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*

Community Health Centres – Another View

By Jamie Uhrig

At last autumn's MRG meeting Gord Guyatt summed up the state of the organization with two statements. We don't bicker, and we know what we're talking about. I don't want to bicker, but when it came to community clinics, we didn't seem to know what we were talking about.

The Medical Reform Group includes community health centre patients, centre board members, current and former centre physicians, and even a board member of the provincial Association of Ontario Health Centres. A detailed analysis of the problems and strengths of CHCs could have resulted from the meeting. Instead an autobiograhpical analysis of community clinic problems based mostly on experience in Quebec a decade ago was presented.

Community Health centres in Ontario are active and growing. Over twenty are now in operation, serving both marginalized and mainstream communities. The Ministry of Health will provide funds to double the number in the next few years. Some of the concerns expressed at last autumn's meeting should be addressed: problems of community and staff control of clinics, problems of outreach, and problems of physician turnover.

The idea that health care workers and the community should have equal control over clinic management is naive. The community should have full control of all health care institutions, but this rarely happens. Usually doctors run the show. Doctors rarely have training or experience in health care management or community development; there is a lot of truth in the axiom that doctors are poor managers. CHCs in Ontario presently use a different, well-tested model for management – they are run by community boards through executive directors.

One of the problems of community boards is that they never reflect exactly the makeup of the community they serve. This applies to the United Way and the University of Toronto just as much as to Doctor's Hospital or Lawrence Heights Community Health Centre. A community can be well represented by an active and democratic board that works with the executive director on community health problems and concerns. All the staff at Regent Park Community Health Centre did not agree with the board's endorsement of a housing authority's decision to evict all tenants in a unit

Fall meeting to feature proposed changes to Health Professions Act

The Medical Reform Group's fall general meeting has been scheduled for October 13 and 14, 1989.

On Friday October 13 there will be a dinner followed by a discussion in the small dining room at Trinity College at the University of Toronto (NE corner of Hoskin and Devonshire). The dinner will be at 6:30 p.m., with the discussion at 8 p.m. If you plan to come to dinner, please RSVP to 588-9167 by October 5 so we can order enough meals.

The discussion after dinner **Friday evening** will be about the licensed acts approach of the Health Professions Legislation Review (HPLR). How will it affect the allocation of roles on the health care team? Will it lead to democratization and protect quality? Will it lead to a proliferation of health fraud?

Alan Burrows, Director of the Ministry of Health Professional Relations Branch will describe the licensed acts approach and its rationale. Margaret Risk, of the Ontario College of Nurses will explain why they support the legislation and where they see it leading us. A member of the MRG will speak to some of the concerns which have been rasied about undesirable effects. Questions and discussion will follow.

On Saturday October 14, the meeting will be at the South Riverdale Community Health Centre at 126 Pape Avenue in Toronto (Pape just north of Queen). At least one resolution will be introduced regarding the MRG's position on the proposed changes to the Health Professions Legislation.

Also on Saturday, the Resource Allocation Group will have several policy proposals which it will be putting forward for discussion. The proposals, together with a more detailed agenda, will appear in the next issue of Medical Reform, to be published in late September.

where one drug related charge was laid. It was up to the executive director to resolve this disagreement, as she saw that the arguments of both staff and board were aired.

Executive directors of CHCs often have graduate degrees in health care management of administrative experience, and are usually better qualified than doctors to run a CHC. In my view the keys to a successful CHC are the presence of an active community board and professional management by a competent executive director. With control of clinics firmly in the hands of the executive director and the board, CHC doctors can be left free to practice good medicine and become involved in the health promotion movement.

The word outreach too often implies an active knowledgeable centre and an active ignorant community. There are sections of all communities that are not well served by a centre and there are always groups of people who need mobilization for action on a health issue. I prefer to think of outreach as one method in the field of health promotion. Much of health promotion takes place at other levels and in other institutions in the community, but there is an increasing role for CHCs to empower people to have more control over the health of their community. South Riverdale CHC's ongoing role in lead reduction is one example.

