MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

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

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

Introduction to this issue

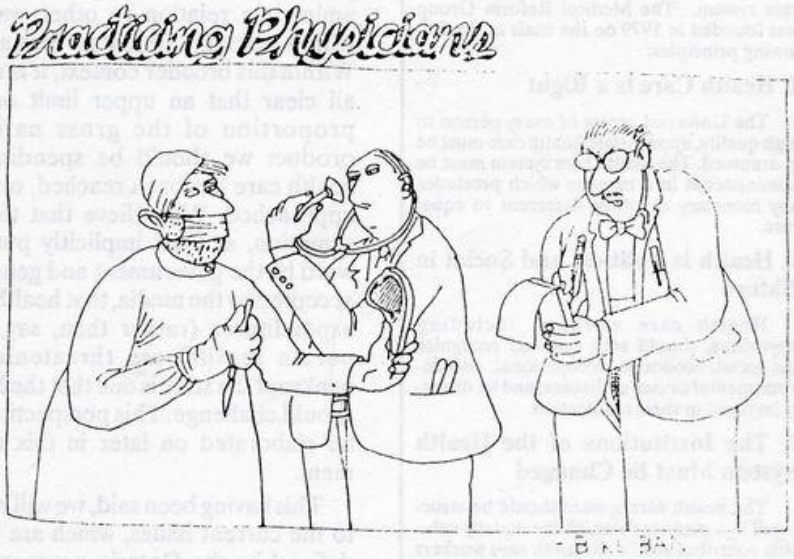
Anyone involved in medicine nowadays is aware of the profusion of articles dominated by the theme: "Health care costs are very/too high". We in the MRG have not yet directly confronted this issue. The priority was to fight for guaranteed access to care by attacking extra-billing. However another of our central principles has been an awareness of preventive strategies in health care. Because of this we have been well aware that the debate on health care costs was looming ever larger.

In this issue we carry two pieces relating to the sharpening of this debate within the MRG. The first can be taken as "retrospective" view, illustrating a common view among the MRG. It was taken from a speech by Mimi Divinsky representing the MRG. There have been no direct policy statements (measured by resolutions) embodying these views, nonetheless such views were and are current in the MRG. Under the increasing pressure of societal debate, a sub-committee charged with codifying views for the MRG was formed at the October 1988 MRG Semi-Annual meeting.This group has started its work and its' first thoughts are offered. It is hoped that direction will be given to the sub-committee by both the readership of Medical Reform, and by the Semi-Annual meeting of the MRG in May 1989. The sense of the article contained herein will be boiled into draft resolutions for the forthcoming Semi-Annual meeting. The topic of resource allocation is so central to any future health initiatives, that a consensus is developing that the MRG should have at least the bones of policy on this matter. It is a sensitive area, so it can be anticipated that the debate will be hot enough to indeed fuse together differing views into a policy.

You are invited to add your heat to the furnace.

Spring General Meeting

The Medical Reform Group's Spring General Meeting has been scheduled for Toronto for Friday May 5 and Saturday May 6. The main topic of the meeting will be Resource Allocation in Health Care. Details of the meeting's agenda will be announced in the next issue of Medical Reform.



Resource Allocation in Health and Health Care

A group of MRG members, including Donna Goldenberg, Gordon Guyatt, Haresh Kirpalani, Catherine Oliver, Andy Oxman, and Roseanne Pellizari have formed a "Resource Allocation Working Group." The following document comes out of our discussions. It briefly describes what we see as the current issues in resource allocation, and presents what we believe should be the cornerstone of the MRG's position on these issues. Resource allocation related to health and health care will be the major topic to which the spring semi-annual meeting will be devoted. We hope that the membership will consider the issues raised in this document, and this will lead to an important and exciting discussion at the meeting.

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 April 3, 1989. The deadline for longer articles is February 23; shorter items such as announcements must be in by March 13.

The subsequent issue will appear June 2, 1989. The deadline for longer articles for that issue is April 27; shorter items must be in by May 15.

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

Opinions expressed in Medical Reform are those of the writers, and not necessarily those of the Medical Reform Group of Ontario.

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

The Medical Reform Group of Ontario is an organization of physicians, medical students, and others concerned with the health care system. The Medical Reform Group was founded in 1979 on the basis of the following principles:

1. Health Care is a Right

The Universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary or other deterrent to equal care.

2. Health is Political and Social in Nature

Health care workers, including physicians, should seek out and recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication.

3. The Institutions of the Health System Must Be Changed

The health care system should be structured in a manner in which the equally valuable contributions of all health care workers in recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

Current Issues

We feel that there are a number of issues related to resource allocation in the Ontario health care system which are currently receiving a great deal of attention, and are likely to continue to receive attention for some time. These issues arise from the general perception that a lot of money is being spent on health care, and that the pressure for increased spending in the future will be great. More particularly, they follow from the apparent resolve of the Ontario Ministry of Health and the Liberal government to limit health care spending.

We recognize that health care expenditures cannot be unconstrained, and that efficient expenditure of resources within the health care system is important. At the same time, we do not accept the premise that there is a crisis in health care expenditures. Expenditures on health care must be examined in relation to other ways in which society allocates resources. Within this broader context, it is not at all clear that an upper limit on the proportion of the gross national product we should be spending on health care has been reached, or even approached. We believe that the assumption, at least implicitly put forward by the government and generally accepted by the media, that health care expenditures (rather than, say, corporate profits) are threatening to bankrupt the state is one that the MRG should challenge. This perspective will be elaborated on later in this document.

This having been said, we will return to the current issues, which are being defined by the Ontario government's agenda. We perceive that the Liberal government has been making, and will continue to make the following points:

- cost containment in health care is a priority
- there are too many doctors in the province
- hospital spending must be restrained
- doctors are engaging in irresponsible clinical practices which are generating unnecessary costs
- new technologies (such as lithotripsy) should be withheld from hospital that want them
- salaries should increasingly be looked to as a method for physician reimbursement

Ontario physicians, as represented by the Ontario Medical Association, are likely to respond to the pressures from the government with the following positions:

- the government is wrong about the excess of doctors
- the government is scapegoating doctors who are in fact practising responsibly and not generating excess costs
- costs can be constrained by user fees
- extra money can be generated by user fees (the internal contradiction between these last two points will not deter the O.M.A. from using both arguments
- high quality medical care demands the acquisition of new technologies
- fee-for-service should continue to be the major mechanism of physician reimbursement

Though the government and the O.M.A. are the apparent major protagonists in the struggle, the role of large corporations should be noted. In general, the perception of health-care spending being out of control and requiring reining in could be seen as in the interests of such corporations, which might otherwise have to bear some of the costs of increased resources being allocated to health care. The exception would be corporations actually involved in the health care industry. Even these corporations could be seen as benefitting if response to the cost crisis is to shift costs from the public to the private sector. If the private sector were bearing a greater proportion of the costs, spending is less likely to be monitored or to raise con-

cern, and profits of the health care industry may actually increase.

It is in this setting, and cognizant of both the visible struggle and the forces and interests underlying the controversies, that we must develop our policies concerning resource allocation. The maximum likelihood of our positions receiving public exposure will be through responding to these controversies during times when they are highlighted by the media. In order to respond effectively, then, we must decide where we stand on these issues.

MRG's Response to Resource Allocation Issues

We believe our position should be based on the following four principles which we found very useful as a conceptual framework. These principles are presented in their order of importance:

1) **Equity** – Everyone should have equal opportunities to make use of available health care resources, and equal opportunity to live in an environment conducive to good health.

2) **Societal Perspective** – Taking a societal perspective has two major implications. First, that the roots of ill health can be found in political, economic, and social policies and situations. Therefore, health may be improved more by spending money to correct the roots of ill health (and thus spent outside of the health care system) than by spending within the system. Second, spending on health care should be examined within the context of total societal resource allocation. As we have implied in our introduction, it could then be argued that, given the way society currently allocates its resources, there is no crisis of health care costs at all. In other words (to use an extreme example) if money to be spent on nuclear submarines were diverted to health care, the cost crunch would be alleviated or eliminated.

Seen in this context, spending on even marginally effective therapies could be justified. That is, if an intervention does prolong or improve the quality of life, it is a more worthwhile allocation of resources than, for example, enhancing corporate profits.

3) **Effectiveness** – Health care diagnostic and therapeutic technologies should be supported only if they have been shown to improve outcome (i.e. the length and/or quality of life). The burden of proof to establish this benefit should be on those lobbying for the acquisition or dissemination of expensive technologies.

