the discipline function of the College of Physicians. We were ahppy to be able to find a distinguished panel to deal with our first choice.

From the social colum, Hamilton branch held a picnic in August attended by about 15 members and their familites. In September, our general picnic at Bronte Creek Park attratced about 12 adults and a flock of children--until we were flooded out by a torrential downpour.

Joel Lexchin spoke to the Senate Committee on the drug patent act and was received with great interest. He also wrote a piece for the op-ed page of the Toronto Star.

Philip Berger spoke to the Steering Committee about the death penalty in June, and was authorized to do a brief on our behalf, focussing on the medicalization of the death penalty. As it turned out we were all relieved, if not surprised, that the resolution was defeated in the House.

We agreed to endorse a country-wide rally about abortion, and made a donation of $150 to support it. We had a mandate from the spring meeting to organize a special MRG meeting on abortion, but we have delayed acting on it.

We had several discussions about incorporation, and a lively debate as to whether it was really necessary. Those in favour carried the day, and it is coming to the general meeting for discussion and approval this morning. The lawyer who has been assisting us, Harvey Hamburg, will be here this morning to answer any questions.

Those in Hamilton have been reminded of the extent of hospital fundraising by campaigns at all the city hospitals. A resolution was presented in the newsletter for debate this morning.

We have been working on a response to the Schwartz commission recommendations about the discipline process in self-regulating professions, and will be presenting a position this morning for discussion.

Prior to the election, Haresh circulated a set of questions about the health care system to the three parties. Their answers were published in the newsletter. Doug Sider was interviewed on Metro Morning about extra charges, and Gord Guyatt was quoted at length in the Globe and Mail. In June, Bob James was interviewd in French on Radio Canada about extra-billing.

Philip Berger stepped down from the editorial board of the newsletter in June, and Gord later in the summer, leaving Haresh to carry on more or less alone. We have nonetheless been able to carry on with an expanded format, and the editor urges you to submit original articles.

Gord Guyatt announced he is retiring from the steering committee. He has been a leader from our earliest days, active in many issues, and has made numerous important contributions. He will be sorely missed. We want to offer him our thanks.

Steering committee membership is open to all. It is an opportunity to deepen your understanding of your organization, health issues, and to get involved in those that interest you most.

Financial Report: Haresh Kirpalani and Ulli Diemer outlined the financial report and the budget for 1987-88. The MRG had a small surplus in 1986-87 even though a photocopier was purchased for $1600. A surplus of about $1000 is forecast for 1987-88. The MRG's finances are very much dependent on members renewing their membership, and also depends on a sizeable number of members renewing at Supporting Member rates. The budget was adopted by the meeting. There was a discussion of what, if anything, should be done with the MRG's reserve account, which now contains about $8,000. The consensus seemed to be that it should be untouched, as a reserve for bad times or crises.

Drug Patent Legislation: Bob Frankford reported briefly on the running battle between the Liberal majority in the Senate and the Conservative majority in the Commons.

Hamilton Chapter: Rosana Pellizzari reported on the last meeting of the Hamilton chapter, which looking at working conditions for interns and residents. About 30 people attended. The meeting decided to form a working group on "on call" and related working condition issues. They plan to set up a meeting with the interns and residents group of Quebec, and also intend to challenge PAIRO to take on the issue. Other MRG members were invited to join the working group. The group was also asked to prepare a short report on its work and on the Hamilton chapter discussion for the newsletter.

Hospital Fundraising: The following resolution **from Gord Guyatt and Haresh Kirpalani had been circulated prior to the meeting through the newsletter:**

Whereas:

1) Charitable financing of health care institutions depends on their ability to sell themselves to the public and to corporations and thus bypasses mechanisms of rational planning of health care delivery, and

2) Charitable financing of health care attracts money that would otherside be donated to areas where charitable financing is more appropriate,

The MRG advocates that health care expenditures be financed by the provincial and federal governments through progressive taxation and not, to any degree whatsoever, through charitable donations by private individuals and corporations.

Gord Guyatt summarized the discussion at the Steering Committee that preceded this resolution, and the thinking that led to it. Bob James spoke about his experience with Planned Parenthood which he said found it difficult to raise money from a number of sources because they had used up their contributions budget giving to hospitals. He also noted that an element of coercion was present in the ways money is raised from staff. After some discussion, the resolution was passed 8 to 6 with the last part of the last sentence deleted. The final resolution read as follows:

Whereas:

1) Charitable financing of health care institutions depends on their ability to sell themselves to the public and to corporations and thus bypasses mechanisms of rational planning of health care delivery, and

2) Charitable financing of health care attracts money that would otherside be donated to areas where charitable financing is more appropriate,

The MRG advocates that health care expenditures be financed by the provincial and federal governments through progressive taxation and not, to any degree whatsoever, through charitable donations by private individuals and corporations.

AIDS Working Group: Gary Burrows reported on behalf of the AIDS working group. He reported that the working group feels a need for MRG policy to be adopted in this area so that they can move forward to deal with the many AIDS-related issues which are rapidly emerging. He cited the example of the recent Burroughs-Wellcome case, and reported a feeling that drug companies are avoiding putting money into vaccines because of the risks associated with developing vaccines. In the approval process for new drugs, there does not seem to be any priority given to drugs dealing with fatal illnesses.

Gary introduced several resolutions which had been developed by the AIDS working group prior to the meeting. These suggested resolutions appear below:

Whereas the high degree of fatality of AIDS renders people with the disease particularily vulnerable to both promises of cures and the early development and release of treatments.

Be it resolved that the MRG calls for thorough but expedited evaluation and relase of all useful AIDS interventions by the Health Protection and Promotion Branch. Delays due to poor bureaucratic process should be eliminated.

Whereas

1) The cost of unique newly released durgs is often high and

2) People with AIDS are often disabled by the disease, uninsured, and unable to get insurance

Be it resolved that the MRG calls for readily available subsidization of AIDS patients drug costs.

Whereas the potential for excessive profit making on a drug to treat a disease over which there is widespread public fear is great

Be it resolved that the MRG calls for

1) Fair pricing of AIDS interventions and

2) Direct government financial encouragement of research be restricted to areas where profit if less likely to be private, e.g. vaccines, education.

In the discussion that followed, several people expressed the feeling that it was hard to consider several substantive resolutions on the spot, and that the resolutions should have been circulated in advance through the newsletter. It was felt that since the AIDS working group feels the need for some policy guidance now, it might be best for them to discuss issues with the Steering Committee, and to wait for formal resolutions to be passed at the next general meeting in the spring.

Gary Burrows identified the issues which seemed to him to be key:

-availability of information and services
-confidentiality of results
-informed voluntary consent
-mandatory testing
-physician burnout and supply
-drug costs
-drug research and drug approval process

Susan Phillips suggested that the MRG's discussion should focus on principles, rather than on specific diseases. A request was made that the AIDS working group prepare short articles for the newsletter which identified the issues and possible policies. It was also suggested that the MRG have an educational on AIDS, focussing more on the politics of AIDS rather than the medical aspects. It was suggested that this be the topic of the next spring meeting. In the meantime, the AIDS working group was asked to have further discussions with the Steering Committee.

Incorporation: Michael Rachlis explained the background to the decision to investigate incorporation, with liability being seen as a clear issue. The meeting then **voted unanimously to proceed with incorporation.** The official head office of the Medical Reform Group is to be 427 Bloor St. West, Toronto. The number of members of the Steering Committee was formally set at 12. It was agreed that the MRG would have an official president, but that this individual would have no more power than any other member.

Steering Committee Election: A presentation was made to Gord Guyatt and thanks were expressed to Gord for his many years of stalwart service on the Steering Committee. Fred Freedman was elected to the Steering Committee, and one position remains vacant.

Panel Discussion on Evans Report and Premier's Council on Health:

The three panelists for this discussion were Ted BAll, president of Health Concepts, and a former policy advisor to Larry Grossman when he was Minister of Health; Maureen Quigley, executive director of the Ontario Health Review Panel (The Evans Task Force); and Dr. Michael Rachlis, a member of the MRG Steering Committee. The following is a synopsis of their remarks.

Ted Ball:

A major problem for achieving things at the Ministry of Health is the revolving door for Ministers and deputy ministers. They are rarely there long enough to learn the issues and act on them. Yet the prublems are serious: the costs of the health system are out of control and things can only get worse as the population ages. The present rate of expansion of health costs is not sustainable, so reform is inevitable. The question is: what kind of reform? Will it be a result of strategic planning or will it be driven by interest groups.

At present, the health system is filled with plethora of perverse economic incentives. One result is our high rate of institutionalization. We institutionalize 10 per cent of our elderly, compared to 5 per cent in Australia or the U.S. The incentives encourage this; for example, the federal government contributes 50 per cent of costs of institutionalization. Comparable incentives don't exist for more rational forms of health care provision. Community pride and politics also conspire to create competition to secure more and more funding for institutions. We now have more than 250 hospitals in Ontario, each one with institutional imperatives for growth.

A typical scenario might be a charismatic physician at a local hospital approaching the hospital's Board of Directors to lobby for a bigger and better facility. The

basic message is: help me get this facility, or you're in favour of dead babies. So the hospital buys and builds, and runs up a deficit of $5 million. This is called government underfunding. Then the pressure is put on the politicians. Hospitals have tough lobbyists, and use heavy-duty PR to lean on politicians.

On any given day, 3,000 chronic care beds are occupied by patients who are in them inappropriately because of a lack of community alternatives. Yet recently the government provided $750 million to build 3,000 chronic-care beds. If that same money had been used to set up a home care system, a first rate home care system could have been provided for the 3,000 people inappropriately in chronic care beds, and it would have been unnecessary to provide the additional beds.

Other examples of perverse economic incentives: Nursing homes are given a flat per diem rate. Obviously, this creates an incentive to cut costs, and results in warehousing the elderly. By contrast, in Israel, the economic incentives are set up to get people rehabilitated and back out of the institution. In Ontario, the money is spent on drugs, not physiotherapy.

The government has abdicated responsibility for the fee for service schedule to the OMA. The OMA sets its rates to favour specialists. So, for example, Ontario has twice the hysterectomy rate of Europe.

Economic incentives for health promotion can only come from the OMA fee schedule. As long as the fee schedule is not tackled, serious reform of the system cannot happen.

Some positive action was taken just before the last election, such as better incentives for home care.

Current developments: 1. The re-emergence of entrepreneurship of hospitals. 2. The pending re-organization of the Ministry of Health with no strategic vision--basically bureaucrats fighting over turf. 3. The proposed Premier's Council.

When he was working Larry Grossman, Ted Ball was appalled by the non-system in mental health. No group homes, no after care. Grossman increased the home care budget from $15 million to $54 million. But in the end, the institutions wound up getting fully 60 per cent of the budget, essentially skimming off the money intended for non-institutional purposes.

The key to change is Strategy, Structure, Staffing. The current turf war between the Ministry of Health and the Ministry of Community and Social Services is likely to result in three years of total managerial chaos rather than in strategic change.

The proposed Premier's Council on Health: Councils are often a way of avoiding dealing with a problem. Central agency people "cream-skim" issues--they don't deal with them in depth. What happened was that the government responded to the yelps of pain from the OMA and others by saying, 'why don't we give you a Premier's Council so you can block future reform?'

Michael Rachlis:

The illness treatment is a minor determinant of our health care strategy. In the nineteenth century, the falling death rate was mostly due to things outside the medical system. Since World War Two, drops in the mortality; rate have been only 10 to 20 per cent due to the medical system. Doctors and hospitals have convinced politicians and society that people would die massively without them.

What resources we have are ineffectively used.

Minor tinkering from the top down won't work.

Ontario desperately needs a strategy for reform of the health care system. What was missing from the Evans report was an analysis of why change hasn't happened despite the consensus of past reports.

What are the barriers to change? Among the most major are hospital administrators and doctors.

In this country, $10 to $50 million is being spent to convince us to give money to hospitals--that they are important, and that they are underfunded.

Little thought is given to value for money. The are no outcome standards, and few quality assurance mechanisms. In the U.S., they are way ahead of us on this. For example, General Motors has a bunch of epidemiologists advising them what procedures their employees should be given.

The government has to get out of the mindset of just giving money to people.

There have to be broad-based community education projects to re-educate the public.

The healthy cities project (Trevor Hancock) is taking an approach which sees health as being more related to issues such as housing.

District health councils and local boards of health can be vehicles for re-education.

A Premier's Council might or might not be a good thing, depending on overall strategy and how it's used. It could be good if it did public education, or could be bad if it entrenches the status quo.

Maureen Quigley:

It has been very difficult to go beyond the idea that health care is sickness care.

The Evans Panel defined specific values and pointed to the need for information to support. It used a broader concept of health public policy. It pointed to the idea of health as a shared thing--shared between government, individuals, and health care providers. It came up with new ideas of who is at the table and how strategy gets established.

A big issue is how can both the consumer and the provider participate in deciding effective utilization?

We need opportunities and also incentives for innovation within the existing fee for service sytem.

What should the strategy for reform be? Goals have to be the foundation for reform.

The Premier's Council is intended to provide a forum in which shared commitment to goals could be explored and defined. It could provide a venue for all sectors to define strategy. Then the Ministry of Health could operationalize its part of it.

We need the leaders of he OMA at the table to draw them into the change process. Otherwise they will just block and not feel responsible to help implement.

Question Period:

Haresh Kirpalani: There are other obstacles to health, such as the food industry, unemployment, and

housing. How are they to be dealt with? The rhetoric of "community" and "individual responsibility" can be mask for cost-cutting. In Britain, the report "Prevention is Everyone's Business" was the first shot in the attack on socialized medicine.

Michael Rachlis: There is always the danger that organized medicine will be allied with forces that provide it with patients.

Ted Ball: With a Premier's Council, no one is in charge to make the tough decisions. The health care system is 200,000 to 300,000 people out there. Their minds have to be changed. Somebody has to be calling the shots.

Michele Harding: It seems that the Ministry of Health may be becoming irrelevant to decision-making about change. A community health centre has to prove its worth in great detail before getting a penny of funding. Yet any MD can set up an office and get immediate access to OHIP money--so can hospitals, at 10 times the cost of a community health centre.

Ted Ball: All issues in the Ministry of Health have been set back 8 to 10 months as briefing of a new minister takes place. The plans and intent of the former minister are now irrelevant (again) and many decisions are back to square one. The language now being used is "community outreach"--through a hospital. This is the story of the last 10 years: reform concepts have been grabbed by hospitals and rec-cycled back to us.