Health promotion around poverty issues at Lawrence Heights Community Health Centre takes place at many levels. Clinicians advocate for patients and clients on social assistance daily. A community meeting to publicize and express support for SARC proposals took place and community residents mobilized to march to Queen's Park. The executive director worked with a group who took out an ad in "Toronto's national newspaper" to push for money to be made available for social assistance reform.

The seniors' health promotion worker at Lawrence Heights has worked with a previously isolated group of residents who have begun a transportation system for older residents and have successfully lobbied for the return of discontinued services.

Physicians are in danger of being left behind by the health promotion movement – work in CHCs assures that they will continue to move forward. Community health physicians can work with communities to develop methods of measuring the effects of health promotion on a community's wellbeing. I am also looking forward to a scientific analysis of the cost effectiveness of the clinical activities of CHCs.

Physician turnover in community health centres has been a problem, though a comparison of patient satisfaction with solo GPs and CHC physicians is a limited way to look at the problem. CHC physicians' salaries have recently been put more in line with fee for service incomes. A pension plan has been introduced, and working conditions in many CHCs are now excellent. These changes provide more structure for physicians wanting to make a career out of CHC work, and should provide more stability. We should make no apologies that many former CHC physicians have springboarded from CHCs to pursue higher studies in community health work or work in other progressive health care organizations. Let us hope that there will be a new cadre of young community physicians to compete for positions in CHCs in years to come.

The MRG is in a unique position to make a sound analysis of community health centres. Will this happen, or will the community clinics lamb be sacrificed at the altar of the Health Service Organization god?

Jamie Uhrig at the Lawrence Heights Community Health Centre

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 August 4, 1989. The deadline for longer articles is June 29; shorter items such as announcements must be in by July 17.

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

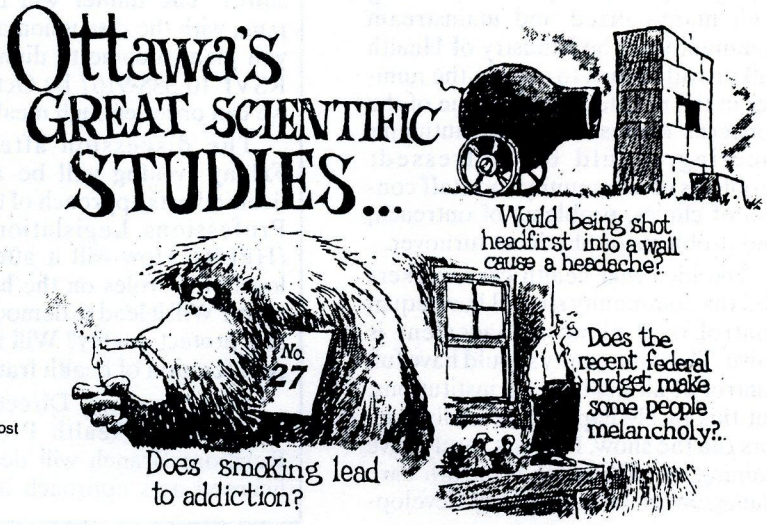
The Universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary or other deterrent to equal care.

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.



Health Care Cutbacks at McMaster University

By Gord Guyatt

MRG members who have been following the intensive discussion on resource allocation that has gone on in the group will be aware that I have been very concerned that our response to resource allocation issues takes into account the major changes in the political environment of health care that have taken place in the last five years. I have characterized this environment as one in which the government has a major incentive to reduce health care spending to protect the interests of the business community in particular (for instance, to maintain or enhance Canadian advantages in free trade) and, in general, to be sensitive to those who would rather see money in private hands than being devoted to public expenditures.

Recent events at the hospital at which I work, the McMaster University Health Sciences Centre, have reinforced my view regarding the current political environment. In the debate about MRG response to resource allocation issues, those who speak of "health care cutbacks" have been criticized on the basis that expenditures on health care have continued to rise (if only very slowly). However, the increasing availability of effective but expensive interventions has (among other factors) effectively resulted in cutbacks in service and care. This has become increasingly evident at McMaster.

