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

Volume 9, Number 2 (April 1989)

LARGE" – *Rudolf Virchow*

Spring Meeting to focus on Resource Allocation

The theme of the Medical Reform Group's Spring general meeting will be Resource Allocation. Under the heading of "Is there, or is there not a crisis in the health care system?" a debate will be held on Friday night, between Gordon Guyatt and Michael Rachlis. The debate will be followed by general discussion. The Friday debate will set the tone for the small group sessions on Saturday.

The Resource Allocation Working group will submit for endorsement at the meeting the distillation of our draft report which appears inside this newsletter. An expanded version appeared in the last newsletter.

The agenda is as below:

AGENDA

Friday 5th May

Dinner and Debate

Venue: Small dining room (reach via the main dining room) Trinity College, University of Toronto, north-east corner of Devonshire and Hoskin.

Dinner 6:00pm. Price for dinner $10-$12.00

IMPORTANT: please RSVP for dinner: 588-9167

Debate: 7:45 pm

Saturday 6th May

Venue: South Riverdale Community Health Centre, 126 Pape Ave., Toronto

9:00 am: Steering Committee Report and business meeting, including:

1. Budget for 1989-90.

2. Resolution re: proposed fee increase for 1989-90: "Be it resolved that the membership fee for physicians be raised to $175", proposed by the Steering Committee.

3. Resolution re: liability insurance (see elsewhere in this newsletter).

4. Questions to Steering Committee (see Steering Committee Report elsewhere in this newsletter).

11:00 am Two small group sessions on Resource Allocation. Each will consider the question: Is there or is there not a crisis in health care resources?

13:00 Lunch

14:00 General Session/Report Back. If there is unanimity on the central question, the following period's small group sessions will address more specific questions. If there is no general agreement the small groups will continue to attempt resolution of the central question. Small groups sessions will be led by Catherine Oliver, Donna Goldenberg, Andy Oxman, Gord Guyatt, and Haresh Kirpalani.

16:30 General Session to direct the Steering Committee and Resource Allocation sub-committee. Vote on draft report.

Steering Committee Report March 1989

By Mimi Divinsky

Since Don Woodside reported in the October 1988 Newsletter, your Steering Committee has continued to be involved in tackling the issue of the budget in respect of Ulli Diemer's time and priorities. The Budget is on the agenda of the Spring General Meeting, May 6th, 1989. Ulli's work is very much appreciated and his contract was unanimously renewed (Nov/88) but we felt unable to afford in future the overtime hours that have become necessary – up to 94 hours per month. We agreed to pay Ulli for half of those hours for the previous year but decided to find ways to prevent this problem in future.

Suggestions were made: for a "time budget" to set limits, that less of Ulli's time be spent on errands, and that outside groups could be charged for the time it takes Ulli to prepare a mailing for them. Currently they just supply the stamps and the envelopes and Ulli's time is not charged for. Since the Newsletter demands the largest amount of time for Ulli, the editorial board decided to take over several of the clerical jobs. At the Feb/89 meeting Ulli reported that his time in the last 3 months – following the institution of some of these "time saving/cost saving" steps has resulted in his time being within target.

The Newsletter still plans to distribute more widely than at the moment. The Steering Committee has agreed to an interim newsstand price per issue of $3.00 and a rate for "bulk orders", and also on the general prin-

ciple of charging non-members for advertisements in the newsletter.

Prior to the Federal Election in November, Michael Rachlis, Mimi Divinsky, and Haresh Kirpalani arranged a press conference to express our concern about the possible effects of the Free Trade Deal on health care.

Mimi Divinsky agreed at the Nov/88 meeting to act as Media Coordinator with the proviso that she would take responsibility for decision making about active and reactive approaches to the media, but would delegate responses to certain issues dependent upon interests or areas of expertise. "Manning" certain newspapers and media outlets would also be a shared responsibility.

In December 1988 Philip Berger and Haresh Kirpalani responded to a questionnaire from the College of Physicians and Surgeons, sent to various "informed groups" regarding the mandate of the college and the perceptions of it held by the public, government and the profession. Catherine Oliver drafted a letter of support on our behalf regarding the proposed College of Midwifery to be set up (Dec /88). Bob Frankford agreed to discuss the MLAM's "writings project" to drug companies.

We approved a description of the MRG to be part of a guidebook for medical students in Ontario, produced by the Ontario Federation of Medical Students Societies and called "Life After Medical School" (Jan 89). Mimi Divinsky spoke to a sociology class at the Univdrsity of Toronto and a political science class at York University about the MRG and the "crisis" in health care.

In January Philip Berger, Bob Frankford and Mimi Divinsky met with Gilbert Sharpe and Dr. McMillan Assistant Deputy Minister of Health regarding the Independent Health Facilities Act. We covered several different aspects of concern (confidentiality, the possibility of "facility fees?" becoming "user fees") and were advised that significant amendments are pending, before the bill goes to committee and submissions are accepted.

In February Bob Frankford, Haresh Kirpalani, and Joel Lexchin met with Elinor Caplan and Martin Barkin (Minister and Deputy Minister for Health) at their request. There was no pre set agenda (despite our request for one) and discussion was free ranging, though focused heavily on alternative forms of payment for physicians. Essentially our support for salaried service was sought. The ministry saw this as the main issue on which to tackle health care costs. They were also quite concerned about the numbers of family physicians clustering in city areas. We pointed out our resolution on this matter (supporting exploration and research of alternative methods of remuneration) and suggested that the Ministry should advertise the salaried service option more. We suggested that persuasion of the profession was more likely to be successful with the force of example, rather than dictat. In response to a request form Andy Brandt (Tory leader Ontario) Bob Frankford drafted a letter regarding our concerns with health care issues on the province, to be sent to all three political parties.

A portion of the each Steering Committee meeting is spent on planning the next general meeting, concerns about membership, the "lost" Toronto chapter (Rumoured deceased) and the depleted Steering Committee. Ben Chan and Catherine Oliver have resigned for personal reasons. Thanks to both of them for their work and time to date. The Steering Committee needs and would welcome any volunteers with time and energy, even limited, to spare.

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 June 2, 1989. The deadline for longer articles is April 27; shorter items such as announcements 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.

Proposed Resolution: Resource Allocation in Health and Health Care

Health care expenditures cannot be unconstrained, and efficient expenditure of resources within the health care system is important. However, 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.

Decisions regarding resource allocation should be based on the following four principles, stated in order of their 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. Thus, health care costs should be constrained only if the money saved will be spent on activities which have a greater impact in terms of improving health, or are of greater social value for some other reason.

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.

