MRG Newsletter

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

Volume 8, Number 3 June 1988

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

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June 17 meeting

On January 29, 1988 the MRG Steering Committee organized a meeting for people on and outside the Steering Committee to discuss directions for the group. One of the decisions taken at that meeting was to hold a follow-up meeting for further discussion of the issues raised. (See the February and April newsletters for reports and impressions of the meeting.)

Any member can attend the follow-up meeting on June 17, 1988 at 8 p.m. at 131 Langford Avenue in Toronto. For further information, call the MRG's number at (416) 588-9167.

Community Mental Health

There is a private member's bill about community mental health before the provincial legislature. If anyone would like to participate in preparing a brief on this issue please call Nick Kates during June at (416) 389-5975.

Newsletter Deadlines

The publication date of the next MRG Newsletter is August 5, 1988. The deadline for that issue is July 18, 1988. Longer opinion and feature articles should be submitted earlier, by June 30.

The publication date for the subsequent issue is September 9, 1988. The deadline for that issue is August 22. Longer opinion and feature articles should be submitted by July 28.

Healthy Communities: A Canadian Project

By Dr. Trevor Hancock, Public Health Consultant to WHO Project, Toronto 2000.

"Many would be surprised to learn that the greatest contribution to the health of the nation over the past 150 years was made, not by doctors or hospitals, but by local government." Dr. Jessie Parfit "The Health of a City; Oxford 1770 to 1974."

For many people today, health has become equated with doctors, hospitals and the health care system. But in the past ten or fifteen years, we have come to recognize -- or rather to re-learn -- that a healthy community needs much more than a good health care system.

When we ask people about the things that are important for their health, they are likely to talk about their family, their friend and neighbours, having a good job, and living in a good neighbourhood. There is very good evidence that much of the improvement in health that we have seen over the past one hundred and fifty years was due to cleaning up the environment, providing clean water, getting rid of waste in a safe manner, increasing income and living standards, providing good healthy housing and well planned communities, and ensuring the availability of cheap, safe and wholesome food.

In many of these areas, and in areas such as parks and recreation, social services, roads and transportation and a whole host of similar activities, local governments have played and will play

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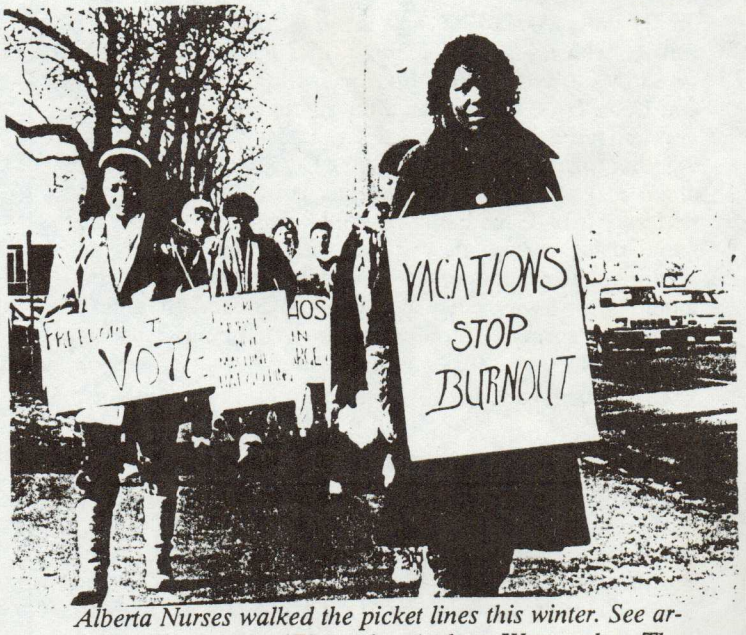

Alberta Nurses walked the picket lines this winter. See article in this issue. (Photo by Andrea Waywanko, The Newsmagazine by Alberta Women)

Healthy Communities: A Canadian Project

a very important role. Of course, provincial and national governments also have a role to play, but local government is the government closest to the community, the level of government that perhaps best understands the community's problems.

The Healthy Communities Project was born out of the recognition that many of the things that make for healthy people and healthy communities do not lie within the jurisdiction of the health care system or the public health department, and the recognition that local communities and local governments can play an important role in creating a healthier future for us all.

The new approach to health that the Healthy Communities Project exemplifies has come to be recognized as "health promotion". The Ottawa Charter for Health Promotion, adopted in 1986 at a conference organized by WHO, Health & Welfare Canada and the Public Health Association, defines health promotion as "the process of enabling people to increase control over and improve their health" and proposes five main approaches:

1. Build healthy public policies (policies in all sectors that support healthy choices);

2. Create physical and social environments supportive of health;

3. Strengthen community action for health (by empowering communities);

4. Develop personal skills for health (including self-care, mutual support and community action skills); and

5. Re-orient health services (towards health promotion and disease prevention, community-based health systems and primary care).

A particularly important aspect of "the new public health", as health promotion is being called, is the attention that is paid both to inequalities in health status and inequalities in such basic prerequisites for health as food, shelter, work, education and income.

The project, which has its origins in a workshop on Healthy Toronto 2000 in 1984, now involves communities all over Europe where -- as the Healthy Cities Project -- it is sponsored by the World Health Organization, and in Australia and USA. Here in Canada, the Canadian Institute of Planners and the Canadian Public Health Association have come together to develop a proposal for a Canadian Healthy Communities Project. The project has been endorsed by the Federation of Canadian Municipalities, in the hope that municipal governments will join with urban planners and public health professionals in a project to make our communities, towns and cities more healthy. Indeed, the Interim National Steering Committee has included politicians from Dartmouth, North York and Victoria.

In essence, the Healthy Communities Project asks two questions:

What is a healthy community?

How do we get one?

A number of communities including Victoria, Calgary, Edmonton, Saskatoon, Regina, Winnipeg, North York, Toronto, Rouyn-Noranda, Montreal, Sherbrooke, Quebec City and Dartmouth have already begun to explore this topic. A number of them have held workshops involving a wide range of community leaders from many different fields. These workshops have asked the first question, namely: what is a healthy community?; and have begun to stimulate discussion on methods for making the community more healthy.

When asked what is a healthy community, people respond by talking about

clean environment, clean air, safe and clean water, lots of trees and green space;

Basic needs such as food, shelter, and housing for everyone;

Work for all that is health enhancing, flexible and satisfying;

Neighbourhoods that are people oriented, where the streets are safe and where there is a good mix of housing, people, services and facilities;

Good health and social services accessible to all;

Local government that is accessible and responsive and that involves people in making decisions about their lives; and so on.

There are a number of shared values and shared concerns in all communities, and a common understanding of what makes for a healthy community. Furthermore, people understand full well that health is not simply a result of health services, but that it involves a much wider range of activities.

When we come to talking about what we can do to develop more healthy communities, the role of local governments becomes very clear. One common strategy that is often proposed is that local governments should explicitly recognize that their activities impact upon health, make a commitment to create a more healthy community and establish mechanisms to do so.

These mechanisms might include formally adopting a strategy to improve health; establishing an interdepartmental and/or Council committee to identify ways in which the community could be made more healthy; involving local citizen groups and neighbourhood associations in thinking about these issues and identifying local projects; involving business, labour, the United Way, church and volunteer groups; establishing health "goals" for each department in local government and asking them to identify ways in which they contribute to health right now and could contribute to better health in the future; involving kids in thinking about the future of the community and looking at what can be done to make the community more healthy for them in the future and so on.

In addition to actions by municipal government, the project will seek to strengthen and support community action for health and will encourage communities to recognize that they can and must exercise more control over their health and its determinants. Municipal governments will be encouraged to strengthen and support community participation and improvement through community development and organization activities. As the definition of health promotion indicates, the health of a community will only be improved if the community, through its members, increases its control over health and the determinants and prerequisites of health.

The purpose of the Canadian Project will be to help communities and local governments develop healthy community projects. The national office will bring together the skills and

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Healthy Communities: A Canadian Project

energies of municipal governments, urban planners and public health professionals in a collaborative effort for better health. The office, which will be established at the Canadian Institute of Planners, will act primarily as a catalyst to support the development of healthy city projects; a clearing house for collecting ideas and stories about innovative projects around the world that contribute to better health at the local level; acting as a network for distributing information, ideas and innovations among participating communities; organizing regional and national workshops and conferences to enable people and communities to learn from each other; and developing resource material, information packages, newsletters and other items to support healthy communities projects.

For more information on the project contact: Canadian Institute of Planners, 30 - 46 Elgin St., Ottawa, Ontario K1P 5K6, (613) 233-2105, or Dr. Trevor Hancock, 629 Manning Ave., Toronto, Ontario M6G 2W2.

The Alberta Nurses Strike

By Trudy Richardson, Education/Publications Officer, United Nurses of Alberta

As Canadians from coast to coast are aware, United Nurses of Alberta (U.N.A.) Hospital Locals returned to work Saturday, February 13, 1988, after a 19-day strike. U.N.A. consistently said hospital nurses would end their strike only when they had achieved a negotiated Collective Agreement. This was attained and nurses returned to work.

U.N.A. Hospital nurses went on strike in 1977, 1980, and in 1982. In all of these strikes we were legislated back to work through court orders. In 1983 the Alberta Government passed Bill 44 which took away the legal right to strike from hospital nurses. Included in Bill 44 was a provision for mandatory compulsory arbitration as an end process to be invoked if bargaining broke down.

Since 1983 U.N.A. has consistently taken the position that U.N.A. members alone will determine if and when they go on strike for an improved offer from their employers. U.N.A. has also rejected compulsory arbitration as a settlement dispute mechanism. This policy is based on the fact that in reality the employer is the government, and the Minister of Labour's ability to name the arbitrator ensures that the employer has ultimate power in the awarding of a binding settlement. U.N.A. refuses to allow a biased third party to determine our wages and working conditions.

In January of 1988 the hospital employers successfully applied for cease and desist orders to stop U.N.A. from taking a strike vote and then from going on strike. The Labour Relations Board's directives were filed as court orders. Thus when U.N.A. Locals conducted a strike vote, and then when the U.N.A. Negotiating Committee called the strike for January 25; the employers and the Attorney General sought assistance from the courts. They charged U.N.A. with criminal contempt, and individual U.N.A. locals and members with civil contempt. In two separate criminal contempt hearings U.N.A. was sentenced a total of $400,000 in fines; in several civil contempt hearings U.N.A. locals and U.N.A. members were sentenced approximately to a total of $26,000. All these court judgments are presently under appeal. Employers individually imposed discipline and terminations upon U.N.A. striking members.

The back-to-work agreement signed between U.N.A. and the Alberta Hospital Association removed disciplinary actions and terminations. But the court fines remain.

During the strike it became apparent that the employers were content to dally at negotiations letting the government and the courts apply pressure to the strikers.

The Memorandum of Settlement which outlines the negotiated Collective Agreement provides a number of improvements (11% wage increase for most members over a 27 month contract; improved overtime provisions; improved benefits; full back-to-work amnesty; and renewal of the dues deduction process), but still leaves a set of demands unanswered.

Outstanding issues which U.N.A. will present to the Premier's Commission on Future Health Care for Albertans include:

1. Working Alone: U.N.A. condemns all instances where nurses are assigne to work alone on a ward or unit.

2. Wages: Alberta nurses, even with the increases in the new contract, are paid less than many other nurses, and substantively less than Ontario nurses.

3. Benefits: The existing benefit package is inadequate and unsatisfactory, not even covering the de-insured services of Alberta Health Care.

4. Health & Safety: U.N.A. has a long list of health & safety concerns including the handling of toxic chemicals, increased back injuries, requirements to search for bombs, radiation hazards, and increased stress.

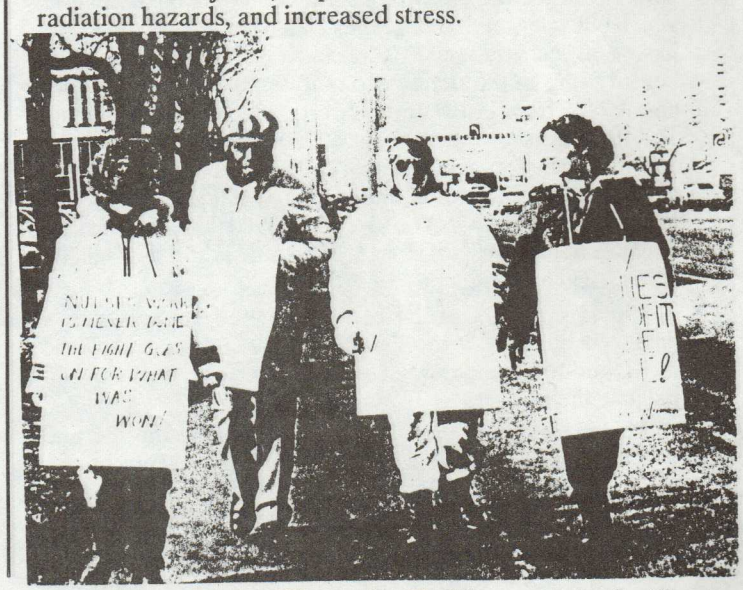


Photo by Andrea Waywanko, The Newsmagazine by Alberta Women

Alberta Nurses Strike

5. In Charge: U.N.A. calls for a nurse to be assigned in charge and to be physically present on a ward or unit at all times.

