MRG Newsletter

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

Volume 8, Number 1 (February 1988)

"MEDICINE IS POLITICS WRIT LARGE" -*Rudolf Virchow*

Contents

MRG Spring Meeting

The MRG's Spring Meeting has been set for Friday May 6 and Saturday May 7. The topic of the meeting will be AIDS. Further details will appear in the next newsletter.

Newsletter Deadlines

The publication date for the next newsletter is April 1, 1988. The deadline for that issue is March 14. Longer opinion and feature articles should be sumitted earlier, by February 25. The publication date for the subsequent issue is June 3. The deadline for that issue is May 16. Longer feature and opinion articles should be submitted earlier, by April 28.

Feature Articles

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

EDITORIAL

Recently we collated the comments that our membership had regarding the MRG. The interests that were expressed in the forms distributed annually covered a wide gamut from health administration to molecular biology. There were some concrete remarks that may interest the membership. The full listing can be obtained from Ulli Diemer at (416) 588-9167 for those interested.

Trying to summarise these is difficult, but the broad range of areas "that the MRG should concentrate on" can be indicated: Extra-billing and enforcement of the abolition; Occupational and environmental health; Women's health issues; including the recognition of non-"medical" personnel in delivery of health care. AIDS and the political ramifications thereof. These will be recognizable to the members and should provoke little surprise given our previous stances.

Perhaps of more interest are areas that we have not placed prominently on the agenda to date. e.g.: "Relationship with other health professionals, support for foreign physicians" e.g. Chile...Third World Aid" or e.g. "All the ones that you have, plus the most dangerous and pressing one of all: the threat of nuclear war; nuclear power; uranium mining, etc.." There were other specific proposals:

e.g. "I would only add coverage of chronic care facility availability."

e.g. "Follow the development of the Premier's Council, educational events on macro/health economics"

e.g. "Get the members in B.C. together, put together a B.C. mailing list..."

e.g. "Could the MRG develop into being a bargaining unit with government ?"

e.g. Let's be specific about what reforms the MRG stands for. A 5 year priority plan. Less back slapping (i.e. remove "progressive" from MRG vocabulary) more action. Given no crises lurk it would be a good time to do this ".

There was more in the vein of the latter, i.e. No back slapping.

e.g. "I do locum tenens and have for 7 years. I have a better idea of what happens in GP offices than most. I am most frustrated with doctors' abuses and their attempts to continue in controlling it. Propaganda 2000 in BC infuriate me.."

Such divergent views reflect our vigorous membership. But these may also be seen as a symptom of what some have termed the Post Extra-Billing Fight Torpor. Are we looking for a new focus? Do we accept that we are at a plateau in membership? Should we diverge our interests and energies to tap other "winters of discontent"? How many directions should the MRG take? Do we want trade union status? Do we want to be purely engaged in being a siren warning of abuses? How should we evolve new policies; as part of government agencies or as agitational foci? Are any of these exclusive of each other?

Sounds a bit dramatic? Well, that is after all why we had a discussion on January 29, 1988 on the running of the organization. The responses of individuals on the membership renewal forms certainly indicate that the membership feels the organization to be fulfilling some roles. (see below)

They also show that there's no lack of thought for new directions. Perhaps members could write their thoughts in a more tangible way for the debate to continue after January 29th, 1988. It is our intention that the newsletter be an active "organizer". It is a bit difficult to see immediately how we should organise a Premier's Council, for instance. Educate us. Next issue will carry an article and analysis of the discussion on 29.01.88.

Until I hear from our correspondent what connection backslapping has with the word progressive I will continue to use the convenience of the word in the sense defined by the Collins Dictionary (1979): "adj 1.of relating to progress...3. favouring or promoting political or social reform through government action, or even revolution, to improve the lot of the majority " p.1168. Currently progressives in Canada have finished one battle with success and are in the middle of another. The Morgentaler verdict by the Supreme Court has just been announced. Its implications will be felt in many ways not related to the most immediate. Those most immediate will be obvious to the MRG. But

whether the verdict can be extended into other areas of health care accessibility must now be considered. We referred last issue to an article that proposed this constitutional type of challenge to health care inequality. Next issue we will carry an article by those involved in the Morgentaler Clinics, on the consequences of the decision for them. In Alberta nurses are experiencing various humiliations not shared recently by the striking physicians in Ontario. These humiliations are of course being labelled unlawful and being refused legitimate bargaining status. These humiliations have also been inflicted on other groups of workers including the rail and postal workers. A clearer illustration of the adage: "Some are freer than others" is difficult to find. Next issue an article from the nurses union leaders. Keep writing!

Haresh Kirpalani

Meeting on MRG Directions

As announced in the December newsletter, a couple of dozen Medical Reform Group members met on January 29 for a wide-ranging discussion on future directions for the MRG.

A good deal of time was simply devoted to members stating why they belonged to the MRG, and what kinds of things they hoped to get out of being a member. This type of discussion is difficult to summarize, but a more-or-less random sampling of comments made appears below:

* Many of those present stressed the importance of having a support group of similarly-minded individuals.
* While the support aspect was important, it was repeatedly stressed that the MRG's "action focus" was the key reason for belonging: The MRG is a vehicle for working together to achieve members' political and social goals.
* A number of people also said that because of professional and family responsibilities, they had less time to devote to MRG activities than they used to have.
* It was suggested that the MRG has been able to compensate for this because it now has more expertise and organizational resources, and thus is able to "produce more with less energy".
* MRG members are able to publish their views in the MRG Newsletter and in journals, and thus are able to spread their political perspective past their own immediate numbers.
* We need to pay more attention to attracting and integrating new members, especially students.
* Much of the MRG's activity has been reactive to what was being done by government or professional bodies. A need was seen to set priorities in what we see as the major issues.
* We need a coherent position to expand our membership. Cameraderie comes after there is a position to feel cameraderie about.
* We need to tap the different areas of expertise within the group.
* A tenth anniversary conference of progressive health care was suggested (for 1989).
* There was a suggestion that the MRG can be seen more as a "coalition of interest groups" rather than as one unified body". The membership is diverse: encompassing students, associate members, organizational members, as well as physicians, with a variety of interests and levels of involvement.
* The Hamilton chapter has lots of new students but no "old members" so the learning process is slow. New members need more contact with older members who have the expertise.
* It is hard for a new member to get a sense of what the organization is about. The MRG's literature is dense and hard to get through. The newsletter should be an "organizer".

The meeting ended with an agreement on the need to delve into the issues raised more thoroughly with an eye to defining priorities for the MRG. Four people present agreed to write short pieces for the newsletter giving their comments and perceptions of the issues raised at the meeting. A follow-up meeting is planned, with some of those present favouring a meeting sometime in the spring, and others wanting to wait until the fall, perhaps making the question of overall priorities the topic of the fall general meeting. Members are invited to make their preferences and ideas known. (MRG, P.O. Box 366, Station J, Toronto, Ontario, M4J 4Y8, (416) 588-9167.)