4) Efficiency – The efficient distribution of resources (maximizing cost-effectiveness) within the health care system should be one goal of the system.

Proposed by the Resource Allocation Working Group.

Community Health Clinics: A Reply to Bob James

(Editors' Subtitle: "The cynics of Toronto")

The following is a response From Francis Kilbertus to Bob James' article on community clinics, which appeared in the December 1988 issue.

Dear Bob,

Firstly I'd like to applaud your taking on the often contentious topic of CHC's at the last MRG general Meeting. I obviously have a personal interest in the area. It is too bad there seems to be such disillusionment with the model. This doesn't come as a surprise considering the number of ex-CHCers in the MRG as well as what I'd been hearing from the grapevine, i.e. a lot of dissatisfaction at certain Toronto CHC's.

Because of what I sensed to be very negative view of CHC's or rather, that they've been a failure, I feel the need to express my support for the model. My experience in Ottawa has been very positive. I feel that this can be generalized to the network of CHC's here as well. Of course there are problems ... BUT, there is a sense we have grown through many of the classic problem areas and that CHC's are a good place to work. In speaking of Sandy Hill, job satisfaction and sense of control over the work environment is good among staff, medical and other. Turnover has been very low in the last five years. There is a very supportive network among CHC medical staff, with regular meetings and sharing of resources. This is critical, I feel, not only on a personal level but also as a way of dealing with the Ministry of Health, as they become more interested in CHC's.

In conclusion, there is an enormous resource within the MRG of ex-CHC staff as well as those still in the system and happy with it. Combining these two groups and the things which didn't works as well as those which DO could be very interesting. I would hope that some ideas and experience from outside the Toronto-Hamilton area would be helpful.

Regards,
Frances Kilbertus

Next issue: Jamie Uhrig on CHCs.

Review:"Controlling Health Expenditures: The Canadian Reality"

By R.Evans, J.Lomas, M.Barer et al: New England J. Medicine. March 2, 1989: 320:571-578.

By Haresh Kirpalani

This article should be of great interest to the readership of the Medical Reform Group. The leading contentions of the authors – all academics within the discipline of health economics – parallel those of the MRG. It would provide some useful information when marshalling arguments.

The article's origins lie in the continuing anxiety in the U.S.A. regarding rising medical expenditures. Because: "Canada and the U.S.A. have conducted a large scale social experiment on the effects of the alternative ways of funding expenditures for health care" – the opportunity is taken by these authors to offer a means of controlling health care expenditures.

Firstly they show that indeed there has been good control on expenditure in Canada. This fact may be surprising to those inclined to the view that "costs are out of control." When gross national product is adjusted for the rate of inflation (greater in Canada) and for the growth of the population (so called per capita – also greater in Canada) it proves to be only 0.4% per year greater for Canada than for the U.S.A.. This it is argued, is very comparable. Average annual per cent increases in total expenditure for health care in Canada and U.S.A. between 1971 and 1985 were as follows: Canada 3.1%, U.S.A. 4.8%.

As they put it: "In 1985 Americans spent an average of $1,710 each on health care. If their rate of escalation since 1971, in real terms, had been the same as that in Canada, they would have spent only $1,362 or 20% less. One may estimate conservatively that if the Canadian rates of escalation in real cost since 1971 had prevailed in the U.S.A., health spending would by 1987 be about $450 less, on average, for every person in the country, or at least $100 billion less in all."

They then break down the locus of additional costs: administration and prepayment expenses sides. This amounts to the great burden of paying for keeping track of who is eligible for which benefits. This instead of simply saying everyone's eligible because of universal coverage paid for by universal tax, as in Canada. Even new technology costs are at least in part so costly because of rises in administrative cost, and not purely because of the new technology itself. Further because all hospital budgets are more or less controlled by government bodies (Ministry of Health): "this process has resulted in a significantly less rapid rise in hospital expenditures in Canada than in the U.S.A.." They also point out that Canada is able to have a more of an accent on chronic care beds, which are cheaper than acute beds as they have lower daily care requirements. Thus: "Canada can have higher rates of hospitalization and greater average lengths of stay than the U.S.A. yet also have lower per capita hospital expenditure."

They identify the political fever that results from vesting the responsibility for funding at the governments doorstep, pointing out that "rhetoric of underfunding, shortages etc" are part of a negotiation scenario. They do not state clearly that they believe that this rhetoric is wholly untrue. But talk about the "boy crying wolf" clearly expresses their underlying view.

Complaints of the medical profession in Canada are viewed as a response to the question of oversupply of physicians and thus the increased competition for short term hospital beds. Pressure on physicians in Canada is acknowledged. Nonetheless the physicians, despite an overall rise in salary from 1971 of 10% of GNP (as compared to US physicians where the figure was 40% in the same time period), have retained control of clinical freedoms. Again in contrast to the U.S.A., where:

"managed care systems and prospective payment designed to alter individual physicians' care of individual patients, have become the principal tools for the control of expenditure for physicians services."

Most of these arguments are familiar to the MRG, even though it is nice to see these views in such a prestigious journal as the NEJM. It was disappointing to me that only one side of the "Rhetoricians" were called – physicians on their rhetoric. What is sauce for the goose is surely sauce for the gander. The governments have their own rhetoric. If the proportion of the GNP going to health in Canada has been so stable, it does surely reflect caution in accepting the dire predictions of governments that health care is now suddenly too expensive.

News and Views With a Personal Slant:

"What Illustrious Canadians said about deficit OR Is there a crisis or isn't there a crisis?"

By Haresh Kirpalani

So does one believe the utterances of pre-election Brian Mulroney, Michael Wilson (Federal Finance Minister) and Laurent Thibaualt ,or are the post election utterances to be believed? Recent "Revelations" from the modern divinity (read the IMF) imply the post-election versions are more believable. Given that Canada is a major contributor to the IMF however, the situation is rather like asking Faustus to comment on if Lucifer has been a good boy!

The elections are not so distant that the various promises of Wilson and Mulroney need to be reiterated. Remember the various bribes in the form of election promises? In the astonishingly short period of time of 2 months we are now confronted by Wilson's bland:

"the commitments that we made as a government ...were taken in the context of a program expenditure profile that was responsible ...what we've seen since that time is a significant increase in interest rates which obviously colour the fiscal position for next year." (Financial Post 10.3.89 p.1.)