6. Staffing: U.N.A. recommends adequate staffing of all wards or units as per real patient needs, and opposes all administrative systems, such as patient classification, whose effect is to reduce staffing levels and to erode the quality of patient care.

7. Contracting Out: U.N.A. oppose the use of private nursing companies to staff hospitals.

8. Sick Leave & Vacation: U.N.A. calls for increased sick leave and vacation entitlements as a way of recognizing the multiple exposures inherent in nursing critically ill patients and the increasing stress of nursing.

These are by no means a complete list of outstanding issues but are major indicators of problems facing nurses and U.N.A.

The combined strength of Alberta courts, the Alberta government, and the hospital employers of Alberta was not sufficient to deter U.N.A. members from their goal of a Collective Agreement which provides job security and fair wages and working conditions.

For U.N.A. members, returning to work, simply means we fight on but this time by policing and monitoring our Collective Agreement, and by continuing to fight for quality health care.

MRG Spring General Meeting Summary

The MRG Spring General Meeting was held on evening of Friday May 6, 1988, and all day on Saturday May 7. The following is a summary of the Saturday sessions, based on the minutes of the meeting.

The meeting was called to order by Bob James.

Chapter Reports:

Toronto: There have been two recent meetings: with Marion Powell on abortion, and with Philip Berger and Phil Hebert on AIDS, with a meeting on smoking and cigarettes on Wednesday May 25. For more information, or to get involved in the chapter, contact Fred Freedman, Gary Burrows, or Doug Sider, or call the MRG number at 588-9167.

Hamilton: The Hamilton chapter has been quite active. The next meeting is on May 25 on "Native Health: Issues and Concerns". The Hamilton chapter can also be contacted through the MRG number: 588-9167.

Financial Report: Ulli Diemer presented a financial report to the end of April. The report indicates that the MRG is projecting a deficit of about $4,700 for the fiscal year which ends September 30, 1988. This would be the first time in several years that the MRG has not had a surplus. Factors contributing to the deficit are that memberships are down about $400 from last year, while total income is down about $1170. Expenses will be about $2000 higher than last year. Significant factors contributing to the increase in expenses are the acquisition of a phone line ($600/year); printing, which will go from $2600 last year to $3950 this year; the cost of general meetings, up from $536 to $2111; and postage, up from $1250 to $1600.

The Steering Committee was asked to produce a balanced budget for the Fall General Meeting, and in the meantime to consider what measures will be necessary to balance the budget.

Pharmaceuticals: Bob Frankford reported that he and Joel Lexchin are continuing to work on the pharmaceuticals issue. The MRG has submitted a letter noting weaknesses in the Eastman review of prices, and will be presenting a brief to the Lowy Commission. The Lowy Commission is to review all aspects of pharmaceuticals use in Ontario. MRG members interested in helping prepare a presentation on pharmaceuticals issues are asked to contact Joel Lexchin or Bob Frankford.

Administrative Charges: There has been some interest in this by the media, but little action by the government.

Midwifery: Bob James reported that Health Minister Elinor Caplan has stated that she is in favour of midwives. The Ministry has set up a person to be in charge of moving on the implementation of midwifery. It's moving, but slowly.

Abortion: Events since the Supreme Court decision were summarized. Despite the change in the law, there has been little or no improvement in access. OHIP will now pay for abortions performed outside of hospitals. The plan by the Health Ministry to set up women's health centres has had little impact so far, none at all in the areas of the province that have the most problems with access. An attempt is being made to set up a nation-wide Physicians for Choice organization, with one of its platforms being that there be no federal legislation on abortion. There was discussion of extra fees being charged at the Morgentaler and Scott clinics. The justification is that they are needed to cover the operating expenses of the clinics but the fact remains that the situation leaves women having to pay extra fees beyond what OHIP covers.

Steering Committee Report: Don Woodside gave the Steering Committee report. (The report follows below.) There are now four vacancies on the on the Steering Committee. Members are urged to consider standing for the Steering Committee, which meets once a month, with meetings alternatively in Hamilton and Toronto. Help is also needed on the local chapters and on the working groups.

Discussion

The meeting expressed its thanks to Haresh Kirpalani and to the Steering Committee for the improvements in the quality and content of the newsletter. The question of how to attract new members was raised, with the specific sugges-

tion that contact be made with University of Toronto medical students.

College of Family Physicians: Fred Freedman raised the issue that this College had been active in support of the doctors' strike. It took a blatantly political stand, yet membership in the College is required in maintain one's C.C.F.P, and the C.C.F.P is required to do obstetrical work in hospitals. He asked for the names of other people who would be interested in pursuing some kind of action on this issue.

Steering Committee Members: Thanks were expressed to the three people leaving the Steering Committee -- Fran Scott Michael Rachlis, and Steve Hirshfeld.

(The above from minutes of meeting prepared by Ulli Diemer)

Resolutions

Resolution on Quorum and Mail Ballots:

Bob James had proposed a motion which stated that "Whereas the business of the MRG has on at least one occasion been held up by the lack of an official quorum, and, whereas as the organization grows this will become an even more frequent occurrence, Therefore be it resolved that the constitution of October 1979, amended October 1987, be amended so that section 30 read: 'A quorum at such a meeting be 10% of the paid up full membership at the date of the meeting', and section 42 be amended to include the sentence 'Such a vote may be taken by mailed ballot.'"

The motion was split into two parts for voting and discussion. The first part, changing the quorum to 10% (from 20%) was passed 23 - 0.

The second part of the motion was amended. The amended version is in the form of a new paragraph to be added to section 42 of the constitution. It reads: "If after presentation at a general membership meeting a quorum is not achieved, a mail-in vote may be taken. Ballots must be received from 30% of the total voting membership, and a two-thirds majority of the mailed-in vote is required to pass a constitutional amendment. The votes must be received within a time specified at the time of notification of motion." This motion passed 22-0, with 2 abstentions.

Resolution on Working Conditions and Call Schedules:

This resolution had been proposed by the working group on Working Conditions and Call Schedules. It passed 17 to 3, with 1 abstention. The resolution reads:

Current working conditions and call schedules for residents entail prolonged periods of sleep deprivation and result in residents working an average 81 hours per week, more than double the hours of the average worker in this country. On-call duties increasingly entail crisis intervention and intensive patient care. The consequences of such working conditions include a high rate of affective disorders among residents.

Inasmuch as cutbacks in the number of residency positions in Ontario threaten to increase the workload borne by residents, and

Inasmuch as we believe that such working conditions are detrimental to both patient and physician wellbeing,

1. Be it resolved that the MRG urge the provincial government to establish an interdisciplinary commission to review residents' working conditions and their impact on patients' care.

2. Be it resolved that the MRG endorse the policy that mandatory working hours of interns and residents be limited to a maximum 16 hours in any one day and 60 hours in any one week.

3. Be it resolved that the MRG reaffirm its commitment to the establishment of part-time residency positions.

Resolutions Re: Discipline Process:

A number of resolutions had been proposed and published in the April 1988 newsletter. The resolution on "Access to the Medical Record" was separated from the other resolutions for the purposes of discussion and voting. The other resolutions were voted on together and passed 20 to 0, with 2 abstentions. The resolution on "Access to the Medical Record" was deferred, perhaps to be considered at the fall general meeting. The motions passed read as follows:

1. Publication of Discipline Hearings: Publication of the evidence but the withholding of names. The physician could be named only after a guilty verdict, as a present.

2. Composition of Discipline Panels: Panels should have a majority of physicians, on the order of 3 to 2, or 2 to 1.

3. Presence of Complainant: The hearings should be open to the public, as in recommendation 1.

4. Counsel; Status of Complainant: The complainant not be a party to the hearing.

5. Practice Review: That the CPSO launch a study to ascertain whether complaints or discipline hearings regardless of outcome are useful indicators of substandard practice.

6. Retraining: That money be set aside either through CPSO or through OHIP to assist physicians retraining when it is ordered by the CPSO.

7. Complaint Assistance: That the complaints procedure be well advertised.

Afternoon Session on AIDS:

Steve Hirshfeld introduced the afternoon session. Three workshops had been set up on AIDS-related issues: 1) Professional responsibility 2) Drug Trials Issues 3) Limiting the Spread of AIDS. The workshops lasted about 1 1/2 hours, and were then followed by a plenary.

Spring General Meeting

AIDS Resolutions:

A number of resolutions on AIDS had been proposed, and were printed in the April 1988 newsletter. Amendments were proposed to many of the resolutions. The following are the resolutions that were passed at the meeting:

Resolution on Drug Trials

Whereas AIDS is a rapidly fatal terminal disease and,

Whereas in Canada presently, there are very few drug trials being offered; and,

Whereas it is necessary that there be patient support of any effective drug trial,

Be it resolved that:

1. The MRG calls for a special government mechanism for any rapidly fatal illness, such as AIDS, so that prospective drugs be processed more quickly, and within this mechanism, if there is preliminary evidence from well-designed and -constructed studies that a drug is effective in treatment or prophylaxis and is less toxic than the disease, that further use of the drug not necessarily require placebo trials.

2. The federal government and research funding bodies be more active in encouraging the establishment of drug trials in Canada, and in cooperating in international, multicentre studies with the goal of maximizing places in drug trials for any Person With AIDS (PWA) who wishes to participate.

3. That the government encourage means whereby PWAs and people working with PWAs are consulted in the designing of drug trials.

Resolution on Anonymous Testing

Be it resolved that anonymous testing for HIV status be made available. Testing should include pre- and post-test counselling and informed consent.

Resolutions on Professional Responsibilities and the Care of Patients with HIV-related Illness

Resolution 1

Whereas, physicians and other health care workers have a duty to provide competent and humane care to all patients without discrimination, and

Whereas, the occupational risks to health care workers of contracting HIV are very low and there is adequate knowledge to reduce these risks even further and,

Whereas, health care providers have traditionally accepted some risk in looking after the sick and dying,

Be it resolved therefore, that fear of HIV should not be grounds for physicians and other health care workers to refuse to treat and care for patients with AIDS and other HIV-related illnesses.

Resolution 2

Whereas, refusal to treat and care for patients with AIDS and HIV-related illnesses often stems from fear, ignorance, and prejudice of homosexuality, IV drug users, prostitutes, and other high risk groups rather than excessive risk,

Be it resolved therefore, that hospitals, professional organizations, and other health care institutions provide:

a) intensive educational campaigns which would inform all health care workers and ancillary staff about the nature of AIDS and its transmissibility, and which would address fear and prejudice of all high-risk groups, and

b) appropriate and readily available protective measures for health care workers to prevent contraction of any lethal antigens including HIV.

Resolution 3 as proposed in the April 1988 MRG Newsletter was defeated. The AIDS working group was asked to develop a revised version.

Resolutions on Mandatory HIV Testing

Resolution 1

Whereas, the identification of individuals as seropositive to HIV infection can cause significant harm to mental health and lead to significant stigmatization and other unfair discrimination such as the loss of housing and employment; and

Whereas, at this time there is no known effective treatment to be offered to those who test positive and are symptomatic; and

Whereas behaviours likely to limit the spread of HIV should be encouraged in all sexually active populations and not just those who test positive; and

Whereas, the screening of low prevalence populations for HIV infection may lead to unacceptably high rates of false positive results; and,

Whereas mandatory testing would not eliminate the risk to health care workers of HIV infection;

Be it resolved that all testing for HIV status be voluntary and done only with informed consent and with pre- and post-testing counselling.

Resolution 2

Whereas, having a positive HIV test result has profound consequences for the individual, and

Whereas, variations in laboratory methods of HIV tests can lead to increased rates of false positive results,

Be it resolved therefore that HIV testing in Canada be carried out only in centralized and rigorously quality-controlled public laboratories.

Resolution on Education

In keeping with previous MRG policy on the importance of adequate funding of preventive medicine, and,

Whereas HIV infection is an illness for which we have no cure, and

Whereas we have good knowledge of how HIV is spread and how this could be prevented through popular education, and,

Whereas education is most effective if the members of the target group are directly involved in it,

Be it resolved that the MRG calls for generous funding of diverse public education efforts for firstly, high risk groups, and secondly, the community at large. These programs should candidly acknowledge the sexual and drug use behaviours that contribute to the spread of AIDS. The educational programs need to be rigorously evaluated to ensure that the most effective programs are used.