Michael Rachlis: All hospitals can do about a serious health issue such as wife battering is to provide plastic surgery for the victims.

John Frank: The fear is that what the Premier's Council will be is like the three blind men and the elephant. The elephant is dancing to its own tune and each blind man is at the head of a long queue of blink men. If it is to work, it needs to include key mandarins. It will also need a lot of support, specific guidelines such as what are its powers, who will pay its bills, who can extinguish it.

Health Disciplines Review: A synopsis of the Schwartz Commission and its recommendations on the discipline process was distributed. (The synopsis appears in this newsletter.) A discussion of the composition of the health disciplines panel made the point that the mandate of the process is to protect the public interest, not to settle dispute between patient and physician. The suggestion that events but not names be published in reporting on hearings was approved. The suggestion that the review process look at the broader context, not simply the individual complaint, also met with favour. A clear decision on the composition of discipline panels was not arrived at, but the feeling of the meeting seemed to be that a slight physician majority (60-40?) was appropriate. On the question of whether the complainant and doctor be present, the sense was that the complainant have the right to be present, but not be required to be. It was also suggested that complainants receive the protection of the Canada Evidence Act for their testimony, as a protect of lawsuits for defamation of character.

The meeting adjourned at approximately 4:30 p.m.

Doctors using administration fees to get around billing rules: report

MORE ONTARIO doctors are charging administration fees now that extra billing has been banned by the provincial government, the Medical Reform Group charges.

In a news release today, the group of Ontario doctors said the issue should be addressed by provincial election candidates.

"Bill 94 led to an increase in administrative fees. Many physicians who were charging user fees are charging much smaller amounts in administration fees," said Hamilton spokesman Dr. Gord Guyatt.

"We're more concerned that a group that was charging very little in the way of user fees, family doctors, are now charging administration fees," he said.

Administration fees can include doctors consultation by phone, or physicals done for companies or other third parties such as children's summer camps. Dr. Guyatt said the term is broad and covers any service a doctor performs that is not covered by OHIP's fee schedule.

"The majority of doctors aren't charging anything for these things. But it is alarming because it was something that was never done before and it's outside anybody's control. It's a potential deterrent to equal access," he said.

One of the administration fees being charged is for a letter to a hospital's abortion committee from a doctor giving a recommendation for a woman having an abortion. "The average (administration) fee for that letter is about $200 but it goes up to $500," Dr. Guyat said.

The medical group doesn't have any statistics to back up their claims, but Dr. Guyatt said the group's members are hearing a lot of complaints from their patients.

Why Women's Groups Oppose Depo-Provera

By Marsha M. Cohen, M.D., Assistant professor, Department of Social & Preventive Medicine, University of Manitoba

Depo-provera is an injective contraceptive agent which effectively prevents pregnancy for about three months. While this certainly sounds like an advantage over other family planning medications and devices, this agent is causing deep concern among women in Canada.

No one would deny the need for a long acting contraceptive agent. Any one who has worked in the field of family planning has known the frustration of dealing with the so-called "poor contraceptor"--the woman who always "forgets to take her pills" or the man who did not feel like using a condom. A foolproof contraceptive method, one which is independent of memory and does not interupt sexual activity is most tantalizing. Depo-provera, an injectable which lasts about three months, may seem to fill the bill. Of course, one wants it to be safe as well.

Depo-provera is presently approved in Canada, but not as a contraceptive agent. It can be used to treat some specific diseases such as endometriosis and some cancers. the manufacturer is now seeking approval to market the drug as a contraceptive agent. This means that the drug could then be promoted to physicians for widespread use.

The drug was not approved as a contraceptive agent in the U.S. mainly due to the action of groups opposing it, and it has had limited approval in other Western countries such as Germany and England. It has been approved for use in New Zealand and it is widely used in Third World countries. The importance of Canada for the manufacturer is indirect. If the manufacturer can get approval for the drug in Canada (a relatively small market for a drug), it then has valuable ammunition to get it approved in the U.S.. Therefore the events in Canada have wider implications than only for the Canadian scene.

Why then are Women's Groups fighting an uphill battle against this apparently "attractive" contraceptive agent? there are several reasons for the opposition to this drug. These include reasons of safety, control, informed consent and consultation.

SAFETY

The question of safety is complex. As with any new drug submission, evidence must be presented to show its safety before approval. The problem with Depo-provera is that its safety has not been shown and concerns about it have not been satisfactorily disproved. The main safety issues will be discussed under the headings of short term side effects, long term side effects and carcinoma.

Short term side effects: The side effects attributable to the drug include a long list: headaches, nervousness, dizziness, depression, acne, nausea, weight gain, heavy bleeding, amenorrhea, prolonged delay in the return of fertility, allergic reactions and so forth. This list alone should make one wonder why anyone would want to use it, since these side effects are commonly reported among users. Of course, trying to counsel a woman to expect some of these side effects is a major concern and one must raise the question of how busy general practitioners will counsel women about side effects such as amenorrhea or prolonged loss of fertility (in some instances it may take up to two years for return of fertility). There have been a series of reports (mainly anecdotal, but from various countries and with similar stories) of women suffering from prolonged heavy bleeding (sometimes requiring hysterectomy), enormous weight gains and heavy masculinizing effects. While probably not common, these side effects are debilitating and in some cases did not appear to be reversible. Another problem is of course, that if a woman has a side effect, she must wait three months before the drug has been eliminated from her system.

Longer term side effects: Not much is known about this drug. The studies looking into the longer term effects have been plagued by the usual methodological problems besetting too many clinical studies--insufficient sample sizes, inappropiate controls (if indeed there are any controls), problems with determining exposure to Depo-provera, failure to control for confounding factors, follow-up time too short and excess loss of subjects to follow-up. Several larger studies have been carried out in Third World countries and loss of at least one third of the sample have been reported. One does not know if the women did not return because of side effects or because it is difficult to follow women in these settings. One must also question the extrapolation of results from Third World women to North America women when racial and cultural factors play such an important role. And of course, one must question the possible exploitation of Third World women in studying any new drug.

A 1985 report by a Health and Welfare Special Advisory Committee on Reproductive Physiology (a committee with no consumer representation, composed mainly of physicians), suggested that since Depo-provera is a progesterone and contains no estrogen it "may be advantageous" for women over 35. This recommendation is particularily worrisome because the studies of Depo-provera on older women are even more poorly done and there even fewer of them than studies on younger women. A recent review of the literature on older women and the use of Depo-provera by Dr. P. Kaufert raises several health related issues. There have been (poorly conducted) studies suggesting that Depo-provera may affect lipid levels, blood pressure and may upset carbohydrate metobolism. The effects on other organ systems such as the cardiovascular system and musculo-skeletal system remain unstudied. For example, what might be the effect on osteoporosis? Data on these systems is not available. It may very well be that Depo-provera has no adverse effects, but we simply do

not know at this time. Thus the recommendation for Depo-provera for older women seems premature.

Cancer: There have been reports that Depo-provera was associated with tumor formation in experimental animals. While this raised the argument by proponents of the drug that humans are not beagle dogs, that missed the point. The main issue here is that if a chemical has carcinogenic potential in one species, there may be potential for carcinogenicity in any other species. In other words, these studies are meant to screen for the possibility of cancer causing chemicals. This type of data should not be ignored or glossed over by saying that humans are not similar to other species. Carcinogenicity studies are performed to assess **potential** and need not prove definitively that the chemical "causes" cancer in humans for us to heed the warning.

Human studies on a possible relationship between cancer and Depo-provera have been few in number. Recent studies in Africa and Asia have not found an association, but these studies have serious methodological flaws including very small sample sizes and the fact that breast cancer rates are very low in African and Asian women. Several other studies are ongoing but due to methodological problems do not appear to be that helpful. In other words, Depo-provera has not been shown to **not** cause cancer. While it is always more difficult to show a negative association between a suspected causal factor and an adverse outcome such as cancer, only an impeccable methodological design and statistical analysis can give one the confidence that there is indeed no association . As with other clinical studies into the side effect of Depo-provera, this has not been shown at this time.

The concern about the safety of Depo-provera is a very important one particularily since this drug would be promoted for normal healthy women. Of course, all possible side effects of a new drug will never be known in advance, but surely the basic research must be done before a drug is approved for healthy people. In the 1970's, sequential oral contraceptives were rapidly removed from the market when tumors developed in animals given the medication. Surely the same benefit of the doubt should be applied today.

INFORMED CONSENT

A second major after that of safety is whether there will be appropriate measures to ensure that the drug is always administered with the informed consent of the recipient. Referring back to the "poor contraceptor", it is tempting for the health care professional to want to impose his/her view of the world on the women (often very young and likely immature). But women's groups have questioned the role of the health professional in controlling women's reproduction in society. No matter how difficult the patient and how tempting the use of such drugs, we do not have the moral right to impose our views on these women. The use of Depo-provera for immigrant women, Native women and teens will be tempting for some health professionals, bur it would be difficult to ensure that women who are potential candidates for this drug understand what will be happening to them and that their future fertility may not be at risk.

CONSULTATION

Finally, women are concerned at the lack of consumer representation in the approval process for Depo-provera. At the present time, there is no mechanism for consumer input into the drug regulatory process. There is no mandate for public hearings nor for potential consumers of this drug to present their point of view. The Federal Departmentof Health and Welfare has been approached by various groups about this issue, but they have been secretive and uncooperative at best. A series of closed hearings concerning "fertility issues" was recently held across Canada last fall. Women who had been adversely affected by Depo-provera were not allowed to present briefs to this committee. Since the hearing was closed, many potential presenters were not informed that these hearings were taking place. The press was also barred from the hearings. A uninspiring report from the hearings is available from Health and Welfare Canada.

The issue of consultation is a crucial one, for all drugs as well as for Depo-provera. At present, there is a mechanism for public input for consumers products such as mattresses, infant cribs and the like but not for drugs or medical devices.

In summary, women across Canada have been expressing concerns to Health and Welfare Canada to try to present the wide spread promotion of Depo-provera as a contraceptive agent. There are just too many unanswered questions about this drug and women's groups are urging that more research must be done on Depo-provera before it is widely promoted for use by healthy women. Do we need another Dalkon Shield or DES disaster?

Dr. Cohen is a member of the Medical Reform Group.

A Review of "To Hurt and To Heal"

By Philip Hebert

Neonatology has grown alongside of a number of ethical dilemmas, some that are unique to it and some that are not. Several years ago, for example, Lorter in the U.K. developed standards for treating spina bifida infants that explicitly and controversially took into account quality of life expectations. It is well known, too, that handicapped newborns -- such as Down's infants -- are treated differently than other children and have not rarely been denied care that would be routinely offered to other less handicapped infants. As a study in the NEJM published in the 1970's showed, euthanasia -- both passive and active -- has been practised on neonatal wards and thought justifiable by most physicians working there.

The questions that can be raised about such views and practices are legion. Is it ever right to introduce quality of life decisions into the treatment of defective newborns? What guidelines should govern our treatment of such newborns? Can we utilise criteria like the

patient's 'best interests' that we use in other areas of medicine? How would we operationise such criteria and prevent their abuse? Should we ever take into account such factors as the family's needs and the costs of care? What role is there for the family in directing the care of newborns?

Medicine has a logic of its own that often prevents us from directly addressing these issues. An available technology or treatment is frequently applied and only later do we look at its implications for the nature of human life. Do such innovations truly contribute to human flourishing? Critical inquiry into the ongoing application of medicine is difficult, especially if that criticism arises from non-medical areas such as the non-professional public or disciplines such as philosophy. As well, the nature of medicine--as a craft and as a fiduciary enterprise--resists the critical gaze. It is as if it should be taken on faith that medicine is a benevolent enterprise. To question this benevolence suggests betrayal and sends many medical practitioners into a tizzy.

Laura Sky's film, *To Hurt and To Heal*, casts a critical eye on some of the troubling issues raised by neonatology. The first half of the film is an extended interview with one couple regarding their experience of a neonatal unit. Their experience replicates the one the Stinsons wrote about in their book, *The Long Dying of Baby Andrew*. The last half of the film introduces several other couples and professionals who work in neonatology.

As with other films by Laura Sky, *To Hurt and to Heal* attempts to bring us as closely as possible to the everyday experience and emotions of people who must live through the conflicts that other write about. There is not, therefore, a philosopher interviewed to tell us how to analyze and resolve such issues. There are no graphs and tables looking at satisfaction with medical care or the incidence of the ethical dilemmas. Instead, there are parents, nurses and doctors telling us about their roles and experiences, often in a very moving, and at times contradictory, way. Some of the stories they tell are not happy and we cannot always be proud of medicine's practises.

It is left up to the viewer to try to develop his or her own answers to situations portrayed in the film. This must leave some viewers unhappy. However, in showing it to groups of students, I have found it a very useful educational tool. The film portrays the dilemmas of one area of medicine with all their emotional power. As well, leaving these dilemmans open portrays neonatology exactly as it is at present. We indeed do not have clear, certain and morally sound answers to the problems raised in treating defective infants.

Moreover, coming to adequate answers here will likely require input from many sources -- medical, philosophical, and societal. The importance of *To Hurt and To Heal* is as a contribution to what should be a public debate.

This film is the first in a series of films Laura Sky will be doing on ethical issues in medicine. Given the paucity of such efforts, I would encourage any MRG member who may be interested in working on such films as a resource person --films on AIDS and psychiatry are presently in the works -- to please contact me, or *Skyworks* directly at (416(536-6581. I would also encourage financial contributions to *Skyworks,* a non-profit charitable foundation which employs Sky, as a contribution to a valuable and exciting project.

Philip Hebert is a member of the Medical Reform Group.

Another Review of 'To Hurt and To Heal'

By Haresh Kirpalani

This film was screened at a highly successful and well attended meeting of the Hamilton Chapter of the Medical Reform Group. The film concerns neonatal intensive care units (NICUs) and the ethics underlying them.

In his response to the film, R. Whyte, a practising neonatalogist articulated his main feeling as one of confusion. To be frank that was also my feeling. I had been hoping for guidance in day to day clinical life in the NICU, from parental comments.