Wilson has made two assertions: firstly that inflation has to be fought against by high interest rates and secondly that the "crisis" was unpredictable. Of the first assertion it is enough here to say that oversupply of money (i.e. printing of it by governments) is recognized as the root cause of inflation – not spending of money by corporations or private individuals, requiring high interest rates by Wilson's logic. Secondly it should be noted that the necessity for the rise in interest rates is challenged by some. (Report on Business Globe and Mail M. Mittelstaedt 10.3.89). Certainly all this furore does not seem to have deterred business from planned major capital expenditure according to Statscan of: "$133.3 billion up 8.2% from $123.2 billion in 1988." (J. Kohut Business report. Globe and Mail 9.3.89)

As for "unpredictability": "The last time a Canadian federal government ended a year in the black was 1969. Red ink has been the order of the day ever since." (H. Solomon Financial Post 14.03.89.)

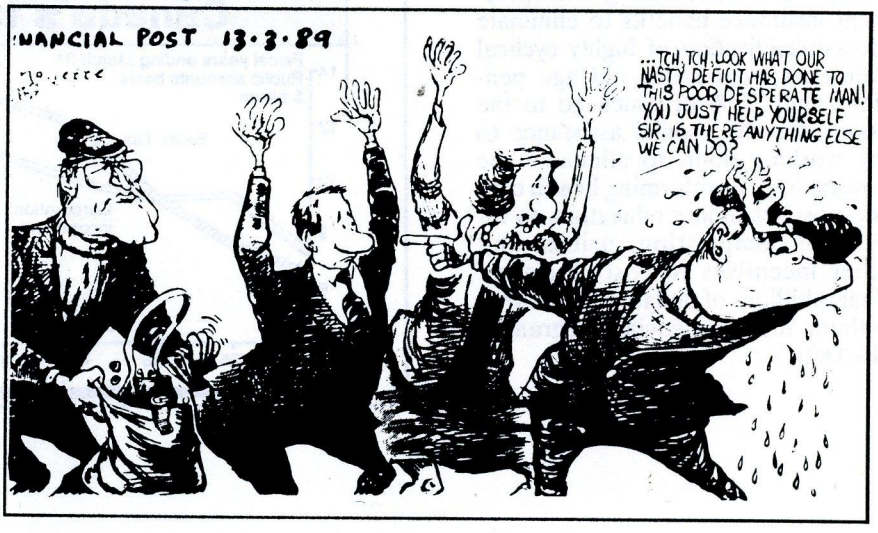
The upshot appears to be that there will be changes of which: "few Canadians will escape (the) impact" (H. Solomon Financial Post Ibid.) Grants and payments to provinces account for $32.5 billion in the year ending March 31, about a quarter of federal spending. (A. Cohen Financial Post. 11.3.89). If transfer payments are cut (something that B.C. Finance Minister M. Couvelier calls "a cheap fix - transferring the burden form one government to another. (Cohen Financial Post Ibid) then says Ontario Treasurer Robert Nixon: "It would be very, very serious". (Cohen Financial Post Ibid)

What has been said by illustrious businessmen? Thus Tom D'Aquino President of the Business Council on National Issues: "We cannot afford to satisfy each interest group, each constituency, each region or regions within a region, by giving them something. We cannot afford to give everyone the same public pension or the same baby bonus whether they need it or not. We cannot afford mismanagement or abuse of the very costly unemployment insurance program – a program that is vital to the all too many Canadians who cannot find work."

(In H. Solomon, Financial Post 14.3.89.)

These are code words for assaults on the so called "middle classes" and those over the "Official Poverty Line". Rather less coy was Laurent Thibault, head of the Canadian Manufacturer's Association: "It's clear we're wasting a lot of that money on people who don't need it – the Canada-U.S. Free Trade agreement that we fought hard for creates great opportunities but also makes it more urgent that we tackle the outstanding issues that affect our competitiveness". (Report on Business, Globe and Mail 1.3.89)

Apart from taking apart social services and education – are there any other solutions? Well no illustrious Canadian seems to think much about company taxation increases; notwithstanding that: "for the first 10 months of this fiscal year corporate tax revenues were $7.1 billion down from $7.7 billion a year earlier...despite a promise by Wilson that under tax reform corporations would begin to bear a greater share of the tax burden" (Business Report Globe and Mail, March 1989.) In an editorial: "Tax increases not the answer" the Financial Post (14.3.89) invokes the spirit of Mil-



ton Friedman in rejecting taxation, especially capital gains taxation. Invariably the bogey of the U.S.A. is already used as a reason NOT to do something. Thus Madelaine Drohan: "Wilson's ability to tap the corporation sector for increased revenues is restricted because he has to keep corporate taxes here broadly in line with those in the U.S. While the average individual is unlikely to pack up and move to the U.S.A., just because personal income taxes may be lower there, the same cannot be said of corporations. (Financial Post 14.3.89)

What solutions does the Financial Post offer us then? "There is still fat in government budgets. There is plenty of room to make cuts, or at least hold the line on spending."

Where is this room? Enumerating VIA rail (save 2 billion) Dept. of regional industrial expansion (save 2 billion) agriculture (save 3.8 billion) airports (save 700 million) they also propose cuts in transfers to provinces, especially since "some of what is labelled "health" or "education" is siphoned off to other purposes." The Financial Post concludes another editorial: "None of this even mentions saving from restructuring unemployment insurance benefits to eliminate cross-subsidization of highly cyclical industries; redirecting old age pensions, only 20% of which go to the poor; extending social assistance to the working poor, to eliminate the poverty trap; or reforming health care and post-secondary education, to introduce competition, prices, and other incentives to cost-efficiency. That is billions of dollars can be saved without touching social programs". (13.3.89)

I suppose I always was confused when I thought that old age pensions were social programs!

It appears clear that tax increases will be aimed as always at the bulk of the population who can least afford them. J. Simpson (Globe and Mail 14.3.89) castigated the "blame throwers" those who in a poll "wanted more taxes on the "wealthy", "the rich" and "corporations". They said yes to higher taxes on booze and cigarettes, but resisted increases in personal income or sales taxes. This is refusal to accept any personal responsibility". Well Wilson will be pleased to hear this. As Madelaine Drohan predicts: "only the very poor will be spared" (Financial Post 14.3.89). Below are shown two graphs from her article showing the relative contributions of sales, corporate and personal tax.

