MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

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Volume 8, Number 6 (December 1988)

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

The MRG and Community Clinics

(Address to the MRG Fall General Meeting)

One of the resolutions that the MRG passed fairly early on was one in favor of community clinics. While the concept of community clinics was not one of the founding principles of the group, it was the area from which many of us came, and where we saw many of our principles embodied. Whenever progressive medical students got together in the 1970's, and talked about ways in which we wanted to practice medicine, the issue of community clinics always came up. They seemed ideal: people would work on salary; there would be a more equal sharing of responsibility among the health care workers; decision-making would be democratic; they would serve as a vehicle for doing political or organizing work in the community. They took on an almost mystical quality, and it would have been heretical to even question the inherent correctness of the community clinic. We thought we all knew what the term, Community Clinic, actually meant. In 1980, after almost a year's work, some of us in the MRG put down on paper what we at the time took as the key concepts of clinics at that time. This was based in part on the experience of several of us, and in part on our own research. As usual, it was hard work, and we did a better job than had been done for this type of document in the past. (It's worth noting that the OMA has yet, to my knowledge, to produce any document on community health care.)

When I started to work on tonight's talk, I pulled out that old Community Clinics brief, and had another look at it. I was part of writing the original, as was Gord. We were quite proud of it at the time we wrote it, but I expected that it would be very out-dated in the light of all of our experiences over the past eight years.

I was wrong. The brief sounds as good now as it did when we wrote it. It talks about the need to get away from fee-for-service medicine. It suggests that the clinics be governed by a board which has equal decision-making power in the community and in the health care workers (doctors were to be only a part of the health care workers section). It talks about the need to have means, through the board, to express what they wanted and needed to the workers in the clinic, so that the clinic could carry this out. It talks about the need for preventive medicine, medicine practiced in the community rather than in the hospitals, and the need for patient education. It talks about the need for the community to feel that it has the power to influence decision-making in their lives. It emphasizes the need to educate the health care workers. Al the things that we wanted in a Clinic back in the 1970's.

And it states, with some back-up facts, that the clinic idea could even, in the short run, save the government money. In the long term, it would almost certainly save money. So how could you lose? It was clearly the correct way to go, as we had thought in medical school.

I began medical school in 1971. I had come through the student movement in the 1960's, had participated in marches and sit-ins and demonstrations. I was one of the New Left that our parents feared. I got into McMaster with a degree in Political Science, and experience in community organizing. My interest in medicine was as a tool to help organize the community for political action. I took to the idea of community clinics like a duck to water (or is it a pig to shit?)

There was no other way, as far as I was concerned. And while these ideas of mine were formed before the brief was written, I had no reason to change them by the time I helped write the brief.

I did my medical school electives in community clinics in Canada and the U.S. This only confirmed my desire to work in that type of facility. And when I finished my residency training, I began to look for that kind of work. I found it in the Pointe St-Charles Community Clinic.

So I used to work in a community clinic. Not just any community clinic, but the archetypal one for Quebec; one which was doing all the things that community clinics are supposed to do, one where I was a member of a team, on salary, working with the underprivileged, and so on.

I don't work there any more. Actually, I have now been in private practice almost ten years. By many standards, I lasted a long time: I was there for three years. And that was better than the average for that clinic. In fact, for most clinics.

Now, I am not alone in being an alumnus or alumna of a community clinic. When I look around the room, I can see probably ten of us – all staunch MRG supporters – who *used* to be in the clinic movement, and are not now. Some of us have gone into private practice (I have); some are in academe; some are in public health. And **all of us** voted loudly and proudly for the MRG proposal on Community Clinics, back in 1980.

So What Happened??

Well, you see, we all had families coming along. We got tired of all the

Medical Reform

MEDICAL REFORM is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at $25/year.

Articles and letters on health-related issues are welcomed. Submissions should be typed (preferably double-spaced), or submitted on IBM-compatible computer disks (any program, but tell us which program you used.)

Deadlines: The next newsletter will appear on February 3, 1989. The deadline for longer articles is January 3; shorter items such as announcements must be in by January 16.

The subsequent issue will appear March 31, 1989. The deadline for longer articles for that issue is February 23; shorter items must be in by March 13.

Correspondence should be sent to Medical Reform, P.O. Box 366, Station J, Toronto M4J 4Y8. Phone: (416) 588-9167.

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Editorial Board: Haresh Kirpalani, Don Woodside, Fran Scott, Bob Frankford, Ulli Diemer.

energy that had to go into the clinics. After all, we gave them the best years of our lives, didn't we? We did have to think of ourselves a little bit. And they were not doing the right things anyways. They were down on doctors, often elitist or even racist in their own ways, and didn't share our goals. When you got right down to it, people in the disadvantaged areas wanted the same kind of fancy waiting rooms and middle-class medical practices that existed in the suburbs. They had often bought the image of the modern doctor more than people in those middle-class suburbs that we all came from. They were opposed to nurse-practitioners, fair working conditions for health care workers, equal pay for work of equal value (in the clinics), etc. Whenever we dared poll them, they wanted us available for service only, and preferably from 8:00am to 12:00pm, daily. They saw the other, socio-political work, as being the price they had to pay to keep us there to provide the service.

The community board was often democratic, but often got bogged down dealing with the government for financing; or dealing with the workers over salaries or contracts. As so often happens in these things, those with more time, or a vested interest, took or were given control over vital functions of the clinic. For instance, in my clinic, two 'Marxist-Leninist' groups used the clinic as a battleground for their inter-group fighting. Much of our energy went, not into patient care, but into dealing with the various political infights that were going on. This was tiring us, and confusing the community.

It was not clear what the mandate of the clinic was: were we giving medical service, working politically in the community, working to get better government financing for health care, or developing a model of democratic functioning among health-care workers?

So what did go wrong? Is it us? Or is it them? Was it so bad that no one could have tolerated it? Or were we such liberals that we only talked a good line, but were not prepared to act it out in any meaningful way? How did we deal with the issues of lifestyle, or did we deal with them at all?

Now the MRG is not stupid, and is not usually unrealistic in what it does. We need to look at where we have gone with the resolution on Community Clinics, and why it is so good in theory, yet not in fact good enough to draw our members' attention and work. How can we begin to match the reality of our work styles with the good theories that we propounded back in 1980?

And that is the issue that I wish to bring to you to talk about this evening and through the weekend.

Bob James

MRG Fall General Meeting
Friday October 21, 1988

Historical Overview

Gord Guyatt presented a historical overview of the Medical Reform Group. He noted that one of the earliest debates revolved around the question of whether the MRG ought to be a physicians' group. The perception was that the group could be most effective as a lobby group as a specifically physician group.

The founding of the group was followed by a "spectacular burst of energy" which resulted in a number of resolutions and position papers, most notable among them a paper on community clinics (which the MRG then favoured) and a brief to the Hall Review of medicare.

After the group's success in influencing the Hall Commission, there was something of a letdown in the group and the group entered a period of organizational crisis. There were administrative problems caused by overwork. In the early days of the group, all administration had been done by Steering Committee members. The burden had now become too great, and the decision was made to raise membership fees to $100 and to hire someone on a part-time basis.

The next few years saw the group focused especially on issues relating to accessibility, privatization, and extra-billing. The emphasis was on defending a health care system under attack.

Then came the Canada Health Act and Ontario legislation outlawing extra-billing. The result has been another period of re-evaluation for the MRG. However, Gord saw a difference between this period and the post-Hall Commission letdown. He felt that the group has matured since then. "We don't bicker, we listen well to each other." People have gained considerable expertise in looking at issues. On the other hand, people have children, and less energy available.

Overall, Gord saw the group's history as a history of achievement and credibility.

