MRG Newsletter

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

Volume 8, Number 5-- October 1988

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

Fall General Meeting

The MRG's Fall general meeting is on Friday October 21 and Saturday October 22, 1988. The Friday night session will be in Room 340 of the Larkin Building at Trinity College at the University of Toronto. The meeting starts at 8 p.m.

The Larkin Building is just of the north-west of the main building, at the corner of Devonshire and Hoskin (one block east of St. George, and one block south of Bloor St. W.)

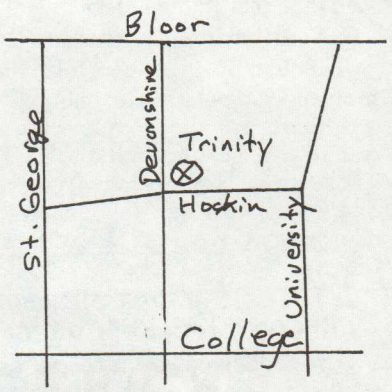
For those coming for the pre-meeting dinner at 6 p.m., the dinner is in the small dining room at the west end of the building.

The Friday night session at 8 p.m. will feature a panel with three speakers, followed by a plenary discussion.

The Saturday session is at the South Riverdale Community Health Centre, 126 Pape Ave., Toronto, Registration is from 8:45 to 9:05; the meeting starts at 9:05 sharp. For a detailed agenda, please see the September MRG Newsletter.

The registration fee for the weekend is $25, and includes Saturday lunch.

How to Get to Trintity College



Questions and Themes for the General Meeting

The fall meeting will focus on issues related to primary care, and will attempt to link those issues to the question of **Where does the MRG go from here?** Several members of the planning committee (Bob James, Mimi Divinsky, Fred Freedman) have prepared some questions which they hope will help to focus discussion for the meeting. Their contributions appear below:

The role of the GP in General/Family Practice

The 1980's have seen several changes to the role of the GP in Canada. While we are not in the same situation as that in the States, the GP in major cities is often left with the role of deciding which of several primary-care specialists to refer to. Our heritage here comes as much from Great Britain, where the GP is still in many ways the centre of the health care system.

However, we have allowed our traditional roles to change over the last decade. We used to do obstetric care; we now refer even the normal low-risk cases. We used to do emergency care; we now rely on the specialized Emergency Room Physician. We used to do on-call; we now sign out to Physician Replacement Services. And the vast majority of us talk about the poor distribution of physicians while we practise in Toronto, Hamilton, and Ottawa.

"Well", many would say, "that was for a good reason: we have **our** lives to lead as well" -- and so we do. Yet we see family medicine as being a way of giving health care (not just sickness care) to the entire person. Do we not see that this care has to come at all hours of the day and night? And don't we laugh at those physicians who only work from 9 to 5? After all, people don't get sick according to the clock. And we need to take account of their social and psychological needs as well as their medical ones.

Topics

1. City vs. Country GP

What are the issues that divide us on this? Do they do more work than we do? Do we have more time or money than they do? What is the job satisfaction involved?

2. GP-Obstetricians

We all have horror stories about the way in which we are treated in the L & D wards of our hospitals. Are there creative ways of dealing with the diminishing responsibility of GP's towards their pregnant patients? How do we keep more GP's doing OBS, and attract more back into it? How do we keep doing it ourselves. What about *our* quality of life?

3. GP's in Emergency Rooms

Are we competent any more to do ER work? What about outside the major centres? Can we call ourselves General Practitioners if we don't?

Continued

Questions and Themes for the General Meeting

4. Walk-in Clinics

They appear to be a threat to the quality of care that is given by the GP. Why have they arisen, and what should be our response to them? Should medicine be organized along these lines for the rest of us GP's?

5. Hospital Privileges for GP's

We all know it is getting more difficult for those of us in cities to work in the hospitals. We are looked down on or ignored by the specialists. Specialists insist on doing primary care, although they do it badly. Money is spent on high tech and research that could be spent on better primary care. Specialists will refer to each other and often undermine what we have done. And then there's the nurses...

6. Academic vs. Community

The Family Practice Units have pretty poor reputations in many cities. Yet these are the people who are training the next generation of GP's. They do what is often useless research, and we do what they think is useless clinical work. We don't talk with each other.

7. The role of the College of Family Practice of Canada

The College has taken political stands in the past, and will likely continue to do so. How can we influence them to work as they are supposed to? Should we resign, and would they notice if we did?