What about that other "Half Witted Radical Evergreen Idea" – cutting nuclear subs and all that? Illustrious Canadian Brian Mulroney speaks: "Reducing (this) would not be a big ticket item in budget cutting because the cost is distributed over a 23 year period, equalling about $350 million per year ... if you were looking for a big hit that would not be it because you would still have to have submarines. If the submarines were non-nuclear they would still cost a substantial amount of money." (Globe and Mail March 1989)

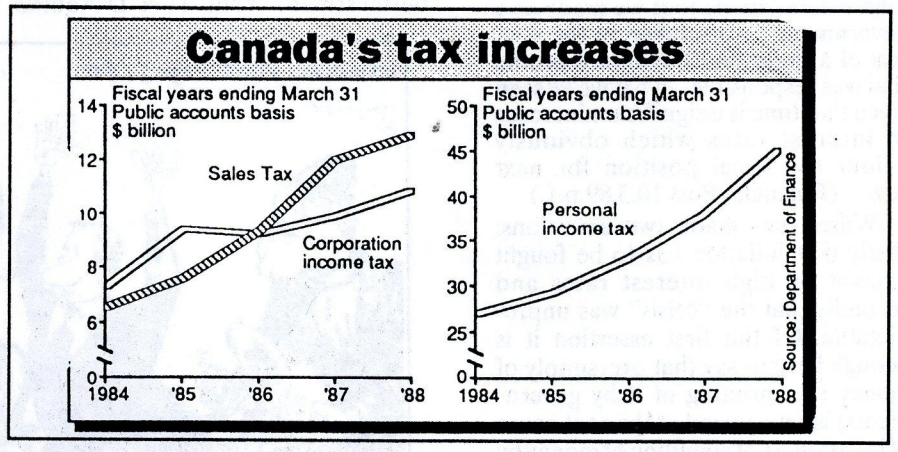
In the midst of all this Saskatchewan is reading the Thatcherite Books. Says Premier Grant Devine of opposition to the privatization plans he has: "this is their Alamo, their Waterloo. This is the end of the line for them". (Globe and Mail 9.3.89) So far plans are public only for Potash Corporation, Government Insurance and SaskEnergy privatization.

I have not directly answered the question in the heading. Instead I offer two additional questions:

"Who do you think the Financial Post speaks for and to?"

and "If indeed there is a crisis, whose is it and who should suffer its' brunt?"

There are no prizes for correct answers.



MRG Meets With Health Minister Caplan and Deputy Minister Barkin

By Joel Lexchin

On Feb. 10, three members of the Medical Reform Group, Bob Frankford, Haresh Kirplani and Joel Lexchin, met with the Ontario Minister of Health Elinor Caplan and her deputy Dr. Martin Barkin. Caplan's stated reason for the meeting was to meet with members of the MRG and to get their opinions on a wide range of issues. Although Caplan had to leave for another meeting after about 45 minutes, the session with Barkin lasted a further hour.

One of the main topics that Caplan and Barkin raised was the issue of salaries for academic physicians. The Minister's position was that it was necessary to adequately fund these departments, (or to control expenses in these areas?) before similar moves could be made with similar specialists in private practice.

Barkin was most concerned with the cost of providing primary care. His feeling was that this was the area where expenses were most out of control and that, in general, the provision of primary care was the weakest part of Ontario's health care system. Although he said it was a gross simplification, Barkin claimed that with a ratio of 2,000 patients per general practitioner the entire population could be covered by 4,000 GPs. There are currently 10,000 in Ontario. Barkin's question was: "What are the other 6,000 doing?" He was quick to point out that he didn't have the answers and admitted that the Ministry didn't even have the data base to try to find the answers.

The MRG raised the question of alternative methods of health delivery, specifically HSOs and CHCs. Barkin's position on CHCs was that they were probably going to be used only in special circumstances where health needs could not be met through other ways. Barkin and Caplan seemed much more enthusiastic about HSOs. One suggestion from the MRG was that older GPs who were nearing retirement should be encouraged to associate with HSOs as a way of staying in practice part time and maintaining some continuity of care especially for their older patients. The MRG also felt that HSOs were not meeting their full potential because they were not allowed to advertise their services.

The question of the Independent Health Facilities Act came up along with the concerns about inspections of medical records. Barkin said that the Act had a number of purposes. After the abortion law was struck down the Ministry was concerned that some physicians would start doing abortions in unsafe settings and some method was needed to regulate this. The Act was also seen as a way of controlling certain forms of extra billing e.g. charging people for storing their medical records or for disposable gowns. Under the Act anyone charging these sort of fees is deemed to be operating an independent health facility and is subject to regulation by the Act. Barkin said that inspections were going to be turned over to the College of Physicians and Surgeons to alleviate fears about the confidentiality of medical records. One MRG worry about the Act was that under the present wording it was possible for a clinic, e.g. an abortion clinic, to be closed down simply at the discretion of the Minister. Barkin admitted that this was a possibility. He said that changes to the act would remove the threat.

The MRG queried Barkin about the elimination of OHIP premiums and the income cut-off levels for OHIP premium assistance. On the latter topic Barkin did not seem to be aware of what the levels were and promised to look into it. Barkin said that the government remained committed to the elimination of OHIP premiums but refused to put forward any time table for this to happen. On this matter, Barkin also raised the argument about limited government resources and where the best place to put them was. The MRG response, only half facetiously, was to make the defense department run bake sales to buy nuclear submarines.

Finally, the topic of waiting lists for surgery came up. Barkin was particularly emotional on this topic and said that as former CEO of Sunnybrook he knew all the techniques that hospitals tried to use to get more money. His position was that if hospitals did not do the things that they were funded for, then the Ministry would take the hospitals over and run them. Whether this is also Caplan's position is unknown as she had left the meeting by this point. Barkin gave an example of one downtown Toronto teaching hospital which he said had been funded for 1100 cardiac bypass operations last year but had only done 700 because the head of surgery there had taken one of the ORs out of service to concentrate on liver transplants.

I do not feel that the meeting had any concrete results. However, I think that it's a measure of the MRG's standing with the Ministry that we got 45 minutes with the Minister and more than double that time with her chief deputy. Going to these kinds of meetings also keeps the doors open for future meetings when the MRG may want to push its own agenda.

Comments on Malpractice

By Haresh Kirpalani

(These comments were made to M. R. Pritchard, chair of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care. See the February 1989 issue of Medical Reform for a summary of the Review's work.)

Mr. Prichard was first made aware that the MRG as yet does not have formal policy on this issue. The nearest we have come to formal policy on redress by patients is concerning the CPSO Disciplinary Board.This is contained in the resolution of moved by Don Woodside and Bob James. These were discussed in the Newsletter of Feb 1988 Number 1 Vol 8, p.7-8, and the final voted and carried text is in the issue of June 1988, Number 3 Vol 8, p.5.

In the absence of other firm policy I proffered my own personal views. I think these were tempered to fall within the broad spirit of the MRG's principles 1 and 3.

Number 1. the universal access of every person in 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.

Number 3. The institutions of the health care system must be structured. ... (so that) ... the public and health care workers should have a direct say. ... in determining the setting in which the health care is provided.)