Preventive Medicine

John Frank spoke about issues of prevention. He said that "we are in the grip of a fanatical push from the United States to do certain things which we don't know are useful and

may be unethical or even criminal." A preventive approach is circumscribed by the fact that the Americans, like us, can only do things that are covered by fee for service, and things that are doctor-driven. The result has been, for example, an emphasis on a variety of diagnostic tests which aren't very useful. The whole system is driven by vendor driven greed but also by consumer demand for tests and drugs which are believed to be useful.

As an example of a preventive measure poorly done John Frank identified the inability of most practices to identify which patients are over 65 and who is chronically unwell. We have to be able to recall people after one year in a systematic way. We are doing an appalling job of keeping track of what drugs people are on. Twenty per cent of the elderly in one study had major potential drug interactions. Our thinking is mechanistic; it should be probabalistic.

Community Clinics

Bob James spoke about community clinics, and the MRG's attitude to them. Support for the idea of community clinics was one of the earliest resolutions passed by the MRG. The brief on community clinics written at the time still sounds good, with its emphasis on the need to get away from fee-for-service, teams of health care workers, community outreach, and preventive medicine. A number of MRGers started out working in community clinics; however, most of them don't any longer. What happened?

Many of us had families coming along. We got tired of all the energy that had to go into community clinics. Many of them did not work out as planned. Elitism and political infighting were common; often they got bogged down in dealing with the government over financing, or in dealing with workers over salaries and contracts. Often, people in disadvantaged areas wanted the same kind of fancy waiting rooms and middle-class medical practices that existed in the suburbs. The had often "bought the image" of the modern doctor. They often had no interest in fair working conditions for health care workers or equal pay for work of equal value in the clinics.

It was not clear what the mandate of the clinic was; were we giving medical service, working politically in the community, working to get better government financing for health care, or developing a model of democratic functioning among health-care workers?

So we are back to the question: how can we begin to match the reality of our work styles with the good theories that we propounded back in 1980?

The Discussion

Fred Freedman said that the group's focus on defending equal access absorbed so much energy that we didn't have time to ask access to what. The main causes of ill health are outside the health care system, e.g. smoking, poverty.

John Frank said that one thing we can do for patients is to help prevent them falling into the wrong medical hands.

Mimi Divinsky said that in her practice, she is not authoritarian in imposing care, but she is being more forceful in talking patients out of inappropriate health care which they want.

Miriam Garfinkle said that we have to redefine what 'doctor' means. People are going to other types of practitioners who they believe can "solve the problem". Health food stores are now full of "millions of drugs" which people use to treat themselves.

Catherine Oliver said that we have to remember the value of care-giving. There is a basic human need for primary care.

Adrian Sohn said that we don't want to be on a pedestal but we want to tell people not to do things that are bad for their health.

Christine Zarowksy said that we do have an area of expertise. If someone asks our opinion on our area of expertise, it is OK to give our point of view. It's the same as going to an architect or electrician or lawyer.

Michael Rachlis said that one of the great delusions of the twentieth century is that without lots of doctors and hospitals we'd all die like drought-stricken Ethiopians. We could achieve the same health status with 70 per cent of the expense and redirect the rest of the money into social problems. The people who particularly benefit from the present set-up are drug companies, suppliers of technology, and doctors, especially the ones who bill $200,000 per year.

Gord Guyatt said that we don't want to tell the community what its values should be. The value of being healthy is good. We can state the evidence as to what achieves these values and what doesn't. People are being misled as to what will help them achieve health.

Joel Lexchin said that what people want is a reflection of the values of the society. A capitalist society treats things as individual problems with individual solutions.

Fred Freedman said the medical model, in the sense of being scientific, is valid; particular applications of it may not be. He criticized the pseudo-holistic approach that deals in unverifiable superficial theories.

Bob James said that we are better at criticizing than at proposing alternatives.

Chris Daly said that her experience as a board member of the Association of Community Health Centres is different from what Bob James described. She sees community health centres as being more 'main-stream' now.

Mimi Divinsky said that many women have had bad experiences with the health system. We have to understand that this is why there is a demand for women's health centres.

John Chong said that the MRG's role should be as that of a strong public voice for our analysis and positions.

Gord Guyatt said that at McMaster, we are being successful in getting students to ask 'what is the evidence for doing this?' There is a tremendous amount of such expertise in the group now. Despite problems, we have one of the best health care systems. There is a lot to defend.

Jamie Uhrig said that in his experience, community clinics are working. He invited members to visit the Lawrence Heights Health Centre.

Haresh Kirpalani said that there are a lot of people outside the MRG who hold similar views and who also have expertise. We need better liaison

with other groups. Many of the underlying issues are issues of capitalism. We need links with other groups that have a vested interest in change. One should be careful about justifying cost-cutting because savings won't be distributed to the things we want them to go to.

Miriam Garfinkle saw the MRG as a more limited group. She doesn't see it as a forum for wider issues. She does see us liaising with other groups, but it's important to remember that we're a small group.

Bob James said that clinics in Ontario don't embody the things we thought clinics should do, for example outreach. There is a problem of physician turnover at the clinics.

John Frank posed the question of 'what makes this group more than just a bunch of critical liberals?' He identified two factors:

1. We've based our positions on broader political analysis, not just on the 'scientific evidence'. We talk about social equity.

2. We've linked with other groups.

Questions which we should use to evaluate the MRG are:

Is it vigilant about bad public policy and bad private initiatives?

Does it take strong public stands based on evidence and analysis?

John Chong said that there is a role for the MRG in supporting those in medical school who are progressive so that they don't get jaded. We can provide a model of collegial support, and recruit them to the organization.

The evening closed with much discussion still to come.

The MRG Fall General Meeting
Saturday, October 22, 1988

The Steering Committee report, which had previously been published in the October 1988 MRG Newsletter (Volume 8, Number 5) was adopted.

A New Quorum

The motion to change the constitution regarding quorums and mail ballots, which had previously been passed at the Spring General Meeting, was passed by a unanimous vote. The motion reads:

"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 read '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.'"

The Budget

The proposed budget for 1988-89 was presented by Fred Freedman. The budget projected an income of $23,525 and expenses of $22,725. The assumptions accompanying the budget were that the number of members would remain the same; that the membership fee for physicians would be raised to $150 from $125; and that expenses would go up at about 5 per cent on the average.

The meeting approved the Steering Committee's decision to use some of the funds in the reserve fund to cover last year's deficit.

It was decided that in the future, the MRG's budget would be presented to the spring general meeting rather than the fall general meeting.

The Lowy Commission

Joel Lexchin announced that the MRG would be appearing before the Lowy Commission on pharmaceuticals on November 3. Appearing for the MRG will be Rosanne Pellizzari, Bob Frankford, and Joel Lexchin.

Free Trade

Fred Freedman proposed that the MRG hold a press conference on free trade and its possible effects on the health care system. This was agreed, and a working group of Fred, Mimi Divinsky, Michael Rachlis, and Haresh Kirpalani was set up.

Should the MRG Focus on Primary Care?

The meeting then divided into two workshops. One of the workshops focussed on **The role of the GP/General Practice/Scope of Practice.** The other workshops focussed on **Professional Identity and Doctor-Patient Contract issues.**

The workshops reported back to the afternoon plenary. The discussion revolved around the question 'Should there be a focus to the MRG's work and should it be primary care?'?

Bob James said that we can't be all things to all people. We need to have a focus, to set priorities.

Fred Freedman said that in the past, we did have a primary focus, namely accessibility and opting out. We can still address other issues even though we have a primary focus.

Brian Hutchison asked what would having a primary focus mean? How would it be played out?

Haresh Kirpalani said that it would involve a decision to put energy into it, not to exclude other things. He, for example, could see himself working primarily on things other than the primary focus.

Gord Guyatt said that he wanted resource allocation to be a primary focus.

Mimi Divinsky said that in planning the general meeting, we questioned two issues that have been assumptions of the MRG:

1) community health centres, and

2) prevention.