Consideration of quality of life outcomes implies a "humanist" perspective that may outweigh considerations of "cost-effectiveness" (when effectiveness is narrowly defined). An example would be allocation of health care resources to the elderly.

4) **Efficiency** – The efficient distribution of resources (maximizing cost effectiveness) within the health care system should be one goal of the system. This was seen as very definitely the bottom of the list in terms of the four principles.

In the final part of the discussion, we provide examples of how these principles could be brought to bear on the current issues regarding health care delivery in Ontario.

1) **Equity** – We would continue to oppose any proposal, like user fees, which would compromise equity. We would support proposals, like selective allocation of resources to the economically disadvantaged, or to the socially or physically disadvantaged, that would improve equity.

2) **Societal Perspective** – In general, we would lobby for allocation of resources in ways that would improve health outcomes, and against allocation of resources in ways that would have adverse health consequences. This would be true both in and outside of the health care delivery system. There are a number of specific areas in which the MRG could lobby on the basis of the health consequences of societal decisions regarding resource allocation. Examples include the following:

a) Support for the tobacco farmers: we might support allocation of funds for switching over from growing tobacco to other crops.

b) Social programs which would improve health: we might support programs which would deal more effectively with homelessness, and with domestic violence and its consequences. We could suggest that the health costs of unemployment be factored in when the decisions concerning employment subsidies, job creation schemes, and the like are considered.

c) Road traffic accidents: we might support changes in the transport policy that would decrease the number of civilian casualties in highway wars.

d) Alcohol: we might support policies that would decrease alcohol consumption, and the consequent deleterious health effects.

e) Occupational health: we might emphasize stands we have already taken in support of a safer work place.

f) Nutrition: we might support policies that would encourage the production and consumption of healthier foods.

Conceivably, we might prepare a yearly commentary on the provincial budget from the point of view of its impact on the health of the people of Ontario, in terms of issues such as those raised above.

3) **Effectiveness** – We could speak against allocation of resources to any new technology in which evidence of improved outcome was not available. This would clearly mean knowledge of the evidence regarding the issue about which we spoke.

4) **Efficiency** – While we would certainly support an efficient allocation of resources within the health care system, we recognize that there is currently a danger in so doing. The reason is that, because of the atmosphere of general assault on health care spending, money saved on health care spending is unlikely to be spent on other more cost-effective (in terms of improving health) social programs. Nevertheless, there will be instances in which the MRG will want to speak in favour of efficient allocation of health care resources. One might be expenditure on the development of new pharmaceutical agents which achieve little incremental advantage over existing agents (so called "me too" drugs). Another might be expenditures on sophisticated imaging technologies in which effect on health outcomes is likely to be minimal. Whenever such statements are made, we feel that it is crucial to emphasize the areas to which the money saved should be allocated. Such areas might include:

- home care for the elderly (despite its cost-ineffectiveness)
- palliative care
- shelter for battered wives
- social, environmental, and nutritional intervention in pre-natal care
- occupational health
- family planning clinics
- mammographic screening in 50 to 60 year old women
- dental care
- care for the chronically psychiatrically ill
- chronic care facilities for the handicapped

We believe issues of resource allocation will determine the future of health care in Ontario. The MRG must take part in what is certain to be a heated debate. Clearly, we hope the membership will in general endorse the principles we have outlined. Most certainly, we hope these principles will be given thought and consideration, and useful alternatives or modifications will be raised.

Under-Funding or Resource Allocation?

By Mimi Divinsky

There seems to be persisting conflicting claims that on the one hand, the health care system is underfunded and, on the other, that we must decrease health care costs. By comparison with the US they spend a greater percentage of their GNP on health care than we do (10.5% compared to our 8.5%). The Canadian Medical Association in order to address this issue, funded an independent Task Force Study in 1984 (around the time that the Canada Health Act was being introduced.) The Task Force has a great deal of credibility I think, because of its independent nature and significant consumer in-put. It failed to support the claims of the Canadian Medical Association that our health care system is "dangerously underfunded". (p.105) To say that it is, we must prove that spending more money will produce an improvement in health status *and* that the improvement is greater than that achieved by spending the money in some other way – i.e. on affordable housing, road-blocks to detect intoxicated drivers, pollution control, etc.

If you decide to argue that we must decrease costs, the focus is on hospitals which account for 40-50% of health costs. Hospitals have instituted cost-saving programs such as Day Surgery and pre-admission out-patient testing (the Victoria General in B.C. reports a decrease of 1 day of hospital stay per patient) with no adverse effect on patient care or outcome. The Medical Reform Group has, since its inception in 1979, supported the establishment of Community Health Centres which have been shown to decrease hospital utilization by about 20% (Ontario Economic Council Occasional Paper 13 on C.H.C.'s and Hospital Costs in Ontario, M.L. Barer, 1981, p.164) compared with private physicians caring for comparable patient populations. There is not as convincing evidence for their effect on decreasing costs – apparently about 5-8% reduction only, but one may still consider this to be a significant reduction and contend that there are other non-budgetary benefits of CHC's re health care, community involvement, physician accountability, alternative patterns of practice, etc. One of the fundamental ideological platforms of the MRG is the acknowledgement of the contributions of other health care professionals. We are concerned that one of the results of professional "territory battles" has been the demise of the Nurse-practitioner programme which was shown to be cost-effective, safe, acceptable to patients, and according to a 1983 study, estimated a potential saving of approximately $300 million per year from the introduction and full utilization of nurse practitioners. (Denton et al, Socio-Economic Planning Sciences, 17(4), p. 199-209). Nurse-practitioners are no longer being trained in Ontario.

If you decide to argue that our system is *under*-funded, audiences of both physicians and consumers of health care will nod their heads when you mention hospital waiting-lists, shut-down of wards, nursing home and chronic care bed shortages, inadequacy of facilities for cancer patients, AIDS research and patient care, etc. The Privatization Study (October 1985, Health and Welfare Canada) and the Task Force both make the argument that the method of organization is more likely to be the main problem, and I quote:

> "Since there are no official statistics, it is not easy to assess waiting lists. They can be "alleviated" by the removal of certain structural rigidities in the exercise of hospital privileges by physicians, by regionalization of services, more appropriate utilization of health care institutions and by reducing average lengths of stay. ...Canada's hospital bed supply relative to population compares favourably with other countries ... The primary problems are many and may include unnecessary hospital admissions, excessive surgery rates, unnecessarily high lengths of stay, the rapid growth of physician supply, maldistribution of physicians, overuse of highly trained manpower, duplication of facilities and programs and the high emphasis on technology-intensive curative systems even when effective and less costly alternatives exist. The analyses suggest that the perceived "underfunding" is but a symptom of these basic problems and that what is needed is not a greater infusion of more funds, whether public or private, but significant restructuring and reorganizing of our health care priorities and delivery systems." (p. 108 TFStudy)

Even the cry for more nursing home beds is challenged. Canada has one of the highest rates of geriatric institutionalization of any industrial country – United States is 5.3%, United Kingdom is 5%, Australia is

5.9%, while we are 9.45%! Not only is it expensive, but it is not seen to be desirable. The Task Force which, in my mind, again gains credibility by being willing to say on certain issues "we don't know", makes a *very, very* strong statement about the care of Canada's elderly population:

> "Summary: Canada's elderly population has received too little attention in the past, and the health services available to them are inadequate. A major problem identified is that if we continue to put old people in institutions at the rate we do now, the costs will not only be prohibitive, we will perpetuate the callous practice of "warehousing" the elderly. Old people do not want to live in institutions.
>
> The evidence presented to the Task Force was overwhelmingly in favour of a new program of care of the elderly, which emphasizes independent and productive living at home. If the appropriate community support systems could be put in place, this is not only possible, but also cheaper.
>
> Population projections are presented in this chapter which demonstrate that indeed, the present policies and rates of institutionalization cannot continue. Not only would significant increases in operating budgets be required, but the necessary construction activity would be prohibitive. The projections also show that there will be a greater increase in the numbers of elderly in the next twenty years than in the first twenty years of the next century. This issue is therefore with us now, and cannot be postponed. The planning period for provincial governments is also, therefore, relatively short." (p.37)

As well, the Task Force acknowledged that old-age homes run for profit compare *un*favourably with non-profit ones as regards standards of care, food, rehabilitation, recreation, compassion and palliative care, and they give special mention to Baycrest Centre, here in Toronto, as an example of how things can be done.