There are those who view the prospect of health care institutions getting the financial squeeze with some gratification. Such individuals would experience great delight when surveying the current situation at Chedoke-McMaster Hospitals. The hospital was faced with a projected deficit of over four million dollars in the current fiscal year. The response of the administration and the Medical Advisory Committee was a dramatic reduction of services. Beds have been closed and less operating room time made available. I will mention the impact of these events on four areas of which I am aware.

First, the pressure on the service of internal medicine (in which I work) to keep people out of hospital, and to arrange early discharge for those in hospital, is becoming progressively more intense. I find myself trying to talk elderly patients (generally with chronic, debilitating illnesses that have undergone some sort of exacerbation) and their relatives, into returning home from the emergency department. I subscribe to the view that, whenever hospital services are not absolutely necessary, patients are much better off at home. Nevertheless, I have found myself exercising my persuasive powers in situations when I was, at best, quite uncertain whether it was really in the best interests of patient and family to return home. If my fears are correct, health status is being adversely effected by the pressure to keep such patients out of hospital.

Three other areas affected are ones in which large and very visible expenditures are being made, and in which major cost savings can be easily effected. They are the bone marrow transplant program, the availability of hip replacement for older people with severe osteoarthritis, and the neonatal intensive care unit. What struck me is that these are three areas in which we know we are doing more good than harm with our interventions. Moreover, these are three areas in which there is relatively good evidence about the cost-effectiveness of the interventions, and in which the cost-effectiveness is high in relation to many other health care activities. Those unaware of recent developments in the area of bone marrow transplantation might question its inclusion in this category. The advent of cyclosporin has markedly increased the success rate of bone marrow transplantation to approximately 75%. Given that the recipients are all children or young adults, many life-years are gained by the procedure. With regard to hip replacement, anyone who has experienced the change in life quality experienced by an older friend or relative with debilitating osteoarthritis of the hip after replacement will understand my chagrin at the increasing waiting times consequent on the reduction in available operating room time. With regard to the neonatal intensive care, the government has informed McMaster that the cuts in beds are unacceptable, and the hospital will have to reverse its policy and save money in other areas.

It could be argued that the hospital could have been far wiser in its choices, and reduced services in areas in which it is less certain that more good than harm is being done. To take one example: a group of us have just completed a controlled trial of the Chedoke Geriatric Day Hospital demonstrating that patients allocated to conventional care do as well, and perhaps a little better, than those who go to the day hospital. Shutting down the day hospital would clearly be a better way of saving money than reducing hip replacements, bone marrow transplants, or beds available for critically ill neonates. Political pressures make this course impossible; indeed, there is pressure for increasing unproven (which is not to say necessarily cost-ineffective) rehabilitative services at Chedoke-McMaster.

The point is that we have reached a juncture where in-hospital services which we know do substantially more good than harm are being reduced and sick people are suffering. Any public position the MRG adopts must take this fact into account.

Issues in Home Care

By Bob James

Back in March, 1989, the Minister of Health received a report from the accounting firm (sic!) of Price Waterhouse, dealing with the Home Care Program in Ontario. The Steering Committee has responded to this by letter. I would like to describe a bit about this report.

The need for the report was outlined by the Minister in her covering letter. She stated that the past decade (the life of the Home Care Program) had seen a tremendous growth in the program, partly because of demographic changes, and partly because of population expectations (people now want to be treated at home if possible, even if this requires 24-hour nursing care). There have been different models of management across the province, and these have led to different ways in which the program was getting to the people that it was designed to help. In Hamilton, for example, the program is administered by the VON; in Toronto, by a separate agency which then contracts with sub-agencies like the VON.

The report made several suggestions. They looked for more efficient and uniform management procedures, as might be expected. They looked for better budgeting, and for a senior bureaucrat to oversee the provincial Home Care budget. I don't think we can have any problems with the desire to spend the money more wisely.