Steve Hirshfeld said that there are broader ways of looking at those questions. He would prefer a broader focus.

Brian Hutchison said that there is a difference between what is a problem for primary care providers and what is a problem for the health care system. There is a danger of confusing these issues because so many of us are primary care providers.

Fred Freedman stressed the issues of the push to privatization and budget cutbacks. He would love to see the MRG come up with a model of primary health care allocation.

Brian Hutchison said there would have to be an intensive effort -- a working group. We can't just chew the fat if we are serious about the issues.

At this point, two possible foci were identified:

1) Primary care

2) Resource allocation in the health care system.

Bev Davis said that there is a lot of connection between the two topics.

Steve Hirshfeld said that primary care is one aspect; part of the whole system. We have to look at the hierarchy of the system. It's not just a family practice kind of issue.

Brian Hutchison said that the choice of a primary focus depends on what we are interested in doing as well as any a priori analysis.

Haresh Kirpalani added that we need enough people to put energy into it.

Gord Guyatt said that we have shown our capacity to deal with resource allocation issues and a good deal of agreement. We don't have a clear consensus about a model of primary care.

Bob James said that some of the individual issues that we talked about regarding care are also system issues. These issues also have an economic dimension.

Brian Hutchison said that we can't be too narrowly identified with family medicine or we'll be just another self-interest group.

Two Working Groups Formed

At this point, two working groups were formed, one on primary care, and one on resource allocation in the health care system.

People interested in the two groups met briefly to discuss how to proceed and to plan meetings of their groups.

Members interested in the resource allocation group should contact Gord Guyatt at (416) 628-0162. Members interested in the primary care group should contact Bob James at (416) 627-3914.

Rosanne Pellizzari said that there are 15 to 20 students involved in the Hamilton chapter. She would like to try to get some of them involved in the working groups.

The meeting adjourned at approximately 4 p.m.

Construction And Composition Of The Measures Of Clinical Practice: A Short Review

Compiled by Bob Frankford

(This review was prompted by a desire to encapsulate some of the dilemmas faced in clinical practice. It's purpose was to aid discussion at the Fall General Meeting.)

The measures of clinical practices were derived from physicians' answers to a question assessing:

How often, in their everyday practice, physicians succeeded in integrating various aspects of a global approach to care when meeting a patient?

Fourteen aspects were surveyed. For each aspect, four answer categories were provided ranging from almost never to almost always. Study of the intercorrelations among the items show that the fourteen items basically fell under three dimensions. The labels given to these three dimensions and the items composing them are as follows:

Educating And Involving The Patient In His/Her Health Care

1. Try to provide the patient with sources of information about his/her health problem.
2. Ask the patient to explain the prescribed treatment in his/her own words.
3. If the patient if hesitant about medical recommendations, encourage him/her to ask for another opinion.
4. Explain to the patient that the ultimate decision about treatment belong to him.
5. Encourage the patient to ask questions.
6. Find out his/her worries about his/her illness.
7. Encourage the patient to make use of resource persons other than those of your profession.
8. Inquire how the patient copes with his/her health problem.

Scale Reliability Coefficient = 0.76

Promoting The Patient's Health

1. Try to find out about the patient's living environment.
2. Review living habits with the patient.
3. Further healthy habits in the patient.
4. Inquire about personal problems that may be troubling the patient.

Scale Reliability Coefficient = 0.73

Caring For The Patient

1. Display warmth toward the patient.
2. Take your time with the patient.

(Canadian Family Physician Vol 34: August 1988)

From Literature and Medicine as a Critical Discourse

1. "If care is something that is constructed at every point in the evolution of an illness, then the evolving dialogue between a physician and a patient is quite important. This dialogue creates the condition of appropriate care, the best care for this particular person. Yet recent studies report that physicians are insensitive to the importance of dialogue or to the impact of their discourse on patient's and patient care. (See my analysis 1983a of the erroneous construction of a diagnosis of depression on a woman who was a cancer patient. See also Fisher And Todd 1983, 1986, Mishler 1984, And Treichler et al, 1984.)" Paget, Marianne A. The Unity Of Mistakes: A Phenomenological Interpretation Of Medical Work. 1988 Temple U. Press P.143.

2. "Everywhere one sees, according to Paul Starr, 'the growth of a kind of marketing mentality in health care.' Coinciding in time with this growth...has been the emergence of patient-physician communication as a genre...Close attention to the details of spoken language rewards the efforts of the clinician...As physicians become hands in the corporate practice of medicine, one wants to know what advertising images consumers prefer, what personal qualities in physician improve production, what forms of patient-physician communication promote profits." pp25/29/31

Psaty, Bruce M. "Literature and Medicine as a Critical Discourse" in Literature and Medicine Vol. 6, Johns Hopkins University Press. 1987.

World Health Organization On Primary Health Care

According to the World Health Organization primary health care must:

- Be built on the principle of community participation
- Be staffed by a multidisciplinary team
- Serve as the first point of contact with the national health system
- prevent diseases, promote health and encourage rehabilitation
- maintain a continuity of relationship with every member of the population it serves
- systematically identify those at highest risk
- help people to assume greater responsibility for their own health
- Encourage the appropriate use of technology.

MRG Statement on Free Trade

The Medical Reform Group of Ontario calls upon Canadians to reject the Canada-U.S. Free Trade Agreement

Today the Medical Reform Group of Ontario asked Canadians to reject the Canada-U.S. Free Trade Agreement (CUSFTA) because it provides insufficient protection for our health care system. Speaking on behalf of the group, Dr. Mini Divinsky said the prime threat to health care is that the negotiators did not define the term 'subsidy'. Dr. Divinsky explained that many American business interests consider medicare to be an unfair subsidy to Canadian industry. She claimed that the U.S. will press Canada to change our health care system through the negotiations on the definition of subsidy. Simon Reisman, Canada's chief negotiator said in November, 1987, "Powerful American interests had targeted our social, cultural, and regional programs for elimination as their price for the agreement. The Americans wanted very tough rules on subsidies for us, but not for them." This is all the more likely with yesterday's election of George Bush as President of the United States. Bush is a bitter opponent of public health insurance.

Dr. Divinsky added that there are at least two other threats to our health care system from the CUSFTA. Under articles 2010 and 2011 the federal and provincial governments would have to consult the United States before designating new monopolies. The MRG believes this would preclude the establishment (or expansion) of dental insurance, drug insurance, or other new programs.

Dr. Divinsky noted that health care facility management is specifically included in the CUSFTA in section 1408. The provinces would still have the power to prohibit for-profit management but U.S. firms would apply political pressure to provincial goverments (as they have in the past) to gain access to our market. Dr. Divinsky mentioned that there is a large body of evidence which indicates that for-profit health care management is less efficient than non-profit management.

The MRG does not believe that the CUSFTA would immediately destroy medicare. But, over time, it would lead to its erosion and stifle its development. Dr. Divinsky closed by saying,

"Especially with George Bush as President, it is an error to believe that medicare would be unaffected by the CUSFTA."

The MRG represents 150 physicians and was founded in 1979 to preserve and improve medicare.

November 1988

Health Professions Legislation Review Update

On reviewing the most recent, and probably last round of documents from the Health Professions Legislative review (Schwartz Commission), I see that many of our concerns have been addressed.