The study on Privatization (Stoddard and Labelle, Health and Welfare Canada, October/85) also dispels the myth that private industry does a better job:

> "First, it seems highly relevant to remind ourselves that greater public involvement has occurred over time in all health care systens *precisely because* of the failure of private mechanisms to achieve equity or efficiency (or both) in the delivery of health care, even though such mechanisms may produce and allocate other commodities in ways society finds acceptable. Therefore, commonly heard assertions to the effect that 'there are problems in the health care sector because government is involved' demonstrate a dangerous ignorance of history as well as economics. The reverse statement would be more factual." (p.64)

Once again, the MRG maintains that the profit-motive is highly inappropriate as regards the commodity, health-care.

If we have concluded that the problem is one of "where do we spend our money?" then the issue of allocating more money to preventive medicine arises. There is, for some, as much deep faith in the value of preventive medicine as there is, for others, in the wonderfulness of medical technology. Obvious medical advances such as vaccination – ridding the world of smallpox, insulin giving years of life to diabetics, don't require expensive random, double-blind control trials to prove their efficacy. But many proposed medical treatments are not, at first, so obviously beneficial and we have learned (or have we?) to be more cautious about intervening with our wonder drugs and miracle cures before they are proven to be harmless, at the least. I think it's very important to realize that proposed 'preventive or alternative' cures should be subject to the same scrutiny and criticism. It is only intellectually honest to admit that for so many 'unorthodox' or alternative treatments there is just no evidence to support their claims of positive effect. It took us a long time to realize the power of the placebo effect - that is, if you believe something is going to work, it will, about 40% of the time.

From a medical-ethical point of view there are strict criteria for the implementation of what we call a valid screening test – a test that promises to pick up disease at an early or pre-symptomatic stage that allows for a different outcome because of early intervention. It has to be proven to be accurate, non-invasive (i.e. no significant side-effects), acceptable to patients, and of reasonable cost. Controversy still rages about mammograms and stool-testing for microscopic blood. Is cancer detected earlier or do false positives and equivocal results subject lots of normal healthy people to more invasive testing and its consequences? It is a bit disillusioning to discover that there are very few preventive medical procedures that satisfy these requirements – the Pap smear is one of them. If you are a woman who has ever had viginal intercourse, please, please don't forget to have an annual Pap smear!

If we ask the big question "what do people die of and how can we prevent it?" it is shocking but true that "self-destructive behaviour is the major killer of our society" – alcohol, smoking, drugs, accidents and suicide are responsible for the vast majority of life-years lost. (Not main causes of death over-all necessarily, but 'deprivers of full life'.) If we are concerned about the quality of life it is heartening to learn that public education programs about the effects of smoking, driving with alcohol, seatbelts, etc. do have an effect. The impetus for these programmes is just as likely to be social and political in origin as medical, and consumer participation is crucial in calling attention to neglected areas of concern and demanding that research time and money be re-directed. I think that the medical profession acknowledges its limitations to the extent that it's willing to share the responsibility for the health care of its community. It's always exciting for me to be involved in medical public education. Thank you for giving me the opportunity to speak.

This was a speech to a public forum on health care issues in Toronto at the time of the doctors' strike in 1986.

Medical Malpractice and Redress of Grievances by Law

In a recently concluded and lengthy case, a family sued for damages believing their child's severe neurological deficits to be the result of a pertussis vaccination reaction. The judge, Mr. Justice Osler, ruled against their claim, holding that liability had not been proven against the defendants. However, he endorsed the need for financial compensation for the family. He suggested that the solution to this type of dilemma would be a No Fault Insurance scheme, thus removing renumeration from difficult and ultimately bitter litigation.

In so ruling, the Judge reflects an increasingly common point of view.

The MRG has not yet taken a stance on medical malpractice. Yet it is an issue that inflames passions of physicians, patients, and lawyers. A Federal Committee has been struck, known as the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care. The MRG Steering Committee was asked by the Chairman of this committee, Dean Pritchard (of Law at University of Toronto) for comments on the general problem.

The Chairman's written views on the question were presented to the Steering Committee. It serves as an excellent summary of some possible reforms, and is extracted below.

The Review of Liability and Compenation Issues in Health Care

Address to the Medico-Legal Society of Toronto, February 24, 1988, by J.R.S. Prichard.

A. REFERENCE TERMS

The terms of reference for the Review Committee set out the scope of our task. The mandate is described as follows:

1. To examine and report on the issues relating to liability and compensation matters associated with health care delivery provided by professionals, institutions, voluntary organizations and the Canadian Blood Supply System;

2. To advise on possible legal reforms designed to ameliorate the cost of liability claims on the Canadian public health care system; and

3. To advise on the possibility of alternative mechanisms to litigation for persons who have become disabled following injury occurring during the provision of health care.

The terms of reference also include three specific tasks, namely:

1. To examine and report information, statistics and trends on liability and compensation matters in health care;

2. To examine and evaluate the current process for establishing liability compensation; and

3. To examine and evaluate alternative ways for establishing liability or need for compensation.

The terms of reference do not include...liability and compensation issues associated with vaccines, pharmaceuticals and other health care products with the exception of blood. With respect to vaccines there is already an accelerated policy process being conducted by the Conference of Deputy Ministers.

My sense is that the exercise was motivated by a combination of factors which would include public expressions of concern by the CMA and leading members of the medical profession, concerns by governments about the growing cost of malpractice litigation and consequent demands for financial adjustments by physicians and hospitals, and a worry that in light of American experience there is little reason to be confident that the pressures of the mid-1990's represent a high water mark...

We have initiated a research plan...with four principal components:

First... a substantial empirical study intended to identify the scope and **growth of liability** in the health care system with principal attention being paid to the liability of physicians and hospitals.

Second, a preliminary assessment of **the effect of civil liability** in the health care system **on the quality and availability of health care services.** In particular, we are trying to trace the major causal relationships between liability and the behavioural responses of various professionals and institutions in the health care system...research will focus on three case studies with the expectation that a detailed examination in selected areas of health care (obstetrics, anaesthesia and family practice) will be more productive than a general study.

Third, we will... assess the current operation of the liability system in both civil and common law as it affects individuals suffering medical maloccurrences. Possible reforms of the liability system and possible alternatives will also be examined.

Finally, fourth, we have initiated a separate research project on the Canadian Blood Supply System which is specifically mentioned in the terms of reference as a problem worthy of particular and distinctive attention.

B. BURDEN AND EFFECTS OF LITIGATION IN CANADA

Perhaps the most striking lesson that has emerged so far is how little we know about why change occurs in the legal system and what the effects of these changes are. While there is now relatively firm empirical evidence of the growth of malpractice claims in both Canada and the United States, there is very little available by way of convincing explanation as to why there

have been such substantial increases in litigation activity, and why these increases have occurred at this particular time.

While one can point to a variety of features of the American legal system which explain why malpractice litigation is at a higher level than in Canada, there are no robust explanations as to why there have been such sharp increases both in the mid-1970's and now in the 1980's.

Similarly, we now know that there has been an important upswing in medical malpractice litigation in Canada over the past 15 years, whether measured by the number of writs, the number of trials, the number of cases settled, the total number of claims paid, the total dollars paid out in claims or total membership fees paid to the CMPA. Futhermore...the rates of increase in litigation have been well in excess of the increase in the number of physicians in Canada and that the increase in dollar payouts substantially exceed the rate of increase of expenditures on medical care...we have very little by the way of reliable explanation as to why these changes have occurred and why they occurred when they did.

There is equally high uncertainty with respect to the impact of changes in liability on the behaviour of health care professionals and institutions. The empirical evidence in support of any claims about the causal relationship between liability and the quality of health care is modest indeed...

C. POSSIBLE REFORMS

I want to turn to a brief overview of possible legal responses to the current dilemmas surrounding liability and compensation issues in the health care system.

Let me begin with a proposition that is so simple that it may appear trivial, but is in fact absolutely central to all debates about medical malpractice. The single most important goal of the health care system must be to reduce the frequency of incidents giving rise to medical maloccurrences. This, more than anything else, will contain the problem of medical malpractice litigation. As the United States Government Accounting Office in its recent report stated: "Eliminating to the extent possible the conditions that lead to malpractice is the ideal way to deal with the problem of increasing insurance cost. Doing this requires aggressive action... by the providers of health care, primarily physicians and hospitals." While perhaps trite, this is a truth that should not be forgotten. Patients and health care providers have a common interest in reducing the rate of injury and any scheme of compensation, whether fault or nonfault based, will always be a second best response to the residual injuries which still occur despite a primary emphasis on accident avoidance.

To place this emphasis on minimizing the frequency of medical maloccurrences does not, however, permit us to avoid difficult questions about **which set of legal rules is most likely to encourage the reduction of medical injuries and which legal regime should govern the provision of compensation** in response to those injuries that are not avoided...Many commentators believe that some change in the current regime of negligence-based liability administered through courts in the adversarial system is required. Where disagreement begins is in identifying the most promising direction of change, and the magnitude of the changes that are required.