Ulli Diemer

Next Issue

The next issue of the MRG Newsletter will contain articles on tobacco marketing in Asia, abortion, the nurses' strikes in Alberta and Britain, an analysis of the British NHS, and possibly other articles. The deadline for the next issue is March 14. Longer articles should be submitted by February 25.

Announcements

Physicians Needed

Urgently needed: physicians to train and work on a part time basis at the Morgentaler clinic. Help make the benefits of the recent judgment a reality. Contact Dr. Nikki Colodny at 462-0150.

South Riverdale Seeks MD

Family physician required to replace male M.D. Full range family practice with varied clientele including family planning clinic, visiting obstetrician, chiropody, housing service for mentally ill, and new programs for elderly. Three MD/NP teams; some evening hours; 1 in 4 on call; obstetrics not required; CCFP desirable; other languages, interest in gerentology or occupational health and community program development would be assets. 1987-88 salary range: $56,000 - $67,000 plus benefits. Send c.v. and covering letter immediately to Liz Feltes, Administrator, South Riverdale Community Health Centre, 126 Pape Ave., Toronto M4M 2V8. Phone (416) 461-3577.

Partner Sought

Two Hamilton MRG physicians are looking for a partner to join them in their east end practice in 1988. The terms of partnership would be negotiable depending on mutuals needs and interests. At present the practices are well established, but have expansion potential. For further information, please contact Mark Cornfield or Barry Munn at (416) 547-2302.

Family Physician Wanted

Pinecrest-Queensway Community Health and Social Services requires a family physician to work with us to establish a commmunity health program as part of a multi-disciplinary centre providing a wide range of supportive, developmental and direct care services.

The physician will work as part of a medical team and will be responsible for providing primary care services within the context of a health promotion mission.

The position will begin as part-time afternoons and evenings and move to full-time as a roster is established. Salary prorated based upon full-time of $60,000 to &65,000 plus full benefits.

Please reply by February 15 with resume to: Sandra Mark, Co-ordinator, Pinecrest-Queensway Community Health and Social Services, 804 Grenon Ave., Ottawa, Ont. K2B 6G2, (613) 820-4922.

Living With Aids

By 1991 there may be a total of 1700 AIDS cases in Toronto according to the Toronto Medical Officer of Health--enough people to fill two hospitals the size of Toronto General. The implications are staggering and they point to the inadequate and haphazard supports currently available to AIDS patients in the areas of health care, social services, and housing. Many argue that demands currently placed on hospitals and hospices must be supplemented by the well planned development of services to match both the present and future needs of those with AIDS. Centre Stage Forum and the AIDS Network are sponsoring a panel discussion on living with AIDS on February 16, 1988 at 8:00 p.m. at the St. Lawrence Centre, 27 Front St. East. Panelists are Noreen Dunphy of the Co-operative Housing Association, Ron Lentz, Directory of Clinical Services at the Toronto AIDS Drop-in, and Pat La Mariana, an AIDS Training Specialist from New York.

Healthy Toronto 2000

"Healthy Toronto 2000" is a discussion paper about how the City of Toronto can achieve the healthiest city possible by the year 2000. It discusses the current state of Toronto's health, identifies major health challenges and makes preliminary suggestions on appropriate ways of meeting these challenges. Through a public consultation process the Board of Health is hoping to encourage feedback on the ideas in "Healthy Toronto 2000". A public meeting has been scheduled for Wednesday March 9, from 7 to 10 p.m. in Committee Room 4, Toronto City Hall. For more information contact the office of Councillor Jack Layton, (416) 392-7307. (See related article next issue.)

Anti-Smoking Bill

The National Campaign to Pass Bill C-51 is seeking to organize public support to pass The Tobacco Products Control Act (Bill C-51) and the Non-Smokers" Health Act (Bill C-204). The Campaign says health and human service groups need to take action to counteract the tobacco industry lobby. Suggested actions include sending letters to the Prime Minister, members of Parliament, and the Minister of Health and Welfare. The Campaign has copies of the free brochure, **Give Kids a Chance,** as well as **A Primer for MP's and Media: How to Cut Through Tobacco Industry Deception)** $8. The Campaign can be contacted at 344 Bloor St. West, Suite 308, Toronto, Ontario M5S 1W9, (416) 928-2900.

AIDS AND ETHICS

AIDS and Ethics: a joint Toronto-Hamilton chapter meeting with speakers Philip Hebert and Philip Berger. To be held on Wednesday March 9 at 8 p.m. at the South Riverdale Community Health Centre, 126 Pape Ave., Toronto. There will be a slide presentation, and discussion about issues ranging from mandatory testing of hospital patients to anonymous testing for HIV-antibody, to the right of physicians to refuse treating AIDS patients. Case histories will be used.

Is Ontario Now Ready for H?O's?

By Dr. Robert Frankford

"Later this year, Health Minister Murray Elston will announce the approval of a Health Maintenance Organization for Metro (Toronto) -- a 200-bed facility which runs on different principles from our expensive doctor-oriented hospital system" wrote the Toronto Star's political correspondent Rosemary Speirs on July 26th 1986.

This premature and unsubstantiated story appeared to have originated from the institution intending to be the site of the HMO.

In August 1987 it was announced that The Toronto Hospital (i.e. Toronto General and Toronto Western) would receive a grant of $250,000 to develop an alternative health care arrangement. The term Health Maintenance Organization (HMO) did not occur in the news announcement, but this was the latest stage in the proposed development of what has been described as the province's first HMO. Initially a draft proposal of their HMO arrangement was prepared for the District Health Council containing a number of questionable assumeptions, e.g. an enrolment of 20,000. The final grant proposal was a remarkably brief one.

The media, notably The Toronto Star, have been persuaded that Ontario needs Health Maintenance Organizations based on the belief that HMOs have proved to be a successful development in the United States. They have barely noticed

that for a number of years, Ontario has seen the development of Health Service Organizations (HSO). The name resembles the American form and superficially there are resemblences with HMOs. The HSO does enroll a population of patients and contracts to provide them with medical services.

The existence of capitation funding for medical care in the province is not widely recognized by politicians, the public or the profession. However, the OMA recently issued a position statement that can be read as being far from hostile.

The Group Health Centre in Sault Ste. Marie is the best known example of a capitation funded centre. There are presently 27 Health Service Organizations (HSOs) in the province. All of them contract with the Ministry of Health to provide family practice primary health care to their enrollees. The amount paid for each enrolled member varies by age and sex. The reasons for changing to capitation vary. From a financial planning point of view it provides a more regular and assured funding.