The lay person coming to the film presumably comes to be informed about the process of decision making in NICU's, or perhaps out of curiosity about this area of high tech medicine. I suspect that many of these individuals would react with anger and confusion at the evident pain in the film. This pain is expressed by parents of infants with a poor outcome and by individual health care givers--nurses and physicians. Perhaps the most graphic pain was that of the parents of an infant named Jordan who was discharged with a tracheostomy.

It is pertinent at this stage to ask what genre the film is in. It it a documentary? To me it was an anthology of personal reminiscences. To my mind this was its simultaneous success and failure. To become the voyeur into people's lives, emotions, anguishes is the point of much film making (indeed of art in general) and the more emotion the better. However if that particular field of view is to be relevant to the global picture, there has to be great care in selection. The success in the anthology approach is self-evident. Humans in any situation are interesting when asked about their lives.

However, anthologising here was a failure, in really dealing with the major underlying issues.

These are clearly: Are parents told the right things about their babies? Are they given major opportunities to **affect** and even **change** basic decisions about their babies?

Paradoxically, had the anthologizing been **even more** specific, it could have succeeded in answering even more difficult questions. In Jordan's case we were not told the medical facts: was Jordan ventilated for extreme prematurity? It should have been possible to grapple with these following dilemmas: Could Jordan have been more severely affacted had no attempt at resuscitation at birth been made, and yet had he survived? Would these parents have been able to make a

decision in the delivery room not to intervene? Should society expect them to make such a decision at any stage? If Jordan has survived with "relatively" little intervention until the age of one month and than had a crisis, what happens to the parents' "objective" view of his future after they have "bonded" to the infant? Can they then take decisions? Had Jordan had congenital anomalies would it still be acceptable to "do everything for him"? Is society more obligated to the parents or to an infant with congenital anomalies?

Many such issues are raised in both print and in other films, and to mind are told better than in the current film. I would recommend to the interested reader: *Sarah Boston, Will My Son: The Life and Death of a Mongol Child, Pluto Press, Bristol UK, 1982*, and *The Long Dying of Baby Andrew* by the Stinsons, 1986, and I am sure there are hosts of other titles.

None of the real issues in NICU care will be successfully dealt with until society itself becomes involved. In my experience, most intensivists do **not** wish to be "gods". Until society becomes willing to be 'God' someone has to make the daily decisions. How should that be done? This film does not address that.

However if society is to become actively 'God' in this context, the more films, books, articles about the issue by non health care workers the better. By that manner, an overall representative feeling will prompt more concrete solutions. In this light, this film is a contribution.

AIDS and the restriction of liberties

By Philip Hebert

The MRG needs to address a number of ethical and political issues surrounding AIDS. The central conflict in all of these issues is that between the protection of public health and the protection of individual rights. It has been long recognized that private liberty may be infringed upon where the safety and interests of others are at stake. Mill, for example, recognized that state power may be exercised over a member of a community "to prevent harm to others". In this century public health laws -- around child abuse, communicable diseases, and so on -- mandate intervention into private lives. In a more paternalistic vein -- of which Mill would be unlikely to approve -- the Lalonde report suggested that private acts have social consequences and that the state has a pressing need to promote healthy lifestyles and discourage ones that lead to enormous social and medical costs. The unique dilemma of AIDS is that its control will involve some dramatic infringement -- either voluntary or involuntary -- of private liberties. Given the MRG's general social philosophy, these issues cannot and should not be avoided.

There are two public documents the MRG should address. The first is the CMA's suggestion that patient confidentiality around HIV results could be breached "when public interest clearly outweighs the interest of the patient". Elsewhere I have suggested this guideline is faulty because (1) the danger that those with a positive HIV antibody test pose to others is uncertain, and (2) breaching confidentiality in such situations would be unlikely to prevent harm and may jeopardize other voluntary efforts aimed at controlling AIDS. The only reason I can see to breach confidentiality are (a) if a patients consents, (b) if a court orders it, or (c) in situations where a truly positive HIV individual refuses to acknowledge the risks s/he poses to others. I will return to such individuals later.

The second public document is the Canadian Bar Association - Ontario report on AIDS released last year. This document has many strong points, but some serious flaws and will require study. Overall, I was surprised at how ready lawyers were to restrict civil liberties -- and I thought only doctors did such things! Specifically, the report recommends mandatory testing of donated fluids/organs to protect the donor pool, of blood when health care workers are exposed to blood products, and of immigrants (all who test postitive for HIV antibodies would be kept out for at least three years). The report also recommends mandatory reporting of all antibody positive individuals and mandatory contact tracing.

The core problem with the CBAO report is, however, this: will the means proposed help to slow the spread of AIDS and are they the best means to do so? While some of the suggestions regarding protection of the donor pool and of health care workers are unobjectionable, other proposals are less helpful. The report fails to stress the centrality of widespread and well-funded agressive education campaigns designed to encourage voluntary compliance with guidelines that reduce the risk of HIV spread. It fails also to consider that mandatory testing and reporting might undermine these efforts. Will contact tracing, with all the uncertainties that presently exist around the natural history of AIDS, be useful? How can testing immigrants help? I worry that the logic of some of the CBAO's mandatory proposals might lead to calls for more coercive measures, such as the quarantine of infected individuals.

The report is uncritical of the HIV testing procedure. Will negative tests have to be repeated six months (or 18 months) later? Who will pay for these tests? What will happen to the accuracy of the testing procedure as more and more tests are done at more and more facilities? Moreover, the tests are not entirely reliable, especially if done in low prevalence populations. How certain do we need to be of our testing before we can recommend significant infringements on liberty? How many "victims" of the testing process are we prepared to tolerate in order to ostensibly slow the spread of AIDS?

The present public health legislation allows coercive action, such as quarantine. For example, the Venereal Disease Act allows "the MOH or a physician designated by him" to enter any premise, and "remove to a place of detention" any infected person. Little used in recent years -- though abused in the past -- this legislation has been protected from scrutiny. The legislation lacks the clear criteria and procedural safeguards (such as the

right to a review board hearing) that are now in the Mental Health Act of Ontario.

Such legislation may come into play when a physician has a sero-positive patient who is known to be putting others at risk -- e.g. by engaging in high-risk sex with anonymous partners or by refusing to inform a spouse. With proper counselling most infected individuals will acknowledge their risks. Where they do not, a series of measures that would encourage voluntary cooperation could be introduced: liaison with AIDS support groups, attendance at medical and/or mental health clinics, in-patient management of drug dependency, and so on. These sorts of community-oriented and educational measures could obviate the need for more intrusive measures. Where an individual **still** resisted all such efforts, he or she might have to be supervised by a public health official and might lose their right to confidentiality.

In the specific case of a seropositive individual who refuses to inform a spouse, the family doctor faces a particularily difficult choice: either breach of confidentiality or put the spouse and/or offspring at risk. Such dilemmas are tragic because, no matter what decision is made, some wrong will be done. As in any ethical conflict, one will have to weigh the various consequences of the alternatives and decide for each particular case which one offers the prospect of least harm. One will have to take into account features specific to the individual case -- what is the likelihood and magnitude of harm? Who will be harmed? Can one deal with the conflict other than by breaching confidentiality? As well, it is necessary to look at the broader, long-term consequences of breaching prima facie duties of medical care such as confidentiality. Weighing such matters will not be as simple as the CMA's guidelines suggest and should not be left in the hands of the individual doctor alone.

In all this it should be said that procedural safeguards of due process must be introduced if public health control measures are to be imposed and ethical principles breached. Specifically, affected individuals must be shown to be a threat to others in the community. As well, all voluntary efforts should have been exhausted and no less restrictive or harmful alternatives be available. Finally, where serious principles such as privacy and liberty are to be breached there must be recourse to an impartial hearing. These sorts of safeguards should be built into any mandatory proposals.

The MRG has an important role to play in articulating a nonpunitive, non-coercive ethical response to AIDS that would stress the intelligent and thorough use of community resources. If such a response is not forthcoming, fear in the public and medical community may generate demands for more drastic action.

Philip Hebert is a member of the Medical Reform Group

News Briefs

Ontario plans to move on abortion

Health Minister Elinor Caplan has said that the Ontario government will spend $2.5 million on a proposed network of women's health centres which are supposed to improve access to abortion services. She that that ministry officials are reviewing about 12 proposals from hospitals to establish centres that would provide abortions and other medical services for women.

According to Dr. Marion Powell, who prepared the study that recommended creation of the centres, the first one should open in January or February 1988. Dr. Powell estimated that each year at least 6,000 women seek abortions outside hospitals, at private clinics in Toronto, Quebec, and the U.S. Dr. Powell said that the new centres will also provide services such as counselling on birth control, menopause or premenstrual syndrome and treatment for sexual assualt victims, and low risk birthing centres.

However, the government's plans have been criticized by the Ontario Coalition for Abortion Clinics (OCAC) and the Ontario Public Health Association (OPHA). The OPHA said at its November general meeting that the plan will do little or nothing to improve access to abortion. By relying on hospitals to provide the service, it does nothing to address the problem in those areas of the problems where no hospitals provide abortions, the OPHA said. The OPHA called on the government to allow free-standing clinics to operate legally. "Let them designate, for example, every clinic as a hospital," said OPHA spokesperson Dr. Peter Cole.

-Globe and Mail, Nov. 17, 21; Toronto Star, Nov. 18, 21

Toronto passes smoking bylaw

The City of Toronto has passed a new workplaee smoking bylaw which requires every employer in the city to draw up and enforce a workplace smoking policy which is agreeable to non-smoking employees. Employers will be responsible for enforcing the bylaw and city health inspectors have the authority to enforce compliance.

-Toronto Star, Nov. 9, 1987

B.C. takes custody of fetus

The British Columbia courts have upheld a recent move by the B.C. Ministry of Social Services to apprehend a child while it was still in its mother's womb. The move occurred after the mother initially refused a caesarian section birth, even though doctors told her that without the procedure the child would die or suffer permanent injury. Following the apprehension order, the mother underwent a caesarian and the child was born healthy 90 minutes later. The case has aroused strong debate in B.C., with a number of human rights and women's advocacy groups charging that the province has abused its powers. It also opened the ques-

tion of whether provincial authorities could legally apprehend a fetus. The cort accepted evidence that the mother, an alcoholic and drug user, could not be an adequate parent. He ruled that the baby should remain a ward of the state.

-Toronto Star, Sept. 4, 1987

Routine tests for drugs violate Human Rights Code

Employers who routinely test job applicants for drug and alcohol use are violating the Ontario Human Rights Code, the Ontario Human Rights Commission has ruled. The Commission said that drug tests are a type of medical examination, and that under the code medical examinations can only be given after a written job offer has been made, and then only when the examination is specifically to look for medical conditions that can directly affect an exmployee's ability to perform a job safely and effectively.

-Toronto Star, Globe and Mail, Nov. 245, 1987

Report suggests pollution health peril

Environment Canada has released but refused to endorse a controversial report by two of its researchers that suggests that people living in the area of the Great Lakes are suffering from the effects of pollution. The report, *Toxic Chemicals in the Great Lakes Basin Ecosystem,* suggests that pollution is increasing the rates of cancer, birth defects, and other diseases among people living around the lakes. It was completed over a year ago, but was not made public because the department could not decide whether to endorse its findings. In the end, the decision was to publish it with a disclaimer. Department officials say that they agree with the report's conclusion that pollution is harming wildlife, but say there is no proof it is harming humans. The researchers say that pollution is now so complex that it is impossible to clearly prove the link between health and widespread pollution.

-Globe and Mail, December 1, 1987

Drug makers' help sought in AIDS fight

The World Health Organization (WHO) is seeking help from private North American companies to design a global strategy for biomedical research against AIDS. The WHO says that even if existing trials of an AIDS vacinne go as well as possible, it will still be 1992 before a vaccine is availalbe for large populations. The WHO estimates that in the meantime, between 10 and 30 per cent of the five to 10 million carriers of the AIDS virus worldwide could develop the disease. This would mean between 500,000 and three million new cases around the world, and an enormous challenge for pharmaceutical companies to produce a range of options short of an actual vaccine or cure. One of the main technological challenges for the immediate future is development of simple, cheap and reliable diagnostic test to shorten the time between infection and detection. One of the WHO's major concerns is that when improved tests and drugs -- or a vaccine -- emerge from private sector research and development, they be affordable and available in sufficient quantity for AIDS patients in all countries, including poor ones.

-Globe and Mail, October 24, 1987

Cuts hit Alberta health spending

Despite protests from handicapped groups, welfare recipients, women's organizations and some churches, the Alberta government has removed a range of services and items from the province's medicare plan. Expenses no longer covered by medicare include birth control counselling, vasectomies, respiratory aids, most eye examinations, and wheelchairs. Also included in the cuts are substantial reductions in insurance benefits for physiotherapy and chiropractic care.

-Globe and Mail, August 1987

B.C. considers private hospitals for the wealthy

B.C. Premier Bill Vander Zalm says that his government will be looking at the possibility of allowing businesses to build and operate private hospitals which would serve the wealthy. According to Vander Zalm, this would be one way of taking pressure off the public health system and reduce costs.

-Toronto Star, October 26, 1987

Hospitals divert pension funds

The Ontario Hospital Association will take $80 million usually budgeted for an employee pension fund and divert it to the purchase of hospital equipment in 1988. The hospital employers declared the "contributions" holiday because it says that the Hospitals of Ontario Pension Plan has a surplus. The plan covers 216 Ontario hospitals with about 100,000 employees. The diversion drew strong criticism from hospital unions. They said employer contributions should be maintained at a level high enough to provide full inflation protection for 20,000 retired workers and for future retirees instead of being siphoned off for non-pension purposes. "We should be moving to index the pensions, and instead we'll have the employers not paying a nickel while the purchasing power of the pensions shrinks," said John Van Beek of the Service Employees International Union. The unions are not represented in the management of the pension funds, nor can they apply collective bargaining clout to the pension dispute. Ontario law prohibits hospital strikes and sends all disputes to arbitrators appointed by the government.

-Toronto Star, November 19, 1987

Sewage workers' health problems

A report by the Ontario Workers Health Centre shows that 60 per cent of sewage workers tested by its doctors have been affected by hepatitis viruses. The preliminary report, based on an analysis of medical examinations of 100 employees, also showed that three-quarters of the workers have been afflicted by skin ailments and 95 per cent display some evidence of kidney malfunction which may be a sign of heavy metal contamination.