Possible avenues of legal reform can be divided roughly into four categories and arranged along a spectrum from relatively modest change at the end to substantial revision of the applicable legal rules at the other.

The first avenue of reform is to focus on changes within the tort system, at least as it apples to medical malpractice litigation. The catalogue of possible tort reforms is well known to lawyers. While the details vary from province to province, it includes restricting limitation periods, abrogating the collateral benefits rule, introducing periodic payments in lieu of lump sum awards, eliminating gross-up, restricting claims under the Ontario Family Law Act, altering the rules of joint and several liability, dampening the incentives for litigation, reducing the availability of legal aid, filtering out relatively less meritorious claims, eliminating OHIP's claim to a portion of the damages in Ontario, providing an evidentiary privilege to post-accident investigations and numerous other possible modifications.

Common to all these proposals is the belief that the negligence based liability system, despite its imperfections, represents the best possible compromise between the goals of creating appropriate incentives for the provision of high quality health care and providing fair treatment of persons suffering medical maloccurrences. While it is acknowledged that the system may fall short of the ideal in terms of both deterrence and compensation, its advocates argue that it comes closer than any other legal regime to defining an appropriate balance between the two.

That said, it is acknowledged that there is room for improvement and each reform in the catalogue offers the possibility of fine-tuning the existing system. The catalogue normally focuses on steps that would, in one way or another, reduce either the frequency or severity of liability, reflecting a belief that developments of the past decade or so have unreasonably expanded the scope of liability beyond its proper limits... Support for these reforms is not limited to the health care community as many professional groups and other organizations have joined in common cause in recent years in advocating variants of this agenda of reform.

It is perhaps worth noting that enthusiasm for these tort reforms has not, on the whole, been as intense in the academic communities as it has been among some interest groups. Numerous academic commentators have suggested that it is **difficult to find a principled basis for these reforms while maintaining a commitment to the essence of negligence-based liability** and the concept of full compensation which it entails.

The second major avenue of possible reform contemplates greater attention to institutional responsibility and liability, and correspondingly less attention to the individual liability of the physician. The actual legal form this change might take varies. In its more modest form, it would involve the extension of vicarious liability to nonemployee physicians so that the hospital or other health care institution would be joined in liability with

the physician even in the absence of any direct negligence by the institution. A more radical version of this reform would substitute institutional liability for individual liability, holding the hospital liable for the torts of the physician and granting the physician immunity from suit.

The rationale for this change would emphasize the central role of the institution in the contemporary health care system, noting that the great majority of medical maloccurrences giving rise to liability occur in hospitals. Further, the rationale would rest upon the argument that the provision of high quality health care is a team responsibility drawing upon multiple inputs of which physicians' services are but one. The argument runs that the incentives for better care should rest on the institution, not the individual physician, and that the institution should be responsible for organizing, regulating and monitoring the various inputs to ensure high quality care through risk management and quality assurance procedures.

Put differently, the case for institutional liability posits that the current individualized emphasis of medical malpractice victimizes the physician; that exposing him or her to the traumatic experience of litigation is misguided; and that to the extent there is a case for liability it should be directed at the institution which is responsible for the overall quality of care and is better able to manage the financial uncertainties generated by fluctuating membership fees or insurance premiums. (The Honourable Mr. Justice Charles Dubin advanced the case for institutional liability in the Report to the Hospital for Sick Children Review Committee [1983]).

While the prospect of immunity from negligence actions may have substantial appeal for physicians, the initial euphoria maybe diminished once it is recognized that this proposal could be characterized as part of the more general phenomenon of reduced physician autonomy and enhanced managerial authority of institutional administrators. The current liability regime emphasizes the individual professional; the proposal, at least for liability purposes, subordinates that role. As a result it is difficult to imagine that the profession's response on the liability issue could be divorced from broader questions about institutional management and developing trends in health care delivery systems. Similarly, it is **critically important to assess this proposal in terms of its likely effect on physicians' behaviour since its rationale focuses on reducing the frequency of medical maloccurrences.**

A third direction for reform focuses on process rather than substance, arguing that the principal defects of the current liability system is **not the fault standard or individualized liability, but rather the court-centered litigation process** within which fault must be established. Advocates of reform in this area urge that greater attention be paid to alternative forums within which issues of fault and damages might be established, hoping that these forums might lead to more expeditious and lower cost dispute resolution and would exhibit agreater appreciation of the technical, scientific and professional complexities of medical maloccurrences than courts are normally given credit for. It is also argued that these forums (which might include arbitration, administrative tribunals, mediation, screening panels or similar mechanisms) might lead to less traumatic experiences for defendant physicians and that these tribunals could focus more on the truth and less on the current crossfire of litigation.

Advocates of this approach have recently received a major boost with the release last month of the American Medical Association's major report entitled *A Fault Based Administrative-Based System: A Proposed Alternative for Resolving Medical Liability Disputes.* In essence, the AMA proposal calls for moving medical malpractice claims from courts to a new specialized administrative tribunal which would employ the full range of administrative law techniques to resolve claims arising from medical injuries. It should be emphasized that this proposal does not contemplate an alternative to the fault standard; rather it looks to alternative procedural institutions within which fault would be established.

Proponents of this approach, which might be called alternative dispute resolution, hope that it would offer more reliable and higher quality decisions through a lower cost, less adversarial, faster and more accessible forum. As one leading commentator has stated: "The time is long overdue for a serious appraisal of the comparative advantages of the civil jury and the administrative tribunal in handling personal injury claims; the AMA's ingeniously-designed candidate would likely fare quite well in any such open-minded comparison."

I should hasten to add that this confidence in an administrative solution is far from uniform. Critics doubt each of the claims of superiority of administrative tribunals and fear that the real losers would be the people who have suffered serious injury and would be deprived of their long-standing civil remedies.

The fourth and final broad avenue of reform contemplates a more radical policy change which would replace the fault principle and substitute **compensation on a nofault basis.** This displacement of the fault principle could be partial or complete and experience elsewhere provides examples of each approach.

The partial no-fault approach is illustrated by the State of Virginia's *Birth-Related Neurological Compensation Act of 1987* which is known colloquially as the Virginia "bad baby" statute. (A similar scheme has recently been adopted in Florida). The Act provides nofault compensation to infants who suffer injuries to their brain or spinal cord due to deprivation of oxygen or mechanical injury during labour, delivery or in the immediate postdelivery period and which produces the total and permanent disability of the child. Compensation is awarded for all medical, hospital, rehabilitation, nursing and custodial expenses which are not covered by other public or private insurance sources and for deemed loss of earnings from age 18 to 65 basedon half the state's average weekly wages. Obstetricians and hospitals are given a voluntary election whether or not to participate in and contribute to this compensation fund and in the event they do choose to participate, then this programme becomes the exclusive remedy for the infant and the family.

The comprehensive no-fault approach has been implemented on a mandatory basis in New Zealand and

on a voluntary basis in Sweden and in both cases the available literature suggests that in these particular sociolegal contexts, the schemes are working as intended.

The appeal of these nofault schemes derives from their focus on the needs of injured and disabled persons independent of whether or not their situation has been caused by substandard medical care. This focus on the need for compensation instead of cause has a well rehearsed intellectual foundation. It is typically placed in stark contrast with the limited compensatory objectives of the fault system which, by definition, confines compensation to a subset of injured persons, and the high cost of administering compensation through negligence litigation as opposed to nofault compensation schemes.

Despite this appeal, it is only fair to add that most commentators over the past twenty years have believed that a comprehensive no-fault compensation scheme for medical maloccurrences lies beyond the outerboundary of achievable reforms. Most have argued that such schemes face both philosophical and practical objections. At the level of principle, **critics ask how it could be justifiable to single out medical injuries** for particularly advantageous treatment among the full range of personal injuries and disabilities. They **question how it would be possible to give a principled justification for any scheme short of a universal disability programme.** At the level of practice, commentators query **how the boundary would in fact be drawn** if its task were to be distinguished medical injury or accidents on the one hand from illness, genetic defects, predictable sideeffects and other disabling causes on the other. Indeed many suggest that these causal issues at the boundary of any nofault scheme would be as complicated, expensive and adversarial as current arguments about the presence or absence of fault. And furthermore, it is argued that if these decisions generally assumed an inclusive posture, the cost implications for the nofault scheme might be enormous. At the same time, however, there is growing interest in a serious examination of the possibilities of a comprehensive no-fault scheme, and the scholarly community is beginning to revisit its previously skeptical views.