HSOs are organized in a variety of ways. They may be physician sponsored group practices, a family practice unit in a hospital or sponsored by a community-based non profit corporation. All these models exist at the present time. In addition to providing primary care an HSO may spend its income on providing non-physician services. There is also a capitation rate for the various medical specialists. The Group Health Centre in Sault Ste. Marie with over 40,000 enrolees, has the broadest range of specialists. There is nothing to stop an HSO having a complete range of specialists if it so desires. The Group Health Centre prefers to consider itself a community health centre, but could also choose to be considered a comprehensive HSO.

The payment arrangement is more properly called capitation negation. Negation refers to the fact that if a patient sees a doctor that the HSO could have provided (i.e. family practitioner or any other specialist with which it contracts) the capitation payment is **negated** in that particular month. Consequently there is some risk to attempting to offer a broad range of specialists if there is a likelihood of patients exercising their freedom of choice to use any specialist they wish. The likelihood of such outside use is presumably greatly increased in large metropolitan areas.

The Evans report to the Ontario Government of June 1987 "Toward a Shared Direction for Health in Ontario" chose to highlight two models for development:

The multispecialist group practice linking primary and secondary care by a number of different medical specialists to facilitate the coordination of required services to the individual.

The Comprehensive HSO which would take the current HSO one step beyond primary care to include hospital care, to make available a full range of specialist care. All within capitated reimbursement.

American residents indicate that the attractions of HMOs are not so clear. An HMO is essentially a closed insurance plan. Subscribers to the plan get medical insurance, but they are also restricted to the doctors and the hospitals that the HMO has made an arrangement with. Since there is no universal health plan, each HMO is independent. The Canada Health Act guarantees universality of coverage as well as universal access. Canadians therefore have come to expect that they have the right to see any doctor practicing in their jurisdiction. Organized medicine would react strongly and point to the Canada Health Act if there was a complete restriction of access.

The Department of Family Practice of Sunnybrook Hospital - a University of Toronto teaching hospital - has been organized as an HSO for the past few years. It would be in a good position to develop a comprehensive arrangement incorporating in-patient care and using its own specialists. Preliminary discussions were held there, but foundered. They found it difficult to decide whether the HSO should contract with one member of a specialist department or with the entire department. All new patients attending the Sunnybrook Department of Family Practice are offered enrollment in the HSO. They are told that enrollment offers no special benefits of more comprehensive services or easier access to specialists.

Maureen McKenna, the manager of the HSO sees this as a problem of the setting; it is impractical to separate off the HSO patients. An HSO clinic in a non-hospital setting would not have this problem and would be able to offer a variety of services to its enrollees. Sunnybrook is developing a centre away from its main location to provide community based services. Such options already exist at some HSOs; counselling

and nutritionist services are available at the centres in Sault St.Marie and Flemingdon in Toronto.
An American HMO cannot be directly translated to Canada because of the existence of universal medical insurance. An HMO is essentially an insurance plan that provides its own doctors to the subscribers. In the HMO it is the subscribers who are penalized if they use outside doctors, whilst in Ontario it is the HSO that is penalized for outside use. Making available a **full range** of specialist care in a comprehensive HSO has little attraction to potential subscribers in Toronto, presently able to choose any doctor or hospital.
To attract a significant enrollment an organization would have to provide some incentives. These could be financial, such as insurance features that are not currently part of OHIP, or even rebates for reduced use of medical care. The College of Physicians and Surgeons is in the process of lifting restrictions on professional advertising and health centres along and walk in clinics are likely to take advantage of this when it occurs.
It would appear that the delay in the development of new and broader hospital based HSOs is related to the question of how to add specialists. Should the HSO contract with the entire department of, say, surgery or should it have one specialist of its own? This might well be desirable, but could lead to internal hospital problems of organization, as faced by Sunnybrook (see above). The addition of specialists has evolved most in community based HSOs in Ottawa and Sault Ste Marie and appears to work satisfactorily both for doctors and patients.
The current HSO arrangement has a number of attractive features for physicians, users and administrators. Capitation payment is also attractive to governments since it allows better control on costs than under fee-for-service. For family doctors the HSO can be a more satisfying way of practice, encouraging a team approach to care and a more epidemiological approach (assisted with the use of computers) to the care of a well defined population. However growth has so far been slow.
One reason for this has been the lack of information to potentially interested parties. Mainstream doctors have been suspicious of alternatives encouraged by government and mistakenly felt that this is a scheme to put them all on salaries. The capitation payment schedule has not been readily available and updates for increases have been introduced slowly. Physicians are not aware that the Ministry of Health will calculate a capitation income based on their volume of fee-for-service practice, or will provide guaranteed payment during the time of converting to capitation. Patients are not informed of the existence of capitation payment and are distrustful when asked to enrol into an HSO, not realising that the arrangement can provide a broader range of services.

Conclusions

The changing OMA attitude to HSOs (see below, Appendix 1) will make a greater number of doctors look at capitation practice. A number of developmental thrusts can be seen. There is the hospital based model versus the community based model. Physicians of both left and right wing persuasions will see ways of using capitation; the former to develop a multi-service democratically run model, the latter a profit oriented model. Innovative leadership from government might be able to develop a mutually acceptable compromise.
Changes are occurring. In the 1987 election campaign, Premier David Peterson stated that the government intended to double the enrollment of the population in CHCs and HSOs. The grant to the Toronto Hospital suggests a commitment to developing present and other models of integrated care. Whether they will be called HSOs, HMOs, CHSOs or some new acronym remains to be seen.
Below are some items of information that may be helpful in assessing the impact for individual GP's of these possibilities, and a statement of the current OMA position.

APPENDIX 1

-OMA Position on Health Service Organizations, Capitation Based Salaries. OMA Review Nov\Dec 1987

1. Ontario physicians must always have the freedom of choice of the method of compensation for professional services.
2. Current evidence does not demonstrate any difference between HSOs and fee-for-service medicine, in either the quality of medicine practised or the attention to preventive medicine.
3. The Ontario Medical Association supports the development of alternate methods of health care delivery and alternate means of compensation for physicians, provided that there is careful scientific assessment of the quality, cost-efficiency and effects of their operation.
4. The Ontario Medical Association urges that a conjoint committee be struck with the Ministry of Health to formally study all aspects of the economics of health service organizations.
5. Ancillary health services should be equally accessible to all Ontarians, whether in dedicated facilities established by the Ministry of Health or in private facilites utilizing separate provincial funding.
6. The Ontario Medical Association has equal obligations to members who practise fee-for-service medicine and to members who are compensated by salary or capitation.

APPENDIX 2

Capitation rates (effective April 1987)

Maximum Annual Income per Head: For males, these range from $71.69/year annual payment for age group 15-20 years to $504.69/year for age group 90-95 years.
For females, they range from $65.44/year annual payment for age group 10-15 years, to $470.63/year annual payment for age group 90-95 years.