-Toronto Star, August 14, 1987

Workers get right to pick own MD

Ontario employers can't make workers submit to tests by a company doctor to determine the effects of toxic workplace chemicals, the labour ministry has ruled. The decision, which settled a test case at Fleet Aerospace of Fort Erie, says workers have the right to chosse their own doctor at company expense when being tested for the effects of lead, isocyanates and other substances regulated under the Occupational Health and Safety Act. Union spokesman Mike Daley said that "we wanted our members to have the right to choose a doctor they can trust and who knows a lot about workplace health. We weren't getting much information from the general practitioner chosen by the company. This decision protects our right to get expert advice."

CUPE focuses on back injuries

The Canadian Union of Public Employees says it wants to raise awareness of what it calls a "hidden epidemic" of back injuries across Canada. Delegates to the union's biennial convention adopted a policy paper that called for legislation imposing limits on how much workers have to lift. A position paper said that workers are blamed too often for injuries that could be prevented with new equipment or weight limits. The paper said that in 1984, about 137,400 workers were incapacitated by work-related back injuries. The injuries, it says, account for 27 per cent of workers compensation costs.

-Globe and Mail, October 28, 1987

Hospital uses surveillance in disability claim

Mississauga Hospital is trying to challenge an employee's disability claim by using videotapes of his daily activities made by a private investigator. The hospital's actions have frightened the family of the employee and threaten to bring intrusive surveillance techniques into an area of dispute in which they do not belong, said Andrew King, a lawyer representing the worker. "They are now, to a certain level, paranoid," said Mr. King. "They don't know when they are being watched....I find it particularily incongruous that a hospital, which is publicly financed and concerned primarily with health, would get into this activity." Having viewed the videotapes, Mr. King stated that in any case they supported his client's case. "You can see times he is clearly holding his back in pain. We're not saying my client is a vegetable and can't move. We are saying his limitations are such that he can lift something, but he suffers pain from it."

-Globe and Mail, September 16, 1987

Cannery workers protest company lead tests

More than half the employees on the workfloor at Continental Can in Concord have complained to the College of Physicians and Surgeons about their company doctor's tests for lead poisoning. The workers say Dr. Abraham Friesner has conducted insufficient tests, and refuses to turn their medical files over to a workers' health clinic. At the heart of the dispute are workers' concerns about lead and chemicals to which they are exposed in the workplace, and their perception that the company doctor is not independent of the company which employs him. Damian Bassett, a company spokesman, said that "I think it's an insult to the medical community to suggest that their opinions can be purchased."

-Toronto Star, November 22, 1987

Obstetricians warned about fees

The Ontario Ministry of Health has warned obstetricians who charge pregnant women a fee for personally delivering their babies that they are violating the Health Care Accessibility Act. The College of Physicians and Surgeons has been receiving complaints that some obstetricians are charging women "stand-by fees" --as much as $1500 -- so the women are assured the specialists will actually show up to deliver their babies. The Ministry says that patients who are charged the fees will be reimbursed if the fees are reported, but has announced no plans for cracking down on the practice.

-Toronto Star, December 4, 1987

Patients said poorly fed

Many patients in Canadian hospitals are suffering from malnutrition, according to Paul Pencharz, the head of the clinical nutrition division at the Hospital for Sick Children. Some patients were malnourished when they entered hospital, and others became malnourished during their stay because of their disease, he said. There are not enough medical personnel in hospitals charged with diagnosing nutritional problems, he said. And other doctors may not understand the problems that malnutrition can cause, and may be reluctant to have others on their turf. "Medicine is organized by organ-specific specialities, the liver, the heart, and so on. And when you come in with something that cuts across these specialities, you stand on people's corns."

-Globe and Mail, November 4, 1987

Patients to get right to see records

The Liberal government will be introducing an amendment to the Public Hospitals Act which will give patients the right to see their hospital records.

-Globe and Mail, October 29, 1987

Red Cross concerned about private blood banks

Canada's first private blood banks have opened their doors this fall. For a price of $200 a unit, people who fear catching AIDS or other viruses from transfusions will be able to store their own blood in one of the banks. The Canadian Red Cross has expressed concern about the banks, fearing that they will undercut Canada's system of voluntary blood donations.

-Globe and Mail, October 23, 1987

Complaint files on doctors ordered opened

A court ruling has opened files kept by the Ontario Health Disciplines Board when it reviews the handling of complaints against doctors. The Divisional Court allowed appeals by two complainants who were appealing against decisions of the Board refusing them access to reports used by the College of Physicians and Surgeons in rejecting their complaints.

Globe and Mail, September 23, 1987

MRG Working Group on Working Conditions for Interns and Residents

The Hamilton chapter of the MRG welcomes members to join the newly formed working group studying working conditions for interns and residents. The group's goal is to lobby for new legislation limiting working hours. Issues we will address range from the political-economic to those regarding quality of medical training, public safety, and occupational health. For more information, call Rosana at (416) 529-6010.

Editorial

There have been a number of major issues that have evolved over the past six months. Whilst we have had relatively little coverage of some of these, the implications for physicians interested in social ramifications of health are clear. To link these disparate issues coherently with health impacts requires considerable ink. This is intended to simply and crudely weld some of the filched cuttings from more reputable (sic!) sources together. Someone surely in the MRG will elaborate more fully in the following newsletters.

Perhaps the most serious issues in the news for progressive Canadians have been the stock market crash and the free trade talks. The parallels of the 1987 crash to 1929 are shown by the graph from the New York Times. Progressives who had been predicting such an event for some time should not be saying: "I told you so." Now is the time to consider what we do if and when there is accelerated pauperisation. Disraeli's "Two Nations" within one nation becomes ever clearer south of the border. (See book review.)(p. 18)

Of course the Keynesian view (that social spending is in fact essential to industrial countries because it injects necessary spending power into the poorest of the population) is continuing to be put forcefully. This may limit social health and welfare cuts. Is anyone listening out there? (See New York Times article.)(p. 19)

Well the world trade and stock market crisis is certainly going to lend urgency to the strident calls for either redistribution of health service budgets ("community" versus "hospital" is the formulation) or cost-cutting. Behind this is the issue of "guns and cruises or butter", i.e. where should cuts in government expenditure fall? Beyond this I will not venture for the moment. The impact will certainly be felt by us. (See Pat Rich, Medical Post, Marina Strauss, Globe and Mail, and Globe editorial on Evans.) (p. 20, 21, 22)

Free trade appears to be on the table signed and sealed. But will the midwife come in time? Progressives will fight for an election to give a mandate on free trade. We have had a little on Free Trade previously (see October newsletter) but a delightful little insight was provided recently on the negotiations. (See Globe and Mail, C. Waddell.)(p. 23)

Joel Lexchin and Bob Frankford have educated us previously on the likely consequences of C22. The Senate backed down and it was impossible for them to do otherwise. (Cartoon Globe and Mail October 21, 1987). (p. 27)

The oft cited issue of democracy obviously became an issue with Conservative Party members shouting about their recent discovery of this dormant political entity. However our rejoinder is that it is hardly democratic for secret deals with big companies to made and not divulged, as in the case of the free trade bill and C-22.

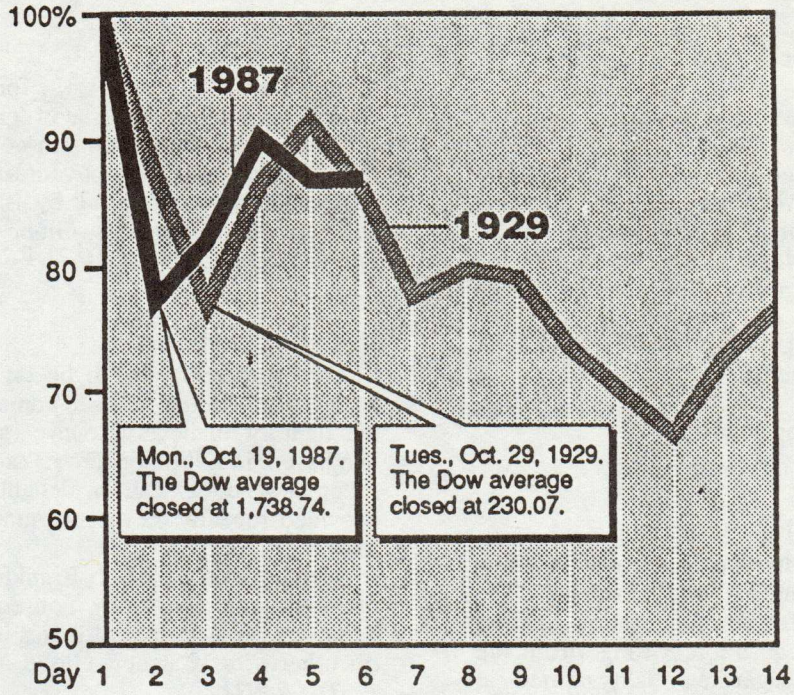
The issue of redress for mishandled, mistreated patients (or patients who perceive themselves as such) has been addressed by Don Woodside and Bob James in relation to the Colleges. However there are (as everyone practising knows), increasing legal activities in this field. In an article by Sullivan in N.Y. Times Nov. 8, 1987, it is reported that the New York State Commissionor of Investigation has recommended new laws on medical liability saying "there was a conspiracy of silence" among health care professionals. (Article not reprinted here.) An interesting more general twist on this link between law and medicine is given in the article from Ontario Medicine. Progressives should note Mr. Golden's thrust to "enforce the right to Health."

We have as an organization some common aims with the Law Union. Perhaps some of these links should be more concrete e.g. in the issues of the legality of withholding medical insurance for AIDS patients; certain medical/surgical interventions without prior HIV testing; in the area of child abuse, etc. Bob Kellerman of the Law Union in the next issue will address the issue of treatment of the unborn.

Finally we cannot ignore the recent debate on tobacco. Progressives will certainly applaud the new steps. To be accurate in their assessments of how policy changes occur however, it is important to understand that big business has now become interested in the issue. This is big business outside of the tobacco business clearly!

Finally continue sharpening your feather quills, plug in your work processor or prepare your wall posters for the next newsletters.

Cheers for the New Year!



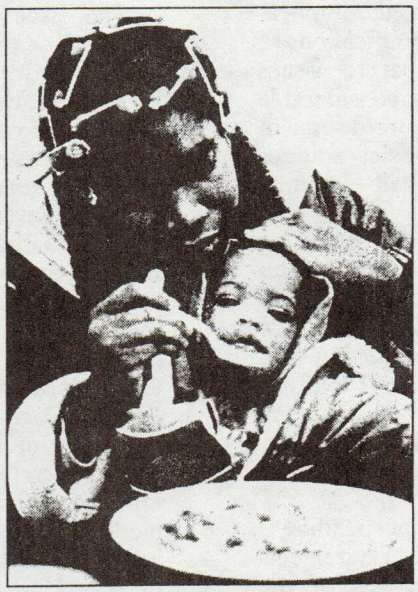
THE NEW YORK TIMES, SUNDAY, OCTOBER 25, 1987

THE ECONOMIST November 1987

Skid Row revisited

THE Reagan administration contends that hunger is not a problem in America; there are merely ignorant people who do not know how to feed themselves. A group of doctors from Harvard University, unconvinced, travelled round the country between 1983 and 1985 to check the evidence for themselves. Their report, LIVING HUNGRY IN AMERICA*, by J. Larry Brown and H.F. Pizer, keeps the reader in a state of suspended rage until the last chapter, when some proper statistics and respectable analysis emerge. Until then, it is all poignant and unsubstantiated hearsay: a series of interviews with poor people whose accounts are never questioned and whose motives are never less than pure. This is exactly what the Reagan administration meant when it said, wrongly, that the evidence of hunger was "anecdotal". The book plays into the hands of its enemies.

Its authors often say that they wanted to keep politics out of the report. They failed. Local congressmen, especially Republicans, often refused to see them or help them; this was grist to their mill, but their prejudices were established early. Hunger is the government's fault, therefore the government alone can cure it. The poor are always willing to work, given the chance. Money spent on weapons would be better spent on food programmes. More than anything else, bureaucratic obstructionism is what stops the hungry getting food. And so on. In all these propositions there is a piece of truth, but by themselves they are simplistic. And sometimes the analysis goes right over the edge. In some soup kitchens run by fundamentalists, the managers "needed the hungry to stay hungry" in order to feel virtuous. On a walk through a slum in Chicago, one of the authors uncritically reports the remark "This is genocide." This is tosh.



Ignorant people? Hardly

Many aspects of the book cry out to be argued with. The authors describe a nationwide and relatively new epidemic of hunger, yet the places they visited were those that have been hungry for generations: the Mississippi delta, the Appalachians, a Navajo reservation, rural Alabama. Only in Peoria do they seem to have found hunger where it would not have been expected.

The worst of it is that the doctors have a good case. Hunger in America is far more common than it should be. The Reagan administration, principally by cutting down the information service of the food-stamp programme and by studied disdain, has done nothing to help, and much to harm. Certain state governments are miserly to a fault: in Texas in 1985, only a quarter of the 2m people living in poverty obtained any public assistance. The number of Americans living in poverty—26m in 1979—had reached 33m in 1985. Rates of infant mortality are higher than in other industrial countries. As the doctors say,

> America's safety net for the poor was weaker than any of us had realised—by almost any measure, from family health care to hospital coverage, from food assistance to income supports, from job security to day care, poor Americans are more vulnerable than their counterparts in industrialised nations that have fewer resources than we do.

This is true, and it is the obverse of the rugged individualism that foreigners admire. In arguments over how big or intrusive government should get, the hungry and the poor are rarely heard. Nonetheless, in a penny-pinching and suspicious world, their story should be told straight: without artifice, and without tears.

*Macmillan. 212 pages. $19.95.

THE NEW YORK TIMES, SUNDAY, NOVEMBER 22, 1987

Social Spending Can Avert a Recession

By FORREST CHISMAN and ALAN PIFER

DON'T cut Federal social programs — particularly not now — as Congress and the President are preparing to do. Social spending can help stave off a recession, or at least reduce its severity.

While some programs might be better targeted or made less expensive in other ways, major cuts would be a self-defeating exercise. That is because social programs act as an economic stimulus in hard times by propping up consumer spending, creating jobs and investing national wealth in long-term growth.