This then gives the outline of the spectrum of reform: tort reform, institutional liability, alternative dispute resolution, and no-fault schemes. These options are not mutually exclusive and one can readily imagine combinations and variations...

I approach these alternatives which have been debated in the medical legal literature as possibilities and not as options to which I yet attach particular preferences.

In the next issue we will present comments on this report., and a resolution which will be presented to the Spring General Meeting of the Medical Reform Group of Ontario. Comments are invited, either to the newsletter, or to Don Woodside or Haresh Kirpalani.

Announcements

National Conference on Multicultural Health, March 30, 31, April 1, 1989

The changing demographics of Canadian society have necessitated a re-examination of our health education, care, services, and systems, to ensure that they are appropriate and sensitive, as well as equitable and accessible to multicultural communities. The challenge is to respond to the needs of a culturally diverse society.

On March 30, 31 and April 1, 1989, the Canadian Council on Multicultural Health will sponsor the first national conference to examine issues of health in a culturally-diverse society.

The conference will be an opportunity for you to: discuss successful approaches, discover existing programs and services which have developed across Canada, obtain information on specific issues, and network with other groups across Canada. It is expected that the gathering will provide an exciting opportunity to develop awareness and practical solutions.

For a registration form and information on the program, transportation and accommodation, please write:

CCMH/CCSM
Suite 407, 1017 Wilson Avenue
Downsview, Ontario M3K 1Z1
or call (416) 630-8835

Come to the North!

Locums of 2 weeks to 6 months needed for Sioux Lookout zone starting March 1989. Phone Drs. Ian Casson or Ruth Wilson at 807-737-3030 or write with CV to Box 1500, Sioux Lookout, Onario P0V 2T0

Spadina Health Centre Seeks Partner

The Spadina Health Centre, Fred Freedman, Mirian Garfinkle and Lea Rossiter, are looking for a new partner to replace Gary Burrows who is leaving private practice this spring.

If you are interested, please call Fred Freedman at 531-2861 evenings.

Davenport-Perth Community Health Centre

is a community based program managed by the **Davenport-Perth Neighbourhood Centre.** Our multi-service Centre responds to the needs of a high risk community by integrating health and social service programs. Complementary Services include: Primary Care, Preventive Health Care, and Health Promotion and Education; and programs for Families, Youth and Seniors.

Preferred candidates should have the following qualification in addition to any specified below:

- demonstrated leadership abilities
- a firm commitment to social change
- a commitment to an interdisciplinary team management approach
- multi-lingual language skills.

We are presently recruiting for the following positions:

Coordinator – Community Health Centre

The Coordinator will ensure the delivery of quality health care services to community residents.

Responsibilities include: financial and administrative management, including fundraising; human resource and material management; health program planning and evaluation; liaison with the Ministry of Health, community agencies/services and other appropriate bodies; maintaining and auditing comprehensive record keeping systems; Experience in managing professional and support staff in a community service environment.

Primary Care Nurse

The Primary Health Care Nurse will provide services as a member of the clinical team. The incumbent will be registered with the College of Nurses of Ontario and have education and experience commensurate with the roles and responsibilities of a primary care nurse.

Responsibilities include: assessment, diagnosis, treatment and follow up on health concerns of clients; maintaining medical equipment and supplies inventories, drug inventories and control books; establishing health care education/counselling as an integral component of all patient encounters.

Physician

The Physician will provide medical services as a member of the clinical team. The incumbent will be licensed to practice medicine in Ontario.

Responsibilities include: providing direct primary care to patients; maintain hospital privileges; provide on call services; advocate on patients' behalf with specialists, other agencies and/or hospitals; participating in designated Neighbourhood Centre and community committees; assisting in the ongoing development of health promotion programs and development and implementation of clinical protocols.

Community Health Worker

The Community Health Worker will develop, design, implement and evaluate health promotion strategies, campaigns and programs in the community using a community development approach; advocating for the development of self-help initiatives and mobilizing direct action with community residents will be a primary focus of activity. Post secondary training in health services, social services, or a related field and/or equivalent experience required.

Salaries for the above positions are commensurate with the Ministry of Health Guidelines, qualifications and experience. Total Compensation includes an excellent employee benefits package.

Interested applicants should apply in writing no later than March 17, 1989 at 4:00 pm to:

Executive Director
Davenport Perth Community Health Centre
1904 Davenport Road
Toronto, Ontario M6N 1B7

Pushing pills: who's to blame for so much poor prescribing?

THE GLOBE AND MAIL, TUESDAY, DECEMBER 13, 1988

BY JOEL LEXCHIN

Dr. Lexchin practices emergency medicine in Toronto. The author of The Real Pushers: A Critical Analysis of the Canadian Drug Industry (New Star Books, Vancouver), he is active in the Medical Reform Group and Health Action International Canada.

YOU HAVEN'T been feeling well for a couple of days, nothing serious — just a bit of a cough, a sore throat and a low-grade fever, but to be on the safe side you decide to pay your doctor a visit. If your doctor is like the majority of general practitioners studied recently in Hamilton, Ont., you stand a better than 50-50 chance of leaving the office with a prescription for an antibiotic.

The problem is that your symptoms were almost certainly due to a viral infection, and antibiotics are useless against viruses. Your prescription will do you no good, but it will still cost you money and then, of course, you run the risk of developing one of the side effects associated with antibiotics.

Going to the doctor with a sore throat isn't the only time you run the risk of getting an antibiotic misprescribed. Studies in hospitals across Canada have shown that only 52 per cent of the prescriptions for antibiotics are appropriate. Antibiotics are also not the only group of drugs that are often misprescribed. Cimetidine, the widely used ulcer drug, is prescribed correctly only 50 per cent of the time. In 1982, 2.4 million prescriptions were issued for it.

Why don't doctors prescribe better? In some cases, they are under pressure from their patients to prescribe a drug and feel that if they don't, the patient will go elsewhere. While this argument may have some validity, it isn't completely supported by the facts. Eighty per cent of British physicians estimated that patients expected a prescription in 89 per cent of consultations, but in a national survey in England, patients indicated that they expected a prescription in only 43 to 52 per cent of visits.

It would appear that doctors themselves have to take most of the blame for poor prescribing. Sometimes doctors just don't know what they are prescribing. More than 75 per cent of all prescriptions are written using the brand name of the drug, as opposed to the generic name. Brand names are often "catchy," easier to remember and spell, and the drug companies spend more than $300-million a year promoting these names among doctors.

But when doctors prescribe by brand name, they may not know what is in the drug. Sixty Montreal physicians were asked to name the active ingredients in three fixed-dose products that they had prescribed in the previous year. (A fixed-dose product contains more than one active ingredient.) A total of 23 drugs were named by the 60 doctors; in only four of the 23 cases did most of them know all the ingredients.

While the available evidence is not conclusive, there are strong reasons to think that the patient's gender may play a role. Study after study has demonstrated that women are prescribed tranquillizers, such as Valium, twice as often as men. One reason may be that male doctors do most of the prescribing.

The bias of one group of male physicians was reflected in some of their comments about women: "It's constitutional. The female's nervous system is more sensitive. They're affected by problems and emotional upsets more. That's the way the Lord made them" ... "Females have more time to indulge in neuroses than men. They're bored, often, and frustrated. As they get older, there's the menopause, which we men do not indulge in."

The same group of male general practitioners was asked to describe a typical complaining patient. The question made no reference to sex but 4 per cent of the doctors said men are particularly troublesome, 24 per cent mentioned neither sex and 72 per cent cited women. Seventy-eight per cent of these doctors reported that they wrote more mood-modifying prescriptions for their female patients.

The type of practice doctors have also influences their use of drugs. In Montreal, "simulated" patients (students trained to describe symptoms) complaining of tension headaches were sent to see a random sample of salaried physicians practicing in government-financed community health centres (CHCs) and physicians practicing in fee-for-service groups. Whereas more than half of the physicians in private clinics prescribed an "inadequate" therapy, only one-quarter of CHC physicians did so. They also were twice as likely to provide explicit warnings on the implications and dangers of chronic use of the medications that they prescribed.

One reason community health centre physicians are better at prescribing drugs is that they can spend more time with patients without worrying about any financial penalty. The average fee-for-service doctor sees a new patient every 10 to 12 minutes and so has little time to go into a patient's problem in any depth.

Finally, where doctors get their information about drugs seems to be a major contributing factor on how well they prescribe. Many doctors rely heavily on the drug companies for information. While that may seem reasonable, since whoever makes the drugs should know the most about them, the companies are not unbiased. Their aim is to sell as much as they can; they will present their drugs in the best light possible.