Resolution on Quarantine:

Whereas AIDS is spread not through casual contact or by airborne droplets, and

Whereas the activities that do spread AIDS are generally voluntary and consensual, and

Whereas a policy of quarantine for any class of HIV infected individual would be ineffective at eliminating the spread of AIDS, could lead to a false sense of security in the general public and would be both legally and administratively extremely difficult to enforce,

Be it resolved that quarantine is an inappropriate measure for containing AIDS and is a dangerous and massive infringement of civil liberties.

The meeting expressed its *thanks to the AIDS Working Group* for its work in organizing the meeting.

Steering Committee Report

Presented by Don Woodside. The Provincial Steering Committee is the body which manages the day to day functions of the Medical Reform Group, and co-ordinates its response to issues of public interest. In the last six months we have been juggling a number of longstanding issues some of which, like abortion, midwifery, and pharmaceuticals, you have already heard about this morning.

Incorporation is stalled as the registration office has objected to the 'of Ontario' in our name. They say it sounds like an official body. We have asked them to reconsider their objection.

A meeting with Elinor Caplan, has been planned to introduce ourselves to the new minister of health. Michael Rachlis, Bob Frankford, and Catherine Oliver will represent us and discuss economics, especially administrative fees, abortion, and pharmaceuticals.

The newsletter serves a vital function in communicating among the membership and publicizing our positions. Interest and energy devoted to it have been sporadic over the years. It has moved to a more rigorous schedule of six publication dates, and thanks to Haresh's efforts, a flow of interesting original articles. We will spend $3200 on publication this year. Plans are afoot for an extended editorial board and volunteers are welcome and needed.

AIDS was the obvious choice for this spring's meeting, after an informal agreement at last fall's discussion. We also wanted to draw out a big crowd, and decided to spend a lot more money than usual. The total budget for this meeting was $1775, some of which is offset by meeting fees. We owe the AIDS working group our thanks for a great deal of work in putting the program together. For next fall's meeting there is some strong support for looking at general practice, including obstetrics and walk-in clinics. We always want to hear from the members about the choice of topic.

Our financial position has been a source of concern, and the projected deficit for 1987-88 has slowly risen to the present level of $5000. We have sufficient reserves to cope this year, but we will have to be watchful in future. Contributing factors have included a decrease in supporting memberships, physician renewals, and students' payments, and expenditures for incorporation, a telephone line to increase accessibility, a postage meter, and this meeting.

The financial picture mirrors questions about whether there is life after Bill 94? We have never been a single issue organization but there is no doubt that opting out mobilized us into being, and always came first. That battle, on paper at least is won, but it is obvious that the pressures to make the health care system a money-making operation like all good enterprises have not abated. To begin the process of setting new priorities the Steering Committee held an open meeting on Friday January 29 in Fran Scott's living room. About 25 people showed up, and everyone had their say. There are reports of the proceedings in both the February and April newsletters, and I urge you to read them for more details. The MRG was viewed in three different ways: a support group, a coalition of interests, and a unitary activist organization. Some felt that only through well-organized activism can we fulfill the support function. If we can set priorities and articulate our position there is a place for us to have an impact on the health care system which is being reorganized around us. It was pointed out that we have always been reactive to the issues of others rather than setting the agenda ourselves: we have only to look at our own three principles for guidance.

There was also attention drawn to the new facts of life for many of our longstanding members; career pressures and young children arriving at once, thus less time for activism; and without a focus, less inclination to devote precious time to the MRG.

There was consensus that we need to meet again to define priorities, and we have set another meeting for June 17. We invite everyone to come along and express your views and take part in shaping our future.

Within the steering committee there has also been discontent about the pressure of time within our one two-hour meeting each month. There is a lot of business and too little time for interesting and needed discussion. We extended our March meeting by one-and-a-half hours to review the process, and agreed to: establish a chairperson for six month's tenure, require 48 hours notice for agenda items, and give more attention to priorizing the agenda. The main

Steering Committee Report

alternatives are to increase the number of steering committee meetings which we are reluctant to do, or to establish an executive within the steering committee which would meet more often to handle the business. Although we now have a treasurer and a membership co-ordinator, we are reluctant to set up an inner circle, which suggests exclusivity, and whose positions may become more and more difficult to fill, as is often the case with voluntary organizations.

Part of the process of change has been the retirement of some key players from the steering committee; Michael Rachlis and Steve Hirshfeld this spring, Fran Scott in March when her baby was born. Added to the one vacancy left last fall, we now have room for four new steering committee members. I would like to urge everyone present at the meeting or reading this report to consider joining the steering committee. One assumes tasks at your own pace and it is a marvellous opportunity for a much more regular involvement in this unique organization.

There are other equally important levels of engagement, and for those not steering committee-bound, there is lots of room within our local chapters and our task forces on AIDS and Working Conditions, or in the newsletter.

Letter on AIDS Education and Care

Editorial Note: This letter was addressed to the Provincial Advinsory Committee on AIDS (PACA). Shortly after its sending the Ontario Government did introduce a public educational campaign which however was not targetted at high risk groups.

March 7, 1988

Dr. Bernadette Garvey

Chairperson, Provincial Advisory Committee on AIDS

Public Health Branch

5th Floor--15 Overlea Blvd.,

Toronto, Ontario M4H 1A9

Dear Dr. Garvey:

I am writing to place on record and to expand on my concerns expressed to the Provincial Advisory Committee on AIDS at its March 4, 1988 meeting. I would be grateful if you could distribute copies of this letter to other members of PACA.

1. PUBLIC EDUCATION

Apparently substantial amounts of money have been directed towards public education from the Ministry of Health. But evidence of public education is hard to find. Nowhere to be seen is a mass media campaign including paid television and radio advertisements. There is no awareness on the part of the public of a government sponsored mass education campaign.

On the very day of the March 4, 1988 PACA meeting yet another major review of HIV transmission was published in the Journal of the American Medical Association. The author stated that "... education and risk-reduction programs will be the primary public health weapon for prevention of HIV infection. It is necessary for all individuals to be aware of how HIV is transmitted to reduce high-risk behaviours. It is equally important for the public to be aware of how HIV is not transmitted to avoid unnecessary fears and actions." And in a February 19, 1988 New England Journal Of Medicine Sounding Board entitled "AIDS: Politics And Science", the author states that "there is an urgent need to warn the public about certain kinds of behaviour" (that places people at risk). In reference to explicit education on prevention methods the author further states that "Failure to warn people about the new virus and its lethal consequences would be an extraordinary punishment for unapproved sexual activity." These are just two recent examples of many admonitions in the American literature calling for widespread public education.

In its June 24, 1987 Operational Plan for the City of Toronto AIDS program, the Toronto Department of Public Health set September, 1987 as its target date for advocating with the provincial government for a province-wide mass media campaign. Well into 1988 with people continually being infected the time has come to embark on a sound highly visible policy of HIV disease prevention. If the government's reticence to pursue frank public education programs is based on a belief that the AIDS epidemic is temporary then the government is misguided. "AIDS is here to stay" (NEJM--February 19, 1988) but its devastation can be tempered by widespread public education and outreach programs to high-risk groups.

Further to the strategy of public education is a determination of which sectors of the public deserve priority in expenditure of public funds for prevention purposes. Widespread consensus exists in the medical literature (and was expressed by many at the third International Conference on AIDS in Washington, June 1-5, 1987) that priority should go to those groups most likely to be infected or who practice high-risk behaviours. That is, after prevention strategies (including counselling) are in place for high and moderate HIV prevalence groups, then programs for low prevalence groups should be established. This appears to be the most effective order to contain the spread of the virus. This does not seem to be the position of the Ontario government or the Toronto Department of Public Health. Targetting high risk populations does not preclude mass public education.

2. PROFESSIONAL EDUCATION

The Ministry of Health has made sincere and serious attempts to educate the medical profession. The 1987 Ontario government pamphlet entitled "Understanding AIDS and HIV Infection--Information for Hospital and Health Professions" is generally of high quality and is informative. But certain deficiencies in the pamphlet render some aspects of it obsolete or incomplete.

The pamphlet does not include (nor has there been an update distributed) the Revision of the CDC Surveillance Case Definition for AIDS (MMWR Supplement, August 14,

1987) adopted and "put into effect immediately in Canada" by the Epidemiology and Public Health Subcommittee of the National Advisory on AIDS (CDWR--September 26, 1987). Most physicians are unaware of the revised case definition and complete reporting/epidemiology data collection is over six months out of date in Ontario. Dr. Wallace explained that the Ontario government is awaiting publication of the federal government case report form. As more time passes with use of the obsolete case report forms, the decision to wait for federal government forms is questionable.

The pamphlet section entitled "What is AIDS" (page 3 - 10) needs to be re-written incorporating the August 14, 1987 MMWR supplement in its entirety. It might be useful to make reference to the HIV Infection Codes, Official Authorized Addendum, ICD-9-CM effective January 1, 1988 published as an MMWR Supplement December 15, 1987.

The pamphlet section entitled "Serological Testing for Antibodies to HIV" (page 20-22) is insufficient.

The pamphlet does not list the clinical indications for performing a test. The absence of published indications is worrisome, particularly in view of a recent JAMA report that in 44% of tests performed in a Minnesota hospital, the patient had no recognizable risk factor (JAMA January 8, 1988). The pamphlet should incorporate the CDC's "Public Health Service Guidelines For Counselling and Antibody Testing to Prevent HIV Infection and AIDS" (MMWR--August 14, 1987) -a document which outlines in detail the indications for HIV antibody testing.

The pamphlet does not advise physicians to inform patients of the reporting requirements under Sections 25 and 26 of the Health Protection and Promotion Act and Ontario Regulations 161/84, 162/84 and 490/85 in regard to AIDS. The pamphlet does not advise physicians to inform patients that if insurers, employers or other third parties request medical information from the physician with the patient's consent, the physician must release all information including HIV antibody results. The pamphlet does not advise physicians to inform patients of the potentially severe psychological consequences of a positive HIV antibody test. This is particularly crucial in view of a March 4, 1988 JAMA report entitled "Increased Risk of Suicide in Persons with AIDS." The report and an accompanying editorial raised the "serious public health challenge" of "the risk of suicide in persons without AIDS who are informed of a positive test result for HIV antibodies." Finally the pamphlet does not advise physicians to inform patients of the joint false positive rate of HIV antibody screening.

The Canadian Medical Protective Association recommends a written consent form to be signed by the patient before an HIV antibody test is ordered. A recent commentary in JAMA (January 8, 1988) recommended a written consent be signed as have authors of other articles published in the literature. The requirement for written consent is law in some states of the U.S.A. I have enclosed a copy of the consent form used in my practice. Although imperfect it attempts to list the major items of information that should be communicated to patients. An October, 1987 article on HIV antibody testing published in Canadian Family Physician also contains useful recommendations. PACA should develop and distribute a model consent form for physician use.

The section on HIV antibody testing urgently requires updating before more patients are tested inappropriately with unfortunate consequences.

The June 24, 1987 Toronto Department of Public Health AIDS document calls for an assessment of community physicians' current level of knowledge. The document also calls for meetings with these physicians, the provision of resource materials and the implementation of other measures to educate community physicians. The target dates for these plans range from September, 1987 to March, 1988. Thus far none of these proposals (which are worthy) have been implemented. There is no organized professional education and development for community based physicians.

Furthermore, there is no organized leadership or guidance from the specialists involved (in the care of HIV infected patients) in regard to standardized city-wide protocols for investigation and treatment or prophylaxis in HIV disease. The Ministry has made a well-intentioned effort (regarding investigations and referral) on page 10-12 of its 1987 pamphlet. But the Ministry's protocols are impractical, outdated and do not account for the saturation of patients in the Toronto system.

Primary care practitioners have been left on their own to interpret and act on treatment recommendations for HIV infected persons without any consensus or uniformity from the Toronto specialist group. Blame cannot be assigned to individual specialists--they are lost in much the same chaos and fragmentation of care that affects the community doctors. In the rapidly changing world of HIV disease patients are the main victims of the chaos, receiving inconsistent and sometimes outdated care. A good example of recommended treatment protocols can be found in a December 26, 1987 Lancet article entitled "Treatable Aspects of Infections Due to HIV."

There, again, is an urgent need for PACA to formulate definitive policy in regard to physician education, not only for those doctors currently managing HIV infected patients but for other doctors who should be encouraged to share the increasing patient load. The proposals for physician education outlined in the Toronto Department of Public Health Operational Plan (never implemented) would be and excellent starting point for policy formulation.