Bob James

The Doctor-Patient Contract

The MRG has policy regarding the right of access to competent medical care but we have not as yet tackled policy questions regarding the doctor-patient contract. Perhaps this is because we believe that such an 'individualistic' concern has less impact on quality health care than other broader issues which involve public policy. But it's clear that assumptions which both parties bring to this relationship (or contract) have an important effect on the structure and content of the doctor-patient meetings and therefore need to be articulated.

1. What assumptions do we have about patient expectations as part of the implicit doctor-patient contract? Are new 'consumer demands' a result of disappointed expectations or a professional failure to provide adequate service to certain specific patient populations? Is quality primary care threatened by Walk-in Clinics, women's clinics, specialty clinics, access to 'alternative health care'?

Issue: 'Patient' versus 'client' as a description of the 'contract' between the parties involved. Starting with definitions i.e. a patient is one who presents him/herself for medical care (autonomy vs. fear). A client contracts a service for an agreed upon fee.

2. Is a physician obligated to see any/all patients who request his/her attendance? If not, with what limitations and responsibilities? (obstetrics, geriatrics, AIDS) What policy do we have regarding the physician side of the doctor-patient contract?

Issue: What is the mandate of our profession? What are our rights and obligations as physicians? Is there a medical code that we adhere to - Hippocrates? Maimonides? W.H.O.?

What is the domain/essential nature of the family physician? All things to all people? Translator/interpreter of the 'system'? Referral service? Medical educator?

Is it our job to be gate-keepers regarding the use of publicly-funded services?

General Questions:

1. In the Canadian Family Physicians Journal Volume 27, May 1981, p. 801, McWhinney says "the patient defines the problem". And yet patient satisfaction does not necessarily equal quality medical care (i.e. antibiotics on demand for upper respiratory infections). If we take the opportunity to 'remind' patients about prevention and follow-up is this our, or their agenda? Do attempts at patient education or re-education really make the relationship more 'equal'?

2. Does the C.H.C. model answer the needs of the patient population or only those segments that have, so far, been relatively neglected? i.e. elderly housebound; chronic psychiatric patients; 'street' adolescents without OHIP; new immigrants. What other (political) forces are at work to reshape the doctor-patient contract?

Mimi Divinsky

Issues of 'Professional Identity'

Some specific issues that may be raised:

1) Is there a role for specialty training in Family Medicine?

2) Is the College of Family Physicians a self-serving sham or a mechanism, however flawed, for protecting family practitioners?

3) Continuing Medical Education and Family Practice Units -- do hospitals, medical schools, Family Practice Unites, have a role in CME and continuing competence?

4) What professional duties/responsibilities do we have in the face of personal needs (e.g. obstetrics)?

5) How do physicians in practice in the community keep in touch with each other?

6) Walk-in clinics, special interest clinics (e.g. women's clinics): how do they impact/interfere with our roles and provision of client-centered care?

Some more general issues:

Is the model of physician and ancillary workers 'the' way to provide primary care? Do Community Health Centres represent the most progressive path to a rational provision of services or are they destined to always be a solution only for the marginalised?

What is our role as individual practitioners in the overall socio-economic milieu? Stopping people from smoking would have a greater impact on the general health of Ontarions than all of us together -- what are the implications of this?

Fred Freedman

Steering Committee Report Fall 1988

The major concern of your steering committee in the last six months has been the deficit, predicted in May 1988 to be $5000.00. It has now shrunk to $3500.00, mainly because of membership revenues, and has been covered by our contingency fund.

Fred Freedman, our treasurer, prepared a detailed review and recommendations, which after much discussion led to the proposed fee increase. We elected not to set a separate fee category for interns and residents, but to notify members of the option of paying a reduced rate at their capacity. We decided to keep the phone, and to hold the newsletter within budget.

The newsletter also received a lot of attention, including the first meeting of an editorial board, chaired and prepared by Haresh Kirpalani. Its name will be changed to 'Medical Reform'. Please refer to the September 1988 newsletter for more details of our deliberations and our plans to distribute it more widely.

The third major job has been planning the fall meeting around general practice and primary care. Bob James, Mimi Divinsky and Fred Freedman have done most of the work. The June 17th meeting on future directions for the MRG led us back to the central role of primary care, and many members were interested in the dilemmas of general practice, so these two threads joined in this meeting.