It should come as no surprise, therefore, to learn that the more doctors rely on drug company sources for their information, the less rational they are as prescribers. This conclusion has been reached by five separate studies in the United States, Britain, the Netherlands and Belgium.

The consequences of poor prescribing are not innocuous. Almost 20 per cent of 170 admissions to a geriatrics ward in a Saskatoon hospital were attributed to adverse reactions to prescribed drugs. Fifteen to 30 per cent of patients in hospital are believed to have adverse drug reactions some time during their stay.

Not all adverse reactions are the result of misprescribing, but it is estimated that about three-quarters could be avoided if prescribing were done correctly. While the financial cost of adverse drug reactions is obviously secondary to the health aspect, it is not trivial. Back in the mid-1970s, the cost was in the range of $300-million a year for all of Canada and it can only have climbed since then.

What can be done to improve doctors' prescribing? Since physicians not in fee-for-service settings appear to be better, there should be more encouragement by government of alternatives such as community health centres and health service organizations, and less resistance from the medical community to their adoption.

Although there are more than 3,500 different prescription drugs on the Canadian market, the average general practitioner uses only a few dozen to write more than 50 per cent of his or her prescriptions. While general practitioners use relatively few drugs, it is not likely that their choice of products is based entirely on objective scientific criteria.

One concept is that general practitioners should rationalize the decision about which drugs to use by scientifically evaluating the range of drugs available and then choosing the ones that would best suit the kinds of patients they deal with. This type of a list is called a general practice formulary. It is clearly easier to become familiar with the indications, effects, side-effects, interactions and contra-indications of a limited number of preparations.

Formularies of this sort are already in operation in Britain where it is felt that their use will lead to improvements in prescribing and a curbing of prescribing costs. Indeed, one health centre in South-

western Ontario uses a formulary of 175 drugs and has dropped the price of a prescription by 10 per cent compared to the provincial average.

Finally, given that the use of company sources of prescribing information is incompatible with appropriate prescribing, measures have to be taken to provide doctors with independent factual sources of information. If such efforts are to be able to counter the $300-million promotional budget of the drug industry, they have to be more than mere tokenism.

One measure is the use of face-to-face educational interventions. Here, specially trained drug educators, either physicians or pharmacists, meet with doctors individually to go over their prescribing to identify problems and offer suggestions for improvement. The aim is not punishment, but education.

In U.S. studies, such educators made long-term improvements in the prescribing of a wide variety of drugs. Particularly encouraging is that few doctors seem to be resistant to these educational visits.

In Ontario, a provincially appointed commission headed by Dr. Frederick Lowy is studying the use of prescription drugs. Dr. Lowy is due to submit his report to Health Minister Elinor Caplan next spring. Will luck, the report will incorporate some of these suggestions so that the next time you go to your doctor with a sore throat you leave with some good advice rather than a prescription for a worthless antibiotic.

MDs using Squibb drug in study receive computers for office use

BY LINDA McQUAIG
The Globe and Mail

One of Canada's largest pharmaceutical companies is offering doctors the use of a personal computer in their offices, but denies that the equipment is a perk to encourage physicians to use one of their products.

Squibb Canada Inc. is providing computers, which have a market value of more than $2,000, to doctors who put 10 of their patients on Squibb's Capoten, one of many drugs on the market used in the treatment of hypertension.

Company vice-president Dan Burns said in a telephone interview yesterday from Montreal that about 2,000 doctors across the country are participating in Squibb's study, which involves approximately 15,000 patients who are taking Capoten.

Although Squibb retains ownership of the computers, doctors will be permitted to keep them after the study is completed, Mr. Burns said.

"We have no intention, for example, of putting the computer in only for the study."

He denied that this might have the effect of encouraging doctors to prescribe Capoten over another drug for patients suffering from hypertension.

"I know what you're getting at," he said. "I'm trying to be as candid as possible. We don't look at it that way."

It is possible that a few doctors might be influenced in that way, he said, but the majority would not be.

Dr. Joel Lexchin, who practices emergency medicine in a downtown Toronto hospital and has written extensively on the drug industry, said he believes the computer program is a "very attractive bribe."

"While Capoten is a very useful product in certain circumstances, there are also other drugs that in some patients are equally effective and less expensive," said Dr. Lexchin, author of The Real Pushers: A Critical Analysis of the Canadian Drug Industry. "The worry with this kind of program is that doctors will put patients on this product not because it's necessary, but because they want access to the computer."

Anti-hypertensives are among the most widely prescribed pharmaceuticals, partly because once started on such drugs, patients generally remain on them for the rest of their lives.

As a result there is considerable competition among pharmaceutical companies for a share of the market.

Capoten, which has been available for six years, is among the more expensive anti-hypertensives. Some of the older ones are now being produced in no-name generic forms, which are considerably cheaper.

Mr. Burns said he is confident that doctors participating in the Squibb computer program will be prescribing Capoten only to patients for whom it is appropriate medically.

Squibb deliberately did not impose tight time constraints on the study, Mr. Burns said, so doctors would not feel under pressure to come up with the patients.

He said the company did not want doctors to be in the position of saying, " 'Oh my god, I have to get 10 patients within a month.' We don't think that's a proper way to conduct a trial."

Mr. Burns said the company is concerned that the study be done properly and does not want to be associated with "giveaways." For this reason Squibb does not pay the doctors or give the computers to them outright.

Although Mr. Burns said the study involves 15,000 patients, a company letter to doctors describing the program says 25,000 are involved.

Data about the patients' response to the drug is fed into the computer, to be analyzed electronically as part of the Squibb program.

Asked whether patients are aware they are part of a study, Mr. Burns said patient consent is not strictly necessary, as the drug is already approved for sale in Canada.

"There's no experimental aspect, so it does not necessarily require patient consent."

He said, however, that a doctor would generally inform patients. "Professionally, he's obliged to do that."

Squibb, a subsidiary of Squibb Corp. of Princeton, N.J., also provides software programs to participating doctors showing how various drugs interact.

Mr. Burns said this kind of computer study might be used in the future to meet some of the requirements of Canada's new drug patent legislation, under which pharmaceutical companies have promised to double their spending on drug research and development in Canada.

Globe & Mail, Thursday, December 13, 1988

Globe & Mail, May 27, 1988

Drug advertising's bitter pill

Prescription medicine has no business starring in a 30-second TV spot

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

LAST FALL, a puzzling ad appeared on Toronto bus shelters. It showed a young man absorbed in examining his bald spot with a hand-held miror, and delivered the message that there was medical help at hand. No sponsor's name was attached.

The ad itself may have caused some hair loss from head-scratching. Was this a pitch on behalf of the medical profession? With health-insurance billings escalating at 10 per cent a year, this would hardly seem necessary, and surely there are better examples of serving patients' interests. Was it, then, a public-health message, akin to those about drunk driving or AIDS, designed to prevent human suffering? No particular organization or government agency was mentioned. And since when did the prevention of baldness enter the ranks of urgent public-health causes?

The ad's sponsor turned out to be Upjohn Co. of Canada, makers of Rogaine, the only medically prescribed lotion for baldness in Canada. This makes Upjohn the only drug company in a position to benefit from any stampede of male hair-shedders to doctors' offices.

It is illegal in Canada, under the Food and Drugs Act, to advertise prescription drugs to the public. By omitting mention of its product, Upjohn has been able to sidestep the ban on direct advertising. The sales strategy relies on the fact that, with no other medically approved drug to choose from, chances are good that molting men spurred to visit their doctors will walk out with a prescription for Rogaine.

The surreptitious campaign for Rogaine now has taken to the airwaves, and it raises anew the moral issues involved in advertising drugs, both to the public and to doctors. There is a conflict of interest between the self-serving promotion of a drug by a drug company and the balanced scientific information needed to assess it.

Rogaine is a good case in point. Its effectiveness as a baldness remedy is very much in doubt. The hair that results is usually little more than peach fuzz. Fewer than 10 per cent of patients have hair growth that is actually noticeable, and they must use the drug indefinitely at a cost of $70 a month to maintain their new growth.

The drug can also have other costs. Originally developed as an anti-hypertensive, Rogaine is absorbed into the circulation and can cause cardiovascular side effects, such as an increased heart rate. Doubts about its effectiveness and safety have caused U.S. authorities to withhold approval so far for use as a baldness remedy.

THE TENSION between salesmanship and truth is inherent in all advertising. What sets direct advertising of prescription drugs apart, and why the public must be protected from it, lies in these special factors:

1. It is misleading. Drugs can be both life-saving and life-threatening. To make an informed decision about the use of a particular drug in a particular situation, a formidable amount of information about effectiveness, side effects and alternative drugs is required. So, a flashy ad or a 30-second TV spot, stressing a single selling point and omitting the rest, is akin to the glamorous cigaret billboard with the microscopic warning at the bottom. Both are deceptive advertising.