3. CO-ORDINATION OF HEALTH CARE DELIVERY SERVICES IN TORONTO

The Ministry of Health's decision to place more funds into hospital based AIDS clinics in Toronto might have been unwise. The decision was made in the absence of any consultation with primary care practitioners who are on the front lines of the disease, carry a high patient load and are the source of many referrals to hospitals. There never was and there still is not any provision for plan for the integration of community-based physicians into the expanded system of hospital AIDS clinics.

I still wonder how a rational decision to expand these clinics could have been made without assessing the potential number of patients requiring care--most of whom are to be found in the practices of community physicians. The hospitals' needs study could not have been properly con-

ducted without input from primary care physicians. Similarly the hospitals must have little idea of appropriate mechanisms to support community physicians, whether through investigative tools or access to treatments such as blood transfusions. None of this adds up to sound health care planning.

In the past month three patients (including two newly diagnosed with AIDS) have shown up in my practice, discharged from different Toronto hospitals (including two teaching hospitals) without initiation of indicated AZT treatment and without proper follow-up. Another patient from a teaching hospital was referred by the attending physician to me for follow-up despite the hospital's having an AIDS clinic. A fifth patient was recently discharged from a Toronto hospital with active PCP (Pneumocystis Karinii Pneumonia) and without follow-up, requiring admission the same day to another hospital.

There is a total lack of co-ordination of services for HIV infected persons. The hospital AIDS clinics exist in isolation from each other and in isolation from the community. They are inadequate to provide comprehensive services (including primary medical care) to AIDS patients. Too many patients are being bounced about in the system, denied access to investigations and treatment and left alone without proper social/psychological support--the latter a glaring deficiency in the provision of services.

Finally, these AIDS clinics are not community based despite the Ministry of Health's consistent statements in support of community based services. This is a natural consequence of a decision process that did not include community based physicians or patient and community groups.

Unless systems of co-ordination are rapidly set in place the money spent on these clinics might be wasted through fragmentation, inefficiency, duplication and inaccessibility. Long term planning (for 1991) is required now so that the numbers of HIV infected persons will not overwhelm the current structures of health care delivery.

4. RESEARCH INITIATIVES

A major controversy is brewing over the proposed multicentre (including University Of Toronto hospitals) Fisons placebo controlled trial of aerosol pentamidine. Most Toronto primary care practitioners caring for HIV infected persons will be advising their patients not to participate in the study. And community groups have expressed their objections to PACA and to the hospital/university ethics committees of the various investigators.

This is an unfortunate but natural consequence of not consulting community physicians and patient groups on the objectives of research proposals. To plan research in a highly charged area of medicine with terminally ill patients without consulting 'key informants' from the community is a serious error of judgement.

Problems will continue to arise until the lines of communication are wide open. PACA would serve patients, doctors and researchers well by formulating policy or guidelines on research planning. Perhaps properly conducted trials could then proceed on a united front.

5. REFUSAL TO CARE FOR HIV INFECTED PERSONS

The statement on page 28 of the 1987 Ministry pamphlet is strong and helpful. But PACA could further issue an unequivocal public statement on the ethics of refusing to care for HIV infected persons as well as a statement on the miniscule occupational risk to health care workers. Numerous articles exist in the literature on physician responsibility to HIV infected persons and occupationally acquired HIV. Some of the helpful recent reports include those from the AMA's Council on Ethical and Judicial Affairs (JAMA March 4, 1988); and Transmission of the HIV (NEJM October 29, 1987), risks to dentists (NEJM January 14, 1988), Prevention of HIV transmission in health care workers (CDWR November 1987 supplement) and 3 articles and commentaries on physicians' ethical obligations in JAMA October 9, 1987.

The problem of refusal to care is not imaginary. Numerous patients have been refused dental care and some dismissed from medical practices due to their HIV status. Silence or low profile on the part of PACA (or the Ontario government) will send the wrong message to health professionals.

6. OTHER MEASURES TO CONTROL HIV DISEASE

This area is very complicated, made difficult by public demands for extreme action unsupported by scientific evidence.

The Ontario government and the Toronto Department of Public Health hold positions that are at substantial variance with an emerging consensus in the medical literature and amongst many authorities in support of the provision of anonymous HIV antibody testing sites and reporting on an anonymous basis (no unique identifier data) persons who test seropositive. Neither the provincial government nor the Toronto Department of Public Health have consulted community physicians (who are on the front lines) on the negative public health impact of mandatory reporting requirements with identifier data.

In my own practice (and in other primary care practices) many patients refuse HIV antibody testing because of reporting requirements. But at least these patients receive counselling about risk reducing behaviour. As the NEJM February 19, 1988 author noted "If one had to choose between testing and counselling, the latter would be far more important." Other uninformed high-risk patients without knowledge of the system and without access to anonymous testing sites do not receive counselling, remain isolated from the system and promote (unwittingly) the spread of HIV disease. The gathering of epidemiological data is essential in the fight against AIDS but if people do not come forward because of reporting requirements then the data will be vitiated.

The inclusion of persons "born in Haiti or of Haitian parentage" as a high-risk group (under the Health Protection and Promotion Act, 1983, Ontario Regulation 490/85) is troublesome. This category was dropped as a risk group by the CDC in April, 1985. If this has not been dropped already from the Ontario Regulations, it should be.

PACA's opposition to mandatory HIV antibody testing of hospital patients is bold and admirable. But PACA will have to meet head on other ill-advised or drastic options

proposed for HIV disease including mandatory testing of HIV index case contacts, mandatory mass screening programs (eg. pre-marital screening) and quarantine. PACA should directly address the issues of warning unsuspecting third parties exposed to a known HIV index case and sanctions for the reckless disregard of others by HIV infected persons. Neither PACA nor the Ontario government can afford to wait until cases arise that force quick and poorly thought out policy decisions (such as the Dr. Pattee case).

Other areas of concern are intravenous drug abusers/needle exchange programs and measures to reach out to other high risk but hidden communities. I wish to note them for the record.

I am grateful for the opportunity to bring these matters to your attention. I hope that my comments are accepted in a spirit of constructive criticism. A consensus conference is a good first step towards opening lines of communication between the various sectors involved in the fight against this terrible disease. An appointment to PACA of a front-line community based physician would also ensure input into decision making and policy formulation that affects the day to day practice of these physicians and their thousands of patients.

Thank you again for your consideration of my concerns.

Yours sincerely,

Philip B. Berger, M.D.

CC: Dr. Richard Schabas

Dr. Mary Fanning

Information Sheets for Immunization

Dr. Bob James (Hamilton, Ontario) uses the following handouts for information to patients in his practice. Immunizations have over the years accrued much publicity and many questions remain in the public mind. The following sheets are found helpful in allaying some of these questions.

THE DPTP (QUAD) VACCINE

We give the DPTP vaccine as a single injection at 2, 4 and 6 months, with a booster at 18 months and five years. It offers your child protection from diphtheria, pertussis, tetnus and polio. A booster for diphtheria, tetnus and polio must be given every ten years after age 5 to maintain protection. Pertussis immunization is unnecessary after five years of age.

Diphtheria

Diphtheria is a serious infection which starts in the throat. The nose, skin or heart can be involved in **10-25%** of cases; the nervous system may also be involved in up to **10%** of cases. **One-tenth** of all those affected will die of this disease.*Vaccination prevents diphtheria in almost 100% of children.*Common side effects from the diphtheria *vaccine* are mild fever (38.5 C) and local pain and swelling at the injection site.Rare side effects from the diphtheria *vaccine* are allergic reactions, high fever (40.5 C) and fever convulsions.

Pertussis (Whooping Cough)

Pertussis is a serious respiratory infection that causes severe coughing spells with "whooping" and/or vomiting for up to ten weeks. Complications of the *infection* include pneumonia, seizures, encephalopathy (brain infection and swelling), permanent brain damage--and death.*Vaccination prevents pertussis in 80% of children.* If pertussis does occur in immunized children the disease is usually very mild.Common side effect from the pertussis *vaccine* are mild fever (38.5 C), local redness and swelling at the injection site, drowsiness and fretfulness.Severe reactions are uncommon and usually occur within two to three days of the injection. **One in 100** have persistent unconsolable crying for more than three hours. **One in 1750** have a seizure. **One in 140,000** develop encephalopathy. **One in 310,000** develops permanent brain damage. **No deaths** have been known to have been caused by the vaccine.The risks may appear frightening, and are the source of the controversy about this vaccine. But compare the risk of developing the same complications for **un**immunized children under one year of age--this time from the disease itself. **One in 5** develops pneumonia. **One in 40** has a seizure. **One in 200** develops encephalpathy. Of these **at least half** will have permanent brain damage. **One in 200 infants will die from the disease.**Research has shown that without the pertussis vaccine there would be **71 times** the number of cases of pertussis and **four times** the number of deaths.We recommend routine immunizations for all children except those with a history of seizures or neurologic disease, those with a family history of seizures (parents and siblings) and those with previous severe reactions to the vaccine (including temperature 40.5 C.)

Tetanus

Tetanus infection from contaminated wounds causes severe muscular spasms. Death occurs in **60%** of those affected. **Most cases occured after wounds so trivial that medical attention was not sought.Vaccination prevents disease in virtually 100% of people.**Side effects of the tetnus vaccine are mild fever and local pain and swelling at the injection site. Severe local reactions along with fever and muscle pain may occur in people who have received an excessive number of boosters. Rarely, febrile seizures or allergic reactions may occur.

Polio (Poliomyelitis)

Infection with **polio** can cause a mild fever or a severe illness resulting in permanent paralysis.**Vaccination prevents the disease in 95% of people.No serious side effects from the type of polio vaccine used in Ontario have been reported.** Allergy to the vaccine is rare.

Information Sheets for Immunization

Diphtheria, pertussis, tetnus and polio have all but disappeared in our community thanks to the DPTP vaccination. We encourage everyone to keep their immunizations up to date.

If you have questions, please ask one of us.

MMR

MMR vaccine protects your child from measles ("red measles" or rubeola), mumps and rubella ("German measles").It is given in one injection at age 12 to 15 months. No booster is required.

Measles:

Measles causes an upper respiratory infection along with high fever, cough and skin rash.Middle ear infections and pneumonia often occur with a measles infection. Encephalitis (brain infection) occurs in **one in 2000 cases,** permanent brain damage and/or death occur in **one in 3000 cases.** A fatal chronic brain infection can occur. Infants are at higher risk of developing problems than adults are.**Vaccination prevents measles in 95% of children.** Minor side effects from the measles vaccine are fever (this occurs between 5 and 10 days after injection in **5 to 15%** of children) and transient rashes (in about **5%** of children.)More serious and uncommon side effects are fever convulsions and allergic reactions. Children who have severe allergy to eggs, an allergy to the drug neomycin, or an immune deficiency disease should not receive the measles vaccine.

Mumps:

Mumps infection may cause no symptoms. More commonly it causes fever, fatigue and swelling of the parotid (saliva) gland(s) in the jaw (this is called parotitis).

About **10%** of those children with mumps go on to develop meningitis (infection of the membranes surrounding the brain). A small number go on to get encephalitis or deafness. An infection of the testicles develops in **25%** of teenage or adult men who get mumps and this rarely leaves them sterile.**Vaccination prevents the disease in 95% of people.**Side effects of the mumps *vaccine* are rare and include mild parotitis.

Rubella:

Rubella is usually a very mild disease in children. They have only a mild fever, rash and swollen glands. Symptoms are more severe in adolescents and adults.Sometimes rubella causes a mild joint achiness in teenage and adult women (this goes away after a short time without treatment). Rarely, encephalitis or a bleeding problem may happen.If a woman has been fully immunized against rubella, her unborn child is at no risk from exposure to German measles. However, if an unimmunized woman becomes infected with the disease during the first 3 months of a pregnancy there is a 75% chance the baby will either die or have serious malformations of the eyes, heart, ears or brain. Other risks for the baby are diabetes, poorly-functioning thyroid and chronic encephalitis.

Vaccine prevents rubella in 95% of recipients.

Side effects of rubella *vaccine* include rash, fever, and swollen glands within 10 to 14 days of injection in **5%** of people. Painful joints may occur in **15 to 20%** of teenage and adult women about 7 to 21 days after injection. Rarely, chronic arthritis may occur.Although probably safe, prgnant women should not receive rubella vaccine. It is safe to immunize children of pregnant mothers.

If you have questions, please ask one of us.

Lawyers for Tobacco Firms Reconnoiter at Trial

By Morton Mintz
Washington Post Staff Writer

Three tobacco companies being sued in a smoker's product-liability trial have suffered sharp setbacks in recent weeks, leaving their attorneys wondering aloud how to proceed.

The attorneys express optimism about the jury verdict, expected later this month in Newark. But they must deal with the jury's exposure to damaging industry documents of a kind never before made public.