APPENDIX 3

Ministry Estimates of Income

The Ministry will estimate your patient population from the volume of your recent OHIP billing and give you an estimated monthly guarantee. Write a letter like the one below, giving your fee-for-service OHIP billing for the past six months.

Colleen Savage
HSO Program Co-ordinator
Ministry of Health
15 Overlea Blvd, 6th Floor
Toronto, Ontario M4H 1A9

Dear Ms Savage,

Would you kindly provide an estimated IPP and target roster for my practice.

I enclose the total OHIP payments for the last 6 months. Would you also confirm the availability of sign up grants and of grants for the provision of roster information to the Ministry.

OCAC Response to the Proposed Women's Health Centres

The Ontario Coalition for Abortion Clinics (OCAC) has issued a paper detailing their position with regard to the Women's Health Centres recently proposed by the Ministry of Health. A brief summary of the position is presented here in the hopes of stimulating some debate among members of the MRG.

OCAC characterizes the proposed plan as "little more than a streamlining of the status quo... that consistently denies women reproductive choice". They question how the proposed centres will increase the availability of abortion or improve the poor quality of care which so many women receive in the hospital setting. The Powell report documents the numbers, in the thousands, of women who go to the free-standing clinics in Toronto and outside Ontario, for abortion services which are not available within the hospital system in Ontario. How will the Women's Health Centres which will not themselves perform any abortions improve access to abortion under the present hospital system? OCAC is particularly incensed that funding will be given under the Women's Health Centre program to St. Josephs Hospital in Toronto, a hospital which not only does not do abortions but also refuses to provide birth control counselling. They point out that this funding will actually deny rather than expand reproductive choice for women.

The OCAC document cites the experience in Quebec in the late 1970's when the Minister of Health sought to encourage hospitals to establish abortion units to improve access. This initiative failed, and access was only improved through the community health centres (CLSC's) in addition to the existing private clinics. OCAC suggests that Ontario follow the Quebec policy of not prosecuting clinics providing safe abortions.

The problem of the poor quality of care received by many women undergoing abortions in hospitals in Ontario has not been addressed by the Women's Health Centre initiative.

Finally, OCAC proposes that the Ontario government bring the existing Morgantaler and Scott clinics into the public health care system and fund them publicly.

On the whole, I agree with the OCAC analysis of the Women's Health Centre initiative. I have been in family practice since 1974, and have referred many women for abortion from my own practice and more recently from a family planning clinic in Toronto. When I practiced in Wawa in northern Ontario we had to refer women to Hamilton for abortion. I have had many return to my office after difficult hospital abortion experiences. The staff is often unsympathetic if not downright hostile. Most hospitals insist on doing early abortions under general anesthesia even though local anesthesia is safer in most cases. I fail to see how the hospital system, however it is tinkered with, is going to provide the needed access to safe, humane abortion. From the MRG point of view I believe the main stumbling block to full support of the OCAC is that the current clinics which OCAC supports are funded on a "user-pay" basis. It is encouraging to see repeated calls in this current OCAC document for publicly funded abortion services.

Catherine Oliver

pleasantness rather than incompetence. However, both discipline cases and civil suits should perhaps trigger a review. At present, a review may be part of the remedy, to be followed by upgrading if necessary. The college has no independent power to prosecute incompetence, but legislation has been drafted and approved in principle to allow prosecution before an Incompetency Committee.

Recommendation 8.1: a discipline hearing should lead to a practice review as part of the remedy, with recommendations for remediation if required.
Recommendation 8.2: The CPSO should launch a study to ascertain whether complaints or discipline hearings, regardless of outcome, are useful indicators of substandard practice.

9. Retraining
The college is piloting an assessment procedure at McMaster which will document competency and highlight retraining needs. They have found little value in slotting a mature physician into a residency program. A tailor-made educational package is required.
The CPSO will require access to institutions prepared to offer retraining. They have considered setting aside the profit from operating the new College building to help fund retraining. The OMA might consider negotiating with government to direct a portion of a fee increase to such a fund, which would greatly facilitate the acceptance of such recommendations.

Recommendations 9: Money should be set aside to help fund retraining. It could come partly from the rental of the CPSO building, and partly from fee negotiations.

10. Complaint Assistance
Users of the health care system may be unaware that there is a vehicle for a complaint against a professional other than a lawsuit. They should be reminded of this right and have ready access to information about how to pursue a complaint.

Recommendation 10: A pamphlet should be prepared and distributed outlining the procedures, levels of appeal, and rights of the patient, physician and College, and distributed. Assistance should be available to users to help drawing up a letter of complaint.

11. Civil Suits
Complainants make an early decision, often with the advice of a lawyer, whether to pursue a civil suit for damages or lay a complaint. Ideally, a suit and a complaint should proceed together, but if the discipline hearing occurred first it might prejudice the latter case.

12. No Fault Medical Insurance
The federal government is considering no-fault insurance for medical mis-adventure. Many more patients suffer harm by bad luck than by negligence. In such a situation, a claim and a hearing could be concurrent.

As the discipline process is made more public, it may appear that we are re-inventing courts of law at physician expense. One of the benefits to physicians 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 patients in general if the outcome of a complaint is upgrading of the physician rather than a financial settlement to a particular individual.

Don Woodside and Bob James

"... oh, Harold ... what a wonderful coincidence ... it's so romantic ... both our beepers went off at the same time ..."

Health Promotion & Pesticides: The Nicaraguan Strategy

Paper from "Healthy Ontario 2000: 38th Annual Educational and Scientific Meeting of the Ontario Public Health Association", 18 November 1987.

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By Donald Cole and Merri Weinger

INTRODUCTION

Acute pesticide poisonings are a serious consequence ofagricultural production in the developing world. Based on modelling data from the WHO, Bull estimated that 750,000 poisonings and 13,800 deaths from pesticides occur each year in developing countries (1). During the 1960's and 70's, Nicaragua was a leader in Central American cotton production and pesticide use. In the early 1980's, the new Nicaraguan government moved rapidly to confront problems generated by pesticides. In the cotton growing departments of Leon and Chinandega, between 312 and 1,187 poisonings were documented annually for the years 1976-1980 (3), following the failure of initiatives in the 1960's and 1970's by the Food and Agricultural Organization FAO (2). This article details the new strategy that was developed in Nicaragua when the Sandinistas took power in July 1979.

BROAD STRATEGY

The Ministry of Labour (MITRAB) in 1980 initiated inspections of agricultural enterprises and new regulations to control pesticides use.(4) In 1981, the **Ministry of Health (MINSA)** identified pesticide poisonings as a priority problem and started cholinesterase screening programs to identify and remove overexposed workers (5). In 1982, the **Ministry of Agrarian Reform and Agricultural Development (MIDINRA)** broadened Integrated Pest Management (IPM) activities to nearly one sixth of cotton acreage. In addition, **a National Pesticide Commission** was created including the aforementioned ministries, the **Institute for Natural Resources and the Environment (IRENA) and the Association of Rural Workers (ATC).** This commission severely restricted the use of five of the Pesticide Action Network's (PAN) "Dirty Dozen": DDT, DBCP, HCH/Lindane, 2,4,5-T and Aldrin/Deildrin/Endrin (6).