But the report went on to look at other ways to reorganize the program. They suggested that the program be split into two separate programs. The "Acute" program would be renamed a "Rehab" program, to look after the return of patients from institution to community. This would be much as we know it now: physio, social work, O.T., nursing, Homemaker. It would be time-limited. If a patient were felt to need more chronic care in the community, they would be transferred to the other program. While this happens now within the Home Care Program (there is a "chronic" program with different criteria), the new program would be separated off from the Ministry of Health and run by the Ministry of Community and Social Services. It is specifically called a "social" program, would be seen as being predominantly Homemaker and Meals-on-Wheels; it would rely on community, rather than physician, referral. Price Waterhouse speculated that the Government could get funding from the Federal Government in this way, since social assistance programs are funded through a different budget than is Health Care. This division would exist at the central level, and there would be different case managers for the two programs (there is now one manager for both programs). An attempt at integration would occur at the local level, with a single office to run the two programs. (The role of the District Health Council is not outlined.) Clearly, the MRG would be opposed to the arbitrary separation of "social" from "medical" aspects of community care.

As well, in its desire to "manage" the program better, Price Waterhouse has suggested that there be a set number of slots for the program in each area, decided by the age-sex ratios in that area. No mention is made of socio-economic status or of the need for special consideration (e.g., areas with a higher proportion than average of AIDS patients or halfway houses, or higher cancer rates, or dispersed clienteles in areas of sparse populations). The Steering Committee felt that, at a time when there is an increasing emphasis on the provision of community-based care, it could be quite detrimental to cap the number of spaces in the Home Care Program. It also seemed to us that this approach would necessitate a greater number of people hired in the two Ministries to supervise the programs. Since the overall dollars apportioned would remain fairly constant, there would obviously be fewer dollars for the program itself.

Our response was sent to Elinor Caplan with copies to the Medical director of the Hamilton-Wentworth Home Care Program, and the President of the Hamilton Academy of Medicine).

Letter to Elinor Caplan on Home Care

Elinor Caplan,
Minister of Health,
Province of Ontario

Madame Minister:

I am writing to you as a representative of the Medical Reform Group of Ontario. I have recently read the report commissioned by your Ministry: *"Operational Review of the Ontario Home Care Program"*. While we were not listed in the covering letter as one of the groups from whom you were eliciting responses, I was concerned about some issues raised by the consultants.

Your consultants firstly decided to divide the Home Care program into its Chronic and Acute functions, and assigned the "medical" care to the acute program, keeping the "social" aspects for the chronic program. The Medical Reform Group would not see this division as being appropriate. The issues of medical and social care are closely intertwined, and cannot be separated. To attempt this would be to poorly service both population groups.

There is further a desire to place the "social" aspects of the program under the aegis of the Ministry of Community and Social Affairs. While, in many ways, this Ministry is more in tune with the real needs of the community than is the Ministry of Health, the separation of the program into two parts would lead to confusion at the local level. Even though your report suggests local cooperation, our ex-

perience is that this works only in principle, and seldom in fact.

Lastly, we would argue with the idea of "managed growth" that is proposed by the report. Even if one acknowledges the need for some sort of "managing", the method which is suggested would serve better to restrict access to services, than to expand those services as would be requested by the communities.

At a time when there is increasing pressure on governments to cut back on hospital funding, and when there is an absolute reduction in the availability of hospital beds (partly due to budget restrictions, and partly due to the aging population), the Home Care Program must look for an expanded role, not one which is restricted as Price Waterhouse has suggested.

We would suggest to you that the report has done a disservice to the overall plan for medical care in this province. We should be moving toward a more community-based approach. An expanded role for the Home Care Program would go a long way towards this goal.

Thank you for your attention to these concerns.

Sincerely

Robert James, M.D. for the Medical Reform Group of Ontario

Psychiatric Drugs: letter from Phoenix Rising

On behalf of *Phoenix Rising*, I am writing this letter to find out if any progressive and caring doctors in the MRG are interested in discussing psychiatric drugs – particularly their many serious risks and alternatives.