1. I stated that we have to date concentrated on stiffening the resolve of the CPSO to deal with misconduct. This concentration was in part due to the debates on the Disciplinary Body of the CPSO; related to the Schwartz Commission.We wished to make this process as accountable to the public as possible. We consider that one of the clearest means of ensuring a "public", control on potential rogue physicians was to have an effective lay representation on the Disciplinary Boards of the CPSO; to ensure that the process of the CPSO Discipline was seen to be unbiased and above board. (As per Previous resolutions MRG.) I expressed concern about the apparent meekness of the CPSO in dealing with certain instances of abuse.

2. There clearly is a need to make public right of redress to the medical professions as easy, cheap, visible and demystified a process as possible. To this end, ensuring subsidized legal counsel for the process of legal redress would be seen as important in any system of reform. Personal experience of the expenses incurred by patients obtaining legal advice has led me to advocate the CPSO Disciplinary Process as a substitute for any legal avenues. At least the grievance then had a chance of being aired without undue financial burden to an already distressed family.

3. The primary reason for the burgeoning litigation "crisis" was an inability of physicians to admit error, to be able to even communicate effectively to patients, and a generalized arrogance of the profession that has reaped its own harvest. (See for instance "legal issues in ambulatory paediatrics. A.R.Holder LLm. in Medical-Legal Issues in Paediatrics. 18th Ross Roundtable Ohio 1987.)

When patients are treated as fools they get angry; they are well aware when mistakes have happened and resent being lied to in a cover-up operation. In my personal experience when I have made a medical error; invariably, honesty to the parents/patients has resulted in mutual respect regarding an "honest mistake".

4. A frequently recurring theme in my medical practice is that when litigation is embarked upon, the patient/parents are also above all concerned to try their best to prevent further unnecessary suffering. They are in effect attempting to initiate public policy regarding quality control.This is hardly ever acknowledged.

5. Financial remuneration in cases of chronic disability was likely to be sought by families simply because of the financial burden to the family/patient of long term disability possibly related to malpractice. In this context it is interesting to read the following quote from Mr.E.P. Richards of the U.S. National Center for Preventive Law:

"I believe that the major lesson from Europe, particularly Sweden, is that socialized medicine is a very effective cure for malpractice litigation, which is extremely unusual in Europe. The primary reasons those countries can support a non-contingent fee-based legal system are that people don't have to go to court to get their medical bills paid when they are injured and that disciplining of doctors is not done by Star Chamber proceedings of local competitors, but by state regulatory agencies."

(Medical-Legal Issues in Pediatrics. Ibid.)

6. That adjudicating for error in malpractice cases was frequently difficult as often it is possible to put opposing Expert Opinions such that effective reconciliation becomes a matter of some discrimination the part of the Bench. That often there may not be clear error. That definitions of Standard of Care are as yet often not fully available, or at best open to sharp disagreement - since randomized double blind clinical trials are as yet too few. Standards of Care are evolving in a more formal manner than the previous informal reliance on professional educational consensus. However there are still very few instances that parallel the Standards adopted by the Anesthetists at Harvard Medical School. (See The setting of Standards of care. Editorial JAMA 1986:256;1040-41.)

7. That the issues of protection of Quality of Care, and financial security for the patient in the light of "genuine error" or "mishap" resulting in disability/death are confused in the current system. That the issue of Quality Control should be more formally,and aggressively dealt with by Practice Review by the CPSO, and for formal retraining schemes financed through the CPSO, when found necessary by the CPSO.

I did not say, but should have, that there needs to be a much more careful expansion of Quality Assurance programs throughout the hospital services at least. That this would in fact therefore include some of the thrust contained in Mr. Prichard's section on institutional liability.

8. That primarily we would support a clear no fault insurance scheme in as much as it would allow disability to be financially compensated. (For review

of its functioning see Law-Medicine notes. Medical Malpractice in Sweden. Jonsson E and Neuhauser D. New Engl. J Med. 1976: 294:1276-1277.)

However negligence by health care givers should be OPENLY and FAIRLY ruled on by professional organizations. By fair I mean in a manner acknowledged as different from the worst traditions of the Old Boy's Club habits of sweeping under the carpet nasty messes.

In order to ensure this it should be a much more overt expectation by the Provincial and Federal Government that the Professional Bodies fulfill their role in this matter.

9. One final comment relates to Informed Consent, and the need to ensure adherence to standards regarding this. The forum of discussion of this point is the CPSO who will also have to address the extremely difficult question of monitoring adherence. (See Malpractice prevention through the sharing of uncertainty, informed consent and the therapeutic alliance. Gutheil TG, Bursztajn H, and Brodsky A. New Eng J Med 1984:311;49-51.)

In the belief that we need policy on this issue, D.Woodside and I have proposed a draft resolution for the MRG Semi-Annual Meeting. This is put now and it is expected will undergo debate, modification and voting upon in May 1989.

PROPOSED RESOLUTION

Medical Liability and Compensation

Whereas the present negligence-based adversarial liability system

a) Is a costly and uncertain recourse for patients who have suffered harm during medical treatment;

and its cost may deter some legitimate claims

b) Compensates only the small proportion who can prove the harm followed from negligence

c) May unduly penalize the individual physician for an honest mistake

d) May focus attention on individual errors when health care system problems are involved

e) Fosters the practice of defensive medicine to the detriment of patients and health care in general

f) Is a poor substitute for quality assurance which can be better provided by other institutional and regulatory measures

Be it resolved that The Medical Reform Group supports the introduction of no fault insurance for medical mishaps.

-Sponsored by Haresh Kirpalani and Don Woodside

Malpractice Insurance: Is There a Better Way?

By Joel Lexchin

Is there a way of protecting doctors from malpractice suits while at the same time compensating people who have legitimate grievances about the quality of care they received? Can both of these objectives be reached outside of the court system where legal proceedings can drag on for years and cost hundreds of thousands of dollars?

The answer to both questions is yes. The example we have to draw upon comes from New Zealand. Since the mid 1970s the Accident Compensation Corporation (ACC) has been operating in that country. Essentially the ACC is an extended Workers Compensation Board (WCB) system; all accidents however caused are covered under this program. People who have suffered an accident receive either lump sum payments or ongoing payments, depending on the circumstances and the nature of the injury. In addition, all medical expenses arising from the accident are covered by the ACC. As with the WCB in Ontario the program operates on a no fault basis.

The ACC compensates people who suffer adverse consequences as a result of medical acts, thereby avoiding the long, costly and bitter court battles that we see in Canada. Having the ACC does not, of course, mean that doctors who have exhibited gross incompetence escape free of any penalties. These doctors can still be taken before the professional disciplinary body in New Zealand, just as they can in Canadian provinces. The ACC also does not generally cover acts of omission, that is instances where doctors have neglected to do something.