Their effect on consumer spending is easiest to see. About 80 percent of the Federal domestic budget — more than $450 billion — is devoted to cash or in-kind transfers to individuals. The Federal Government provides cash payments through Social Security, Supplemental Security Income, veterans benefits, Aid to Families with Dependent Children, pensions for former Government workers and other programs. Most of these payments go to people who are likely to spend, rather than save, the money they receive: low-income individuals and retirees. In-kind benefits, such as Medicare, Medicaid, food stamps and low-income housing subsidies, go to the same types of beneficiaries. About one third of American families receive benefits from one or more of these programs in any given year. Reducing them would result in an almost certain decline in demand for goods and services.

Of course, Government policies that would reduce aggregate demand are exactly the wrong medicine if we are worried about preventing a recession, because a recession is, among other things, a falling off of demand. And if a downturn occurs, lower levels of social spending and less income available for consumption would increase its severity.

Worse, if social programs were cut back, consumption would fall in precisely those areas of the economy that we would least like to see harmed. Low-income people tend to spend on the essentials, such as food, shelter and clothing. Many Federal programs, such as housing subsidies and food stamps, are targeted at increasing these types of consumption.

Most serious would be a reduction in Medicare, Medicaid or veterans benefits. The Federal Government spends more than $130 billion each year on health care, and through tax breaks it subsidizes most private medical insurance plans. Health care is one of the largest and fastest growing industries in the United States, consuming over 11 percent of our G.N.P. And it is one of the largest providers of jobs for both skilled and unskilled workers. Reducing Federal support for the health care industry would have a direct effect on employment, wage levels and investment in a mammoth sector of our economy.

Food, housing, health care and most of the other goods and services that Americans would buy less of if social spending were reduced are "made in America" products, not foreign imports. The companies that would be harmed are American companies; the jobs that would be lost are American jobs.

But stimulating demand is not the only way in which social programs can help fend off or ameliorate a recession. About $120 billion in domestic spending directly creates jobs. A large portion of it goes for public works projects, such as building highways, and various community development activities administered by states and cities. What are often called "pork-barrel" programs are really jobs programs that are needed to shore up local economies.

Finally, reductions in social spending would throttle back some of our major engines for long-term economic growth — social investments that would help to pull us out of a recession and build a stronger economy in the years to come. An obvious example of this is Federal aid for education and training, which consists of more than $30 billion in direct spending and $10 billion in loans or loan guarantees. Most experts believe that a better educated and more highly skilled workforce is essential for long-term prosperity in the United States. And a large body of evidence shows that people with higher levels of education are far less likely to be unemployed or to suffer abrupt declines in income than other Americans.

The same is true of child development programs like Head Start. They have shown their ability to improve the prospects of low-income youngsters. And getting all of today's children off to a good start in life is important. If the United States is to shoulder the burden of supporting the baby boom generation in its retirement without a major decline in the nation's standard of living, we will need the best efforts of each of today's young people, including the 20 percent who now live in poverty.

A less obvious way in which social programs build long-term economic strength is through the effect that Social Security has on savings. Many economists lament the fact that the United States has a lower savings rate than other developed countries. But Social Security is a form of enforced savings.

THE payroll tax requires workers to set aside a portion of their earnings to support the elderly. And since 1983, the system has been designed to build an ever increasing reserve of funds not needed to pay present retirees. That reserve is invested in Government securities, and within a few decades it will add up to $2-3 trillion.

By accumulating this reserve, the Social Security system is gradually buying up a large part of our national debt. That will free private funds for investment in the expansion of business and reduce our dependence on foreign creditors in the years to come. Any measures that would undermine confidence that the Social Security system will deliver benefits as promised — such as proposals to convert it into more of a needs-based program — would destroy these long-term benefits for the economy.

But if it is so obvious that reducing social spending is just the wrong thing to do when a recession threatens, why are so many people saying that cuts in this area are a necessary part of any Federal deficit reduction plan? The answer is that it has long been an article of faith for many politicians and business people that social spending is harmful to our economy. They see it as a sterile use of national resources that is required for humanitarian purposes alone.

And they're wrong. Social spending does not destroy national wealth. There is not a great Federal incinerator in Washington where all those tax dollars are burned. Social spending re-routes national wealth. And in troubled economic times it re-routes wealth in precisely the right directions: to maintaining consumption of American goods and services, creating jobs and investing in the long-term future of the economy. We all pay for it and we all benefit enormously, particularly when the economy turns sour. ■

Forrest Chisman and Alan Pifer are co-authors of the newly published book, "Government for the People: The Federal Social Role."

THE MEDICAL POST, JULY 21, 1987

Utilization of health care in Ont. partially falls in laps of doctors

BY PAT RICH

TORONTO – **The Ontario government has succeeded in making physicians partially responsible in a fiscal sense for increases in utilization of the health-care system over the past year.**

While this was not generally publicized in the news media, it is one of the important and interesting elements included in the report prepared by fact-finder Jim Baillie which was unanimously accepted by both sides on the joint committee on physician's compensation and led to the agreement signed late last month (see The Medical Post, July 7, 1987).

While the $41 million granted in compensation for giving up the right to extra bill was the focus of most of the publicity surrounding the report, the issue of utilization was actually dealt with in more detail by Baillie.

And in his final reckoning, Baillie reduced the global fee increase by 0.75% (approximately $30 million) to account for an increase in per physician utilization of the system.

Attempts to make physicians partially or totally responsible for utilization of the health-care system are now becoming part of the negotiating process between physicians and provincial governments.

In British Columbia, the government's attempt to make doctors responsible for any increase in utilization of the system has stalled attempts to negotiate a new contract. In addition, as Baillie points out, guidelines exist between the Manitoba Medical Association and the Manitoba government on who is accountable for various changes in utilization, and in Alberta the government attempted to have the fee schedule decreased because of increased utilization.

Unrealistic

In its original bargaining position for the new Ontario contract, the government wanted an agreement "on an acceptable means of dealing with the economic implications of utilization growth" as a condition of part of the increase to the fee schedule.

The Ontario Medical Association (OMA), on the other hand, said Baillie, agreed that utilization is an important issue and expressed a willingness to address the issue but said the deadline of Jan. 1, 1988 proposed by government was unrealistic.

The association said it was inconsistent with quality care to penalize physicians for increased workloads and meeting patients' needs and said there should be no utilization adjustment to the final agreement.

Faced with these positions, Baillie said, what he attempted to do was estimate the percentage increase in utilization which could be attributed to factors affecting the global revision to the fee schedule and deduct this proportion from the final settlement.

Using Ontario Health Insurance Plan (OHIP) increases in payments per physician, Baillie said an estimated 1.5% increase in the fee schedule could be attributed to increased utilization, although government negotiators said the increase was at least 2%.

Rejected

Accepting that there was a per physician utilization increase in physician incomes of about 1.5%, Baillie's recommendation was that the final fee increase should be decreased by half this amount, or 0.75%.

In doing this, he rejected any approach which attributed increases in utilization to increases in the total number of physicians billing the plan.

"... if the government believes that Ontario is admitting too many physicians, it should address the problem in ways other than by asking for an agreement in the OHIP benefit schedule that will penalize physicians at large."

At the signing ceremony for the new agreement, Health Minister Murray Elston said a joint government-OMA committee designed to look at utilization issues will be reactivated, having been dropped in 1985.

"We, in fact, as an association and a government have just newly committed ourselves to reconstituting the group that was dealing with the utilization study and we are pursuing that together—jointly.

Results

"We are very serious both as a government and a profession about pursuing those much more vigorously (than) in the past and with a resolve which will produce results this time," Elston said.

OMA President Dr. Hugh Scully also spoke in favor of a joint approach to the whole utilization question.

Another issue which Baillie termed the most difficult issue of principle he encountered in his analysis dealt with the government's attempt to tie the fee negotiations to the current state of funding for health care as a whole and physician remuneration outside the province.

He said the government pointed out health care consumes 32% of the provincial budget and payments to physicians account for almost a quarter of this sum, and that the compensation committee "should take cognizance of the reality of provincial budget setting."

The stand taken by Baillie in his report is "if the government wishes to force the medical profession to accept fee constraints designed to enhance budgetary objectives or maintain interprovincial uniformity, it can do so by legislation, with the attendant public debate and political action that would seem appropriate to such a decision."

Hospitals find sidelines to raise money for care

BY MARINA STRAUSS
The Globe and Mail

When night falls, an empty wing of the Toronto General Hospital is sometimes transformed into a police station. A permanent sign above the College Street door labels it as the Mid South Precinct.

The cops-and-robbers action at Canada's largest acute-care hospital is no accident. Episodes of the popular television series Night Heat and many other productions have been filmed at the hospital as a lucrative way of raising cash.

At Ottawa Civic Hospital, staff, patients and others stroll through the yellow-brick arches of the hospital's shopping mall, where passers-by can buy an ice-cream cone, browse in a clothing store or get their hair cut. The Main Street mall makes the hospital about $2-million richer a year.

Opening pizza parlors, restaurants and stores, manufacturing medical and computer equipment, building new wings jointly with private companies and even hiring a private firm to run a hospital: these are some of the entrepreneurial activities that hospitals across Canada — but mainly in Ontario — are increasingly adopting.

Some hospitals have hired marketing directors to help sell their wares, and a growing number of cash-starved hospital administrators are keeping a keen eye out for ways to bring in more money through the private sector — among other means.

"It shows you the changing times that we're in," said David Allen, director of public relations for the Toronto General. "In the past, the Toronto General and major hospitals would lend staff, lend expertise and would give away all the educational materials that had been prepared at great expense. We now don't do that. We sell them and we sell people's time."

Buying and selling is becoming serious business for Canada's financially strapped hospitals that have seen their multi-million-dollar budgets dwindle in the face of inflation and government belt-tightening in recent years.

"Things are developing fairly quickly across the country," said Daniel LeTouze, the Canadian Hospital Association's vice-president of research and development. "It's part of the privatization philosophy."

Yet many hospital officials are stepping extremely cautiously into these business ventures. Some critics warn that hospitals could become commercial outlets similar to some U.S. hospitals that turn down patients for not being cost-efficient.

"Some hospitals believe that they are not in business to make money — that they're in business to provide the best possible services," Mr. LeTouze said. "It (privatization) might divert some attention and effort to non-health-related activities."

But, Mr. LeTouze hastens to add: "Hospitals will have no choice but to go along with this trend."

The trend includes hospitals setting up their own companies to commercially develop home-grown technology and products (for example, Toronto's Hospital for Sick Children); and hospitals contracting with private health care companies such as Extendicare Health Services Inc. to build and manage chronic care facilities (e.g., Toronto's Queensway General Hospital).

The Toronto General's pharmacy department is managed by Hospital Corp. of America's Canadian affiliate. The University Hospital of London has a deal to purchase high-tech equipment from the same company, which is based in Nashville and owns and operates 485 hospitals in the United States and elsewhere.

The London hospital — which said it saved $500,000 in 1986, the first year of the deal with HCA — is preparing to franchise nationwide a unique occupational health centre it runs for local industries. The hospital has also set aside about 22 beds for out-of-province residents — a move that has sparked some criticism that Ontarians might be denied care.

At least two public hospitals in Canada are totally run by private companies and report glowing results.

The Hawkesbury General Hospital in Hawkesbury, Ont., east of Ottawa, which was suffering severe financial troubles, signed a 13-year agreement with American Medical International Inc. of Beverly Hills, Calif., in 1983 to run the hospital for an annual fee of about $300,000.

"A lot of hospitals could benefit from this sort of thing," said Michel Lalonde, executive director of the 110-bed hospital. "I think it's a model."

The 65-bed Athabasca General and Auxilary Hospital in Athabasca, Alta., north of Edmonton, was also deficit-ridden when it signed a three-year contract with Extendicare in 1986 to run the hospital for $139,000 a year. Last April, a year after the private nursing home chain took over, Athabasca General was more than $100,000 in the black.

"What we have right now is really the best of both worlds," said Geoff Weber, Athabasca's hospital administrator. "I would certainly encourage other hospitals to take a very serious look at it."

In fact, the concept of hospitals turning to the private sector to run some of its activities is not entirely new. Laundry, housekeeping, security and food services have been contracted out to private firms for many years. Hospitals have made money from dry-cleaners, parking lot fees and premiums for private rooms and a room with a view.

The notion of entire hospitals being put in private hands is a relatively novel one for Canadians.

"There's not a lot of (hospital) management contracts in this country but I think more people are starting to talk about the concept," said Gary Chatfield, who is president of Extendicare's hospital management division and who has served in senior Health Ministry positions in both the Ontario and Alberta governments. "I think it's going to be a growing component of the health care system."

Mr. Chatfield predicts that at least a dozen hospitals will move to private management in the next few years. "We're anticipating significant growth in the hospital management sector over the next two to five years."

The move has its detractors. Pran Manga, a health economist at the University of Ottawa, said the potential for more costly patients to be deprived of hospital services under private management is disconcerting.

Continued...

THE GLOBE AND MAIL, SATURDAY, AUGUST 8, 1987

Hospitals

"Foreign evidence suggests that it is not a wise policy direction," Mr. Manga said.

He said private management companies tend to target hospitals that are experiencing greater-than-average operating and financial problems. In the United States, the companies follow a "loss leader" strategy, providing services at uncharacteristically low prices to generate surpluses and thus increase their share of the management market.

"Some forms of privatization are, in fact, counter-productive and will have an adverse impact on important public policy objectives," Mr. Manga wrote in a recent article for the Journal of Consumer Policy. "Even the forms of privatization such as contracting-out services which could have a positive effect on efficiency and have benign effects on equity are not likely to be quantitatively important enough to make much of a difference in our effort to contain health care expenditure."

The Ontario Hospital Association gives a qualified nod to private sector involvement in the public system.

"But the nature and extent of that involvement must be carefully monitored and controlled to ensure that private sector forces are not dominant," the OHA said in a brief last April to an Ontario Government committee looking into commercialization of health services. "Health care in Ontario cannot be produced or marketed like a commercial product."

The Ontario Government gave hospitals a boost to develop private ventures in 1982 when it introduced the Business Oriented New Development Program (BOND). It allows hospitals to keep additional funds they raise from revenue-generating enterprises.

As for Toronto General, it charges up to $10,000 a day for filming there. Some have complained that filming interferes with regular hospital functioning. "Let's face it, the revenue is good and that revenue provides for the extras that we want to give the patients and the staff," Mr. Allen said. "As with anything, it's a little bit of pain that goes with it."