1. Scope of Practice
   a) Midwifery is now included, and has a defined scope and satisfactory licensed acts
   b) Ordering of laboratory tests is not licensed and could thus be more readily open to other health professionals.
   c) Prescription of hearing aids is now licensed to audiologists and doctors, taking it out of the domain of business.
   d) Non-medical acupuncture could be exempted from extinction by regulation.
   e) However, diagnosis is still licensed to physicians.
2. A permanent forum for disputes. The Health Professions Regulatory Advisory Council will provide an ongoing forum where the unregulated may apply to be regulated, and for resolution of turf issues between regulated professions. It will be advisory to the minister who will retain the power of decision. Medicine will still regulate nursing to a considerable extent by virtue of acts of diagnosis and treatment licensed to physicians who are empowered to delegate them to nurses.
3. The power of the minister to order a discipline hearing of a practitioner was deleted as too intrusive.
4. There will now be Continuing Competence Committees with considerable latitude in choosing their criteria for assessment.
5. As for publication of names in discipline hearings, the commission has not accepted the "Young Offenders Act" solution of publishing everything but the names, opting in principle for disclosure. They have added a section to allow a closed hearing, for which the committee must give its reasons in writing.
6. The CPSO's recent (Sept. 88) letter to members states that their legal advice is that Section 27.04 may open the floodgates to unregulated practitioners. Its intent, according to the commentary provided, was the opposite. It appears that new technologies not presently itemized under licensed acts may emerge with which harm could be done without infringing on the list of licensed acts. This is a legal matter which needs to be resolved, not a conflict of intent.
7. Prosecution. Some colleges have wanted the act to mandate them to prosecute infringements on their scope of practice. The commission holds that such prosecution is governed by a different act, the Provincial Offences Act, which it does not propose to alter.
8. Complainants will have a right to documents used at a complaints hearing if they go to an appeal. Such documents will not be admissable in a civil action, a move to discourage use of the complaints process as legal fishing expeditions.

Overall, the recommendations would seem to be useful. Perhaps a B+. Any real effect on the system will depend on administrative and financial responses within these new guidelines. Herein lies the challenge.

Don Woodside

The Children of the Siege

By Haresh Kirpalani

The title gives one an incorrect pediatric perspective on this book, for it is more than just about the "Children Of The Siege", presumably, its title is meant as a metaphor for all adults. It is a very moving book that explicitly eschews political biases. At least it does so in the beginning. However, the book portrays P. Cuttings' voyage through a Civil War and though implicitly portrayed, shows her trying to make some political sense of it all. Taking in starvation, bleeding, bombing, terror and the sheer waste of life, P. Cuttings amongst other things picks up a vigorous skepticism of the role of certain political factions. Such as her anguished realisation of Nabiberri's hypocrasy revealed in his preposterous claim that he was attempting to help Palestinians caught in the siege.

The narrative really reminds me of a previous surgeon whose memoirs echo the philosophy of a physician ineluctably drawn into the maelstrom of politics - N. Bethune. Cuttings and Bethune both went to desperate situations armed with skills and a great desire to help the underdog.

Like Bethune, it is clear that Cuttings has no effective political analysis of the situation, despite her heroism and self sacrifice. If it impels the reader to foray further into the the reasons for the current state of Lebanon (that Lebanon has become a political ploy for the major imperialist nations, including the local imperialism of Israel), then it has accomplished something beyond a simple individual account. Dr. Cuttings' book demands that "sense" be made of such "senseless" events that she describes so vividly. As a document of a personal voyage and a portrayal of the miseries of the Palestinian refugees it is gripping reading.

P. Cuttings "The Children Of The Siege", 1988 London, Pan Books

Prescribing In Canada: A Review Of The Literature

Medical Reform Group Of Ontario Brief To the Pharmaceutical Inquiry Of Ontario, September 1988

Executive Summary

Prescribing is an essential feature of work of almost every physician engaged in clinical practice. However, despite the central role that prescribing plays in medical practice there has been no systematic exploration of this topic in Canada. Through a review of the available literature the Medical Reform Group of Ontario will describe the general characteristics of prescribing and then focus on three main themes: factors affecting prescribing, the appropriateness of prescribing and adverse consequences from prescribed medications. Based on the analysis in these three sections our conclusion and recommendations offer suggestions on approaches to improving prescribing.

Canadian general practitioners issue prescriptions on average to 48 percent of all patients seen in the office. Each prescription is for 1.2 to 1.4 drugs. In general, doctors use only 100 to 200 of the 3500 prescription products available and over 50 percent of all prescriptions are written for no more than 27 different medications. The most commonly prescribed groups of drugs are antibiotics and psychotropics. The elderly are the most heavily prescribed age group.

Studies in Canada have identified a number of factors that appear to influence appropriate prescribing. Generic prescribing may promote more rational prescribing since an awareness of the generic names of drugs would mean that physicians would know the contents of drugs. One anecdotal report showed that in the case of fixed dose combination products doctors were largely ignorant of their contents.

Economic factors can influence a doctor's choice of drugs in provinces with formularies. Excluding expensive irrational products from a formulary leads to a marked decrease in the prescribing of those drugs to people covered by a drug plan.

Doctors' attitudes and personal characteristics affect their prescribing. Physicians' attitudes about the validity of using drugs for psychosocial problems appears to be a determinant of how frequently prescriptions are written. Attendance at continuing medical education courses seems to promote more appropriate prescribing. Finally, there is some evidence, although not conclusive, that male physicians may overprescribe psychotropic drugs to women.

The type of practice doctors have influences their uses of drugs. Salaried physicians practising in government funded community health centres in Montreal were superior prescribers compared to physicians practising in fee-for-service group practices.

Physicians source of information about pharmaceuticals is a major factor in how well they prescribe. Canadian physicians, both general practitioners and specialists, often rely on commercial sources, that is those originating with the drug companies, for information about drugs. With only one exception all the studies done on the relationship between prescribing appropriateness and the source of information about drugs have reached the conclusion that the more doctors rely on commercial sources the less rational they are as prescribers.

A study of retarded residents in five institutions in Eastern Ontario found that there was a striking lack of association between the degree of subnormality of the patient and the use of psychotropic medication. The use of multiple drugs, or polypharmacy, did not seem to be related to either demographic factors or clinical diagnosis.

In another centre in Ontario, the rationalization of drug therapy resulted in substantial drops in the number of patients on anxiolytics, hypnotics and antiparkinson medication as well as a marked reduction in the incidence of polypharmacy.

Those over 65 years of age receive in excess of 12 prescriptions a year. These people often take 4 to 6 different drugs daily. Evidence that there is general overprescribing to the elderly comes from the results of five different studies. In every case, after either an educational campaign or a prescribing review, there was a reduction in drug use.

The bulk of the Canadian literature on prescribing for the elderly deals with psychotropic drugs. Per capita, people in this age group receive, by far, the largest number of psychotropic prescriptions with elderly women running ahead of elderly men. Evidence from across Canada shows that individual psychotropic agents or particular classes of these drugs are prescribed irrationally, particularly benzodiazephines and barbiturates.

A summary of the results of five surveys on cimetidine prescribing shows that of a total of 396 patients studied exactly half received cimetidine inappropriately.

Little is known about antibiotic prescribing in the ambulatory care setting, but some evidence does exist to indicate that there is excessive prescribing to people with upper respiratory infections.

Out of a total of 1478 drug courses reviewed in twelve surveys of hospital antibiotic prescribing, antibiotics were prescribed appropriately in only 52 percent of cases. For 13 percent of prescriptions appropriateness could not be determined and prescribing was clearly inappropriate 34 percent of the time.

There has been a reassuring decline in propoxyphene prescribing in recent years. In Saskatchewan, from 1977 to 1982, propoxyphene prescriptions declined from 16.4 percent of all analgesic prescriptions to just 4.2 percent.

Currently, prescriptions for psychotropic drugs make up between 15 to 28 percent of all prescriptions written. The question of whether or not psychotropic drugs, especially enzodiapines, are rationally prescribed is a complex problem to which there is no easy answer and probably depends on what group(s) of patients they are considered appropriate for. Diazepam may only be effective for patients with high levels of pre-treatment anxiety and it appears to be better than placebo for relieving anxiety for only the first out of six weeks of therapy.