We endorsed Joel Lexchin's brief to the Lowy Commission on the prescription and use of pharmaceuticals. Recommendations include a low-cost alternative to the CPS and the development of a general practice formulary.

We accepted Haresh Kirpalani's offer to represent us at the Ontario Health Coalition, after Carole Cohen stepped down.

With Michael Rachlis' resignation from the steering committee, we searched for a new media rep. Mimi Divinsky took on a coordinating role, with help from Bob James, Fred Freedman and Don Woodside.

Having failed to reach a quorum for constitutional change even at our high-profile spring 1988 meeting, we decided to advertise this change to 10% and request members to make any objections known in writing to the steering committee or in person to the fall meeting.

Concerns about the inactivity of the Toronto chapter and recruiting at the U of T were again discussed. We look forward to Shawna Perlin's planned move to the Toronto chapter committee.

Fred Freedman and Shawna Perlin are leaving the steering committee at the fall meeting. There will be six vacancies. Volunteers are welcomed and needed.

Don Woodside

Health Focus Group on CHOs

Meeting Report on Ministry Of Health Focus Group Re: Comprehensive Health Organizations, September 15, 1988

By Bob Frankford

I attended this focus group on behalf of the MRG. It was one of three such discussions called by the Planning and Programs Branch Of The Ministry. One of the discussion groups was between members of different ministries. The other two were by invitation to a variety of health related organizations with a stake in the proposal.

The group I attended included Dr. Stanley Bain, President of the CPSO and Dr. Anthony Shardt, Associate Registrar. Also John Hastings, representing U of T, representatives of the colleges of pharmacy and optometry, a physician representing the Ontario Association of Medical Clinics and representatives of the Ontario Hospital Association, nursing and physiotherapy. Michelle Harding was present as a representative of the Ontario Health Coalition. Ministry of Health representatives included Charlie Bigenwald, Giah Einstein, Dave Brindle and John Marriott.

Discussion

The object of the exercise was to discuss and critique an outline proposal for Comprehensive Health Organizations (CHO's).

In broad terms the proposal is that CHO's would incorporate a wide range of services, funded by capitation and under the control of a community board.

This proposal has largely developed from the proposals to have Health Maintenance Organizations (HMO's) in the province. These proposals have largely been initiated by hospitals, looking to get involved in primary care.

A number of the participants said very little. The physicians, Michelle Harding and the OHA representative had the most to say. There was no fundamental opposition to the proposal, though the representative of the Association Of Medical Clinics (and Stanley Bain to a somewhat lesser extent) felt that fee-for-service was fundamentally sound and the problem of excessive costs could be solved by user fees.

The proposal is largely and elaboration of the existing Health Service Organization arrangement and was most familiar to myself and Michelle Harding. Important elements of the proposal include a community base, alternative funding and a comprehensive team approach to care which are MRG objectives and I felt no difficulty expressing support.

Questions about the implementation of the proposal included:

a. The role of physicians and the definition of primary care. The optometrists wished to be included as primary care. There was discussion as to whether primary care means direct

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Health Focus Group on CHOs

patient access and whether physicians should have a 'gatekeeper' role. I found myself speaking up more strongly for the physician as gatekeeper than Dr. Shardt.

b. Calculation of the capitation payment rate. The Ministry was unable to clarify how this would be done or to whom incentive payments would be made.

c. When CHO's might be implemented. There were questions whether this was going to be yet another experimental scheme. The impression was that these particular ministry officials would like to get some CHOs started soon (subject to cabinet approval).

d. Issues of liability. The more comprehensive nature of the patient relationship would presumably require more comprehensive assumption of liability than that of physicians at the present.

e. Quality assurance. Considerable discussion about how and by whom this would be done. To me it seems less of a problem than many others perceive it to be. The checks and balances of complex institutions would seem an improvement on the present situation.

f. It is noteworthy how little awareness there is even among this informed a group of current alternative health organizations. It supports Michael Rachlis' contention that to reform the system one should first devote five years to community education and awareness raising.

g. How will the OMA respond? Maybe one can guess by observing Dr. Bain and the Ontario Association of Medical Clinics representative's reaction. They are being offered a change in ideology and a paradigm shift and their initial reaction is to rationalize their present ideology or denying the existence of a problem (including the typical transference of responsibility by blaming the public for the problems and suggesting user fees as the solution). I so however sense that a more open attitude to alternatives develops as it is perceived that they can offer positive advantages such as guaranteed income and professional satisfaction of working in a team approach.

h. From a personal interest point of view, I am in favor of growth of alternative arrangements and feel that those of us already in Health Service Organizations would benefit from the right kind of CHO arrangement. I would hope that MRG members will look closely into working in capitation arrangements; a CHO could be developed from a collaborative Health Service Organization arrangement. For one thing, I would much prefer the initiative to come from physicians than from hospital administrators or District Health Councils.