NEWS ANALYSIS

The case is critical for the defendants. A loss not only could open the floodgates for additional lawsuits, but would also come at a time when the industry is suffering headaches on several fronts—from a new smoking ban on airplanes to an expected law banning all tobacco advertising in Canada.

A pivotal point in the trial came April 7, when the plaintiff rested its damaging attack. The question on most everyone's mind: How could the defense counterattack?

Could the companies—Liggett Group Inc., Philip Morris Inc., and Lorillard Inc.—defuse or destroy the case the plaintiff had been putting on for more than two months? Could they neutralize the adverse impact of the internal documents? How credible would their witnesses be?

Finally, how would U.S. District Judge H. Lee Sarokin rule on defense motions to throw out parts—if not all—of the plaintiff's case?

It's conventional legal wisdom that, for either side, the first witness is particularly important because of the potential to create a favorable mindset and momentum.

SMOKE, From H1

Dr. Jeffrey E. Harris, a physician and health economist who teaches at Harvard Medical School and the Massachusetts Institute of Technology, led off for the plaintiff, widower Antonio Cipollone.

Fred V. Carstensen, an associate professor of economics at the University of Connecticut, led for the defense.

Harris had reviewed the internal documents—nearly a thousand scientific articles on smoking and health from the 1920s onward—as well as pretrial depositions taken from industry executives and scientists.

Perhaps his most hotly opposed testimony—which figured prominently in Sarokin's controversial ruling of 10 days ago on the defense motions for directed verdicts—involved two related issues:

- A "cancer clock" constructed by Harris, which showed major developments that strengthened the link between smoking and cancer, as well as the industry's response to each event.
- Liggett's decision not to bring to market a "safer" cigarette after spending about 25 years and $14.5 million to develop it. The cigarette relied mainly on palladium, a heavy metal, to remove carcinogens from smoke.

For much of three weeks, the jury heard testimony about the safer cigarette, mainly from Harris and James D. Mold, who had led the product's research and development but became disillusioned and finally left Liggett.

The witnesses said Liggett executives wanted to sell the new product, but lawyers blocked its marketing for fear that it would be an admission of liability to smokers of conventional cigarettes. Although Mold disagreed, Harris contended that if Liggett had spent more, sooner, on research and development, it could have begun to sell the palladium cigarette in 1971.

By then, Rose Cipollone had smoked Liggett's Chesterfields and L&M filters for about 26 years, switching in 1968 to Philip Morris's Virginia Slims and Parliament and to Lorillard's True in 1974. She had begun to smoke at 16, continued even after doctors found cancer in her right lung in 1981, and died in 1984, at 59.

According to Harris, a worried Rose Cipollone would have switched to the safer cigarette, which would have reduced her risk of getting lung cancer by 8 percent to 17 percent. The bulk of the risk, he testified, had developed in her early years of smoking.

Along the way, an official of the National Institute of Drug Abuse testified, she had become tobacco-dependent. By contrast, a cornerstone of the defense is freedom of choice: smokers smoke because they choose to do so, in full awareness of the alleged hazards.

Harris' chronology sought to put Liggett in the bull's eye of the plaintiff's target. Liggett was left particularly vulnerable because Cipollone only smoked Liggett's cigarettes before the government required, starting in 1966, a health warning on all cigarette packages.

Under an appeals court ruling assailed by Sarokin, all cigarette makers were immunized from a duty to inform smokers of any additional knowledge the industry had of health risks.

The plaintiff charged that each defendant—but Liggett foremost—could have developed and sold cigarettes less likely than ordinary ones to cause lung cancer, but chose not to do so.

The defense asked the judge to drop this "alternative design" charge from the case, which he did on April 21. Even assuming that Rose Cipollone would have switched to the safer cigarette, he said, nothing but speculation was in the record to show that she would have continued to smoke it.

Liggett attorney James V. Kearney hailed the action, saying the claim had been "frivolous" from the start. Plaintiff's lawyer Marc Z. Edell was "disappointed."

Sarokin also granted a defense motion to dismiss a separate claim that the tobacco companies were negligent for not doing "reasonable research" into the possible health hazards of smoking. He dismissed Philip Morris and Lorillard—but not Liggett—from a count alledging failures to warn Rose Cipollone of the risks of cigarettes.

"I think [the defense] legal position in the case has been significantly improved," said Peter K. Bleakley of Arnold & Porter, Philip Morris' law firm in Washington.

But even if Sarokin chopped off parts of the plaintiff's case, he dealt the companies a severe blow by denying their motion for a directed verdict on the one charge that, in Edell's words, "was always the crux of our case": allegations of a conspiracy to fraudulently conceal or misrepresent the health risks of smok-

Washington Post, May 1, 1988

Lawyers for tobacco firms

ing. In doing this, the judge kept in the case all of the evidence the jury had already heard, particularly that about the safer cigarette.

"The evidence . . . permits the jury to find a tobacco industry conspiracy, vast in its scope, devious in its purpose and devastating in its results," Sarokin wrote in an opinion that infuriated the defense, although it was kept from the jury.

The next day, Arnold & Porter's Thomas E. Silfen and other defense lawyers told the judge—out of the hearing of the jury—that they were in a terrible bind, and that the only possible cure, given Sarokin's refusal to throw out the whole case, was to strike the safer-cigarette, cancer-clock, and certain other sensitive testimony and tell the jurors to ignore it.

"What do we do?" asked Silfen. "Do we explain to this jury what they obviously want to know—what happened to that [safer] cigarette? What happened to Dr. Mold [who left Liggett]? If we explain, we obviously dig ourselves deeper into a very deep hole. If we don't explain, we [still] dig ourselves into a very deep hole. . .

"There is not . . . one millimeter of safer cigarette testimony that is not bathed in the aura that we killed the plaintiff. . . . I don't know how you could build bigger prejudice."

Predictably, the plaintiff saw no justification for striking the safer-cigarette evidence.

"We want it in," said lawyer Cynthia A. Walters. "Sure, it prejudices the defendants because it's an admission from their own files. . . . But every single piece of evidence in this case goes toward the fact that the defendants killed Mrs. Cipollone. That's what we're out to prove. . . . We're entitled to put all our proofs in . . ."

Sarokin said he would ponder the dispute over last week's recess and announce a ruling when the trial resumes Monday.

Part of the defense problem with Harris became apparent during prolonged cross-examination: He neither waffled nor backed down on anything, and the questions often boomeranged. That was not the case with the first and at least three more of the initial five defense witnesses.

The lead-off defense witness, economist Carstensen, supported the companies' contention that smokers who persist in the habit do so in an exercise of freedom of choice.

Repeatedly calling himself a "historian" and "scholar," he testified that news reports "related" to smoking and health saturated Rose Cipollone's "information environment" in the five years before the federal package warnings.

Edell brought out that the reports were less than 1 percent of the news, were dwarfed by cigarette advertising, and were often not prominently displayed. In addition, Carstensen conceded that many of the reports were conduits for industry claims that smoking hadn't been proved to cause disease.

Following Carstensen was Claude R. Martin, professor and chairman of marketing at the University of Michigan. He testified at first that the industry's costly public-relations campaigns—and the advertising that in the 1980s cost it about $250,000 an hour—have "relatively small or no impact" on the decision of people to take up smoking. On cross-examination he abandoned the "no impact" claim.

In a first for an industry leader, Dr. Sheldon C. Sommers, former scientific director of the industry-funded Council for Tobacco Research, recognized smoking as a "risk factor" in lung cancer and conceded that it could account for 45 percent to 55 percent of a type of cancer called small-cell. His claims of CTR independence from the sources of its money appeared to be badly shaken on cross-examination.

Stanford University toxicologist Arthur Furst, who last published an article on smoking and lung cancer 20 years ago, faced sharp cross-examination about his contention that an association hasn't been proved.

He has testified several times for the industry in court cases and on Capitol Hill. His relationship with the industry goes back to 1960, when an attorney for the CTR and two nondefendant tobacco companies invited him to seek a CTR grant.

Suppose the companies lose? Philip Morris Chairman Hamish Maxwell faced that question at the annual stockholders meeting in Richmond last week. He said he wouldn't be surprised if the industry loses one or another of the more than 100 cases now in the courts. But, he said, "It would not be the end of the world."

Washington Post, May 1, 1988

Tobacco Companies Mount Major Legal Effort in Trial

— Morton Mintz

During most court sessions, six to nine attorneys sit at the defense counsel tables of the three tobacco companies defending themselves in the biggest cigarette product-liability case ever. One lawyer says their fees run at an hourly rate of about $275. Some, he says, may be paid more.

Behind them is a phalanx of additional defense attorneys; sometimes about two dozen show up. Combined, this staff outnumbers the three plaintiff's lawyers about 8 to 1. Working with the attorneys is a large contingent of public relations officials who serve Philip Morris Inc. and Lorillard Inc., and a smaller group for codefendant, Liggett Group Inc.

The companies' attorneys are on hand to listen, confer and prepare for each day's session. Many spent 4½ years in intense pretrial proceedings, which were triggered by the lawsuit filed by Rose D. Cipollone and her since-widowed husband, Antonio.

From beginning to end, the cost to the three tobacco companies will be in the millions of dollars, making it the most costly case of its kind ever.

But this could be seen as a necessary and modest expense for an industry that spent an estimated $2.5 billion on cigarette advertising and promotion last year. More important, a defeat in Newark could lead to a flood of smoker lawsuits against a $22 billion-a-year industry that has never paid a penny to a litigant.

The regulars at the counsel table for Arnold & Porter, the huge Washington law firm representing Philip Morris, are partners Peter K. Bleakley, 51, formerly of the Federal Trade Commission and the Justice Department's Antitrust Division, and Thomas E. Silfen, 45, formerly of the National Labor Relations Board.

Bleakley's legal skills apparently impress the U.S. district judge in the case, H. Lee Sarokin, who in a recent slip of the tongue addressed the attorney as "your honor." The jury didn't hear Sarokin say that; it does hear Bleakley utter sentences that are almost invariably free of grammatical error, even when formed in seconds.

Backing up Bleakley and Silfen are five more full-time Arnold & Porter lawyers, including David R. Kentoff, 50, the firm's managing partner, and at least one legal assistant.

Also constantly on hand is former Arnold & Porter partner Murray H. Bring, once a clerk to Chief Justice Earl Warren.

In an unusual division of legal labors, Philip Morris and Lorillard, a division of Loews Corp., are represented together by six full-time attorneys and seven full-time legal assistants from Shook, Hardy & Bacon of Kansas City, Mo. Two lawyers from a New Jersey law firm also work full-time on the case.

The front-line Shook, Hardy attorneys are Robert E. Northrip, 49, Steven C. Parrish, 38, and Patrick W. Sirridge, 49. Also at hand is Lorillard's vice president and deputy general counsel.

Northrip and Parrish, in particular, are consistently low-key and soft-spoken. By contrast, Bleakley and Silfen are frequently passionate in arguing and objecting, with or without the jury present.

At the counsel table for Liggett, a unit of Grand Metropolitan PLC, a British conglomerate, are two Webster & Sheffield attorneys: Donald J. Cohn, 59, and James V. Kearney, 40. Working with them is another member of the same New York firm, Liggett's vice president and general counsel, a local attorney, and Alan Hilburg & Associates, a Dallas-based PR firm.

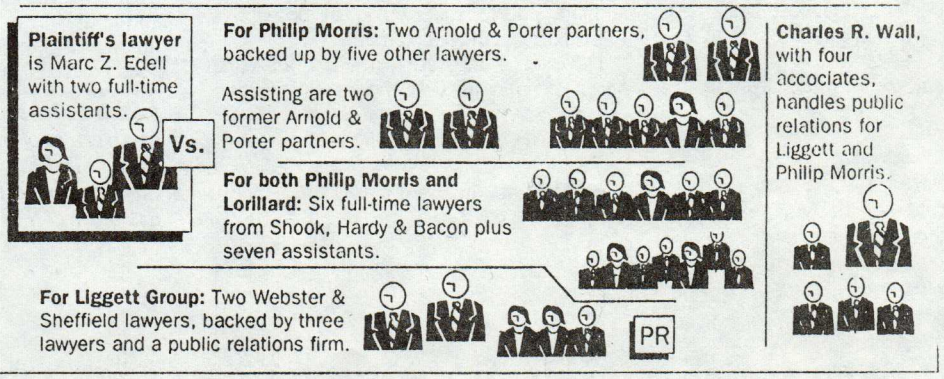
Leading the Philip Morris/Lorillard public relations operation in the courtroom is Shook, Hardy partner Charles R. Wall, 43. He and his four associates display true-believer enthusiasm for their cause. On occasion, when speaking with the media, they mock plaintiffs' witnesses and attempt to downplay the significance of internal company documents to be presented by the plaintiffs.