Women are by far the major recipients of prescriptions for psychotropics. Between 62-77 percent of all such prescriptions go to women. While women tend to seek support and assistance during times of marked stress more readily than men the high level of prescribing to women does not seem to be explicable on the basis that women visit physicians more often than men. As we mentioned earlier, there is also strong, but not conclusive, evidence that male physicians overprescribe to women.

Psychotropics, especially benzodiazepines, are often used in the treatment of somatic disorders despite the lack of objective evidence that they do any good. Finally, sedatives and hypnotics are routinely, and probably inappropriately, prescribed to hospitalized patients.

All the Canadian research into acute drug overdoses has shown that psychotropics, especially benzodiazepines, were the most commonly used products. There is a highly significant correlation between the number of prescriptions of different drugs and their selection for overdose.

The elderly seem to be the group most likely to suffer adverse drug reaction. This may be a reflection of the decreased metabolism of drugs, or more likely, of the number of drugs they are prescribed. In one case 20 percent of hospital admissions to a geriatrics ward were the result of adverse drug reactions.

Fifteen to 30 percent of hospital patients were reported to have had adverse drug reactions. Adverse drug reactions, both in hospitals and in ambulatory settings, are probably greatly under-reported. The occurence of an adverse drug reaction does not necessarily imply inappropriate prescribing. Furthermore, these reactions cannot always be prevented by appropriate prescribing, but in adults 64 to 80 percent of reactions may be potentially avoidable without compromising any therapeutic benefit.

To improve physicians' prescribing the Medical Reform Group makes the following recommendations:

1. There is an acute need for additional research about all aspects of prescribing.
2. Drugs included in formularies should not only meet strict scientific criteria for efficacy, but they should be included in formularies only if there is a demonstratable need for them. This latter criteria may mean that only a limited number of drugs in any therapeutic class, for example the nonsteroidal anti-inflammatories or the benzodiazepines, would be listed in the formulary.
3. Medical students need to be made more critical in their evaluation of the claims of the pharmaceutical industry through courses in medical school.
4. The government in conjunction with the medical and pharmacy professions and other interested groups should develop both a low cost Canadian equivalent of the AMA Drug Evaluation book to replace the Compendium Of Pharmaceuticals and Specialties and a Canadian equivalent of The Medical Letter.
5. Pharmaceutical promotion needs to be much more stringently controlled than is now the case. The visits of detailers to hospitals should be regulated in line with policies adopted by some Swedish hospitals.
6. Since physicians in non fee-for-service settings appear to be better prescribers than those practising under the traditional method of payment there should be widespread encouragement by government of non fee-for-service practice settings.
7. Physicians practising in health service organizations should receive "prescribing incentive payments" similar to the ambulatory care ones currently offered. These payments would be made to HSO doctors whose per capita prescribing costs for Drug Benefit recipients were below the regional average costs.
8. The provincial government in cooperation with the medical and pharmacy professions and consumer groups should encourage and develop general practice formularies.
9. Physicians should receive quarterly reports comparing their prescribing for patients covered by the Drug Benefit Plan with the prescribing of other doctors in the same region and with all doctors in the province.
10. Funding should be made available for the training and hiring of drug educators to engage in face-to-face educational interventions on prescribing with Ontario doctors.

From a brief prepared for the MRG by Joel Lexchin

THE PSYCHIATRIC CARE OF DETAINEES

Held in Terms of Section 29 of the Internal Security Act of 1982

Dr. A.J. Lasich

Introduction

Direction 29 of Notice 877 of 1982 by the Minister of Law and Order reads:

"Detainees who show any inclination towards suicide or who become exceptionally depressive or morbid shall receive special attention. The assistance of a District Surgeon shall be obtained".

The Department of National Health and Population Development has advised that, when a District Surgeon feels that he is in doubt as to the handling of a specific case, he should consult a psychiatrist.

It is current practice that the contact person for the District Surgeon is the Professor/Chief Psychiatrist who can either undertake the consultation himself or who can nominate a senior registered psychiatrist experienced in forensic work to act as consultant.

Nature of Detention

Incorporated in the process of detention in terms of Section 29 (1) of the Internal Security Act are the following:

1. Isolation - strictly enforced by means of solitary confinement: The detainee is usually kept in a small room only slightly wider and longer than a bed. Adjoining this room is a much larger area used for exercising and providing ablution facilities. Solitary confinement may be carried out for a duration of 22-23 hours out of every 24 hours. The general surroundings are drab and totally lacking in stimulation. Both rooms may form part of a single unit.
2. Interrogation
3. Manipulation of daily existence to suit the needs of the captors.
4. Interaction with a specific person whose sole purpose is to obtain information in order to facilitate their investigations.
5. Methods to induce compliance
6. Development of a pathological bond with and dependency on the interrogator.

Detention thus constitutes total social isolation imposed upon a person against his will. The individual becomes a prisoner of conscience.

Of all the elements encountered by the detainee, solitary confinement causes the most damaging effect on his psychological apparatus.

The Initial Interview

The detainee having been referred to a psychiatrist is interviewed and a formal psychiatric assessment is carried out at the place of detention.

The interview has to be conducted in a suitable office (usually one used by the district surgeon) and in private.

Problems are encountered if the detainee has difficulty in communication because of language. The psychiatrist may then have to rely on the services of a policeman to interpret. The mechanism of referral, pre-existing conditions (type of imprisonment, development of psychological ill health) the involuntary nature of becoming a patient all operate to prevent the creation of a therapeutic alliance. The psychiatrist finds himself in a real dilemma as he has unwittingly become the dispenser of a service not arising from the normal practice of consultation-liaison psychiatry.

Management

Once the psychiatric assessment has been completed and a provisional diagnosis made the detainee is referred (on the advice of the psychiatrist) by the district surgeon to a psychiatrist in private practice who is of senior standing. This procedure has been adopted in the Durban area. Due to the nature of the psychiatric disorder, the detainee is transferred to a hospital where a further assessment is made and treatment can be carried out in an environment beneficial to the detainee's expected recovery.

Issues of Concern

1. Psychiatrists are called upon to treat patients suffering from the consequences of detention within the context of the patient possibly returning to such harmful circumstances if treatment is successful. Psychiatrists would thereby be preparing their patients for further detention.
2. Lack of appropriate facilities for management within detention situations and the apparent contradiction between the aims of the detaining authorities - to stress the detainee in order to obtain information - and the aims of the caring professional - to aid the patient to regain personal and psychological control - militate against the possibility of providing appropriate care in such a situation.

Types of Conditions encountered

During the period 1980 - 1985 a total of 22 detainees were referred for psychiatric care in the Durban area, Over 50% of cases were diagnosed as suffering from a depressive disorder. Other conditions dealt with were Post Traumatic Stress Disorder, Brief Reactive Psychosis, Anxiety State, Psychosomatic Disorder and Schizophrenia.

Sex distribution showed a predominance of males i.e. 20 men as opposed to 2 women. Of the cases referred 16 were African and 6 Indian. Interestingly, none were considered to be simulating a psychiatric disorder.

The findings are in keeping with the experiences of other professionals dealing with the care of persons detained in solitary confinement.

Conclusion

There is no doubt that the situation of detention constitutes a psychosocial stressor that is beyond the range of normal human experience. Many of the practices allegedly involved in the implementation of Section 29 should be considered as torture (and this includes isolation). It should be remembered that participation in caring for our fellowman is these circumstances contravenes some essential ethical principles (Declaration of Tokyo 1975). Therefore no detainee once he has been under psychiatric care can be considered able to return to detention. The psychiatist is bound to effectively treat and prevent the relapse of the mentally disordered and health workers would be failing in their duty if they did not provide a powerful and active opposition to the existence of such conditions that lead to mental breakdown. Detention of children in particular should be condemned as the isolation of a child can only be viewed as the ultimate in cruelty. Such an experience can have lasting psychologically damaging effects for the child.