THE GLOBE AND MAIL
SATURDAY, AUGUST 8, 1987

Hospital in the home

Health care in Ontario is fiendishly expensive. Between the government's health budget and private spending on dental care, eyeglasses and the like, Ontarians spent $14.5-billion in 1985 to ward off, cure or ease their pains. As the population ages, that total can only increase.

Yet Dr. John Evans, chairman of a government-appointed health review panel which reported last month, says his group "found no evidence that health-care costs in Ontario are out of control." If this is so — or, more precisely, if no one can agree on what constitutes abuse of the system — Ontario has a choice between accepting an ever-increasing spiral of health costs and devising a strategy to spend less to care for people. The challenge is to buy more efficiency without sacrificing quality.

One such way, the panel says, is to keep people at home instead of putting them in hospitals. In this, it repeats a recommendation made by several earlier task forces, and notes that "well-founded recommendations made by credible groups over a period of 15 years have rarely been translated into action."

But Dr. Evans and his colleagues persist. "Evidence suggests a significant proportion of hospital admissions could be avoided. The length of hospital stay could be reduced. Some patients now being cared for in long-term care institutions — including nursing homes and chronic hospitals — could be cared for in their homes with the appropriate level of home care and support for their family care-givers." Such care is "more likely to address the problems that contribute to the patients' illnesses than treatment provided in a detached, institutional context."

At least one hospital shares this sentiment. Sunnybrook Medical Centre in North York has submitted a draft proposal to the Health Ministry for a "hospital-in-the-home" project similar to those in New Brunswick and at Montreal's Verdun Hospital. This would concentrate on patients who would otherwise be in an acute-care hospital, whether for recovery from surgery, cancer therapy, palliative care or "multi-system disorders as occur in the elderly."

Doctors from the community and the hospital would visit patients on a "ward" of 50 patients, all in their own homes. Such a ward "would cost about $5,000 a day to operate," the Sunnybrook document says, "in contrast to about $25,000 a day for acute hospital care." It would avoid "the dehumanizing effects and family separation that characterize acute hospital care." Patients would be admitted to and discharged from acute care in their own homes, with a medical and support staff on call as required.

Echoing the Evans report, Sunnybrook notes that "the 9 per cent of the population that is over 65 now occupies, for sound medical indications, at least 45 per cent of the acute care beds. When this 9 per cent becomes 18 per cent (as it will in the next 25 years), all available acute beds will be taken." The hospital-in-the-home concept, it says, could lower the current bed use by as much as 40 per cent.

There's more. It envisions a van "with cellular phone, pagers and a computer hook-up to the hospital's patient care system for patient care instructions, lab tests and results, and unit-dose pharmacy management. A nurse, social worker and/or other relevant personnel can administer care in the home, mobilize other home care services and assistive devices, train the family, monitor the state of the patient and communicate with the physician."

This is the stuff of the Evans report and those that preceded it. It makes sense, promises to save money and stands to benefit the patient. The government should give the proposal an enthusiastic reception.

THE GLOBE AND MAIL
July 7, 1987

Ministers differ on linking of trade, drugs

BY CHRISTOPHER WADDELL
The Globe and Mail

OTTAWA

There is no link between Government efforts to pass controversial changes to drug-patent legislation and a free-trade deal with the United States, Harvie Andre, Minister of Consumer and Corporate Affairs, maintained yesterday.

"I have said repeatedly that Bill C-22 was not part of the trade negotiations," Mr. Andre told the Commons.

But late in the day, Mr. Andre's comments appeared to be contradicted by a written statement released by Patricia Carney, the Minister of International Trade.

She said a commitment on Bill C-22 was agreed to by officials of both countries in the trade talks but rejected at the last minute by senior Canadian negotiators.

The statements yesterday by the ministers were in response to a barrage of opposition questions following a report in The Globe and Mail yesterday that the original version of the free-trade agreement included a commitment by Canada to pass the drug-patent bill currently stalled in the Senate.

The agreement was initialled by negotiators for both countries on Oct. 3.

A subsequent version of the deal initialled by the two countries on Oct. 4 made no reference to the drug-patent bill. That second version was tabled in the Commons on Oct. 5 by Mr. Mulroney and then made public.

"What was ultimately agreed to in Washington and the only version signed by ministers was the document tabled in the House of Commons Oct. 5," said Ms Carney's statement.

It noted that in last weekend's final bargaining, a dozen working parties examined elements of the final deal.

"One such working party sent forward to the negotiators a draft initialled by the working party chiefs recommending the commitment by the Governent of Canada with respect to C-22.

"The Canadian negotiating team rejected this proposal that was brought forward by a working party in the final stages of the negotiations. This was part of the natural process of these negotiations."

The need to alter the agreement to remove the drug-patent reference may have been the reason for Canada's delay last weekend in announcing that a deal had been reached.

When asked about this, Bruce Phillips, director of communications in the Prime Minister's Office, replied, "I don't think so. I was around that time. I heard the speakerphone and I don't think it was that late in the day."

Sources indicate Canada apparently requested the change to avoid political embarrassment as the Mulroney Government has consistently claimed there is no link between the trade talks and the drug-patent issue.

"All I know is the agreement we have is tabled on the floor of the House of Commons. It's there for you to see," Mr. Andre told reporters yesterday outside the House, stressing that the tabled version of the trade deal made no reference to Bill C-22.

That statement also appears to contradict Ms Carney's remarks at a press conference with Finance Minister Michael Wilson in Ottawa on Oct. 5. At that time, she indicated the drug bill was part of the negotiations.

When Mr. Wilson was asked whether there were any side letters or unpublished undertakings, possibly on Bill C-22, related to the trade agreement, he replied, "This agreement stands on its own. There are no other undertakings."

Senator Lowell Murray, Government Leader in the upper house and Minister of State for Federal-Provincial relations, also implied yesterday there was a relationship between free trade and the drug bill.

"If the Senate were to defeat Bill C-22, I believe that many congressmen and senators in the United States would think twice about their support for the free trade agreement because, surely, they would take such an action as meaning that one of the houses of the Canadian Parliament was thumbing its nose at the spirit of this free-trade agreement," he told the Senate.

The Oct. 3 version of the agreement was released by the Canadian Embassy in Washington at a briefing for reporters shortly after the deal was signed. The page on which the C-22 commitment appears is initialled by Germain Denis, one of the Canadian trade negotiators.

The relevent section of the trade deal states: "Canada has agreed to pass the pending amendments contained in Bill C-22 in respect of compulsory licensing of pharmaceuticals."

After the document was distributed, embassy officials requested that it be returned to correct typographical errors.

They then handed out another version of the deal, dated Oct. 4 and initialled by the two governments. It omitted the pledge to pass the drug bill.

Report predicts imports will flooa marker

BY JOAN BRECKENRIDGE
The Globe and Mail

Multinational pharmaceutical companies will swamp the market with imported "sister drugs" instead of developing new ones in Canada if the new drug-patent bill passes unamended, says a report to the Senate committee studying the legislation.

But a spokesman for the Pharmaceutical Manufacturers Association of Canada in Ottawa said this is not true because the industry is going to stick to its commitment to invest an extra $1.4-billion in research and development over the next ten years.

Instead of investing money into research and development, the multinationals will get a patent for a sister drug and introduce it after a short period of Canadian clinical trials, said Jerry Taciuk, co-author of the report and former chairman of the Society of Independent Community Pharmacists of Ontario.

Their introduction will reduce the use of generic drugs — produced by Canadian companies — and increase their cost to consumers, Mr. Taciuk said. The imported drugs will be expensive, therefore drug benefit plans will have to increase premiums, he added.

"We see no reason to reward investments into research and development (with patent protection) when there isn't any research and development," said Robert Kerton, chairman of the economic issues committee of the Consumers Association of Canada.

Globe + Mail
October 10, 1987

Good health care: Is it a legal right?

IT'S THE LAW!

BY DAVID GOLDEN

EVER since the emergence of universal health care schemes in Canada, we have taken for granted the public's general right to adequate health care. However, Canada's health care programs are coming under increasing pressure—a function of increased demand, changing demographics, greater sophistication in terms of available treatment options, and rapidly developing medical technology.

The pressure is especially acute in the area of health care services to the elderly. As the number of senior citizens requiring daily health care assistance continues to grow, hospitals, chronic care facilities, nursing homes, and homes for the aged will find it more and more difficult to cope, especially with the limited dollars available.

As a social proposition, few people would argue that there is a right to life and health in Canada. If society values life and prides itself in a belief in human dignity, then there must necessarily be the right to adequate care where it is needed to maintain human health. As these issues come into focus, Canada's lawyers will begin exploring means of enforcing the right to health.

Take for example the rights of senior citizens to receive adequate care and treatment in Ontario's nursing homes and homes for the aged. Although there is no legislation specifically requiring the government to care for senior citizens in provincial facilities, by its own hand, the government has established a system whereby it provides money, sets standards, and enforces regulations for nursing homes and homes for the aged.

It can be argued that the government's involvement in this health care sector obligates it to provide adequate funding in order to guarantee appropriate care. If for some reason adequate care is not being received, citizens should have recourse through the legal system to enforce their rights.

The American law is well developed in this area, despite the fact that the American health care system is less regulated and more privatized than our own. American law will no doubt provide guidance in this country. In the U.S., a "right to treatment" and to the "delivery of reasonable health care" has emerged in a body of case law flowing from the landmark American decision of *Rouse v. Cameron (1964)*.

The significant aspect of the Rouse case is that it was the first to assert the right of the mentally ill to receive adequate treatment. A brief explanation of the Rouse case will help you understand how the principles could apply to the Canadian setting.

A Mr. Rouse was involuntarily confined to a psychiatric hospital in 1962. After more than three years of confinement, he instituted a series of proceedings alleging that he was not receiving adequate treatment. The Appeal Court took a uniquely progressive approach and agreed to explore the implications of the State Legislature's statutory promise to treat the mentally ill.

Essentially, the Court held that once the government legislatively commits itself to providing treatment, the government (or in a larger sense, society) must live up to its statutory obligations.

Chief Justice Bazelon stated in the Rouse case: *"Whether the right to treatment is rooted in statutory provisions or in concepts of due process of law, equal protection, or cruel and unusual punishment, the duty society assumes, to fulfill the promise of treatment . . . is clear".*

The Court was therefore willing to "have some effect on the availability of resources by exposing the inadequacy of treatment in many of today's public hospitals and thereby allowing the community to make an honest choice to honor its promises or to withdraw them."

Although the Rouse case dealt with an individual who was involuntarily committed to an institution, the thrust of Judge Bazelon's comments were that when a legislature promises to treat, it has a duty to do so. In Ontario, the Ministry of Health is required to provide an entire range of health care services through such legislation as the Health Insurance Act, the Public Hospitals Act, the Nursing Homes Act and so on. Almost every aspect of the delivery of health care is regulated, including doctors' fees.

As the inadequacies in Canada's health care system become more apparent, there is every reason to believe that Canadian lawyers will be involved in advancing arguments similar to those which have already been advanced in the U.S. Certainly, the legal climate now exists for the advancement of these arguments given that we have an entrenched Charter of Rights and Freedoms.

Section seven of the Charter may create one avenue for advancing a right to treatment argument. It states: *"Every one has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."*

Certainly the right to "life" and "security of the person" must entail the right to adequate health care where such care is required to maintain a person's life and security. Although this interpretation has never, to the best of my knowledge, been argued, I do not think that it is an unreasonable proposition.

It can also be argued that since the government has undertaken complete control of the health care system, it has opened the door to legal **liability** for any failure to provide adequate care.

As the inadequacies in the current system become more glaring, we should expect lawyers and health care professionals to work together to ensure that Canadians receive the quality of health care that they deserve and that the government has undertaken to provide.

David Golden is an associate at the Toronto law firm Torkin Manes & Cohen. His practice is primarily in the area of health law.

BRIEFCASE

IN A recent decision of the Supreme Court of Ontario, the Court once again considered the legal obligations of informed consent.

The case involved a 22-year-old woman who underwent an excision of her sweat glands in order to stop hyperhidrosis. Unfortunately, the plaintiff was left with thick red scars in her armpits with two scars exposed on her front, even when her arms were held down.

The Court found that the plastic surgeon had told his patient that one year after the operation, the scars would be "flat and pale." The judge concluded that the plastic surgeon breached his legal obligation to disclose to the patient the risk of having bad scarring and hyperpigmentation. The court also found that the surgery was negligently performed.

It is interesting to note that when dealing with the issue of informed consent, the judge had to consider whether or not a "reasonable patient" would have consented to the operation knowing of the risk of hyperpigmentation.

The judge was satisfied that a 22-year-old "attractive young woman" would have continued with excessive sweating rather than risk visible and ugly scarring. However, "had the plaintiff been a man, the reasonable patient would have gone ahead with the operation and run the risk of bad scarring."

Business smells profit in bid for clean workplace

BY CRAIG MCINNES
The Globe and Mail

If any smokers attended the day-long seminar in Ballroom B of Toronto's L'Hôtel last week, they were keeping their butts under wraps.

It would have taken a rebellious soul to light a cigaret in the face of the sign over the podium that proclaimed "Warning: Smoking is hazardous to your corporate health."

And this was not, by nature, a rebellious crowd. The audience of personnel directors and other corporate team players attending the seminar on smoking in the workplace looked as if it would be uncomfortable out of step, let alone out of line.

Yet there they were, notebooks in hand, gathering ammunition for an assault that would have been considered revolutionary only a few years ago.

Big business is getting off the smoking bandwagon. With the exception of the tobacco industry and others who profit from the sale of tobacco products, few defenders of the right to smoke at work are left in corporate Canada.

And entrepreneurs, sensing the change in the wind, have plunged into what they see as a golden opportunity to profit from the corporate quest for a cleaner environment.

"There are 70 million smokers in America. There are seven million smokers in Canada," said Frederick Weston, president of Addiction Management Systems Inc, one of the sponsors of the seminar. Mr. Weston's company publishes a smoking cessation kit called The Last Pack, which is sold to companies for $150 each and to individuals for $225.

"There's one major multinational in Toronto that, combined in Canada and the United States, has 150,000 smokers and they spent five months researching cessation methods that were available and they have bought our program right across the board," Mr. Weston said.

Addiction Management Systems, a private company owned by Mr. Weston, his brother Keith and Charles Borg, author of The Last Pack, was formed primarily to tap into the new market.