By 1983 further progress had become increasingly difficult due to a scarcity of material and technical resources. The American Public Health Association provided a volunteer to work with MITRAB and a group to bolster MINSA surveillance efforts in the Leon-Chinandega region. The surveillance results for 1984 were startling: almost 400 acute pesticide poisonings, 94% of them occupationally related and 13% of them children (7). Cholinesterase screening of organophosphate exposed workers showed a marked reduction in levels as the spraying season progressed, reaching 40% of those screened by December. Workers at airstrips and cotton farms were the most affected.

These findings prompted the Pesticide Health and Safety Program (PHSP) (a joint endeavour between member organizations of the National Pesticide Commission and foreign non-governmental organizations active in development work in Nicaragua (e.g. OXFAM Canada).

The goal of the Program is to bring Nicaragua's high rate of pesticide poisonings under control within three years, using three elements: (1) workplace health and safety, (2) health professional training and illness surveillance, and (3) community education.

METHODS OF EDUCATION/COMMUNICATION

Popular education and communication methods based on mass participation have been a hallmark of recent Nicaraguan health and education. They rely on the training of multipliers who in turn train promoters or "**brigadistas**" of the population of interest. Mass communications reinforce the particular program or campaign.

Surveillance data and field observations indicated our prime populations of interest: agricultural workers, airport workers, small farmers and farm cooperative members. They were represented by: the **Rural Workers' Association (ATC), the Sandinista Workers' Central** (CST), and the **National Union of Farmers and Cattleman** (UNAG). In addition, two departmental cotton growers' associations (ADAL& ADACH) include the vast majority of cotton growers in the Leon-Chinandega region. Secondary populations of interest included non-working family members of agricultural workers and farmers' family members including school-age children, most of whom do agricultural work.

Potential multipliers for these populations existed both within these organizations and in government ministries. The ATC, CST and UNAG each had staff members responsible for social affairs or education. MITRAB had regional health and safety inspectors for whom pesticides and training were priorities and zonal labour inspectors for all workplaces with employees covered by the Labour Code. MINSA had a regional department responsible for hygiene, and sanitary inspectors and health educators in each health area. MIDINRA had a regional education and communication department and agricultural extensionists who provide technical advice to farmers and cooperative members. The **Ministry of Education** (MED) had regional programs for adult, primary and secondary education with teachers in rural communities.

Some pesticide training of worker brigadistas in the ATC and CST had taken place. Advice given by MIDINRA technicians sometimes included safe use of pesticides. Aspects of pesticide safety had been included in adult education and secondary school notebooks. But the content and teaching process had not been systematized. Few teaching materials were available. Effective planning to cover the priority populations had not been done.

Drawing upon materials developed in other countries (8,9) and Nicaragua (10), we conducted initial workshops with popular health educators of MINSA and workers brigadistas. We found that sharing of ideas and experiences was facilitated by orienting the workshop around the key questions, for example:

1. What are pesticides and why are they used?
2. What harm can pesticides cause to people and the environment?
3. How can we reduce exposure to pesticides?

Based on these questions, we elaborated several materials to be used by multipliers in workshops:

1. Safe Use of Pesticides -- a flipchart of 18 drawings with accompanying instructor's guide. Each drawing presents a "codification" of the use or consequences of pesticides for the participants to discuss.
2. **Pesticides: how to reduce their risk and their harm to our health --** a 40 page booklet using comic book style.
3. Pesticides and our health: what do we know and what can we do? -- a set of 36 slides, taken in Region II, with an instructor's guide. The guide includes questions to promote dialogue with participants and the basic contents to consider.
4. Revolution is Health -- a photo poster produced with the ATC. Includes questions and slogans.
5. Puppets and sample scripts for shows, produced in a workshop with popular health educators and rural teachers.

Other materials were used in two-day workshops for specific groups taught mainly by multipliers, e.g. tables of differential toxicity of pesticides for agricultural technicians. E.g. Specifics of the labour code and regulations were amplified for zonal labour inspectors. E.g. Practical sessions on closed systems for loading airplanes with pesticides for those working at spraying airfields. E.g. A dressup with personal protective equipment (PPE) for agricultural workers, cooperative members and farmers. Several hundred agricultural workers were trained over a two year period, covering all the major state enterprises and considerable numbers of private ones. Small farmers and cooperative members were more difficult to reach but regular bi-monthly sessions were included at the UNAG regional training school by the end of 1986. Participants in closed system trainings sessions received baseball caps (a national favourite) with a Pesticide Health and Safety Program logo to foster commitment to safe work practices.In addition, the media were used to promote the pr + ogram during the season of highest pesticide use. E.g. Radio spots based on dialogue between two rural residents or workers to reinforce safe work and hygiene practices when applying pesticides. These ran during baseball games and on Sundays. Radio and newspaper interviews were conducted with Nicaraguan members of the Program.

EVALUATION:

Evaluations of workshops were overwhelmingly positive with respect to content and process. Most participants enjoyed the use of materials and practical sessions. Some real frustrations were expressed about the difficulties of implementing suggested solutions. Some of these were negotiated by representatives of the ATC and the state enterprises during workshops with good rates of completion on follow-up. Others struck at the scarcity of resources and awareness among middle managers of agricultural enterprises or small farmers themselves. Channelling of these frustrations has led to more systematic efforts to obtain and equitably distribute personal protective equipment through national organizations. Shower facilities, provision of overalls and change rooms are being installed at some high use sites, since agricultural workers are more likely to wash up immediately after work with pesticides. The number of reported pesticide poisonings continue to increase as the surveillance system improves, a feature common to occupational health programs carrying out education to prevent pesticide-induced illness (11). Years may be required before this "hard" outcome shows a decline.

DISCUSSION

The educational activities of the Pesticide Health and Safety Program can be compared to other such education efforts among newly literate agricultural populations. At an international workshop on pesticide education, presenters from India, Brazil, Argentina, Uruguay and other developing countries emphasized the importance of locally designed culturally appropriate programs (12). However, none used popular education methodology to guide the design of materials and the process of training. Except in Argentina, few programmes drew on such a range of organizations and technical personnel. Nor did they work through unions and other popular organizations to the same extent. This latter characteristic is particularly important for the process of enabling populations at risk, like agricultural workers, to take some control over the health risks that they face (13). The Canadian Farmworkers' Union was a similar, though unsuccessful, vehicle in Canada (14) and the present grape boycott promoted by California's United Farmworkers has a similar goal. Several programmes did see education activities in the broad context of promotion as advocated by two British authors who reviewed community health education in developing countries (15). The Argentinian and Indian programmes recognized the need for campaigning nationally as well as locally to ensure changes in the use, labelling and distribution of pesticides.