The ACC is not perfect; people are denied benefits because the ACC rules that the outcome of their encounter with a doctor does not constitute an accident, i.e. an unforeseeable event. There are problems with the level of compensation that people receive and there are always complaints about the economic costs of running the ACC. Some people also argue that the ACC is too discriminatory in that it draws arbitrary distinctions between people who have suffered accidents and people who have contracted some form of illness that does not allow them to function normally. There have been calls to extend the ACC to cover all forms of disability.

Although doctors in New Zealand still join defence associations, the annual subscription fee is only a few hundred dollars, not the thousands that we pay in Canada. Part of the difference comes from the fact that New Zealand is basically a less litigious society than Canada, but the existence of the ACC and its no fault system is a major factor in keeping premiums low. Of even greater importance, people are able to get economic redress for medical accidents without having the hire expensive lawyers and wait for years until their cases are decided by the courts.

An ACC in Canada would work to the benefit of everyone and is a concept that the MRG should support.

News Briefs

Law Reform Commission on Fetal Rights

The Law Reform Commission released a working paper on *Crimes Against the Foetus* in February. It recommends legislation which would make it a crime to purposely or negligently cause death or serious harm to a fetus. There would be exceptions for medical treatment and legal abortions. On abortion, it recommends that in the first 22 weeks, a woman can terminate her pregnancy "if medically authorized on the ground that her physical or mental health was threatened." Thereafter, legal abortions would be permitted only when necessary to save the woman's life or to protect her against serious physical injury. The Commission also recommends that abortion could be lawfully performed at any stage if the foetus suffers from a lethal defect. The recommendations regarding abortion were criticized by pro-choice groups as a step backward by requiring medical authorization rather than allowing the woman to choose on her own.

Toronto Birth Centre to go it alone

After several years of attempting to work out a funding arrangement through the Ministry of Health, the group working to set up the Toronto Birth Centre has decided to launch a fundraising campaign so that the centre can exist independently. The Centre had been trying to negotiate an agreement with Doctors Hospital, but the two sides couldn't come to an agreement. According to hospital spokeswoman Diana Moeser, "It was too difficult to work out. The autonomous model promoted by the Toronto Birth Centre just did not fit the system. On the one hand, as hospitals, we're legislated to operate a certain way, and on the other, from the point of view of the birth centre, we were not supposed to impose on their operation. It was like pushing apples and oranges together."

-NOW, March 2, 1989

Weapons Plant Critic Dies

Dr. Carl J. Johnson, an early and outspoken critic of the Rocky Flats nuclear weapons plant (see article by him in February 1989 issue of *Medical Reform*) has died at the age of 59. Johnson was forced to resign as Jefferson County, Colorado, health director in May 1981 after his publication of studies showing a higher incidence of cancer in areas close to the Rocky Flats plant 16 miles northwest of Denver. *-Los Angeles Times, February 1, 1989*

Enquiry on Mental Competency

The Ontario Ministry of Health has set up an **Enquiry on Mental Competency**, chaired by Prof. David N. Weistubb, to examine the issues involved in developing criteria for determining the mental competence of individuals to make decisions relevant to health care. A report is to be submitted within nine months; the deadline for submissions is April 7.

Generic Companies sue OMA

The Canadian Drug Manufacturers Association (CDMA) and two manufacturers of generic drugs are suing the Ontario Medical Association, the Upjohn Company, a video company, and eight doctors over a video recording "What Did the Doctor Order?", which has been used in a campaign to discourage generic drug substitution. The CDMA alleges that the video is slanderous and damaging, and is asking in excess of $100 million in damages.

-Globe and Mail, January 26, 1989

Nurses get seats on hospital committees

The Ontario cabinet has changed regulations under the Public Hospitals Act to require that ordinary nurses be represented on hospital management committees. Currently the committees are staffed by hospital managers, doctors, and nursing managers. Glenna Cole-Slattery of the Ontario Nurses Association said that "It's just what hospitals need – input from the people who do the work."

-Toronto Star, Globe and Mail, February 16, 1989

OMA proposes binding arbitration

The Ontario Medical Association is proposing that the provincial government agree to binding arbitration in future fee negotiations. Premier Peterson and Health Minister Elinor Caplan said that they would be willing to consider the request, but made no commitment.

-Globe and Mail, February 9, 1989

College allows computer deal

The College of Physicians and Surgeons of Ontario has reached an agreement with Squibb Canada which will allow the drug company to continue to provide computers to doctors who prescribe Squibb's drug Capoten. The computer remains the property of Squibb, but may remain in the doctor's office indefinitely. Doctors will be required to sign an agreement promising not to use the computers for personal purposes. Joel Lexchin of the Medical Reform Group criticized the agreement, pointing out that it is unenforceable.

-Globe and Mail, February 21, 1989

British Tories shake up National Health Service

The Thatcher government is moving to implement some major changes in the British National Health Service. The main proposals include: the creation of self-governing trusts to run bigger NHS independently of district health authorities, employing their own staff and setting their own pay rates; development of an internal market allowing patients to be treated in the private sector; tax relief to help pensioners pay private health insurance premiums; GP practices to be allowed to apply for their own budgets and to buy hospital care; imposition of audit controls on doctors to ensure value for money; monitoring of prescription costs to control GPs' drug bills. The plan for larger general practices to run their own budgets, with scope to keep any money left over after they have bought treatment for their patients from hospitals and clinics, was criticized on the grounds that their would discourage GPs from taking on elderly or chronic patients. Fear was also expressed that practices would have to close if they ran over budget, depriving patients of treatment. It was also suggested that the changes would encourage hospitals to concentrate on the more lucrative treatments while opting out of the economically less attractive treatments.