2. It is exploitive. Advertising drugs for serious or chronic illnesses appeals to vunerable target groups that are susceptible to misleading messages of hope and cure. It plays on the fear of disease and death, an area where emotion can often overrule reason.

3. It undermines the doctor-patient relationship. Cancer patients who come into a doctor's office demanding the latest "miracle" drug, perhaps even waving a sales coupon, are not likely to be receptive to a bunch of boring, confusing facts about how that drug may not be the best choice. The conflict thus created can only harm the trust needed for an effective therapeutic relationship.

4. It will lead to unnecessary drug use. We are already an over-medicated society. Drug advertising will compound the problem. Just as everyday discomforts have been "medicalized" by advertising over-the-counter remedies, new "diseases" — drug-deficiency states — will be created by ad agencies out of the flimsiest of scientific pretexts, to sell more drugs.

5. It is expensive. For a variety of reasons, there is little or no price competition while drugs are still under patent. Thus any increase in demand brought on by direct advertising will not result in lower prices. In fact, the opposite will occur. Ontario recently started an inquiry into the spiralling provincial drug bill. It should look at the already high (16 per cent) ratio of advertising to sales in the drug industry. Direct advertising will raise this ratio, and along with it, drug prices. It may also raise the health-insurance tab by generating extra visits to doctors' offices.

Health and Welfare Canada has chosen to allow the Upjohn campaign to run. The department's Dr. Agnes Klein says the issue of whether the ads violate the law is "Talmudic . . . it falls into the non-ethical rather than the illegal realm."

Although Upjohn's president, Dr. Douglas Squires, says the campaign is purely "informational" and designed to protect the public from "snake-oil salesmen," he admits it is far more expensive than Upjohn's usual specialized campaigns aimed at doctors. In addition, in a letter that was sent to doctors and pharmacists, Upjohn states that, "if we were allowed to attribute these messages to Upjohn, we would be delighted to do so."

The Upjohn campaign is the only one so far aimed at the consumer. Prescription-drug advertising is otherwise directed at the consum-

er's purchasing agent, the doctor. Doctors are in a better position to evaluate the merits of a drug but they, too, are vulnerable to the conflict of interest inherent in drug advertising.

The Eastman Commission found in 1983 that the industry spends more than $4,600 per doctor on promotion to the medical profession. (The total budget comes to four times the amount spent on research.) Bombarded by direct mail, journal ads, visits by sales reps, promotional dinners and seminars, and with little time to search elsewhere for more objective information, many doctors have come to rely on the drug industry to keep them abreast.

Public interest would therefore seem to dictate some protection from misleading advertising aimed at doctors. In the United States, the Food and Drug Administration enforces standards for accuracy and balance. Surprisingly, similar regulations do not exist in Canada.

In 1976, the industry set up the Pharmaceutical Advertising Advisory Board (PAAB) to prevent the kind of further advertising excesses that would lead to government intervention. A high-sounding code of ethics was drawn up. The strategy succeeded in getting the Government off the industry's back, but does it really protect the public interest?

The PAAB depends on the voluntary submission of ads. In fact, only 60 per cent of direct-mail material passes through its hands. Once received, ads are screened for technical accuracy by two former pharmacists on staff.

Ninety-eight per cent are cleared without change, and of the changes requested, most are minor variations in wording. Even then, should a manufacturer fail to comply, the PAAB has no power to enforce its ruling.

Drug ads to doctors are no different than any other glossy advertising. They use seductive, eye-catching imagery to sell. The warnings and side effects are usually in fine print and the alluring image may be all that the busy reader retains. The PAAB does not pass judgment on the all-important visual message and the relative weight given to it in the ad.

None of this should be surprising, since the PAAB is a creation of the industry it is supposed to scrutinize. Ironically, Upjohn of Canada, which is now attempting an end run around existing drug legislation, was the prime mover in setting up the PAAB and supplied it with 25 per cent of its start-up money.

What was learned in the case of the tobacco manufacturers and their voluntary advertising code is now being relearned with the drug manufacturers. When public interest is involved, it is naive to entrust an industry that is heavily dependent on advertising with self-censorship.

Musicians' clinic ready by October

By DOUG LeFAIVE
The Spectator

A PIANO may seem an unlikely piece of diagnostic equipment for a medical centre, but a concert grand will play a vital role at the new Chedoke Health Centre.

The $4.5-million centre, slated to open in October, will house the Canadian Musicians' Clinic — the only occupational health clinic in the country specializing in the job-related health problems of musicians.

The 3,660-square-metre (39,500 square-foot) building, to be built at Chedoke-McMaster Hospital on Sanatorium Road, will also house new nuclear medicine facilities, an outpatient physiotherapy unit, offices and a health club.

During their careers, half of all professional musicians will miss some time at work due to a job-related injury, said the press release announcing the expansion.


Chong

After yesterday's groundbreaking ceremony, Dr. John Chong, the clinic's vice-president, said the thousands of hours of intense practice, required to move an amateur musician into the professional ranks, often place undue strain on the performers' tendons, muscles and joints.

For example, he said, the constant repetition of the intricate movements of a concert pianist's fingers across a keyboard can lead to painfully-inflamed tendons in the forearms.

If the pain is ignored, the strain of continued practice can lead to pinched nerves in the forearms, which may disable the pianist until he can no longer lift his fingers.

It was this type of injury that ended Dr. Chong's own career as a classical pianist, shortly after he played Massey Hall at the age of 14.

However, these problems can often be remedied, or avoided altogether, through minor variations in technique which allow the performer to continue, but in a less-stressful manner.

That's where the piano comes in.

Dr. Chong said the piano will be in the building's new performance laboratory, where doctors and occupational therapists will closely examine the patient's style and suggest safer techniques.

Dr. Chong, who co-founded the clinic two years ago, said its facilities are now scattered across three locations.

The clinic has treated about 500 musicians from across Canada and has a three-month waiting list for new patients.

Dr. Chong said musicians of all musical styles are treated at the clinic and is particularily concerned with music students who push themselves to their limits with daily 12-hour practice sessions in hopes of landing one of the very few jobs with a professional orchestra.

He said they suddenly face "very intense practice schedules, a lot of stress, very tough repertoires and then the medical problems start to appear."

The clinic has a contract with the National Youth Orchestra to examine its members, treat their injuries and advise them on how to avoid injury.

Since "a large percentage of our orchestral musicians come out of that very talented student pool," Dr. Chong said, the contract will enable the clinic to stay abreast of new methods and evaluate treatments over the course of their careers.

The clinic also counsels and supports injured musicians, whose careers are slowed or ended by injury.

That's a trauma which Dr. Chong knows about first hand.

He explained that he didn't consult a doctor about the pain in his right arm when he played piano."I just wanted to play hard, and to continue to play really hard. Until my teacher said, 'You're in big trouble kid. You are off for a year.'"

"But if I had been 10 years older, I would have been in big trouble career-wise, because I probably would have committed to a career in music."

Rocky Flats: Death Inc.

New York Times, Sunday, December 18, 1988

Carl J. Johnson, a specialist in the medical effects of radiation, is a consultant in lawsuits brought by alleged victims of nuclear plant radiation.

By Carl J. Johnson

An insider's view from Colorado.

DENVER

The appalling safety record of the nuclear weapons industry nationwide and the threat it has posed to public health — a story that has been unfolding for weeks — is old news to those of us in Colorado who have monitored the Rocky Flats plant, near Denver, for years.

Rocky Flats fell within my jurisdiction as health officer of Jefferson County, a large county adjacent to Denver, from 1973 to 1981. From 1975 to 1981, as a result of evidence that radioactive contamination from the plant threatened Denver, I directed a series of investigations aimed at ascertaining the degree of contamination and assessing the risk to the public's health. These included studies of the incidence of cancer.

My program ultimately triggered political retaliation by the Jefferson County commissioners, who replaced board of health members with others more sympathetic to Rocky Flats. The new members forced me to resign in 1981.

Rocky Flats, 16 miles northwest of the center of Denver, was built secretly in 1952 by the Government on off-limits Federal land, and began operations in 1953. If its ultra-hazardous nature had been known at the time, its construction upwind from Denver surely would have been impossible.

In addition to obsolete nuclear weapons, the plant received plutonium waste, which it reprocessed into new nuclear weapons components.