The Nicaraguan Program operationalizes this perspective through joint work between ministries and organizations symbolized by the National Pesticide Commission, legitimating activities at regional and community levels.

The radically different political climate fosters new approaches to pesticide problems. These challenge both modernist technical 'fixes' and maintenance of the status quo as viable alternatives for agriculturally based less developed countries.

CONCLUSION:

Major efforts in pesticide health education and healthy public policy in Nicaragua compare favourably with similar programs to deal with pesticide problems in other less developed countries. Canadians can both learn from such experiences and support them through the Tools for Peace campaign seeking personal protective equipment for agricultural workers.

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14. Labonte R. Racism and Labour: The Struggle of British

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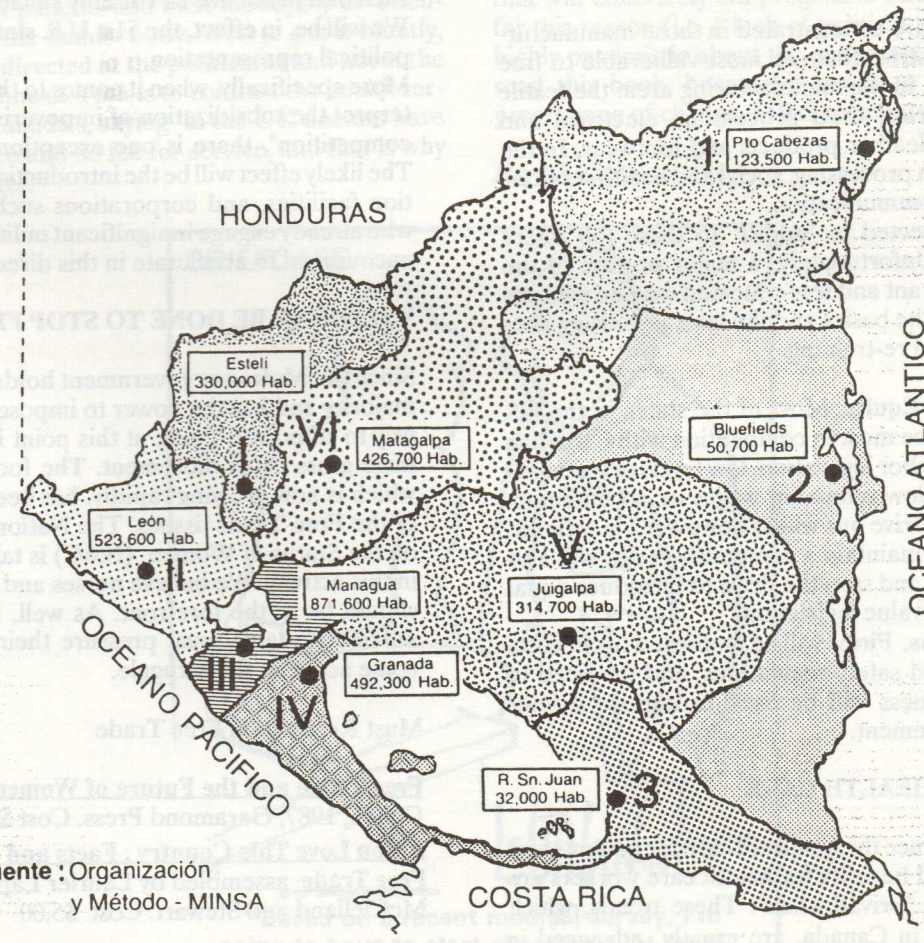
Editor's Note: For those interested in Nicaraguan Health Policies, Prof. David Lumsden of Bethune College, York University, is organizing a conference entitled: "Nicaragua: Peoples' Health". March 19-20 in the Gallery (Room 320) of Norman Bethune College, Main Campus, York University, 4700 Keele St. No conference fee. Program: Is still being arranged, but it is expected that Nicaragua's Health Minister (Commandante Tellez) will attend. Other speakers include representatives of CanSave, IDRC, Toronto City Hall. Full details from Professor D. Lumsden, (416) 736-5164 ext. 3959.



Fuente : Organización y Método - MINSA

Free Trade – It's Effect Upon Women, the Health Care System and the Arms Industry

The Canada-US Free Trade agreement, which is about to be imposed upon the Canadian people in a shamefully undemocratic fashion, carries grave consequences for Canadian economy, culture and national sovereignty. The proposed massive "give-away" of our resources and our independence by the Mulroney government will impact on the entire Canadian nation in a way that will accelerate the polarization between the rich and the poor and erode most, if not all, of the social gains won in the past century. It will have a particularly insidious effect upon women as a class, our health care system (as well as other social programmes) and our ability to influence the arms race.

THE ESSENCE OF THE FREE TRADE AGREEMENT

The agreement calls for the gradual elimination of tariffs over a ten year period. It opens up the entire Canadian economy to increased U.S. ownership and control, by guaranteeing U.S. firms the "right of national treatment" (i.e. to be treated as if they were Canadian. It provides unrestricted access to our natural resources (lumber, hydroelectric power, gas and oil, etc.) In return Mulroney failed to achieve a mechanism to protect against U.S. "countervailing tariffs" aimed at alleged "unfair" Canadian trade practices -- that is, our "subsidizing" of domestic industry through social benefits such as Medicare and regional and other support programmes.

FREE TRADE AND WOMEN

1) Job loss. Women are concentrated in those manufacturing and service industries that are most vulnerable to free trade. These include, in the manufacturing area: the textile and clothing industries, food processing, electrical and electronic products, leather products and footwear. In the service sector are data processing, social and health services, transportation and communication.

Workers will be expected to "adjust" to these job losses through retraining. Unfortunately, a major portion of the workforce are immigrant and less educated women who are already 'deficient' in the basics and the least promising candidates for specialized re-training.

2) Lower Wages and Equity. Most of the states in the US whose industries will be most in competition with Canadian industries have poor labor legislation, low levels of unionization and have either low minimum wages or no minimum wages at all. This will drive our wages downward in order to compete; the need to maintain a competitive edge will also be used to slow down and stop the drive to introduce equal pay for work of equal value legislation.

3) Working Conditions. Firms will be motivated to cut costs by ignoring health and safety regulations, and the need to maintain competitiveness will be used to impede stricter legislation and enforcement.