"If I only capture 5 per cent of the cessation market in total in the next five years, I will consider our venture a huge success," Mr. Weston said. "I really believe we'll do a great deal better than that."

So far, The Last Pack has sold about 7,000 copies.

The focus of the debate about smoking in the workplace has changed recently. The question is no longer whether smokers are a hazard to others but rather how much of a hazard they are. And it is no longer a question of whether employers can afford to ban smoking but whether they can continue to allow employees to smoke on the job.

"I think that there's a writing-on-the-wall element on this smoking issue," said Robert Rosner, executive director of the Seattle-based Smoking Policy Institute, which helps companies set up and implement smoking policies.

Although smoking in the workplace was first raised as a health issue, it is now being sold to businesses as sound economic policy.

For employers, the writing on the wall spells higher productivity, lower costs, reduced liability and healthier employees, Mr. Rosner said.

"If it doesn't bother you that the human lung is hypersensitive to tobacco smoke, maybe it will bother you that the hard disc microprocessor is hypersensitive to tobacco smoke," said William Weis, head of the accounting department of the Albers School of Business in Washington state.

"What CEOs who smoke, and even some of those who don't for that matter, fail to understand is that there is a positive return on investment if only one smoker in five successfully quits," Mr. Weston said.

"At the low end it's $1,000 a year extra in cost to a company for every employee who smokes. At the high end it's $4,500."

These costs include:

- Higher absenteeism — estimated by several large U.S. companies to be between five and six days a year more for smokers.
- Higher insurance costs — "It's very reasonable to ask for a 35 per cent discount once you can say you have eliminated this major cause of industrial fires," Dr. Weis said.
- Higher cleaning costs, including window cleaning, replacing carpets, cleaning walls and equipment, particularly computer equipment.
- Higher ventilation costs — rooms in which people smoke require five times as much ventilation as rooms in which there is no smoking. In most climates that means much higher heating and cooling costs.

And then there is the question of corporate image.

"I can't remember the last time I placed a smoker with a national accounting firm," Dr. Weis said. "You never have to worry about offending a client by not smoking."

Employers worried about being sued by smokers who feel their rights have been violated should really be worried about getting sued by non-smokers if they allow smoking to continue, Dr. Weis said.

Employers who allow smoking "are not conforming to the common law duty to provide a safe and healthy work environment," he said.

The law is now squarely on the side of non-smokers, said David Sweanor, legal counsel for the Non-Smokers Rights Association. It's not that the laws have changed but that the medical evidence that side-stream smoke is a health hazard has become so conclusive in the past five years that many existing laws now protect non-smokers.

"You are not dealing with something that's up in the air any longer," Mr. Sweanor said. "The same judge who might have dismissed a case about smoking in the workplace before, might take it more seriously now."

But a greater risk than legal action for employers is the "hassle factor," Mr. Sweanor said.

It doesn't cost an employee anything to take his or her employer to a tribunal like the Ontario Human Rights Commission, even if the case is lost. But for employers, such tests can be costly and embarrassing.

For example, Vicky Torrance, an employee of de Havilland Aircraft of Canada Ltd., fought a widely publicized battle for a right to a smoke-free workplace last year.

De Havilland, which is owned by Boeing Co. of Seattle, a leader in the movement to ban smoking in the workplace, recently announced that it will implement a plan to restrict smoking, "with the ultimate goal of providing a smoke-free environment for all employees."

Globe+Mail
November 2, 1987

THE GLOBE AND MAIL,
MONDAY, SEPTEMBER 7, 1987

Seizing the unborn

British Columbia's family court was faced with an agonizing decision last week, one in which the interests of a mother seemed to be pitted against those of her child. Even more difficult, the case was one that is sure to have profound medical and legal ramifications. King Solomon wouldn't have wished it on his worst enemy.

The case involved a woman who was a former drug addict and had had three of her children taken from her by the province. When her fifth child was being born in May, problems arose during labor and the doctor recommended a caesarian section. The woman refused. Concerned about the baby's well-being, the hospital called in provincial authorities, who apprehended the child under the B.C. Family and Child Services Act, and the caesarian was subsequently performed. (Consent was eventually obtained, but only after the seizure was ordered.)

"The purpose of the apprehension was to assure proper medical attention for the baby," wrote Judge B. K. Davis in ruling that provincial authorities were justified in seizing the child. "This is not a case of women's rights."

The judge is correct in one sense. It was not a case of women's rights since so few of the woman's rights in the case were recognized. But the judgment has far-reaching implications for women, whether its author intended them or not.

Canadian law does not allow bodily intrusion without clear justification or consent. Even the process of fingerprinting and the donation of body organs after death are closely safeguarded with a phalanx of consent forms and legal rights to counsel. Similarly, no precedent exists in Canadian law to compel one person to undergo a surgical procedure for the benefit of another. A parent cannot, for instance, be forced to donate bone marrow to a dying child.

There are cases, of course, where a person is clearly incompetent to make sound decisions for himself because of mental or physical illness. In such an instance, the law permits the state to take the person into custody or provide some kind of guardian.

But none of these careful legal details seems to have afforded any protection to the mother in this case. She was not deemed incompetent, but her right to refuse surgery was ignored.

The B.C. act permits the apprehension of a child in need of protection, and that was the authority used to seize Baby R. But under Canadian common law, a child is not a child until it is born. That principle was reinforced as recently as April, when the Saskatchewan Court of Appeal ruled against anti-abortion activist Joseph Borowski's argument that the unborn are entitled to constitutional protections.

Much of this appears to have been ignored in the B.C. case, in which groundbreaking law was made on the hoof. Given equally short shrift, it seems, were the clear implications of the decision.

The New England Journal of Medicine warned in May that court-ordered obstetrical intervention could logically be extended to control even the diet and sexual activity of pregnant women, and to enforce other surgical and testing procedures. The undesirable result, the journal concluded, was that "the public image of hospitals may be adversely affected and women may choose to deliver elsewhere. The groups that are most in need of prenatal care may be driven away from it."

Much more is involved in the B.C. decision than the fate of one mother and one child. If the issue has become so pressing that existing legal rights are being ignored, the whole issue demands an overhaul — not piecemeal by the courts, but in its entirety, by government.

Health care system cheaper than in U.S.

Congratulations for your excellent editorial, *The hidden agenda* (July 6), on the agenda of the board rooms to reduce our government spending and, therefore, our corporation taxes, so that we might become allegedly more competitive in free trade with the U.S.A.

To start with, Canada's corporate world pays less in taxes than it receives from government, as the Nielsen Task Force pointed out.

Second, if we abstract the cost of health care, the government of the United States does not spend less than the government of Canada.

Every society has to pay for health care. We Canadians chose a universal, obligatory form of group health insurance, run by the government. Our system is cheaper, more cost-effective as well as more decent than the U.S. greed-driven system of health care.

The U.S., as a society, spends 50 per cent more per capita on health care than we do, even though such care is not universally available down there. And the overhead costs of their private enterprise medicine are four times higher than ours.

But, as the Quebec Board of Trade has said, business would prefer U.S.-style free-enterprise health care because business could then make here the same huge profits out of sickness as are made in the U.S.

PHILIPPE DEANE GIGANTES
The Senate
Ottawa

Toronto Star
July 21, 1987

Rising Costs of Health Care Still Outstrip Medicare Gains

By ROBERT PEAR

WASHINGTON

WHEN legislators and lobbyists win a battle on Capitol Hill, they usually exult in triumph. But they were notably subdued last week after the Senate followed the House in passing a bill to protect more than 31 million Medicare beneficiaries against the costs of catastrophic illness.

By putting limits on the amount patients must pay for hospital costs and doctors' services, the bills would mandate the biggest expansion of Medicare since the Federal health insurance program for the elderly was created in 1965. But supporters of the legislation emphasized that it fell far short of meeting all the health-care needs of the elderly.

John Denning, president of the American Association of Retired Persons, which has more than 27 million members, hailed Senate approval of the measure, but cautioned that it would not provide comprehensive coverage for extended nursing home stays, which are the greatest source of catastrophic costs for the elderly. The association and other groups intend to make the financing of long-term care a Presidential election issue in 1988.

A study by the Department of Health and Human Services found that one-fourth of the elderly's medical expenses in 1984 were not covered by Government programs or private insurance. These out-of-pocket payments averaged $1,059 per person; total health-care costs, $4,202. Nursing home care accounted for 42 percent of the out-of-pocket expenses, while doctors' services and hospital care together accounted for only 27 percent.

For people with more than $2,000 a year in uncovered expenses, nursing home care was an even more significant factor, accounting by some estimates for 80 percent of out-of-pocket costs.

'Unreasonable' Expenses

Lobbyists for the elderly warn that even if a catastrophic health care bill becomes law, Medicare beneficiaries would still be liable for other costs, such as doctors' charges exceeding the amounts deemed "reasonable" by the Government. In addition, the elderly would still be responsible for goods and services not covered by Medicare, such as dental care, eyeglasses and routine eye checkups.

But the legislation would help the elderly by extending coverage to prescription drugs for people outside hospitals. The Government would pay 80 percent of the cost after the beneficiary paid a deductible. A person who now pays $1,000 a year for outpatient prescription drugs would pay $600 under the House bill ($680 under the Senate version). At least 5 million people a year would benefit from this change, said Senator John Heinz, the Pennsylvania Republican who proposed it.

Surveys by the American Association of Retired Persons suggest that more than 60 percent of elderly people take prescription drugs on a regular basis, and that drug costs are their second-highest out-of-pocket expense, after nursing home care.

Drug prices have risen rapidly in recent years, outstripping cost-of-living increases in Social Security benefits, the main source of income for many elderly people. The Consumer Price Index for all items rose 17.6 percent from December 1981 to December 1986, but in the same period, according to the Bureau of Labor Statistics, it increased 44 percent for medical care and 59 percent for prescription drugs.

The Senate and House bills also seek to prevent one of the demeaning consequences of current law: Elderly couples often must deplete their financial resources before they can qualify for assistance under Medicaid when one spouse enters a nursing home. Under a proposal offered by Senator Barbara A. Mikulski, Democrat of Maryland, the spouse living in the community would be allowed to keep at least $750 a month of income and $12,000 in assets.

Representative Fortney H. Stark, a liberal California Democrat, said it would have been "absolutely impossible" to push a catastrophic insurance bill through Congress if President Reagan had not originally supported the idea. In a reflection of the new mood of fiscal austerity, the Senate and House bills, like Mr. Reagan's proposal, would require Medicare beneficiaries to pay the entire cost of new benefits through higher premiums. Mr. Reagan would have charged everyone the same; Congress would require more affluent people to pay more.

Nevertheless, Marlin Fitzwater, the White House spokesman, said the Administration supported the Senate bill and hoped negotiators from the two houses would accept its provisions as they try to forge a compromise.

New York Times
November 1, 1987

A10/ THE TORONTO STAR, THURSDAY, AUGUST 13, 1987

73 of 100 sewage staff have skin complaints, study says

By William Walker Toronto Star

Workers at Toronto's main sewage treatment plant are suffering from such ailments as skin disease, lung dysfunction, hearing impairment, kidney problems, hepatitis and parasites, says a medical report by the Ontario Workers Health Centre.

Preliminary results of medical tests on 100 sewage workers were to be released in a report today by health centre officials, the Canadian Union of Public Employees and New Democratic Party leader Bob Rae, who was to visit the plant for the second time in the provincial election campaign.

"We are seeing certain patterns of illness which are occuring among main plant sewage workers," says the report, dated Aug. 6 and obtained by The Star.

Of the 100 workers tested, 73 complained of periodic bouts of dermatitis, a skin problem, on their hands and arms or other parts of the body, the report says. "Dermatitis is clearly a major problem in the sewage treatment plant," the report says.

Noise exposure

Of the 73 workers complaining of dermatitis, doctors found 30 active cases during physical examinations. Some workers have been sent to specialists for treatment.

"The long-term solution to this problem is clearly not a medical solution," the report states, "but must be found in improving plant conditions to eliminate the contact with sludge and chemicals which causes dermatitis."

Twenty-five workers also showed abnormal lung functions. Of those, 18 are smokers. The workers were sent to Toronto General Hospital for further testing and 14 were confirmed as having "obstructive or restrictive lung function," the report says.

Smoking may have caused the problems, but "effects may result from a combination of smoking and exposure to contaminants," the report says.

Pat Myron of Toronto General's pulmonary function laboratory said she met with several of the sewage workers who were tested.

"It's extremely difficult to differentiate between what could be considered industrial disease and what could be the effects of smoking," she said.

Of 25 workers sent to an audiologist to determine effects of noise exposure at the plant, 16 were shown to have suffered hearing loss ranging from mild to serious. The report says the audiologist recommended Workers' Compensation Board claims be filed in six cases and also suggested workers wear hearing protection in some areas of the plant.

'Completely unacceptable'

Of 100 workers tested for kidney problems, 95 showed protein in the urine, which is an indication of potential kidney dysfunction. The report says the presence of protein could be caused by exposure to heavy metals in the plant, such as cadmium, chromium, lead and mercury.

Of 69 workers tested for Hepatitis A, a viral disease, 40 were found to have antibodies to the virus.

"This is completely unacceptable," says the report, which notes that the disease is recognized as being occupationally acquired among sewage workers.

Another seven workers were found to have had exposure to Hepatitis B, a more serious and potentially fatal form of the disease carried in the blood.

In testing for parasites through stool samples from 95 workers, 15 were found to have parasites "which are probably a result of workplace exposure to fecal matter." Those affected have been treated by specialists or a family doctor.

A group of 13 workers were found to have elevated liver enzymes, which could mean possible liver dysfunction, the report says. But it notes that "some of these workers drink alcohol in moderate to heavy amounts" which may cause the symptoms.

Deputy Metro Works Commissioner Bob Ferguson said yesterday that he supports the study, which is partially funded by Metro due to the high absenteeism rate among workers.

"We find the report very interesting," Ferguson said. "It tells us something but we need more information and medical opinions about just what it means.

Ferguson said the study will continue until all 750 workers in the sewage treatment system are tested. Metro Council approved $41,000 in funds for the study last year, along with the loan of two computers worth $22,000 and programming assistance worth $21,000 to log medical results.