The public's exposure to the plant's toxic radioactive substances peaked in 1957 when an explosion blew out all 620 industrial filters. This scattered over the Denver area a four-year accumulation of fine plutonium and uranium dust trapped in the never-changed filter system. In retrospect, the entire area should have been evacuated.

At the time, Atomic Energy Commission and state health officials denied that there had been any release of plutonium of consequence — despite the A.E.C.'s own limited, secret survey that reported heavy contamination of soil as far as an elementary school 12 miles away.

There was similar secrecy about many large-scale releases of radiation that followed in subsequent years.

In 1957, families downwind from Rocky Flats were more vulnerable to radiation and had less protection than plant workers; at times, they were under or actually within the exhaust plumes from the plant's 29 smokestacks.

From 1947 to 1952, leukemia deaths among Jefferson County children were less than the national rate, but they increased to about twice the national rate between 1957 and 1962. Jefferson County's usual low infant-mortality rate rose above the national average in 1953 and reached a high point around the time of the 1957 explosion. Moreover, fetal death rates rose sharply during those years.

In December 1974, I opposed housing development in several square miles of farmland adjacent to Rocky Flats because of heavy plutonium contamination. The county commissioners, at that time, upheld my position.

Landowners then sued the Department of Energy, which owned the plant, and its contractors who ran it, Dow and Rockwell, and received a $9 million settlement a decade later.

As other land developers sought to build homes more distant from the plant and, astonishing as it may seem, to sell them to new residents from out of state without disclosure of the radiation problem, I began a systematic research program that found that the radiation threat was very serious, indeed.

In 1975 and 1976, working with the United States Geological Survey, my staff and I found 44 times more plutonium in soil near the plant than had been reported earlier by the Government. The concentrations of plutonium in the air, for the months reported, were the highest in the world. The extremely high level of contamination was also found in drinking water.

In 1977, I reported more leukemia deaths within nine miles of the plant than would normally be expected. In the suburban area within 13 miles of the plant, there were 16 percent more people with cancer than would be expected; this was 8.5 percent higher than the rate in older central Denver.

In 1980, I studied Rocky Flats workers and found eight times more brain tumors than had been expected and more cases of melanoma, a malignant skin tumor, and lung cancer than in a comparison group of Colorado males.

Largely as a result of Congressional investigations (I participated in three), Rocky Flats is temporarily closed today. The actual number of people who have been injured or died because of the operations of Rocky Flats and other such plants can never be fully known. Thus, communities near nuclear weapons and nuclear power facilities must insist on detailed investigations of all activities and emissions.

I was a whistle-blower. As a result of the buildup of enormous political pressures by vested interests between 1975 and 1981, I was forced out of office. If the nation is to be properly protected, all studies of nuclear contamination and associated health effects should be conducted primarily by independent scientists who are insulated from cynical retaliation. □

Crisis in the labour room

By Jane Ellison

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EDMONTON is perhaps an unlikely setting for a revolt whose real significance has yet to be realised. But the effects will be felt soon enough by any woman who expects to have a baby in the next few years.

At Edmonton, 44 midwives have handed in their notice at the North Middlesex Hospital. Why? This was just one more round of industrial action from dissatisfied NHS staff; indeed, the midwives are getting a pay increase of around 23 per cent. They are not members of NUPE or COHSE but that most conservative body, the Royal College of Midwives. They belong to perhaps the most dedicated branch of nursing. For women like this to resign en masse something has gone badly wrong. Indeed, the case of the North Middlesex midwives signals a crisis in the entire future of the midwifery profession.

In three out of four births the midwife is in charge. Most women never see a doctor's face until the routine paediatric examination of the baby. The midwife stays with us throughout labour, judges how best the baby will be born, and takes responsibility for whatever happens in the labour room.

In the next few years all this may change. There may simply be no more midwives to give this sort of care. There is already a 17.6 per cent shortage of hospital and staff midwives throughout the country, with a 25 per cent shortage in London teaching hospitals. There is every sign that this is going to get worse. For the profession has been dealt a body blow by the Government's new clinical grading structure.

Frances Stirk is a community midwife, based at the North Middlesex Hospital, and, like her 44 colleagues, she is desperately sad to see her profession in virtual collapse. "The regrading was supposed to address problems but it has left midwives completely demoralised. I wonder if there will be any more midwives now, since anyone who trains to be a midwife could actually lose money."

By deciding to be a midwife, a nurse could lose about £1,000. After 18 months' intensive and difficult training, new midwives are offered the same, or lower, grades as they had before qualifying. Most fully trained nurses who take the midwifery course will be on an E grade of £9,200 to £10,650. At the end of this training period, some newly-qualified midwives will be offered a D grade of £8,025 to £9,200. Most will simply retain their previous E grading, so that after training they will earn more money. It is hard to see who will want to be a midwife in the future, when the skills of the profession are held so cheaply. By training to be a health visitor, for example, an E grade nurse would be guaranteed a G grade of £12,205 to £13,925 after 12 months training. In addition, there would be no unsocial hours, no being on call 24 hours a day. For Frances, and hundreds of midwives like her, the inescapable message is that the role of the midwives is being run down.

"I think the public does not realise what midwives do. In general, they think midwives are nurses who are there to catch the baby when it's born. But in 75 per cent of all births the midwife is the most senior person present. There are forces for change in the profession which now encourage midwives to develop their skills, making decisions about emergency care, topping up epidurals, suturing their own patients, deciding whether a Caesarian is necessary." At the North Middlesex, a hospital which offers care to mothers from Tottenham to Highgate, the disillusionment is palpable since the midwives who have resigned have been part of a progressive movement to develop "midwifery teams" consisting of one consultant, one senior nurse, three sisters and about ten midwives. Each team provides a complete service for its own clients, with a rota which enables women always to be seen by the same team. There are clinics in the community run by midwives who also cover the labour ward, so a woman will always be familiar with the staff who look after her. But this new approach, too, is under threat from a grading structure which means that a "rotating midwife" will lose money as she moves from community to hospital work.

As a community midwife, Frances Stirk works in a branch of the profession where there is no shortage of staff. In the community the midwife can put all her skills into practice, from ante-natal care to delivering a baby. Like her babies, Frances does not work by the clock. On a typical day she made a home visit to one of her patients whose labour was beginning, attended a local GP's ante-natal clinic, carried out four post-natals and eventually delivered the baby at 2.30 the following morning, getting home at 3.45am. She trained at the North Middlesex and has worked in the community for ten years; at the age of 35 she is on grade G, at £13,925.

What worries Frances is the future of hospital midwifery and the chronic lack of students now wanting to train. "I feel we aren't given status for what we do. Our work isn't recognised either by the public or by the medical profession. A midwife must make decisions on her own responsibility, and she's answerable for them. She's got a code of conduct and a statutory rule book which she has to fulfil. She can't say, well, I tried to get the doctor but he wasn't there . . ."

Last week Senior Tutors met at the Royal College of Midwives and reported that significant numbers of students in training at 20 midwifery schools around the country had already withdrawn from their course because of the grading system; and that potential students at 21 schools have now withdrawn their applications. Recruitment is further damaged by reductions in student nurse training; where a student nurse once spent a routine eight weeks in an obstetric unit, she now spends only four weeks there and there is a real risk that obstetric experience may be phased out altogether. This means that in 18 months there will be an acute shortage of staff midwives and that services will be at best incredibly stretched. If this service breaks down, then hospital managers will find it necessary to use other grades of staff to look after women in labour, reserving specialist obstretric care for the last moment when the baby is delivered by the doctor.

Does this matter? Perhaps not to Kenneth Clarke and a Government which continues to pretend there is no crisis in the NHS. But for women and their babies it is a horror story. There will be in future no question of choice in childbirth, no community care, no chance of a home birth, no use of the hospital "birthing room". There will be no trained midwife there to support and sympathise with the mother, to plan a pattern of care in labour, to be aware of all the abnormalities which might arise, to give emergency treatment. There will be only the monitor to measure contractions and the electrode to supervise the baby's condition. Routine care will be given by poorly qualified "obstetric nurses" supervised by obstetricians who have never seen or heard of their patients until they turn up at the labour ward. This is what happens in the US where there is a 50 per cent Caesarian rate and a constant threat of litigation.

Surely it is lamentable that morale among midwives has been allowed to sink so low. Britain's midwifery service was once the envy of other countries. Now at least half of all midwives trained by the NHS never deliver another baby for the rest of their working lives. They become Health Visitors; they go to Saudi Arabia; they go back into general nursing with an extra qualification to get a sister's post. They drop out of midwifery because they are acutely disappointed with their role. "People ask," says Frances Stirk, "what are the midwives complaining about? They've got more money haven't they? But somebody ought to explain it to them."