As you and other MRG members may know, *Phoenix Rising* is a magazine produced by former psychiatric inmates, and it's the only antipsychiatry publication in Canada. It has been publishing during the last nine consecutive years, but it is now experiencing a very severe financial crisis. As a result, publication will be suspended (temporarily we hope) indefinitely after publication of our second prisoner & psychiatry issue this month. Of course, we welcome any donations, but we can not accept any new subscriptions or renewals.

I am enclosing copies of several articles and drug ads published in the "Phoenix Pharmacy" section of several back issues. We believe this material should be of considerable interest to many MRG members.

We also wish to call your attention of the critically acclaimed book *Psychiatric Drugs: Hazards to the Brain* (Springer Publishing Co., 1983) written by Dr. Peter R. Breggin, a dissident psychiatrist who is strongly opposed to psychiatric drugs, as well as electroshock ("ECT") and psychosurgery. This book is available in many medical bookstores and perhaps some alternative bookstores. I strongly recommend it to all doctors who still believe that most psychiatric drugs are "safe and effective" or "therapeutic".

To date, psychiatric drugs has not been a top priority issue for the MRG or any other public health body. It should be. These drugs (both the "antipsychotics" or neuroleptics and "antidepressants") have caused a *world-wide epidemic of brain damage, including tardive dyskinesia*, brain damage directly caused by neuroleptic drugs such as Thorazine (chlorpromazine), Stelazine, Mellaril and Modecate or Moditen (fluphenazine). The medical profession particularly psychiatry, and the multinational drug companies covered up tardive dyskinesia for several years and finally admitted its occurrence as a serious "side effect" of the phenothiazines – *only after* a TD victim sued Squibb for not informing physicians and patients about this common, dreaded neurological affliction which is generally permanent.

We are also very disturbed that in Toronto, and probably elsewhere in Ontario, there are few if any physicians able and willing to help psychiatric inmates and former inmates safely withdraw from various psychiatric drugs. We are very disappointed and frustrated about this huge gap in medical service which should be available to any person who wants it. Perhaps, after having read the suggested readings, some MRG physicians will be moved to consider offering withdrawal care and support. Yes, most of the neuroleptics and antidepressants are very habit-forming or addictive.

Should any group of MRG physicians and other members wish to meet some of us psychiatric survivors and critics of the psychiatric system, we should be pleased to help arrange this. Psychiatric drugs has been a top priority issue for many of us for several years. It's time that the MRG and other health bodies also treated it as a top priority issue demanding action.

Don Weitz, Phoenix Rising
Box 165 Station A, Toronto M5W 1B2

Reply to Phoenix Rising

Dear Mr. Weitz,

Please forgive the delay in my writing to you on behalf of the Steering Committee of the MRG in response to your lettre of May 6, 1989. As a relatively small group of physicians trying to address several important health care issues, we are sympathetic to your concerns about mental health and psychiatric care in Canada. We did in fact devote one of our weekend-long spring conferences (1987) to psychiatry and patients' rights. Carla McCague, lawyer for ARCH, Dr. Tyrone Turner, Psychiatric Patient Advocate Office, and Dr. S. Malcolmson, medical director of Queen Street Hospital, each presented a paper and then sat on a panel which engaged in quite heated debate with each other and the audience at one of our better-attended conferences. None of us can deny the serious problems and potential abuses which arise when diagnoses are made which involve labelling a client/patient 'out of touch with reality' and potentially incompetent to make decisions regarding his/her own care and best interests. No mental health care-giver with any knowledge of pharmacology can deny that anti-depressants and

phenothiazines have potential serious side-effects. But as with many serious medical conditions, we must balance therapeutic and side-effects when we make treatment recommendations. It is our responsibility to advise and consult patients regarding our assessment of both diagnosis and prognosis (i.e. what is likely to happen if the condition remains untreated) and the rationale, expectations, and possible adverse effects of our treatment recommendations. Each of us must use our professional training and experience to assess and critique literature and on-going research and the MRG as a group has no consensus as regards the blanket endorsement or condemnation of current 'orthodox' psychiatric treatments and their appropriate application. On behalf of the steering committee I think it's fair to say that most physicians do not perceive a world-wide epidemic of brain damage due to treatment, as you state in your letter. In any dialogue on this issue it would also be necessary to define the terms 'habit-forming' and 'addictive'.