OHIP a regressive tax

G&M Tuesday December 1 1987

Ontario Treasurer Robert Nixon is stretching the limits of his credibility with his ostensible concern about the effects of the federal Government's tax reforms on low-income earners in Ontario (Ontario Sets Terms For Backing Wilson On Tax Reform Plan — Nov. 19).

If Mr. Nixon truly wants to protect low-income earners from an unfair tax burden, he should eliminate Ontario Health Insurance Plan premiums. OHIP premiums represent a regressive and discriminatory form of taxation whose impact is felt sharply by low-income earners. A well-paid bank executive pays the same premiums as a low-paid teller.

Philip B. Berger, MD
Toronto

Globe + Mail
December 1/87

THE TORONTO STAR, TUESDAY, AUGUST 18, 1987

Workers get right to pick own MD for health testing

By John Deverell Toronto Star

Ontario employers can't make workers submit to tests by a company doctor to determine the effects of toxic workplace chemicals, the labor ministry has ruled.

The landmark decision, which settles a test case at Fleet Aerospace Corp. of Fort Erie, says workers have the right to choose their own doctor at company expense when being tested for the effects of lead, isocyanates and other substances regulated under the Occupational Health and Safety Act.

Fleet has been refusing since July, 1986, to pay a bill of about $3,000 from the independent Ontario Workers Health Centre for the examination of more than two dozen workers for toxic chemical effects.

The firm claimed the law, which requires the workers to be tested, did not permit the employees to direct company money to the independent health clinic that 95 per cent of them chose on the recommendation of their union.

Appeal possible

Labor Minister Bill Wrye, after a six-month delay, last February authorized orders upholding the right of workers to choose their own physicians. Fleet appealed, and the ministry has upheld its February ruling.

"We wanted our members to have the right to choose a doctor they can trust and who knows a lot about workplace health," said machinist union spokesman Mike Daley.

"We weren't getting much information from the general practitioner chosen by the company. This decision protects our right to get expert advice, and it should be of benefit to the entire labor movement in Ontario."

Seeking grounds

Glenn Stansfield, Fleet's director of industrial relations, said many employees are obviously "uncomfortable" with the idea of using a company doctor, but the corporation is "uncomfortable" with having employees examined at the health centre.

Company lawyers are looking for grounds to appeal the ruling, he said.

Stan Gray, director of the health clinic, said claims have been filed with the Workers' Compensation Board after examinations of Fleet employees.

Two were checked for industrial asthma due to isocyanate exposure, one for lead poisoning and one for a prostate cancer attributable to cadmium exposure, he said.

No tests CMA says

CHARLOTTETOWN — Pre-employment drug testing could compromise a person's reputation and there is no guarantee of confidentiality, according to the Canadian Medical Association.

And if the tests became routine, habitual drug users would find ways around them, says a CMA report on pre-employment drug testing which was released at the association's recent annual meeting here.

The report, which strongly opposes pre-employment testing, says an job applicant who is taking a prescription drug containing codeine could submit to a urine test and be positive for morphine as if he or she were on heroin.

A significant number of tests could be falsely interpreted as positive; mass low-cost screening tests are generally unreliable and job applicants have no way of knowing why they were rejected.

The screening also isn't done for epidemiological reasons and it's not intended to help the abuser, the report says. Given the vulnerability of young unemployed people, it's "particularly opportunistic" for employers to subject them to testing that isn't specific or verified by confirmatory testing.

The report adds that while it's generally felt that a considerable number of people use illegal drugs, "only a small minority are known to suffer impairment on the job as a result." There's also no assurance any testing information, correct or not, will be kept confidential, according to the report.

The CMA maintains a doctor is only responsible for assuring the employee's protection and, in some cases, that of others whose safety might by affected by the employee's performance. An occupational physician should only participate in pre-employment screening at the request of a job applicant.

- Ontario Medicine, Sept 21/87

PROFESSIONALS AND SOCIAL RESPONSIBILITY: CONFLICT OR CONGRUENCE?

A Major Conference at the University of Waterloo

16 - 18 March 1988

CONFERENCE CHAIR

Russel Legge
Director, University of Waterloo
Centre for Society, Technology and Values

KEYNOTE SPEAKER

Wednesday, 16 March, evening

Jack Stevenson, University of Toronto (Philosophy)
Author of Engineering Ethics: Practice and Principles (1987)

PRESENTATIONS/DISCUSSION PANELS

ETHICAL CODES FOR THE PROFESSIONS
Thursday, 17 March (morning)

- **PROFESSIONAL CODES: THEIR HISTORICAL DEVELOPMENT**
  Mark Frankel, American Association for the Advancement of Science, Washington, DC
- **ETHICAL CODES IN ENGINEERING**
  Stephen Unger, Columbia University (Computer Science). *Author of* Controlling Technology: Ethics and the Responsible Engineer (1982); *Chair,* IEEE Membership Conduct Committee
- **CORPORATE CODES OF ETHICS**
  Leonard J. Brooks, Erindale College, University of Toronto
- Panel: **ETHICAL CODES IN PRACTICE**
  Chair: **Conrad Brunk,** Conrad Grebel College, University of Waterloo
  Panelists: **Abbyann Lynch,** Westminster Institute, London, Ontario; **Arthur Schafer,** Centre for Professional and Applied Ethics, University of Manitoba; **Will Waluchow,** McMaster University (Philosophy)

GLOBAL PEACE AND HUMAN RIGHTS
Thursday, 17 March (afternoon)

- **WOMEN AS SCIENTISTS: THEIR RIGHTS AND OBLIGATIONS**
  Rose Scheinin, School of Graduate Studies, University of Toronto
- **INTERNATIONAL CAMPAIGNS FOR HUMAN RIGHTS**
  Israel Halperin, Canadian Committee of Scientists and Scholars
- **THE REDEMPTION OF SCIENCE**
  Anatol Rapoport, University College, University of Toronto
- Panel: **GLOBAL PEACE AS A PROFESSIONAL CONCERN**
  Chair: **Tom Perry,** Physicians for Social Responsibility, Vancouver, BC
  Panelists: TBA

ACTIVIST GROUPS Friday, 18 March (morning)

- **BEYOND PROFESSIONAL ETHICS: ISSUES AND AGENDAS**
  Beth Savan, Innis College, University of Toronto (Environmental Studies)
- **Presentations by:**
  Margaret Keating, Registered Nurses Association of Ontario *(issues in nursing);* Gary Chapman, Computer Professionals for Social Responsibility, Palo Alto, CA *(the CPSR program);* Karen Messing, Université de Québec à Montréal, département de biologie *(union involvement in health and safety);* Michael Rachlis, Medical Reform Group of Ontario *(medical issues);* Steve Shrybman, Canadian Environmental Law Association *(legal aid services);* Jeffrey R. Tyndall, Association of Professional Engineers of Ontario, Scarborough Chapter *(engineering ethics);* Calvin Gotlieb, University of Toronto and Robin Cohen, University of Waterloo *(educating future scientists and professionals);* Willem Vanderburg, University of Toronto Centre for Technology and Social Development *(conference wrap-up)*

REGISTRATION/ACCOMMODATION

Conference fee: $120.00, includes all sessions and Thursday banquet. Daily rate: $75.00. Accommodation available through special Conference booking at two leading hotels in Waterloo Region the Valhalla Inn ($60 single, $70 double) or the Walper Terrace ($59 single, $63 double). Full details, including local and Waterloo-Toronto airport transportation, in Conference brochure. To REGISTER, complete the tear-off, enclose cheque payable to "UW STV Social Responsibility Conference" and mail to address shown. To BOOK ACCOMMODATION, call either the Valhalla (1-800-268-2500 toll-free in Canada or (519) 744-4141), or the Walper (519) 745-4321 before 31 January 1988.

FOR MORE INFORMATION

The Conference brochure, providing full program and accommodation details, will be available by early January. For more details before that date, contact the **University of Waterloo Centre for Society, Technology and Values, PAS 2061, Waterloo, Ontario N2L 3G1. Call (519) 885-1211, ext. 6215.**

Doctors' group wants all party leaders to outline plans for ending extra-billing

The Globe and Mail

The Medical Reform Group has criticized the leaders of Ontario's three major political parties for not saying how they will deal with doctors who charge extra fees for abortions and other services.

"Women are being charged $200 to $500 for an abortion under the guise of administrative fees," said Gordon Guyatt, a spokesman for the group of about 160 Ontario doctors who fought to end extra-billing in the province.

"There's still a lot of extra-billing going on," Dr. Guyatt, a specialist in internal medicine, said in an interview. The Ontario Government banned extra-billing last June after a bitter fight with the doctors.

"These issues are being neglected in the election campaign because (the leaders) would rather they didn't exist," Dr. Guyatt said. He said he believes all the parties are tired of fighting with doctors and simply want to keep the peace.

In addition to being charged more than the Ontario Health Insurance Plan rate, lack of easy access to abortion services is threatening women's health, Dr. Guyatt said.

The great demand and a shortage of facilities means "women are waiting longer than they should," when they go to a hospital for an abortion, he said, and many are going to abortion clinics in Canada or United States.

"The longer the delay, the increase there is in the possibility of complications," Dr. Guyatt said. An abortion at 11½ weeks is 35 per cent riskier than one at 9½, and 60 per cent riskier than one at 7½ weeks.

While some of the extra charges levied by physicians are legal because they are for services not covered by OHIP, letters or telephone calls for example, others, such as charging for an abortion, are not.

Since last June, the Ministry of Health has refunded $21,165 to 301 patients who had been billed by doctors at higher than OHIP rates. The amount, plus a $50 administration charge, is then deducted from money the plan owes the doctors.

Informal telephone surveys show "the number of physicians charging these (legal) administrative fees has gone up a lot," Dr. Guyatt said. The group wants the government to negotiate with the Ontario Medical Association to end the fees.

Media omit AIDS facts

A I D S

Although the AIDS crisis has become a staple of news coverage, a just-completed survey indicates there are still large numbers of young people who are ignorant of the most basic facts about the illness.

The **Lakeshore Area Multiservices Project** (LAMP), a community and social service centre in Etobicoke, this summer surveyed 220 people between the ages of 16 and 25 on their knowledge of AIDS.

Although lesbians are probably in the lowest risk category for contracting AIDS, 58 per cent of the respondents stated that many lesbians have AIDS, suggesting that AIDS is still perceived as a "gay disease."

And 83 per cent of respondents said there is a test for AIDS, when screening is actually for the presence of the AIDS antibody, not for the illness itself. A minority of those who test positive for the AIDS antibody actually develops the illness.

Forty-seven of the 220 respondents have had sex with more than one person in the past six months, and 17 of those 47 say they are very worried about contracting AIDS. Yet only 10 of the 17 use a condom, even though they stated that condoms lower the risk of contracting AIDS. (Only one of the 220 who completed the questionnaire acknowledged being gay.)

Despite increasing involvement of health care workers and schools in AIDS education, the vast majority of those surveyed said they depend on TV, radio and newspapers for information.

Doctor **Steven Hirshfeld**, supervisor of the survey, which was undertaken as a summer employment program, says the reliance on the news media puts an enormous responsibility on them.

"It's no shock that people are so misinformed, because you're so limited in what you can say," he says. "News items are not about how to put on a condom."

While the media came in for criticism at the meeting of health professionals where the report was released recently, schools didn't get off unscathed.

Separate schools have announced that the centrepiece of their AIDS education program will be promotion of abstinence from sex. And while public schools have implemented a core requirement of AIDS education, it will be taught as part of physical and health education.

A public school teacher in attendance at the session says the forum for the AIDS instruction is a guarantee that it will not be done adequately.

"The instruction will be given by gym teachers," says the teacher, who asked not to be identified. "That means it will be done in a very conservative way. It won't be done right."

— GLENN WHEELER

NOW

Don't punish the sick with deterrent fees

RE: 'Health care faces crisis' (Oct. 31).

In this article, several Hamilton physicians were quoted as favoring "consumer participation" in health care: patients were warned that they can no longer expect health care as a 'freebie'. The implication is that if the consumers of the health care system were to pay when they used it, a double purpose would be served: more money would be put into the system; unnecessary visits to the doctor would be prevented. Such "participation" is a euphemism for deterrent fees.

We in the Medical Reform Group regret that you did not present a more balanced view. Many professionals and patients alike treasure the universal access to care which our 'first dollar coverage' provides. Studies have repeatedly shown that deterrent fees do deter patients — poor patients. These are precisely the people who bear the greatest burden of illness. A study recently quoted by the federal minister of health showed that men from lower income groups can expect to live six years less, and have fourteen more years of disability, than men from higher income groups. Among the poor we find many of the elderly and single-parent families. Do we want to deter them? It should be the job of the professional, not the patient, to distinguish the trivial symptom from the portent of serious illness.

We would like to see more true patient participation in health care — not by payment of an entrance fee to the doctor, but by representation on the boards of community health centres.

Some sensible solutions to the bed shortages were presented in your inside articles. We agree more resources should be allocated to expand home care, in preference to creating more chronic care beds: Canadians already institutionalize far more of our elderly than other western nations. And there is a lack of coordination and communication among care-givers characterized by Dr. Williamson, president of the British Geriatric Society, as "daft". This is fostered by the physician fee schedule, which pays little or nothing for the co-ordinating work. Other forms of medical payment show greater promise to reduce hospitalization rates and improve team work in health care.

As for the charge that patients see medical care as a "freebie", we think the great majority are well aware that they have already paid through their taxes, premiums, and wages given up in favor of benefits at contract time. One of the gains of universal access and first dollar coverage is that the patient is not hit by a bill when he is least able to pay, nor deterred from care when he is ill.

If there is a group in the health care field who should reconsider their priorities, perhaps it is the Ontario Medical Association, who have encouraged their members to charge 'administrative fees' since extra-billing was ended. And this, despite the fact that much of the money transferred back to Ontario since the passage of the Health Care Accessibility Act went to doctors in their most recent fee negotiations.

Finally, through patients and health care providers working with government, we believe that we can improve our health care system, without punishing the poor and the sick.

Robert James, M.D.
Dundas.
Donald Woodside, M.D.
Hamilton.

Hamilton Spectator, Nov. 5, 1987

NEXT ISSUE CONTAINS...

wait for it.....

Donald Cole....on Nicaragua's health care
Bob Frankford...on HMO's, HSO's, and a host of other prefix MO's
Bob Kellerman....on ethics and law regarding the unborn child

And...

Will there be letters?
Will there be further unsolicited articles?
The tension will be unbearable in the editorial office.