From the National Medical and Dental Association of South Africa (NAMDA), Conference Proceedings of Conference on Health and Human Rights, January 1986, held at the Medical School in Durban, South Africa.

Could free-trade deal lead to bottom-line medicine?

THE GLOBE AND MAIL, THURSDAY, DECEMBER 1, 1988

BY JACK MICAY
Dr. Micay is a Toronto physician and a member of the Medical Reform Group.

DOCTORS IN the United States perceive their prestige and power slipping away, and many are quitting independent private practice to take salaried health-care jobs.

The U.S. phenomenon has yet to be fully recognized in Canada, even by the medical profession, whose members still speak of moving south to greener pastures to counter further government intrusion into the practice of medicine. But with free trade coming, it is important to understand what the ramifications to doctors and patients would be should U.S. entrepreneurial health care infiltrate Canada's system of medicare.

Dr. Roberta Berrien is the kind of physician patients adore — warm and caring, and who takes time to listen. She established a family practice with a colleague in a small town in western Massachusetts. The practice prospered, yet she could practice unrushed medicine in the rural setting where she wanted to raise her family.

But in 1985 her partner quit to take a salaried position at a veterans hospital. A year later his replacement quit to take a clinic job. Unable to entice another partner into private practice, she began to consider a salaried position herself.

What happened? Dr. Berrien's practice got caught in the wave of change that has swept across the U.S. medical landscape, transforming it from a system of independent practitioners responsible only to themselves and their patients, into what Dr. Arnold Relman, editor of the New England Journal of Medicine, has labelled "the medical-industrial complex."

About one-third of all U.S. physicians are now on salary to private health-care enterprises, and the trend will grow. About half of all doctors under 36 are now employees and few of those now in training expect to be in private practice when they graduate.

This shift has major implications for the doctor-patient relationship. As employees, doctors must give their primary loyalty to their employer. What happens when the patient's interest in the best possible treatment conflicts with the health-care company's interest in cutting costs?

Until the 1980s, this sort of dilemma rarely came up. Medical practice was in some ways similar to what now exists in Canada — self-employed doctors working out of their own offices and community-owned hospitals and answerable only to themselves and their patients. Aside from the unpleasant aspect of turning away patients who had no insurance or money, the main difference from the doctor's point of view was in the bookkeeping.

In the absence of a universal health plan, U.S. doctors billed either the patient or a private insurance plan such as Blue Cross/Blue Shield, or Medicare (the government health plan for senior citizens) or Medicaid (a stingier government plan for the poor). Doctors set their own fees and decided what procedures they would order. They manned the levers of the system.

What upset the equilibrium was runaway medical inflation. The U.S. and Canadian responses to spiralling health costs reflect the difference between a privately and a publicly controlled medical system. In 1971, just after medicare was introduced in Canada, both countries spent about 7 per cent of their gross national product on health care. In Canada, with government regulation of health expenditures, that figure has since risen to 8.6 per cent. In the United States, where there is no government purchasing agent to negotiate doctors' fees, set hospital budgets and capital expenditures, medical costs have shot up to 11.4 per cent of GNP and are rising.

The United States turned to competition in hopes that the marketplace would find a way to keep a lid on costs.

President Richard Nixon's administration in the early 1970s had helped sponsor health-maintenance organizations, or HMOs, which work on a capitation principle — subscribers pay a fixed premium to the HMO, which provides services, usually in its own facilities using its own salaried doctors, or in subcontracted facilities using subcontracting doctors. Unlike fee-for-service, which rewards greater utilization and which still predominates in Canada, the HMO capitation system provides a built-in incentive to reduce services and thereby increase profits.

The idea caught on and was given even greater impetus during the Ronald Reagan administration, which slashed spending on health care and positively purred at the mention of "competition." The HMO movement has tripled in the past decade — 31 million Americans are now enrolled with 479 different organizations.

As well as signing on individual families, HMOs caught the eye of the major purchasers of health care — big corporations that provide it for their workers, and insurance companies. These companies saw HMOs as a great way to cut costs. Using their tremendous bargaining clout, the big purchasers began to shop around for the best deals. They demanded discounts and started a price war among health-care providers.

Private doctors, who couldn't match the competition's prices, started losing patients. Many were forced to take jobs or sign on as subcontractors with HMOs (and the alphabet soup of other pre-paid ventures such as PPOs and IPAs, for preferred provider organizations and independent practitioner associations).

Other doctors quit private practice to join the payroll of the other side of the medical-industrial complex — the five large hospital chains, such as Humana and Hospital Corp. of America, which have sprung up in the past two decades and grown fat from Medicare and Medicaid under the old cost-plus billing system.

These companies expanded voraciously and now own or manage more than 150,000 U.S. hospital beds. They were the darlings of Wall Street, which capitalized them into an overbuilding spree. Now, with an excess of beds, falling hospitalization rates because of HMOs and with Medicare's prospective new method of payment (which pays a hospital a fixed amount based on diagnosis) all cutting into their profits, these companies have entered the fray of the HMO market.

It is bottom-line medicine. To maintain investor interest, HMOs are expanding their capitalization and muscling into new territories. Advertising and price wars have broken out and a number of HMOs have gone broke.

HMOs and hospital corporations now call the shots — they dictate to doctors how much they can charge, which hospitals they can work in, what patients they can see, and sometimes how to treat them.

For Dr. Berrien, after 10 years in practice, the financial and personal rewards were shrinking. Her expenses, especially malpractice premiums, were going up and the fees she was paid by insurance plans were going down. She was unable to compensate by extra-billing her patients; even if they were willing to go along (which is unlikely in today's buyers' market), most of the plans prohibit or restrict it.

And Dr. Berrien found it harder to collect the fees she submitted to the health plans. Many were challenged or rejected; sometimes she waited for more than a year to be paid. Like many U.S. doctors, she is seeing her income decline. In 1983, she earned $68,000 before taxes; the 1985 figure was $62,500.

There are other frustrations. New rules to cut costs mean that either doctors cannot order the services their patients require or they must first get them approved by a budget manager at the health plan. Lawsuits for malpractice are growing worse, pushing doctors to practice "defensive medicine." They are pressured by

review committees to discharge their patients from hospital as soon as possible; cutbacks mean there are no home-treatment services to take up the slack.

"There is a loss of control," says Dr. Berrien. "You are asked to do things you can't do right any more. This is sometimes hard for the public to understand, and the disappointed patient is then angry at me."

A year and a half ago, she poured her frustrations into an article in a medical journal. She received more than 100 replies with similar stories to tell. One doctor wrote: "There is no solution; either you get out or be slowly eaten away."

Not long afterward, Dr. Berrien did get out. She reluctantly took a job with the student health service at the University of Maine. She still worries about her old patients, especially those in nursing homes who cannot find any local doctors to look after them. HMOs prefer healthier, more lucrative patients.

Like many U.S. physicians, she is now advising her children against going into medicine. Medical schools in the United States have more than doubled their output in the past 20 years, but now there is a major decline in applications (a drop of one-third since 1974). It has never been easier to get into medical school. Some universities now have marketing plans.

Organizations such as the American Medical Association still cling to an outdated concept of free-enterprise medicine in which care is provided by independent professionals and government is the enemy. They have not yet understood that the unfettered commercialism of a competitive system is far more destructive of doctors' freedom than the alternative of government regulation.

Among their embattled members on the front lines, however, there has been increasing curiosity about why Canada's system works so well at keeping costs down without sacrificing patient access or physician autonomy.

Perhaps there will be a medical migration across the border, but the direction will more likely be north than south.

Legalize midwifery, groups urge

EDMONTON (CP) — Two groups have started a campaign to have midwifery made legal in Alberta.

Letters asking for support have been sent to Health Minister Nancy Betkowski and members of the legislature by the Alberta Midwifery Task Force, an organization open to anyone who wants to see the role of midwives in Alberta made legal.