The always accessible PR team provides reporters with comments, no-comments, complaints about their reporting, and, sometimes morning transcripts by the afternoon.

The plaintiff's lawyer, Marc Z. Edell, and his associates operate in an economical, more traditional mode: If a reporter asks a question, they answer.

FOR THE DEFENSE

THE PHALANX OF LAWYERS FOR THE TOBACCO COMPANIES



Washington Post, May 1, 1988

Setting a Fairer Price for Medicare

The New England Journal of Medicine reported study results last week showing that states that stringently regulate hospital payments have higher than expected hospital death rates. Although the study did not focus on the Medicare payment system, its findings may be relevant to that system's effects.

Medicare now sets rates independent of a hospital's own costs. In 1986 over one-third of the nation's hospitals lost money treating Medicare patients. At the same time, 25 percent of them had large Medicare profits—in excess of 12.5 percent. Although Medicare's Prospective Payment System, which went into effect in 1984, has succeeded in slowing the growth of hospital costs, we question both the fairness and the desirability of such variations in profits.

Medicare pays hospitals a fixed price per case. It is based on the average cost of a similar case at a large number of hospitals, adjusted for various exceptions and special circumstances. The major adjustments are the built-in difference between the prices at urban and rural hospitals and the indexation of payments to local wages. Allowances are also made for teaching hospitals and those serving disproportionate numbers of poor people, as well as for hospitals that treat patients requiring unusually long or costly stays.

The adjusted prices are supposed to be the "fair" ones for efficiently delivered care. The trouble is that the adjustments are not sufficiently precise to cover all legitimate cost differences—that is, differences that are not due to inefficiency. The system pays some hospitals a rate well above their own average cost per case, while paying others a rate below their average cost. Profits and losses are generated without knowing whether cost differences reflect differences in efficiency or in the kinds of patients or quality of care they get.

The basic flaw with this system, despite its adjustments, is that it equates low cost with efficiency. Some high-cost hospitals may actually be more efficient than low-cost hospitals but have higher costs because they treat more severely ill patients within the same diagnoses. Efficient, high-cost hospitals may also be providing higher than average quality of care.

The current Medicare payment system virtually ignores these situations. If hospitals respond nationally as they did in the states cited in the New England Journal of Medicine study, low Medicare payments to these hospitals may be harmful to patient care.

The present system is not only arbitrary but also wasteful. Research we conducted showed that hospitals that received higher payments earned higher profits even though they had bigger cost increases than more constrained hospitals. These higher payments hardly seem appropriate at a time of massive federal deficits.

The system's payment inequities have not gone unnoticed. Influential congressmen have responded to financial problems in their districts with legislation often aimed at increasing payments to an individual facility. A Post editorial ("Tuning Up Medicare," Jan. 11, 1987) decried the intrusion of politics into the payment process.

But asking Congress to set politics aside is not the answer. Aggrieved hospitals will continue to seek remedies, and if the system stays as it is, targeted remedies may often be justified. Instead of a case-by-case political approach, the system should be changed to treat all hospitals more fairly.

Specifically, we propose that the national price list be replaced by a set of prices that is unique to each hospital. Our proposed system would retain the concepts of a separate predetermined rate for each type of condition and a hospital's right to keep whatever savings it generates by providing care at lower costs. But the amount a hospital receives for each case would be based on its own average costs in a base period, not on average costs of hospitals that may be quite unlike itself. This approach is fairer and preserves the cost-constraining incentives inherent in the new payment system.

Once these base period costs were established, the subsequent price lists for all hospitals would be changed by the same percentage amount. The size of this price increase (or, possibly, decrease) should remain a political decision made by Congress. The hospital industry, the administration and the elderly would obviously be part of the debate, as they should be.

Devising a separate price list for each hospital eliminates both the justification and the need for special adjustments. All hospitals would face the same degree of fiscal constraint, though they would not have the same prices. The profit incentive would encourage hospitals to keep their costs below the price schedule, since profit is critical for being able to raise capital for replacing old equipment and investing in new technology.

Some argue that this approach would penalize historically efficient hospitals, since they wouldn't be able to generate as much profit as hospitals whose costs were artificially high in the base period because of inefficient management or underused facilities. But even if inefficient hospitals are able to earn extra profits in the short run, this is preferable to penalizing efficient hospitals that have higher-than-average costs, even after all the adjustments. It is much like the justice system's bias in favor of acquitting a guilty person rather than wrongly convicting an innocent one.

Concern about extra profits need not be exaggerated. Several years under Medicare's current pricing system have led to substantial reductions in hospital staffing and beds—the industry is more efficient now than in the 1970s and early '80s. Thus, there are fewer opportunities for unfair profits from cost reduction. Furthermore, if each hospital's prices are periodically updated based on new cost data, extra profits accruing from efficiency gains will be transitory. Finally, giving extra profits to hospitals to change inefficient behavior is preferable to the current system of national prices that award profits indiscriminately.

The system we propose would be easy both to implement and to administer. Congress and the political process would have one large, visible annual decision to make—how much to increase payment rates. There would be no back-room deals to tilt the system in favor of specific groups of hospitals, nor would it be necessary to decide which special appeals were more meritorious. Hospitals would all face the same fiscal constraint. Our proposal would ease concerns about equity across hospitals and could make it easier for Medicare to further tighten its prices if budgetary needs dictated such a policy.

Judith Feder and Jack Hadley are co-directors of the Center for Health Policy Studies at Georgetown University. Stephen Zuckerman is a senior research associate at The Urban Institute.

Washington Post, May 3, 1988

Controversial program would withhold treatment from half of the 300 patients

IS IT ethical to prove the effectiveness of an experimental AIDS drug by giving it to some patients who are dying with the fatal disease while withholding it from others?

It's a question that's surfaced recently because the pharmaceutical company — Fisons Corporation — wants to conduct a double-blind placebo study to evaluate the safety and effectiveness of a drug called aerosolized pentamidine. The study would be held in seven Canadian hospitals in Toronto, Vancouver and Montreal.

Aerosolized pentamidine is not approved for use in Canada. However, early American studies show it is a potentially promising treatment for pneumocystis carinii pneumonia (PCP), a serious lung infection which is the most common cause of death in AIDS patients.

The Canadian study would include 300 AIDS patients who have had PCP once. Selected randomly, 150 patients would be treated with the drug for six months and another 150, using the same selection process, would receive nothing more than sterile water.

Neither doctors nor patients will know which substance they're getting.

That's morally wrong according to AIDS activists and their doctors, who believe four or five people who don't get aerosolized pentamidine will die.

"This (claim) is pure sensationalism," said Dr. Douglas MacFadden, one of the principal investigators of the study and director of the immunology laboratory at Toronto Western Hospital.

He says there's no chance of anyone dying because medical monitoring techniques are so sophisticated any problem will be detected long before a patient's health is compromised.

In his own practise, he said no patient has died in the last three years because the PCP was properly treated.

When PCP is picked up early it's easy to treat, he said. "There is no situation where someone (in the trial) is likely to die."

However, Dr. Joseph Sonnabend, a highly-respected AIDS doctor in New York, disagrees and personally finds the Canadian double-blind study ethically unacceptable.

"That's immoral, it's unethical..," he said.

Such a study harkens back to Nazi Germany, he said, when Dr. Josef Mengele, The Angel of Death, conducted sinister experiments on thousands of people, mostly Jews.

In a telephone interview Sonnabend said it's wrong to let people with a fatal disease such as AIDS get sick on the premise you'll catch their problems early.

There is no certainty that the pneumonia, PCP, "won't gallop away from you," he said.

The start of the aerosolized pentamidine study is on hold because of AIDS activists strong objections to its placebo arm.

A decision on the moral right or wrong of a placebo trial will come from McMaster University ethicist and epidemiologist, Dr. Arnold L. Johnson, who was appointed several weeks ago to resolve the philosophical deadlock between clinical investigators, AIDS patients and their doctors.

But he's tight-lipped about what he will say.

"I guess my only hope is to work as quietly as I can and seek the necessary advice," he said.

Johnson won't say when his decision will be handed down and declined to release information on his professional background or to have his picture taken by The Spectator.

THE FOCAL point of this ideological squabble is pentamidine, an antibiotic which has been around for 50 years and used successfully in South Africa for sleeping sickness since 1941.

Pentamidine comes as a white powder and it's been used intravenously since the beginning of the AIDS epidemic to treat PCP.

Recent studies show that when pentamidine is transformed into a fine aerosol mist it becomes an effective and less toxic way of preventing AIDS patients from getting another bout of PCP. (Pentamidine is licensed in Canada for use only in its most toxic forms — intravenously, which causes acute side effects such as renal failure, or injected intermuscularly, which results in abcesses at the injection site. In the United States it's widely used on an experimental basis to prevent PCP.)

Studies in New York and San Francisco are showing this experimental method of treatment has great promise and potential, appearing to extend both the length and the quality of life for people with AIDS.

When patients take aerosolized pentamidine the most frequent complaint many patients have is that it tastes horrible and they may have a cough.

AIDS patients want to be able to use aerosolized pentamidine as a preventative measure long before they get PCP and not have to wait until they're so sick that they must be hospitalized.

Because the Canadian government hasn't licensed aerosolized pentamidine, the only way an AIDS patient has access to the drug is to participate in a clinical trial or get it underground from the United States.

Toronto Western Hospital's McFadden says the Fisons' study is "ready to go" and the only thing the investigators are waiting for is the conclusion from Johnson's external ethical review.

"Our delay at the moment is as a result of the public uproar over the initiation of a placebo control study," he said.

"...I get upset when the public thinks we are doing it to further our own ends, our academic careers or for any other reason."

And it "grates" on him that trial investigators have been thrown up to the public as being unethical scientists.

"If we abandon our scientific principles at this point in the game AIDS will be a much more terrible epidemic than we see now," he said.

Studies on the safety and effectiveness of a 60-milligram dose of aerosol pentamidine (the same dosage would be used in the Canadian trial) have been conducted at Memorial Sloan Kettering Cancer Centre in New York with more than 140 patients for over a year. No severe, moderate, or mild adverse reactions have been recorded.

Dr. Wayne Boone of Toronto (right) monitors an AIDS patient.

Despite these promising results MacFadden argues the drug's long term effects still aren't known and that's what the Canadian trial will prove.

A ground swell of public opinion isn't proof, he said.

"It has not been proven to have benefit — it's THOUGHT to have benefit," he said.

That proof is essential, MacFadden insists, because AIDS patients will probably need to use the drug for the rest of their lives.

The Canadian study — which would be the only one of its kind in the world — is designed to prove this point in a six-month trial, he said.

To MacFadden, it's "inconceivable that anyone with any degree of scientific integrity would give a drug to somebody not knowing if it worked or not" and if they were unsure of the long and short-term side effects.

"The U.S. studies have yet to prove that," he said. "There is no proof inhaled pentamidine is efficient in preventing PCP ... not withstanding the Sloan Kettering/San Francisco trials which didn't prove efficacy."

No published or unpublished data is available, MacFadden said, adding that once the Canadian results are in "the world is going to know."

MacFadden said the Canadian results will give investigators a clear cut answer because AIDS patients here aren't using a lot of different drugs simply because they aren't accessible.

Despite the ground swell of public opinion praising aerosolized pentamidine MacFadden argues preliminary data don't provide proof — and it's not the first time a promising drug turned out to have very toxic side effects.

It happened with the antibiotic chloramphenical which at first was lauded as God's gift to man, he said, and later found to be highly toxic.

"We don't want that to happen with pentamidine. If we begin the study, in a very short time, we will have the answer."

MacFadden said the trial will be stopped if significant differences — either in toxicity or benefit — are found between the treatment and placebo groups. "We don't have to go that (six-month) period of time."

COMMUNITY ACTIVISTS and doctors treating AIDS patients in Toronto disagree with MacFadden that a Canadian placebo trial is necessary to prove the drug's long-term efficiency.

Dr. Denis Conway, pentamidine project director for the activist group AIDS Action Now (AAN), says it's unethical and unacceptable because of the accumulated American data.

His group continues to want the placebo side of the study dropped.

In a letter to the chairman of the University of Toronto human subjects review committee, Conway said it's wrong to withhold treatment from half of the participants in the study.

"Since aerosolized pentamidine has been demonstrated to be highly effective and without serious adverse effects, and because of the serious morbidity and mortality of recurrent PCP, it is unethical to have a placebo group," he wrote.

Conway argues that three or four deaths are possible which is unnecessary because of the information that's now available from previous U.S. studies.

Instead of a placebo arm, AAN would rather see aerosolized pentamidine compared by giving different dosages or with another active treatment for PCP.

Sonnabend, the New York AIDS doctor, agrees that this is a more ethical way of conducting such a study on an experimental AIDS drug.