-Manchester Guardian Weekly, February 12, 1989

Hospital considers disclosing negligence

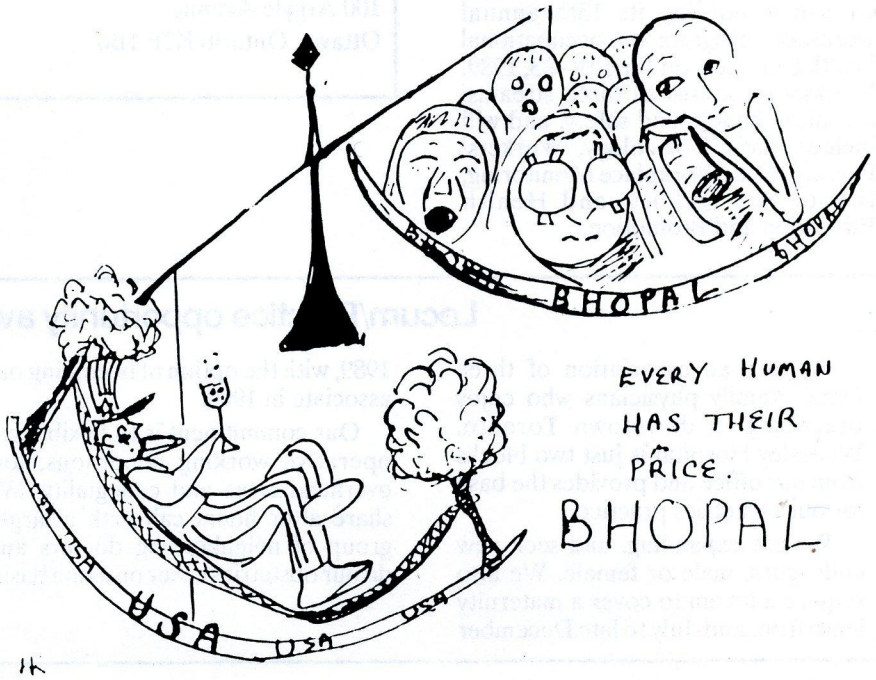
The Royal Victoria Hospital in Montreal is considering draft guidelines that would require disclosure of negligence in patients who may have been harmed by its care or treatment. The guidelines were drafted by the hospital's ethics committee, and are now to be considered by its executive council. Insurers of Canadian hospitals say many incidents of negligence are not disclosed to patients. The Royal Victoria proposal "demonstrates a new sensitivity that people have the right to know what's happened to them," according to Margaret Somerville of McGill University's Centre for Medicine, Ethics, and Law. "It's the other side of the coin of informed consent." She said hospitals have been reluctant to consider disclosure because their lawyers have advised them that this would leave them open to more lawsuits. "That's wrong. If the truth is handled well and sensitively, people are less likely to sue." She said patients who suspect something has gone awry but are met with a wall of silence often feel the only way they can get answers is by legal action.

-Globe and Mail

WCB rejects cancer study

The Ontario Workers Compensation Board has rejected a McMaster University study which found cancer in a group of women factory workers to be linked to their jobs at a Canadian General Electric plant in Toronto. The industrial disease standards panel of the Board ruled that there is no provable connection between the cancer cases and working conditions in the coil and wire drawing area of the lamp plant. The McMaster study was of 203 women who worked in the area between 1960 and 1975. It concluded that statistics supported a work-related cause of 11 cases of cancer – eight of them breast cancer. The matter was before the WCB because three of the women had filed for compensation. According the Shelly Martel, the NDP critic for the WCB, the WCB had previously made compensation awards on the balance of probabilities, but is now insisting on conclusive proof. Ms Martel said that this places an almost impossible burden of proof on the claimants.

-Globe and Mail, February 16, 1989



Announcements & Ads

Housing and Mental Health

A one-day workshop is being held on Tuesday April 11, 1989 on **The Impact of Housing on Mental Health**, sponsored by the Ontario Mental Health Foundation. The workshop has three main aims: **1.** To emphasize the role of research in improving the provison of housing to those suffering from mental disorders and in promoting mental health by careful planning of new housing and the use of existing housing; **2.** To provide helpful models of what a fully developed research grant application should include; **3.** To develop an informal network of researchers and agencies interested in doing research on housing and health. Contact: Ontario Mental Health Foundation, Suite 1708, 365 Bloor St. East, Toronto, Ontario M4W 3L4.

Health and Safety Workshop Program

The University College of Cape Breton is holding its 13th annual workshop program on occupational health and safety on June 19 - 23, 1989. Workshops consist of three streams: technical, health, and safety, and will include Basic Toxicology, Workers' Participation, Workplace Monitoring, Indoor Air Quality, and Health Education and Promotion.

Family Physician wanted for seniors' program

A family physician is needed to join our team in developing and delivering a range of primary healthcare programs for the elderly in the Centretown/Glebe area of Ottawa.

Candidate must be progressive, innovative and able to work on an outreach basis to develop and provide appropriate geriatric services in a variety of community settings. Candidate must be able to work with a multidisciplinary team whose major focus is health promotion and illness prevention.

Requirements are experience in geriatric care and sensitivity to seniors' needs. CCFP is desirable and bilingualism an asset.

SALARY: $50,822 (part-time)

Please reply to:
SHIPS Coordinator
Centretown Community Health Centre
100 Argyle Avenue
Ottawa, Ontario K2P 1B6

Physicians wanted for homeless

STREET HEALTH nursing stations for homeless people in downtown Toronto is looking for family physicians to refer their clients to. We need doctors who view homelessness as a health issue; people who are willing to spend some time to understand who are the homeless people today; persons who will be sensitive to and use a holistic approach to the client and their special needs. Please call Dilin Baker RN, 967-5546.

Family physician Vancouver

REACH Community Health Centre requires a sixth family physician to join a multi-disciplinary team in an established East Vancouver Clinic. Obstetrics required.

Contact:
Ian Ross, Administrator,
REACH Community Health Centre,
1145 Commercial Drive
Vancouver, BC V5L 3X3

Locum/Practice opportunity available

We are an association of three female family physicians who enjoy practicing in downtown Toronto. Wellesley Hospital is just two blocks from our office and provides the base for our obstetrics practice.

We are expanding, and seek new colleagues, male or female. We also require a locum to cover a maternity leave from mid-July to late December 1989, with the option of becoming our associate in 1990.

Our commitment is to flexible co-operative working conditions, low overhead costs and collegiality. We share after hours call with a larger group of neighbouring doctors and do our obstetrics cover on a rata basis.

Our office is being enlarged late this year and any newcomer could play a role in designing our exciting new space.

Candidates must be interested in the practice of obstetrics.

For further details, contact Jane Crispin or Nancy Harris at (416) 964-2993.

THE GLOBE AND MAIL, MONDAY, MARCH 20, 1989

Is anyone reading the fine print?

Drug advertisers seem to be so busy delivering good news that the bad news is lost in the shuffle

BY JOEL LEXCHIN
Dr. Lexchin is an emergency room physician in Toronto and the author of The Real Pushers: A Critical Analysis of the Canadian Drug Industry (New Star Books, Vancouver).

THE CONTROVERSY surrounding the computers that Squibb, a multinational drug company, has given to 2,000 doctors raises the larger question of how drugs are promoted to physicians.