FREE TRADE AND HEALTH CARE

Two factors which reduce the quality of care for patients and reduce protection and benefits for health care workers are "contracting out" and "privatization". These trends, which have begun to occur in Canada, are greatly advanced in Reagan's America. Contracting out various types of jobs in order to cut costs results in lower wages and benefits, the loss of full time jobs to part-time jobs, deteriorating working conditions, and a consequent loss of morale and effectiveness. Free Trade competition demands will accelerate the contracting out phenomenon and encourage other cost-saving schemes such as the introduction of patient classification systems in hospitals. These schemes, which allocate nursing time to various illness have been used to cut "costly" nursing services by reducing full-time nursing staff to supervisory positions to part-time and temporary ones.

The right of national treatment under Free Trade will likely open access to public funding that is now restricted to non-profit operators. This will ensure rapid privatization as has already occurred in the US , where massive conglomerates are taking over the care of the chronically ill and elderly (and child care). As with contracting out, privatization reduces the quality of service as it wrings more work out of health care employees for lower wages, benefits and working conditions.

FREE TRADE AND THE ARMS RACE

In a general sense, Canada's newly-trade driven economy will be intricately tied up with and dependent upon the US economy, far beyond what it is today. The potential for US trade and economic retaliation against independant Canadian policy on peace and arms reduction will render such independence as virtually suicidal.

We will be, in effect, the 51st U.S. state, the only one with no political representation.

More specifically, when it comes to the US's potential to interpret the subsidization of impoverished regions as "unfair competition", there is one exception: military production. The likely effect will be the introduction of new arms production facilities, and corporations such as General Electric, who already engage in significant military production, will be encouraged to accelerate in this direction.

WHAT CAN BE DONE TO STOP FREE TRADE?

Since the Mulroney government holds a massive Parliament majority and has the power to impose Free Trade , the only way to stop Free Trade at this point in time is to develop a huge grass roots movement. The focus of this movement, which is now growing rapidly, has been to force an election of the Free Trade issues. The National Action Committee on the Status of Women (NAC) is taking a prominent role in this activity. We believe nurses and nursing organizations should be in the forefront. As well, individual nurses and nursing students must pressure their organizations to become active in this struggle.

Must Reading on Free Trade

<u>Free Trade and the Future of Women's Work</u> by Marjorie Cohen, 1987, Garamond Press. Cost $8.00

<u>If You Love This Country : Facts and Feelings on Free Trade</u> assembled by Laurier Lapierre, 1987. McClelland and Stewart. Cost $5.00

Cathy Crowe and Roger Hollander

High Price of Health

The High Price of Health: A Patient's Guide to the Hazards of Medical Politics. By Geoffrey York, with an introduction by Philip Berger. Lorimer, 1987. $16.95

Book lists being compiled by MRG members should include this book. As a relative newcomer to Canada, I found it particularly useful as a quick summary and recent history compote of Canada's health services. Perhaps for that reason some MRG members may find it "old hat". They should however still find it a useful summary when mustering arguments. Still more useful would it be, had the publisher/author shelled out for a decent index and **precise** referencing of facts. One possible definition of mystification is unreferenced, (i.e. unsubstantiated), facts.

Mystification of the public by "The Physicians" is the general theme. The author's thesis being that this serves the interests of the medical profession in lining of the pockets. Certainly the author's eye sees through the veil of "Ethics" proposed by earlier physicians in fights against homeopaths, chiropracters and midwives, etc.

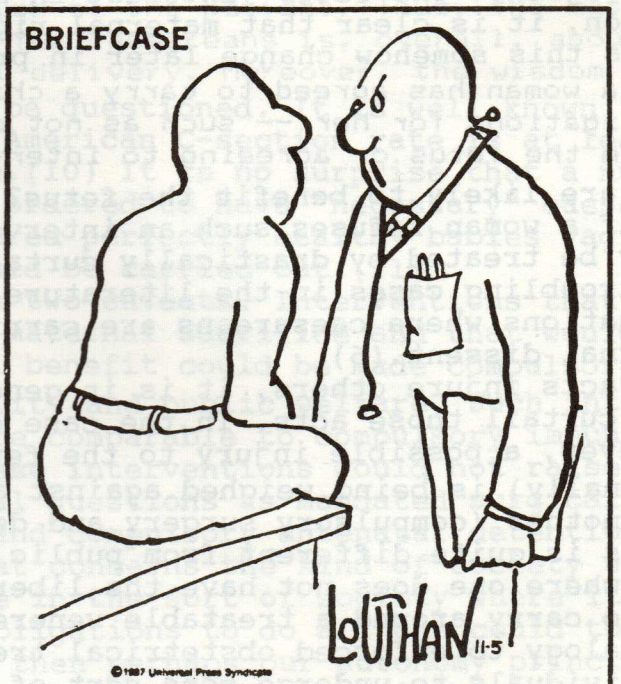
However his sharp eye leads sometimes into not seeing the wood for the trees. In his disgust for the more greedy of our profession, he has a tendency to lay **all** ills of the health service on their shoulders. Briefly, his argument goes: whenever governments have proposed progressive moves, the physicians have prevented their implementation. The physicians have achieved this by their social contracts with politicians, their "political clout" with the politicians and their intimidation of patients and their monopoly of "scientific knowledge" of the human body. Well to put it bluntly, the knife should be **directed at the politicians** and not at the doctors alone. The line of York is to contrast the health service in the UK to Canada's, saying "in the UK doctors have a fixed capitation fee and no fee for service, and that is why the UK NHS is better."

As any progressive in the NHS will tell you this is an inadequate history. One relevant question is, **Why the** political will was found in Great Britain to put such a system on the map? The strength of the trade union movement, and the large number of poor GP's who wished to be nationalized played an important role in the matter. For progressives interested in initiating an end to fee-for-service (and the distortion this brings to health care, superbly documented by York), it is important to know why this was retained in one country and not in another. The logic of York is that doctors in one country are intrinsically less concerned about profiteering from illness than doctors in another country. Jensen & Eyesenck may agree, I do not. It should also be explained to York that despite the constant contrast of doctors practice in the UK with that of Canada (Union Jack good, Maple Leaf bad), the UK NHS has been in big trouble for at least the last two decades. It is not, in Britain, possible to pin the rocketing cost of the NHS on i) fee-for-service, or ii) doctors' referring patients back and forth in order to increase billing.

For myself the best sections of the book involved the rise of the "patients movements." The impact that this has had on the medical profession is well outlined. In taking fire at the medical profession for resorting to "expensive legal" evasions, I would that he had also taken fire at the "expensive legal" evasions themselves and taken on (at least a bit) the legal profession.

To conclude: A good summary of the grossness of the medical profession. However do not expect any political analysis that will concretely aid progessive intentions. It is perhaps for this reason (i.e. a lack of political analysis) that York is highly pessimistic about the prospects for change. Buy and read this book, because it needs to be extended into a programme of change. MRG members take note!

Haresh Kirpalani



"Based on a recent medical survey, I'm going to have to start charging a lot more."