Sheila Harvey, president of the Alberta Association of Midwives, said her self-governing organization, which would represent midwives if they were legal, is launching its own letter-writing campaign.

The association wants "to make the government aware of the number of Albertans interested in legalizing midwifery," Harvey said.

She said midwives have become synonymous with home births in Alberta because "the only way midwives have been able to practise is in the home and outside the law."

In hospitals

She said the two associations are not necessarily advocating midwives be legal just to practise in the home.

"We want to see registered midwives with proper qualifications integrated into the health-care system and hospitals."

Canada is the only industrialized country not to have some provision for midwives in its health-care system, Harvey said.

Dr. Fawzy Morcos, an obstetrician in Edmonton, said a recent 14-month pilot project at the city's Misericordia hospital found midwives could be easily introduced into Alberta hospitals.

The study found women who had midwives with them through labor and delivery needed less sedation, had fewer difficult deliveries and stayed a shorter period in hospital after birth, he said.

"There is a role for midwives in hospitals to augment the role of the specialist," Morcos said. "But I have to convince my colleagues, with the biggest problem being family physicians, who feel threatened by midwives because they both handle low-risk cases."

Toronto Star, Nov. 26, 1988

Epp is criticized for veto of research using fetuses

BY DOROTHY LIPOVENKO
Globe and Mail, Nov. 23, 1988
OTTAWA

Federal Health Minister Jake Epp "was dead wrong" in refusing to continue financing medical research that uses aborted fetal tissue, a British Columbia ethicist said yesterday.

Professor E. H. Kluge, a member of a provincially appointed ethics advisory panel in British Columbia, told a meeting of Canadian ethicists in Ottawa that Mr. Epp had not been ethically correct in announcing earlier this year that he would no longer finance medical research that used tissue obtained from hospital abortions.

"It's premature and rash to say we may not use embryonic tissue because it is embryonic tissue or because of the way it was obtained," said Prof. Kluge, of the University of Victoria philosophy department.

The financing issue was raised last summer when it was disclosed that researchers at Dalhousie University wanted to use brain tissue obtained from hospital abortions for transplants into the brains of patients with Parkinson's disease.

The Dalhousie research team wanted to transplant brain tissue obtained from fetuses aborted in the first trimester of pregnancy. The transplants were to have been performed on up to 10 people with Parkinson's disease in the hope that the cells would continue to produce dopamine, a chemical that helps the brain control motor movement, but which people with Parkinson's have stopped producing.

At the time, Mr. Epp said he would not use federal research funds if the transplant tissue were obtained from women who had had abortions in hospital. He said he would only condone the use of fetal tissue for transplant purposes if it were obtained from women who had had miscarriages.

"For Mr. Epp to come along and say it is unethical to use embryonic or fetal tissue (from a pregnancy termination other than miscarriage) is to prejudge the whole issue," Prof. Kluge said in an interview. "You haven't got a person yet, so how can you be unethical?"

Prof. Kluge suggested it is perfectly acceptable for transplant purposes to use tissue obtained from embryos aborted at seven to nine weeks, and from fetuses aborted at nine to twelve weeks' gestation because "they are not persons."

He said a person is someone who is aware or has the capacity to become aware, and the definition excludes a fetus younger than 20 weeks.

However, Prof. Kluge suggested that women whose abortions yielded fetal tissue for medical transplants should have some say in what researchers did with the discarded tissue.

Soaring health costs are about to torpedo U.S. corporate profits

Louis Rukeyser

NEW YORK — The rapidly accelerating cost of health care for older Americans has become a torpedo hurtling toward the profits of U.S. corporations.

And it may hit as early as 1989.

The first ripple on the water has just been spotted. LTV Corp. took a whopping $2.26 billion (U.S.) charge to set up a reserve against insurance benefits for current and retired employees. Heads snapped throughout the business community, but they ain't see nothing yet.

Insurance executives in the health-care field say that unfunded liabilities for post-retirement health benefits — money that is promised but not actually available — could run as high as $2 trillion.

We're talking in the neighborhood of the national American debt, and the scariest part is that that figure would come right off the corporate bottom line.

Who launched this monster torpedo? Part of the problem is the escalating cost of health care generally, a burden that leaves the government at least as unprepared as private industry.

Another part is the boardroom failure to give the problem sufficient priority, by prefunding health-care insurance for the nation's graying population.

Recording costs

The Financial Accounting Standards Board, which promulgates rules for U.S. accountants, has issued a set of interim regulations that, if made permanent in late 1989, would require corporations to record unfunded health-care charges as a liability on the corporate balance sheet.

Even relatively conservative estimates speculate that if the board's change goes through, corporate profits could be reduced by 25 per cent and the net worth of U.S. businesses slashed by at least $1 trillion.

The size of the problem, then, is clearly enormous — and growing. Already, 6.9 million retired American workers and their dependents receive some health-care coverage from former employers.

More are being added every day as the work force grows older, the cost of long-term care expands and the savings of retired Americans become ever less adequate.

A study conducted by Northwestern Life Insurance Co. of Minneapolis shows that new retirees are using health-care services at a rate 11 per cent higher than their counterparts a decade ago, even after adjusting for inflation. And Medicare, of course, does not foot that entire bill.

So, whether one sees the accounting standards board's action as an unwarranted intrusion into corporate finance, or simply as an effort to make executives publicly face facts, it plainly has made urgent a problem that, in any event, is not about to disappear.

Reluctant employers

As Northwestern's senior vice-president, Michael Conley, put it:

"Understandably, many employers are reluctant to assume the huge cost of retiree health care, particularly long-term care. But if employers don't act on their own, Congress almost certainly will mandate new obligations, much as it has done in the areas of pension and health care for active and terminated employees."

What's the solution? Conley suggested four:

- ☐ Congress should permit corporations a tax-free transfer of excess pension funds (which would create a significant asset for many firms) to underfunded retiree health-care accounts.
- ☐ New tax incentives should encourage employer contributions by putting retiree health coverage on a par with pension plans.
- ☐ Employer programs to rehabilitate disabled workers would save firms money in the long run, as much as $30 for each $1 spent.
- ☐ The U.S. must turn to "creative and affordable" vehicles to encourage workers to start saving early for retirement.

Ironically, the evolving situation is one more evidence that the 1986 tax "reform" may have fostered as many problems as it solved.

Toronto Star, Nov. 26, 1988

Drug patent law under opposition fire

By Janice Turner
Toronto Star

Canada's revised drug patent law is less than a year old, but already its future is in doubt.

If the Liberals or New Democrats formed a minority government or held the balance of power, there would be significant changes to the legislation, party spokesmen say.

The New Democrats say they would scrap the revisions to the Patent Act, which were made last year, while the Liberals insist they must be given "teeth".

Both parties waged lengthy battles against the changes, which provide seven to 10 years of monopoly marketing rights to patent-holding companies.

Critics contend largely foreign-based drug manufacturers are permitted to make enormous profits at the expense of Canadian consumers and taxpayers.

The Progressive Conservatives maintain a price review board will control drug costs and warn that tampering with the law will threaten badly needed pharmaceutical research and development jobs.

Brand-name producers have promised to double their research investment to 10 oer cent of sales by 1996, a projected $1.4 billion increase, and to create 3,000 high quality research jobs.

The Pharmaceutical Manufacturers Association of Canada, the patent-holders' group, points out that as of last month, 26 of its 69 member companies had already announced plans for expanded research and development worth almost $1 billion.

"We believe that the law was part of (Prime Minister Brian) Mulroney's free trade deal so we don't see any reason to keep it," says NDP consumer critic John Rodriguez. "We would go back to the way it was and work from there."

The Liberals say that at the very least they would amend the law to wrestle guarantees from the pharmaceutical companies that drug prices would not rise above the annual inflation rate and that part of the profits reaped from increased patent protection would be pegged to basic research.