Squibb claims these computers are part of a legitimate study of its drug Capoten. Critics of the industry have charged that the program is nothing more than a sophisticated marketing technique. Even Judy Erola, president of the Pharmaceutical Manufacturers Association of Canada, while defending Squibb, agrees that, in some cases, the drug industry has to "clean up our act."

The sums spent on promotion are not trivial. In 1987, drug companies operating in Canada spent almost $400-million on advertising, more than three times the amount that went into research and development. In the first three months of 1988, Squibb paid $400,000 to advertise Capoten in medical journals.

All the money directed at promotion is not without its effects. Study after study has demonstrated that the more a product is advertised the more it will be prescribed. Many Canadian doctors listen to what the drug companies have to say about their products and change the way they prescribe.

The problem is that the more doctors rely on information from the companies the poorer they are as prescribers: that is, they are more likely to prescribe the wrong drug in the wrong amount for the wrong reason for the wrong period of time.

Drug advertising in Canada is monitored by the Pharmaceutical Advertising Advisory Board (PAAB) through its Code of Advertising Acceptance. Since 1978, drug companies have been sending their ads in to the PAAB for what is termed preclearance. The PAAB's commissioner and assistant commissioner examine the ads to see if they conform to the code; if they don't, they are sent back for modification.

Unfortunately, the PAAB's code has major weaknesses. It has almost nothing to say about the visual aspect of an ad, but any student of advertising will tell you that pictures are much more important than words.

A U.S. study found that physicians in the Boston area who said they didn't use ads as a source of information had actually picked up "advertising-oriented beliefs" about the value of two different groups of drugs. These beliefs were diametrically opposed to scientific opinions about the usefulness of the drugs. This finding did not surprise the people who conducted the study. Their conclusion was that drug advertisements are simply more visually arresting and conceptually accessible than are papers in the medical literature, and physicians appear to respond to this difference.

Because the PAAB code ignores the visuals pharmaceutical advertising continues to have a sexist tone. Pictures of naked women are widespread especially in ads for skin products. One ad goes even further and features a profile of a kneeling naked woman with the caption "For a great performnace." Traditional roles of men and women are also reinforced in ads. Sexual stereotyping continues unimpeded by the code. When the schizophrenic woman is "controlled" on medications, she is shown at a children's birthday party; the controlled man is working with his buddies on a construction site.

Ads apparently can say one thing in large type and the opposite in the small print without violating the code. One ad was headlined: "Lower his blood pressure . . . not his potency," but in the small print under adverse effects appears "impotence."

Large type also is used almost exclusively for describing the good points about a drug. The introduction of a new drug to make the heart beat regularly was announced in type three-eighths of an inch high. Buried in a page of type one-fifth the size was the information that one side effect can be fatal 10 per cent of the time. The code sets a minimum print size for that kind of material and the minimum is generally the maximum.

Recently, a series of ads has appeared for a medication to help stop bed wetting in children. Pediatricians, and indeed most parents, know that bed wetting is almost universal, and many non-drug methods can be tried to solve the problem before resorting to drugs. But the ads did not talk about these approaches because the code didn't require it, in effect allowing advertising to take a common everyday problem and turn it into something that needs drugs.

Is Anyone Reading the Fine Print? *continued...*

MORE THAN HALF of the industry's promotional budget is spent on expenses related to "detailers" — people who visit doctors' offices and hospitals to promote their companies' products. In 1985, one detailer left behind a page from his sales manual in the office of a U.S. physican. It recommended using such "attention getters" as cookies the shape and color of drug capsules, pizzas with drug initials spelled out in pepperoni, Easter baskets containing eggs painted to resemble drug capsules and Halloween baskets of free samples decorated with little ghosts made from lollipops and tissue.

What advice do Canadian sales manuals give detailers? We don't know because the code doesn't cover that subject.

A 1986 Finnish study found that, while detailers told doctors about the use of drugs 90 per cent of the time, they mentioned side effects and contradictions only one-quarter of the time and other forms of therapy less than 10 per cent of the time.

What do Canadian detailers tell doctors? Again the code doesn't specify that their activities — which cost the industry about $220-million a year — be monitored.

Finally, the code lacks any meaningful sanctions for ads that violate its provisions. Once an ad appears, doctors or others may file a complaint with the PAAB. But if a complaint is upheld, all the company has to do is modify the ad. The PAAB does not publicize the fact that the ad had to be changed; the company neither has to print a correction saying the ad was wrong nor write to doctors saying the ad was wrong.

Why is the code so weak? Because it is an example of voluntary self-regulation. The advertising advisory board was initiated by the manufacturers' association and, for its first six years, simply administered the code. There have been subsequent modifications but they have not altered the provisions substantially.

Where do we turn to try to toughen up drug advertising? In the United States, drug advertising is subject to legislation and regulated by the government's Food and Drug Administration, but there is no major difference between the U.S. style of promotion and Canada's.

For its part, Ottawa doesn't appear interested in actively monitoring the situation. When he was head of the Health Protection Branch, Dr. Albert Liston defended his agency's system of informal spot checks on advertising by saying that "it's not our policy to treat advertising as the definitive source of information with respect to drugs."

The medical profession does not seem to be any more eager to act than the government. A previous secretary general and a previous president of the Canadian Medical Association both publicly praised a drug industry program for detailers. The Canadian Medical Association Journal and the Annals of the Royal College of Physicians and Surgeons of Canada have written favorably about the PAAB. Editorials in Canadian medical journals have long defended pharmaceutical advertising.

The most critical statement about the manufacturers' advertising the CMAJ's former scientific editor could make was that "their style may not always win universal approval."

A prime reason for this consistent promotion of advertising has been the financial returns that such advertising brings to the journals. For 1984, the CMAJ's net revenue, mostly from pharmaceutical advertising, came to $357,203. Without this income, the medical association would have lost $661,570 that year instead of just under $125,000. (These figures exclude $1,085,553 in extraordinary revenue.)

In the late 1970s the Consumers Association of Canada waged a four-year battle to have all drug advertising to doctors banned. Now, it has a representative on the PAAB, so it's hard to believe that the CAC will be of much help.

The best hope comes from grassroots organizations. In 1985 a play called Side Effects, which critically examined the relationshp between women and multinational pharmaceutical companies, toured the country, playing to almost 10,000 people in church basements, school auditoriums and theatres. Frequently, more than half of the audience stayed behind to discuss the issues the play raised.

In addition, development education groups such as Oxfam (Vancouver) and Inter-Pares have produced literature critical of drug-company practices. Church groups and others formerly active in the international campaign to discourage bottle feeding are now turning their attention to the pharmaceutical industry.

Their goal is a simple one, to make sure that drug promotion does not lead to poorer prescribing and poorer health.