Appendix: Comprehensive Health Organizations

Vertical Integration

In economic terms, vertical integration is defined as combining within a single organization the succeeding levels of delivery and production:

-CHO's would provide their members all necessary primary care (initial point of entry into the health system), secondary care (emergency and critical care, usually upon referral, requiring specialized knowledge or equipment), and tertiary care (care for the most complex, specialized procedures).

-CHOs would provide as comprehensive a range of health services as possible, preferably on-site.

-CHO's would arrange, through agreements, to provide the services of facilities, agencies, etc. which would not warrant direct provision by the CHO due to such factors as the CHO's size or its geographic location.

CHO Funding

While the details of CHO funding would be addressed in the context of specific proposals, the following can be expressed:

-CHO funding would be based upon the concept of an annually negotiated amount for the assumption of responsibility for the health status of a member population, irrespective of the type or volume of services provided.

-CHO institutional funding would provide for the appropriate reallocation of inpatient costs to outpatient and ambulatory programs.

- Approved developmental CHO's would access time-limited (i.e. 2-year) pre-operational funding to a maximum of $250,000 per proposal.

-CHO's would incorporate incentive arrangements.

Drug Use In Zimbabwe And Lesotho

By Norman Nyazema

Pioneering studies of urban drug usage in Zimbabwe and Lesotho have posed important questions on drug promotion by the multinational pharmaceutical companies in these African countries.

The study in the Zimbabwean cities of Harare and Bulawayo showed that most people spent a lot of money on antimicrobial agents, particularly tetracyclines and penicillin. These were obtained from doctors.

In the Lesothian study, analgesics were found to top the list of drugs used.

In the Zimbabwean probe, questionnaires were given to a tenth of the population in Harare and Bulawayo, each with about 50,000 people. Questions on the respondents' state of health, current illness and drug exposures in the 12 months prior to the study were asked.

The results showed that the drugs used, by major therapeutic classes, were anti-infectives, analgesics, cough and cold mixtures, contraceptives, antacids and laxatives, anxiolytics, antihypertensives and vitamins (non-ethical). This was then followed by an investigation into the people's expenditure on medical health in general and drugs in particular. This was done in two stages -- customer and household interviews. The costumer interview was carried out at drug outlets (grocers, pharmacists' shops and doctors' rooms). People were picked randomly. The household study involved interviewing heads of households in the different suburbs of

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Drug Use In Zimbabwe And Lesotho

Harare. Antimicrobials topped the list of drugs purchased. On the whole, people bought their drugs mainly from sources other than the chemist's shop or supermarket.

A similar study was carried out in Maseru, the capital of Lesotho. This is a land-locked country like Zimbabwe, situated deep in the heartland of the Republic of South Africa, where most of the big international companies are located. Any unrest in South Africa causes disruption of transport and/or other services. The results from the study were similar to those obtained in Harare and Bulawayo. Analgesics were the most frequently purchased drugs. This poses a lot of questions, one of which is the way drugs are promoted in Zimbabwe.

The WHO's definition of drug utilisation is a useful indicator of the subject's scope. It is denoted by 'the marketing, distribution, prescription and use of drugs in a society, with special emphasis on the resulting medical, social and economic consequences'. This definition underlines the fact that drugs are not only an important part of the medical practice, but they also relate to cultural, social, educational, economic and political conditions as reflected in local drug and health care policy. Drug utilisation study is described more succinctly through a series of questions:

* what drugs are prescribed?;
* who prescribes them?;
* for which patients are they prescribed?;
* for what reasons and with what resulting benefits or possible ill effects?

These simple questions are, from the first, very difficult to answer and precise answers to most of these questions are not available, particularly in a developing country like Zimbabwe, where economic planning, improvement of prescribing practice and the use of limited resources are important.

Characterisation of the drug use is important to both the drug regulatory and general medical communities for many reasons. The identification of potential problems with various drugs is an obvious pre-requisite for improving the quality of drug treatment received by the public and assessing the qualitative and qualitative characteristics of drug use is essential to this process.