Proclaimed last December, Bill C-22, as it is known, shields new brand-name drugs from lower-cost generic products for up to 10 years. It is retroactive to June, 1986.

New drugs come on to the market at a rate of about one a month.

Federal watchdog

The Patent Medicine Prices Review Board, the federal watchdog set up to monitor drug costs, is still collecting data, says Tom Brogan, director of compliance and liaison.

It is the board's job to decide whether Canadian drug prices are "excessive" and whether to call a public hearing into the matter.

The board has set as a "benchmark" prices in effect as of Dec. 7, 1987.

Liberal consumer critic Dave Dingwall says his party would, "as a minimum, immediately push for the Senate amendments (reluctantly withdrawn last November)."

Under those amendments:

☐ Monopoly rights would apply to drugs that came on to the market only after the legislation became law.

☐ Research and development commitments would be written directly into the bill and would have to be met by each brand-name company, rather than by the industry as a whole. Individual companies that did not live up to their commitments could lose all of their patent protection on all their drugs.

Dingwall says the Liberals would not hesitate to overhaul the review board if it failed to keep a lid on prices.

With the board not yet functioning, it's difficult to determine whether recent drug price increases, many higher than the inflation rate, can be blamed on the new law.

Patent-holding firms deny they hiked prices to give themselves a higher benchmark. For two decades, drug prices generally have risen faster than the consumer price index.

Percentage price increases alone can be misleading. A 20 per cent increase on a substantially lower-priced generic product may still put it at a far more attractive price that a brand-name alternative.

The government passed the legislation despite strong objections from health care providers, provincial governments, consumer groups and the Liberal-dominated Senate, which argued that reduced competition would send drug costs soaring.

The patent-holding drug firms maintain they needed a guaranteed period of monopoly sales to recoup enormous research costs and to spur the development of new drugs.

Since 1969, generic drug companies have been able to produce and sell copies of brand-name drugs at a fraction of the price, with the payment of a token 4 per cent royalty to the originating company.

Until then, Canada's prescription drug prices were among the highest in the world.

The Conservatives say the price review board will keep prices in check. But while the board can ask that future prices come down, it cannot order rebates.

'Fair' price

In addition to keeping tabs on price increases for existing drugs, the board also will have to determine what is a "fair" price for new drugs coming on stream.

Robert Kerton, University of Waterloo professor and economics adviser to the Consumers' Association of Canada, says the review board will have a tough time restricting the price of new drugs.

"You can enter with as high a price as you want," he says. "The message the law sends to the multinationals is, 'When you set your entry price in Canada, set it high.'"

The consumers' group also questions whether U.S.-based multinationals would tolerate the price review board or challenge it as a contravention of a free trade deal.

Nick Leluk, director of the Canadian Drug Manufacturers Association, representing 21 generic companies, says the law is a serious threat to the generic drug industry and the long-term health of provincial drug benefit plans.

Clinics providing 'front-line medicine'

MDs often reluctant to treat homeless

BY ANN SILVERSIDES
The Globe and Mail

On Tuesday afternoons, "Snoopy" sets up a small reception desk in a downtown Toronto drop-in centre and takes names of people who want to see the nurses.

Almost all the men and women on the volunteer receptionist's list are homeless — some spend their nights on the street, some sleep in hostels. Snoopy herself spent four years on the street before getting an apartment that was subsidized by the government.

The nurses whom the homeless are waiting to see are volunteers of Street Health, a community nursing organization that operates clinics in three downtown locations, including the Friendship Centre on Tuesday afternoons.

Street Health nurses see people with complaints ranging from skin rashes to respiratory problems. In addition to nursing care, they provide their clients with everything from clean socks and a new toothbrush to a referral to a doctor. The nurses see about 50 people a week in 18 hours of clinic time.

Health care provided by volunteers seems an anomaly in Canada, a country where medical care is "free" and considered a basic human right. But for the homeless and the destitute, those who live outside the mainstream, there are many barriers to the formal health-care system, said Dilin Baker, a co-founder of Street Health and one of the organization's seven nurses.

It takes about 45 minutes for Ms Baker to help Frank clean himself — he picks up lice in the hostels — and to treat and massage his feet and legs, which are covered with ulcers.

Frank, 67, has lived on the streets for more than three years. He talks about getting a room: "I'm fed up with this, I have to sleep on a hard floor and I get lice," he said matter-of-factly.

But Frank is frail; he can barely walk, has difficulty breathing and his hearing is bad. He goes to Street Health twice a week. Before the organization existed, he sometimes went to a hospital outpatient clinic for help with his leg problems.

"The whole reason we exist is the lack of affordable, secure housing," Ms Baker explains. "What we are doing is real Third World, front-line medicine."

In an information sheet to doctors, Street Health advises: "Think homeless when prescribing the drugs or recommending the treatment — think no bathroom, no sink, no tub, no privacy, no bed or quiet space."

Persuading doctors to treat the homeless — getting their clients hooked into the health-care mainstream so they have their own family doctor — is part of Street Health's mission. According to Ms Baker, it takes education on both sides.

"A lot of doctors in private practice are just not interested in seeing street people," she said in an interview. "I always hear that they don't see them in their waiting rooms. And often doctors are overwhelmed by the problems of the homeless."

Hospitals are not always the alternative, said George Barnhardt, a co-founder of Street Health and formerly a homeless status Indian who now sits on the organization's 12-member board of directors.

"Skid row people don't feel comfortable going to hospital emergency wards . . . and because they often smell, nurses and doctors don't want to spend time with them."

Ms Baker, Mr. Barnhardt and a core group of seven others established Street Health 3½ years ago to offer appropriate and preventive health care for the destitute.

Like a MASH unit, Street Health takes medical care to the people. It sets up portable clinics and, rough and ready, operates where it can. At the Friendship Centre, it sets up in the storage/pool room.

The success of Street Health in earning the trust of the homeless and helping them to help themselves is largely a question of turf, Mr. Barnhardt said in an interview at the Friendship Centre.

"This is their turf," he said, gesturing to the large room where people sit, singly or in groups, drinking 20-cent cups of coffee. "This is their home . . . it is not an 'us' versus 'them' attitude here."

Down at Dixon Hall, a men's shelter, Street Health sets up shop on Thursday nights in a cramped laundry room. Most of the men who come to see the nurses there work during the day. Many, for instance, deliver handbills for about $40 a day. But the work is not regular enough, and does not pay enough, for them to find more permanent housing.

A sign on the door of Dixon Hall advises men about Street Health: "Free, no OHIP necessary. Lots of TLC."

Tender loving care or, as Ms Baker says, respect and affection, are an important part of what Street Health has to offer. The nurses are informal, collegial and not the least bit officious.

"A lot of problems down here are not physical, but mental and emotional. Down here, you can get crushed emotionally. This really is a cold, lonely city," Mr. Barnhardt said.

Gail, 45, has turned to the nurses for help to pay for her prescription drugs — she lives on an alimony payment and, after rent and food, often has nothing left to put toward the more than $100 a month worth of drugs she must take for ulcers and a tremor.

She finds the nurses "emotionally supportive. . . . I'm not just another number to them."

To help clients get access to regular health care, Snoopy — she is known widely only by her nickname — helps people fill out applications for the Ontario Health Insurance Plan.

So far this year, Street Health has spent more than $8,000 on fees for documents that it helps people obtain. The organization subsidizes the application fees for birth certificates, a prerequisite for getting an OHIP number, and for social insurance cards, which people usually need to get jobs.

Street Health now receives financing from the Ministry of Housing ($20,000 this year), the City of Toronto ($42,000 this year to pay one full- and one part-time nurse) and private donations, Ms Baker said.

The Ministry of Health has not contributed to Street Health. In order to receive health dollars, Ms Baker said, the organization would have to forfeit its community control.