In New York Sonnabend is conducting a 200-person trial on aerosolized pentamidine for LyphoMed, Fisons' competitor.

His trial is comparing dosages giving 100 milligrams and 150 milligrams of aerosolized pentamidine to people with AIDS every two weeks.

In addition to the trial he is administering aerosolized pentamidine to people with AIDS who come to him as patients in his Greenwich Village office.

"Patients are not asking for proof that a drug works but a reasonable likelihood. It's bizarre to withhold treatment. If you are dying I don't think you demand 100 per cent proof. All you're asking for is a reasonable chance."

Sonnabend said no one who has had PCP once should be without some kind of treatment because there is a very real chance of getting it a second time.

And the fact that there are other drugs available to treat PCP — such as bactrum, septra and dapsone — Sonnabend said no AIDS patient should be without some form of treatment to prevent PCP.

Sonnabend said drug trials must be conducted for the scientific good but they must also be ethically responsible. "You can't let an individual be sacrificed.

"It's true that monitoring would minimize the damage of PCP...but just allowing people to get sick on the premise that you will catch it...I just don't find that acceptable. There is no certainty it won't gallop away from you and there is no reason to take that risk."

Sonnabend said there is a place for placebo trials but it's not when it involves a fatal illness where promising interventions are available.

"To enter a trial with a placebo is unwise," he said. "Only a fool would enter such a trial."

Sonnabend says it's unreasonable to wait for proof that a drug works because a patient facing death doesn't ask that. "If we're waiting for proof we won't have any patients left."

TORONTO AIDS patient Alan Dewar says he can't understand how a placebo trial will help researchers.

"I can't understand how you have a bunch of patients for six months and you don't give them anything — what does it tell you? It can't be just the placebo effect (where patients think they're getting better even though they're not getting the drug) because there is too much evidence to point to the fact that that is crazy. What does the placebo tell them?"

Although investigators say they want to prove the long-term effects of the drug Dewar argues six months is not long term.

Dewar thinks the only reason for the placebo study is that it's a fast track method for collecting rigid scientific data which Fisons can take to the Federal Drug Administration in the U.S. for licensing approval to market the drug.

"I am absolutely convinced the reason they want this study is in order to get it marketed in the U.S.," Dewar said, which would give Fisons an edge on its U.S competitor.

Brad Stone, an FDA spokesman, said in many cases the FDA requires that a placebo trial be conducted "because that's the best way of determining the true efficacy and safety of a drug." He said it is not an absolute rule and each drug application is judged on a case-by-case basis.

Stone said the general rules governing an investigative new drug are consistent between companies "so I don't know if there would be a circumstance where a company can get a leg up by performing a placebo control as opposed to not doing it."

Drugs are approved on the basis of their clinical data, he said. "It could be said that the company that provides the best data has a leg up and the use of a placebo doesn't necessarily guarantee that."

Advocates for aerosolized pentamidine frequently point to the Sloan Kettering (New York cancer centre) studies as support for their point of view.

However, Dr. Edward Bernard, a research associate in infectious diseases who has been involved in these studies from the beginning, said in a telephone interview studies at his hospital were never intended to prove the drug's efficiency.

They only examined methods of administering the drug and appropriate dosages, he said.

"They are preliminary. They're not a controlled trial. We never claimed aerosolized pentamidine was safe and efficient," he said.

A placebo control is the next logical step, he said, and there is no other option available to prove that it's an appropriate prophylaxis (preventative treatment) for people with AIDS.

"If we had done a placebo control a year ago the issue would have been resolved," he said.

Like MacFadden, Bernard said no one is going to die and added that his hospital hasn't had a death in a long time.

The issue, he said, is more emotional and political than scientific.

"Most of us...strongly feel this is a treatment that AIDS patients will benefit greatly from and we understand the concerns of the community group about the placebo control trial. It has to be done. We are not looking to sacrifice large numbers — or anyone."

Bernard said calling in an ethicist is unfortunate "because ethics isn't necessarily the preserve of an academic expert."

Each doctor is faced with ethical questions every day, he said, particularly when a patient has given informed consent to participate in a placebo-controlled trial.

Is this fair and safe for a patient? Is the patient protected? These are questions doctors ask every day, he said.

Bernard said he's surprised at how heated an issue this has become in Canada.

McMaster's Johnson, he said, has a tough job.

"I find it hard to believe an academician will be able to do a better job than the (hospitals') ethics committees who have already approved the placebo control trial," he said.

Hamilton Spectator, April 23, 1988

Good Medicine, Better Business

Office testing equipment is a medical godsend but raises questions of conflict of interest.

By GLENN KRAMON

THE SMITHKLINE BECKMAN CORPORATION was looking for just the right advertising symbol to sell physicians on new diagnostic equipment that could be used in their offices. It settled on a goose with a golden egg.

Brentwood Instruments Inc., hoping to sell its heart monitoring system, sent a personal letter to doctors emphasizing the "opportunity for substantial extra income for your practice."

Akers Medical Technologies was more specific. In an advertisement for its urinalysis machine, it calculated the potential profit for the doctor's office ($83,540.80 a year, assuming 50 tests a day) and the time required to pay off the $1,500 to $2,500 investment (as little as five days).

As such testing instruments become more accurate and more affordable, tens of thousands of American physicians are buying them instead of using the services of commercial laboratories.

The equipment is a godsend for patient and doctor alike, making early detection of diseases faster, more sophisticated and more convenient.

But it also raises some troubling questions. Encouraged by equipment makers, some doctors are coming to count on the revenues that testing can generate at a time when cost containment efforts and a glut of physicians are squeezing practitioners' income.

As a result, critics say, the tests can be overused and are priced higher than they need to be. That means billions of dollars in extra cost for a medical system that already consumes more than 10 percent of the gross national product. And the overall cost of such testing is expected to increase sharply, with more kinds of tests administered more often, possibly forcing insurers to impose more stringent controls.

"We are only at the dawn of a push to turn great numbers of American physicians into hidden capitalists," said Uwe E. Reinhardt, a Princeton University professor specializing in medical-cost issues. "When this really spreads in the 1990's, there may come a nasty and cynical reaction from insurers and the Government."

Indeed, testing in the doctor's office could be a case study of the potential conflict of interest for doctors whose medical decisions can be affected by their business decisions, Professor Reinhardt and other experts say. It also could be an example of the excesses that can occur when a third party — public or private health insurers — pays a patient's medical bill, they say. And it raises a difficult social question: At what point might the money used for testing of marginal value be better used to other ends, like health care for the poor, or environmental protection measures?

But pushing too hard to discourage testing carries its own dangers. The early detection of diseases made possible by advances in testing can save thousands of lives annually and also eliminate many hospital stays. "It would take a lot of tests to equal the amount saved by eliminating just one day in the hospital," said Dan D. Shilt, director of diagnostic markets at The Eastman Kodak Company.

To be sure, doctors have performed tests like X-rays in their offices for decades. But the number that can be performed simply with fast results outside a hospital or laboratory has increased dramatically with technological advances like the computer chip. The volume of testing in the doctor's office is increasing by 15 percent annually, said Henry M. Weinert, president of Boston Biomedical Consultants Inc. Last year public and private insurers and patients themselves paid at least $6 billion and probably much more for such tests, Mr. Weinert estimated.

Meanwhile, sales of medical testing equipment and supplies for the doctor's office, which exceeded $1.2 billion last year, will more than double in the next five years, said Frank von Richter, vice president of Boston Biomedical. Hundreds of testing products reach the market every year.

American doctors spent more than $300 million last year just on blood- and urine-testing systems, according to Boston Biomedical. The sale of equipment that tests for infectious diseases like strep throat will grow 43 percent annually in the next five years, to $245 million, the company predicts, while the field of tests for pregnancy and hormone disorders will jump 26 percent to $75 million.

At the same time, doctors are going beyond conventional X-rays to offer ultrasonic imaging that, for example, looks for abnormalities in the heart or the fetus. Their patients are wearing Holter monitors, which record impulses of the heart 24 hours a day.

The biggest specialty clinics even offer computed tomography, the computer-enhanced X-ray commonly known as a CT scan, magnetic resonance imaging and other sophisticated diagnostic techniques on machines that cost up to $2 million.

Many doctors say office-testing systems are indispensable. "It's a win-win-win-win scenario," said Dr. Andrew P. Morley, chairman of the American Academy of Family Physicians. He said the patient wins because testing is more convenient — with fewer visits to other medical centers and a wait of only minutes instead of days for results. Surgeons and other specialists win because the tests find extra patients for them. The payers of health-care bills win because many tests that used to require a hospital stay can now be performed on an outpatient basis. And family doctors win because the tests allow them to offer up-to-date medicine, which attracts patients. Indeed, the tests can be "practice builders," in the industry's euphemistic words.

JUST how lucrative the equipment can be is illustrated in figures from industry analysts.

"The physician can get an increase in practice income from $5,000 to $30,000 a year or so just from 'in vitro' tests like blood and pregnancy tests," said one expert, whose research is used by many leading equipment manufacturers. He asked not to be identified. "To earn $30,000 the physician might be spending as little as 10 percent of that, or $3,000, to buy the products," he said.

Profit varies sharply by test, said John W. Teipel, a senior consultant at The Wilkerson Group, a health-care consulting firm. A simple glucose test can cost the physician less than a dollar, including supplies, amortization of the equipment and labor, while the Federal Medicare program will pay at least $3 or $4. A test for strep throat can cost the doctor $3 or $4, and the insurance payment will be $10 to $15. Testing for the correct levels of therapeutic drugs for ailments like heart conditions can cost the physician $2 to $3 but mean a $20 to $25 payback. For in vitro tests like these, that analyze blood and other body substances, private insurers pay an average of 25 percent more than Medicare, Mr. Teipel said.

For manufacturers, the in vitro office testing market is attractive because it is growing so much more quickly than the hospital and commercial laboratory market, said L. John Wilkerson, president of The Wilkerson Group, a consulting firm. But the office testing market has not been especially profitable for most companies. "There are too many companies chasing a market in which distribu-

tion costs are exorbitantly high," Mr. Wilkerson said.

The major in vitro manufacturers include Eastman Kodak, Boehringer Mannheim, Bayer, Abbott Laboratories, Du Pont, Johnson & Johnson, SmithKline Beckman and Becton, Dickinson. "In vivo" equipment, which includes electrocardiogram equipment and imaging machines that analyze the patient's body, is sold by General Electric, Siemens, Philips, Toshiba, Diasonics and Westmark International, among others.

Some medical equipment marketers are increasingly emphasizing the financial payoffs, said Dr. Sidney M. Wolfe, director of the Public Citizen Health Research Group, a consumer group. Advertisements in publications for doctors are filled with phrases like "quick profits," "life-saving, income-earning system," "a better bottom line" and "a rapid return on your investment."

While the profit margins on testing might seem exorbitant to consumers and insurers, many physicians have their own way of justifying the fees. "Nonsurgical specialists like family practitioners and internists have always felt they are getting the short end of the stick," Dr. Wolfe said. "Surgeons can now get $400 for a five- or 10-minute operation while they are paid $40 for a 20-minute office visit."

Indeed, doctors in family and general practice averaged $80,300 annual income, compared with $162,400 for surgeons, in 1986, the latest year for which American Medical Association figures are available.

NONSURGICAL specialists have decided that they could "make up for the low fee for a consultation by providing other services in the office that provide a profit," said Dr. John M. Eisenberg, chief of the section of general internal medicine at the University of Pennsylvania.

The problem, experts in health-care economics say, is that some doctors might be inclined to administer unnecessary tests. "Most physicians would like to think they are not influenced by income considerations, but if it's a toss-up, the physician may in fact choose the option that is the most lucrative," Dr. Eisenberg said.

The growing threat of malpractice suits tends to encourage additional testing, as does the fact that more people are knowledgeable about medicine and are demanding the tests, said Dr. Alan R. Nelson, chairman of the board of trustees of the American Medical Association.

Robert H. Brook, a professor of medicine at University of California at Los Angeles, said that many doctors genuinely want to help the patient and simply do not know or overlook the fact that a test will not help. His research and that of others has found that "at least a third if not more than half of what we do is of no benefit or of such marginal benefit that I think we could reach agreement in society that insurance should not pay for it."

While medical-cost experts agree there is a problem in the office-testing field, they have just begun to look at what to do about it. The proposals vary widely.

Professor Reinhardt would start by "drawing the line on what tests to pay for and how much to pay."

"Who is to say that one of these machines should pay for itself in six months?" he said. "Most businesses amortize their high-tech equipment in three to five years." Medicare has already established a schedule of fees that doctors must accept for various tests, but these are based not so much on actual costs as on what physicians have already been charging, Professor Reinhardt said.