The starting point for studies of drug use in a community is information about the quantity of each drug sold.

This is very difficult information to get. Data on such information are therefore sparse and their rational discussions even more difficult to find. However, drug use of a community is as important as an understanding of the cultural heritage and the genetic, nutritional or environmental background of that community. Its pattern forms part of the total milieu that determines not only the course of disease, but also its expression in a community and the expectations of patients. Furthermore, data on the incidence and epidemiology of adverse drug reactions are meaningful only when considered against the background pattern of drug usage.

For these reasons the studies cited above are important milestones on the road to a rational drug policy on these countries. The data gathered will form the justification for governmental regulatory action on drug marketing.

Towards this comprehensive development in rational drug use, several studies are being carried out in the following areas. Some of the results will also be very useful in the teaching and training of health professionals, from the village health worker to the consultant.

An investigation is now under way into the content of the most popular medical journals in Zimbabwe. It is part of an international comparative study on this aspect of drug marketing. The results of this study may indicate that the pharmaceutical industry should put its house in order with regard to the rational use of drugs.

Another study is in progress in Zimbabwe to find out the people's perceptions on pharmaceuticals and therapeutics. The urban, sub-urban and rural survey is expected to throw light on health and illness behaviour in the country.

A cooperative study on drug use in pregnancy is also being carried out. The objectives of the study are:-

i) to assess periodically, the pattern of drug use in pregnancy and the immediate post-natal period through the collection of standardised interviews of women admitted for child delivery.

ii) to establish a permanent research network in order to test or validate therapeutic or prophylactic and preventive interventions and drug safety issues.

Close attention needs to be paid to the complex mechanisms of reasoning and decision-making that usually involve the use of drugs in which not only the health professional, but also patients play an important role. All factors leading to prescription-drug use, self-medication and compliance have to be considered in drug utilisation studies.

Norman Nyazema is a clinical pharmacologist at the University of Zimbabwe. This article is reprinted from HAI News, April 1988

Announcements

Practice for Sale

Hamilton practice for sale, well established, and fully equipped, flexible on-call, available January 1, 1989. Dr. Barry Munn, (416) 547-2302.

Physician Required

A part-time clinic physician is required for the City of York Health Unit's Birth Control Clinic. It is on Mondays for 5 1/2 hours per week, except statuatory holidays, starting in December, 1988.

Responsibilities involve the medical management of all clients attending the clinic in accordance with current acceptable practice and clinic policy. On-going clinic coordination is planned in consultation with the family planning team. Attendance at four staff meetings is required. Previous experience in family planning is an asset and, as well, an interest in adolescent health care.

The physician will report to the Family Planning Supervisor. Qualifications required are current registration with the College of Physicians and Surgeons of Ontario and current membership of C.M.P.A. Please send resume or call:

Ms Shirley Morrison
Acting Family Planning Supervisor
City of York Health Unit
504 Oakwood Ave.
Lower Level
City of York, Ont.
M6E 2X1
(416) 652-3259

Applications will be accepted until October 28, 1988.

Partnerships in Health

Partnerships in Health-2: Meeting the Needs of a Multicultural Society is a symposium to be held October 28 and 29, 1988 at the Faculty of Education, Althouse College, University of Western Ontario, London, Ontario, presented by the Multicultural Health Coalition. Featured speakers include Ontario Health Minister Elinor Caplan and Hon. Gerry PHillips, Minister of Citizenship. Contact MHC at 388 Dundas St., London, Ont. N6B 1V7, 439-0026 or 432-2153.

Canadian Council on Multicultural Health

The Canadian Council on Multicultural Health announces a national conference on: **Multicultural Health -- Realities and Needs: Policies, Programs, and Implementation.** The theme is meeting the challenge of understanding and responding to health, health needs, and health delivery in a multicultural society. The conference will be in Toronto from March 30 through April 1, 1989. For more information contact CCMH Conference Committee, 1017 Wilson Ave., Suite 407, Downsview, Ontario M3K 1Z1, (416) 630-8835.

Therapists Working with Incest Survivors

There will be a residential training workshop for therapists interested in working with Incest Survivor Groups on November 10 and 11, 1988 at the Bolton Conference Centre in Bolton. The workshop is sponsored by the YWCA. The fee is $350, and is payable by October 21 to Ann Kollo, Registrar, YWCA, 2532 Yonge St., Toronto M4P 2H7, (416) 487-7151.