Compulsory Obstetric Interventions

Last spring in British Columbia, child care authorities apprehended a child shortly prior to its birth. The child's mother had a history of drug abuse and her other children had been previously seized. The courts were apparently prepared to order a caesarean section as well.(1) This order was not carried out as at the last moment the mother agreed to the surgery.

A recent review reveals many US precedents for over-riding maternal refusal of obstetrical interventions. Such compulsory interventions, felt to be in the fetus' best interests, ranged from caesarean sections, and intrauterine transfusions to antenatal hospital detention for management of diabetes. The patients were largely non-white and poor. Their competence was not in question. In one tragic case a woman with terminal cancer at 28 weeks gestation was forced to undergo a caesarean. The child died immediately and the mother died two days later.(3)

Obstetrics and perinatology have provided new scope for antenatal diagnosis and treatment. Some antenatal treatment such as fetal surgery for hydrocephalus and urinary obstruction remains experimental. Other interventions such as intrauterine transfusion for erythro blastosis -- can be considered mainstream.(4) Perinatology has in this process widened the scope for the old conflict between fetal and maternal rights. Hitherto confined to the issue of abortion, this conflict threatens to encompass more widespread aspects of antenatal medical care.(5)

The central question raised by enforced obstetrical interventions is this: May one patient's rights ever be usurped to advance the therapeutic interests of another patient? Specifically, how are the mother's autonomy rights to be balanced against the fetus' interest in health? In the area of abortion, it is clear that maternal rights are paramount. Does this somehow change later in pregnancy? Does the fact that a woman has agreed to carry a child to term create new obligations for her -- such as not doing anything that might harm the fetus or agreeing to interventions that doctors think are likely to benefit the fetus? The problem here is that if a woman refuses such an intervention the fetus can only be treated by drastically curtailing her liberty. The troubling cases in the literature concern emergency situations where caesareans are carried out in spite of maternal dissent.(6)

Where private acts injure others, it is in generally thought acceptable to curtail those acts. In the case of caesarian sections, however, a possible injury to the fetus (to be delivered vaginally) is being weighed against a certain injury to the mother (compulsory surgery and denial of her autonomy). This is quite different from public health circumstances where one does not have the liberty to be not immunized or to carry around a treatable venereal disease. The closest analogy to enforced obstetrical treatment would be forcing individuals to undergo some sort of surgical

procedure, say the donation of blood, bone marrow or organ for another's benefit.(7) The cardinal principle of medical care that a competent adult may not be touched or treated without that adult's informed consent (the autonomy principle) currently would prevent most such interventions.(8)

Thus, a court cannot order, say, the relative of a dying patient to donate bone marrow should the relative refuse such a donation. Here, the moral status of the patient is not in question. Just so, the moral status of the fetus should be irrelevant to the debate over obstetrical interventions. Accepting as fundamental the autonomy principle means that we may not sacrifice the mother's autonomy for the benefit of the fetus. The price of liberty may mean that others may not do what we think they should do. This in turn may mean, tragically, that some patients may die deaths that others have the moral power to prevent. Unfortunately, this happens every day from direct to various indirect ways, such as not donating as much as one could to charities that would prevent starvation.(9)

If the liberty of pregnant women is curtailed, it is because the rights of women are generally devalued in patriarchal society. We do not force others to sacrifice their liberty, let alone their pay cheque, to prevent needless deaths. Moreover, if we think that the autonomy of the woman means less than the life of the fetus, then we are ineluctably led to other dilemmas. Any time an individual's life is at stake, if forcing another to undergo a non-life threatening procedure would save that individual, should we do so? Are we going to start suggesting across the board that the right to be left alone will always be trumped by the "right" of others to be kept alive? Where will this trade-off process end?

Such consequences are repugnant because they involve enforcing surgical procedures. Such procedures always involve some risk to the patient. Thus, the maternal mortality rate for caesareans is, overall, about four times that of vaginal delivery. Moreover, the wisdom of such procedures may be questioned. It is well known, for example, that the North American C-section rate is at least twice what it need be.(10) It is no surprise that a number of the women who were ordered to have "necessary" caesarean sections delivered perfectly healthy babies vaginally before the surgery could be carried out.(11)

I will end with two caveats. Interventions that would require little maternal sacrifice and that would produce great potential benefit could be made compulsory on grounds of proportionality and public welfare. Such interventions would have to be comparable to compulsory immunization to be acceptable. These interventions would not raise as large moral and social questions as mandated surgical interventions and compulsory antenatal detentions.

My second caveat concerns the kind of society we live in. Were we to live in the sort of society where it was expected that one had obligations to do all one could to help and rescue others, then perhaps our autonomy principle would be less paramount. But I suggest that if such a society were

purchased at the expense of everyone's liberty it would not be a happy society. We do not, it seems, know yet how to meet the needs of others without sacrificing our idea of liberty.(12) Until then, the best we can do in our present society to help prevent harm to fetuses will be to improve as much as possible the status of women generally.
The future of the debate concerning compulsory obstetrical treatment in Canada is unclear. Will more cases akin to the one in B.C. occur? Will Canada follow the U.S. pattern? I suspect not or at least not as rapidly because part of the impetus for the American dilemma arises from the inferior care many poor women receive there and the fear doctors have of "judges at the bedside". This national difference should not prevent us from looking at this difficult and new area of medical expertise.

Phil Hebert
January 1988

Phil Hebert is a member of the Medical Reform Group.

Footnotes

1. Globe and Mail, Sept. 4, 1987, pA1

2. "Court-ordered obstetrical interventions", V. Kolder, et al, NEJM, May 7, 1987, pp 1192-1214

3. Medical Post, Jan. 5, 1988, p25

4. "Management of the fetus with a correctable congenital defect", M. Harrison, et al, JAMA, August 14, 1981, pp 774-

5. "How technology is reframing the abortion debate", D. Callahan, Hastings Center Report, Feb. 1986, pp 33-42

6. "Cesarean delivery for fetal distress without maternal consent", Obstetrics and Gynecology, R. Jurow and R. Paul, April 1954, pp 596-598

7. "A new threat to pregnant women's autonomy", D. Johnsen, Hastings Center Report, Aug/Sept. 1987, pp 33-40

8. "Perspectives on fetal surgery", S. Elias and G. Anna, Am J. Obstet Gynecol, April 1, 1983, pp 807-812

9. cf. P .Singer, Practical Ethics, Cambridge, 1979

10. "Comparisons of National Cesarean-section rates", F. Notzon, et al, NEJM, Feb. 12, 1987, PP 386-389

11. "Drawing moral lines in fetal therapy", J. Fletcher, Clin. Obstet. Gyn, Sept 1986, pp 595-602

12. cf. M. Ignatieff, "The Needs of Strangers", Penguin, 1984

Editor: There will be further comment on this subject in the next issue.