"What you ultimately want is a fee schedule that is cost-based," he continued. "You would say, 'Here is a machine that will last four years, and it costs $3,000, and the doctor needs to make a certain profit on it, and, assuming a normal load of tests, this is what he should be paid.' "

The amounts for the Medicare program could be set on the recommendation of the Physician Payment Review Commission, which advises Congress. The panel plans to examine which tests might be unreasonably priced. And once the public sector has taken action, private insurers will try to follow, said Professor Reinhardt, a commission member.

Another method would be for Medicare to require competitive bidding among laboratories and then peg its payment to doctors doing tests in their offices to the amount paid to labs that are deemed efficient.

But doctors and executives of leading equipment manufacturers caution against overestimating the current profitability of office testing. The manufacturers have made enormous investments in research and development, sales and technical support. Mr. Wilkerson said that for most manufacturers the office testing equipment business is at best only slightly profitable.

As for the physicians, Dr. Nelson of the A.M.A. said that most doctors do not run enough tests to make the kind of profits that equipment companies say they can. Indeed, many of them make little or no money from their medical equipment, in part because they do not enjoy the economies of scale that high-volume commercial laboratories do, he said. Dr. Nelson warned that reducing insurance payments would force many doctors out of the testing business, to the detriment of patients.

Even if Medicare and private insurers further limit payments, some doctors could prosper by unnecessarily increasing the number of tests they give. Some experts said tighter reviews of — and even controls on — testing might also be necessary.

But there is still a large gray area in medical testing, and society must decide where to draw the line, said Dr. William B. Schwartz, a professor of medicine at the Tufts University School of Medicine. "If I tell you that, in this marginal area, I will find one person with a treatable lesion for every thousand CT scans I do, and the CT scans cost $300 each, are we as a society willing to allocate that much money to save a life or improve a life? We need to look at the benefits curve and decide at what point we can do more good by spending the money on, say, preventive medicine or the environment." ■

Industry helped at expense of research, student group says

BY MARGARET POLANYI
The Globe and Mail

Industry is being subsidized at the expense of crucial university research through recent government initiatives in research and development, the Ontario Federation of Students says.

"The wave of the future seems to bode an unbalanced emphasis on applied science, leaving far behind basic research, the humanities and social sciences," OFS chairman Sheena Weir said yesterday.

Ms Weir criticized the setting up of centres of excellence to nurture private sector and university co-operation. The centres have been encouraged in Ontario by the Premier's Council, and more recently by Prime Minister Brian Mulroney.

Mr. Mulroney announced last week that Ottawa will spend an additional $1.3-billion on science and technology programs over the next five years.

One of the first projects will be the creation of centres of excellence, turning some universities into specialized research sites concentrating on a specific type of research, such as biotechnology or information technology.

"The principal applicants in these projects are industry. This raises questions about the nature and course of the research," Ms Weir told a news conference.

She said applied research has "some good offshoots," but universities will ultimately be blamed when there is nothing left to apply because basic research has been starved.

Ms Weir expressed concern that a "tiering" of universities might result because smaller and northern institutions are being overlooked in the selection of sites for the centres of excellence.

She made the comments at a news conference, urging Ontario to live up to its promises of excellence in education by boosting spending on universities.

The federation wants the province to increase its share of total spending on universities to 50 per cent from 23 per cent over the next three years, at an estimated cost of several hundred million dollars.

In the mid-seventies, provinces were expected to share half of post-secondary costs, Ms Weir said.

MPP Richard Johnston, the New Democratic Party's education critic, said it might seem like a lot of money, but in the context of chronic underfinancing and the record high enrolments expected next fall it is not too much.

The student federation also called for increases in student assistance programs, better summer job opportunities, affordable housing and the elimination of municipal bylaws restricting the sharing of quarters.

Scholar stresses home AIDS care

BY ANN SILVERSIDES
The Globe and Mail

AIDS has highlighted the critical lack of community health services in Canada for long-term ailments, a research immunologist and ethics scholar from Australia has told a medical conference in Toronto.

Because of bias in the health-care system toward high technology and acute care, it has traditionally been easier to make decisions to cut or not develop preventive and home-care services, said Dr. Margaret Duckett, a special adviser on AIDS for the Australian Government.

But acquired immune deficiency syndrome has underscored the need for home care as an alternative to keeping patients in high-cost acute care beds.

The fatal infectious disease has brought society face to face with a number of problems that repeatedly have been put in the too-hard-to-solve basket, Dr. Duckett told the annual meeting of the Medical Reform Group of Ontario.

Studies have shown the incidence of sexually transmitted disease is high in teen-agers. In Nova Scotia, for instance, 30 per cent of sexually transmitted diseases occur in the group aged 15 to 19, Dr. Duckett told a Friday-night symposium.

But teen-agers also have a "very, very poor" knowledge of the risks they face, and there is no mandatory education to inform this age group about the dangers of AIDS and other sexually transmitted diseases, said Dr. Duckett, a visiting scholar at the Centre for Medicine Ethics and the Law at McGill University in Montreal.

Similarly, there has been a "historical denial" of the sexual activities of the handicapped, meaning that the group is at considerable risk because it receives little sex education, she said.

Denial of sexual activity of prisoners — and the refusal, for instance, to provide condoms to prisoners — will not stop the spread of AIDS, she said.

Health-care professionals are, in theory, committed to confidentiality, but "it is often breached" in simple everyday ways, Dr. Duckett told the meeting of about 60 people.

Such breaches, often not considered serious in the past, become crucial with AIDS because of the risk of grave harm that can accompany disclosure, she said. AIDS also resurrects long-standing societal prejudices, Dr. Duckett noted.

Early reports that left the impression that the illness was synonymous with the male homosexual community have had a profound impact, she said. Some people still have difficulty accepting that AIDS is spread by "a virus, not by self-acknowledged membership of a particular group."

Society also has difficulty accepting the extent of homosexual activity among the general population, another denial that is not helping attempts to control the spread of AIDS, she said.

Globe and Mail, May 4, 1988

Accord Viewed as Near on Medicare Bill

By MARTIN TOLCHIN

WASHINGTON, May 14 — House and Senate conferees have reported significant progress on a bill to protect 32 million Medicare beneficiaries from medical expenses for catastrophic illness. They say they hope to complete their work in the next two weeks.

The bill, which offers the first major expansion of Medicare, would impose a ceiling on the cost paid by patients for hospital and physician services, and drugs. It would also expand coverage for nursing homes and hospices.

The House passed the bill last July, and the Senate passed a similar measure last October. The conferees began working on the bill in February. After more than two months of private negotiations, the conferees met publicly for the first time on Tuesday.

The House bill generally provides larger benefits at less cost to the beneficiaries than the Senate bill, which seeks to hold down Federal spending and make the measure acceptible to the Reagan Administtation.

"We're close together on most of the big issues," said Representative Fortney H. (Pete) Stark, a California Democrat who is chairman of the Health Subcommittee of the Ways and Means Committee. "My sense is that if we just keep sitting down, we'll have the bill worked out next week."

Senator LLoyd Bentsen, a Texas Democrat who is chairman of the Finance Committee, said, "I certainly think we'll have a bill before the Memorial Day recess."

"The most difficult part has been the drug program," he said. "We're setting up an entirely new program and trying to decide what's equitable."

'House Coming Around'

The Senator said the Finance Committee "worked awfully hard on the Senate side to keep the cost down to something the beneficiaries can afford."

"I think the House is coming around more to that point of view," he said. "We've worked very closely, too, with the Administration, to see that they'll sign the bill, and I think that they will."

President Reagan proposed medical insurance for catastrophic illness in 1986, but Administration officials are concerned about the cost of the bill, especially in the House version. The Office of Management and Budget estimated that the House bill would cost $18.1 billion in 1993, when the measure would become fully operational, while the Senate bill would cost $10.9 billion. But the Congressional Budget Office estimated the House bill would cost $12.1 billion and the Senate bill $10.1 billion.

Under the current law, there is no ceiling on the amount that may be paid by Medicare beneficiaries. They are covered for the first 60 days of hospitalization a year, except for a $540 deductible for each "spell of illness." The beneficiary must pay a daily $135 fee for stays of 61 to 90 days. Thereafter, the beneficiary may use a 60-day lifetime reserve from 91 days to 150, at a daily fee of $270, with no further coverage.

Under both the House and Senate bills, beneficiaries would not be required to pay more than one hospital deductible a year. Both bills would provide coverage for all 365 days.

> The House version provides larger benefits at less cost.

Part B of Medicare currently pays 80 percent of what it considers the "reasonable costs" of physicians, laboratories and home health services, after an annual $75 deductible per person. This optional insurance is obtained through monthly premiums of $24.80. Part A of the Medicare law concerns hospital costs.

House and Senate negotiators made progress last week in resolving one of their two major differences, concerning the coverage of prescription drugs for outpatients. The House bill provided immediate coverage of 80 percent of the drug costs. The Senate bill provided that the coverage be phased in, and that intravenous antibiotics, cancer chemotherapy and immunosuppressive drugs be covered in 1991, cardiovascular and diuretic drugs in 1992, and all other prescription drugs by 1994.

The conferees reportedly made progress on how the drug costs should be gradually covered, but the conference broke down over the question of what the Government should pay for the drugs, the manufacturer's price or the pharmacist's price.

Both the House and Senate bills would require beneficiaries to pay supplemental premiums, on a sliding scale based on ability to pay. But the conferees disagree over whether the coverage for catastrophic illness, and the supplemental premium to be paid by Medicare beneficiaries, should be mandatory or voluntary.

The House bill would require mandatory coverage, and premium payments, on the ground that such coverage would provide a larger pool of beneficiaries and more money for the program.

The House bill provided for a maximum supplemental premium of $580 in 1989, increasing to $1,017 in 1993. The Senate bill provides for a maximum of $800 in 1989, increasing to $1,000 in 1992. The House conferees accepted the Senate version, with a maximum of $1,050 in 1993.

The conferees also disagreed on the ceiling on medical costs to be paid by Medicare beneficiaries. The House bill provided a limit of $1,043 for 1990, and subsequent increases indexed to the cost-of-living increases awarded to Social Security recipients. The Senate bill provided a limit of $1,461. The Senate conferees offered a limit of $1,370, with increases indexed to keep the costs constant.

The House and Senate bills also differed on the amount of the deductible. The House bill provided for a $500 deductible in 1989, with increases in subsequent years. The Senate bill provided for a $600 deductible in 1991, with increases indexed by the percent increase in per capita drug spending by beneficiaries.

New York Times, May 15, 1988

Positions Available

Family Physician

Community Health Centre (non-profit, program funded), active in community health issues requires for a general practice family physicians. Full range family practice (pediatrics to geriatrics) with varied clientele; 3 1/2 MDs, 3 primary care nurses working in teams; some evening hours; 1-in-4 call. 1 to 5 years experience; OBS not required; CCFP desirable; other languages, interest in gerentology or occupational health and community program development, and Cantonese speaking would be assets. Salary $60,000 minimum. Positions available immediately. Send curriculum vitae and covering letter immediately to: Elizabeth J. Feltes, Administrator, South Riverdale Community Health Centre, 126 Pape Ave., Toronto, Ontrio M4M 2V8, (416) 461-2493, 461-3577.

Family Physician Wanted

Centretown Community Health Centre requires a family physician for a senior position to provide primary medical care and clinical leadership to the Centre's health service team. The program delivers a full range family practice, counselling, educational services, and planned expansion of services to seniors in a multi-disciplinary setting. Health promotion is emphasized.

Requirements: C.C.F.P. preferred; 3 to 5 years experience preferred; eligible for hospital privileges in an Ottawa area hopsital preferred; bilingualism preferred. Salary to $67,283 (1987-88 scale). Please reply as early as possible with resume to: Health Services Co-ordinator, Centretown Community Health Centre, 100 Argyle Avenue, Ottawa, Ontario K2P 1B6, (613) 563-4771.

G.P. Family Physician Full-Time Position

Required for a health centre in the Metro Toronto area. 35 hours per week. No obstetrics. Focus on preventative care. Attractive salary and benefits package including 4 weeks vacation and 2 weeks paid conference leave. Available June/July 1988. Starting date negotiable. Contact: A. Rebelo or Dr. Sider, Parkdale Community Health Centre, 1257 Queen St. West, Toronto, Ontario M6K 1L5, (416) 537-2455.

Locum

Centretown Community Health Centre requires a physician for a locum postion for June, July and possibly August 1988. The programme delivers a full range family practice, counselling, educational services, and planned expansion of services to seniors in a multi-disciplinary setting. Health promotion is emphasized. Salary is commensurate with qualifications and experience. Please call: Health Services Co-ordinator, Centretown Community Health Centre, 100 Argyle Ave., Ottawa, Ontario K2P 1B6, (613) 563-4771,

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