The steering committee has agreed to publish your letter in the MRG newsletter so that individual physicians can respond. As well, when we plan our Toronto chapter meetings for the fall, consideration will be given to initiating some group discussion and possible action on some of the issues that you raise.

Again, apologies for the delay in our response.

Yours truly, Mimi Divinsky, M.D.
Steering Committee

Ontario plan transfers adults from institutions to group homes

By Darcy Henton Toronto Star

TIMMINS — Ian Battersby has spent most of his 34 years locked away from life.

His only home has been an institution where the staff are trained to deal with adults who see the world through the eyes of 3-year-olds.

He likes it here, and according to his mother, Jane, he doesn't want to leave.

But Ian and 85 other patients at the Cochrane-Timiskaming Resource Centre — like developmentally handicapped adults all over the province — will soon be moving out into the real world.

The plan to shuffle the mentally handicapped out of large institutions and into small group homes in communities throughout the province has been billed as a bid to improve their quality of life, but some people aren't buying it.

Ian's mother thinks the province is just trying to save money.

'Sloughing off cost'

"I'm afraid I don't have very kind feelings for the ministry (Community and Social Services)," said the tough-talking 73-year-old Matheson widow. "They're not as interested in bettering the lives of the mentally retarded as they are in sloughing off the cost."

Ministry officials maintain it will cost the province the same amount to operate group homes as it does to keep its 5,000 developmentally handicapped in institutions.

Battersby said she would better understand the motivation for the move if the province would concede it was being conducted for purely economic reasons.

"When they have the gall to tell us the people in these institutions will be better off in group homes and that's the reason they're being moved, I get sick all over the floor. I just don't believe it."

Battersby wonders how the ministry can provide her son the same quality of services he now has, once he's moved into a group home.

She wonders where it will find professionals to teach her son speech therapy, to keep his hepatitis at bay, to teach him computers and to provide the broad range of activities he now enjoys.

"The physical care he's now getting cannot be duplicated," she said.

Moving people from institutions to group homes may be a good idea for many of the developmentally handicapped, she said. However, it isn't a good idea for the most severely retarded, she said, and it may not work in the north where health care professionals are already in short supply.

Through speeches, petitions and lobbying, Battersby's determined to stop the plan.

"To say I am angry about it is the understatement of the century," she said. "I think they're being awfully stupid and I don't want to have my son victimized by their stupidity."

Ministry spokesman Wayne Davies said the province has already begun phasing out several of its major institutions through a multi-year program aimed at putting every developmentally handicapped individual into the community.

"These people deserve the same quality of life and the same basic opportunities to reach their full potential that anyone else has," he said. "The plan is ultimately to put the province out of the business of running these large facilities and to essentially provide in the community the services that will allow the community to take care of these kids."

John Kelly, the ministry's acting director of services for disabled persons, said no date has been set for closing institutions and it will take at least 25 years to move the 5,000 occupants into group homes.

"There are plans to continue to reduce the size of the facilities, but there are no specific plans to close any one," he said. "We have to go back to cabinet with specifics about closing the facilities themselves."

The 175 staff members at the Timmins centre, located about 13 kilometres (8 miles) east of the downtown core, fear the quality of care will drop drastically if the funding and programs aren't in place before patients are moved.

They're scared that many of the mentally retarded adults in their care — ranging in age from 18 to 60, but with functioning levels as low as 6 months — will just end up in nursing homes, psychiatric hospitals and prisons.

They worry how they will fit into society, and what will happen to them if they don't, since there won't be any other place for them.

"Sure our jobs are on the line, but we will go on to other jobs," said Donna Conrad, an 11-year employee at the centre and chairman of a committee to save the centre. "What happens to these people if they get lost between the cracks?"

Toronto Star, April 6, 1989

What's Sauce for the Goose is not Sauce for the Gander - Two Recent News Items!!

From "Year of the Dragon for Canadian firms" – Patrick Bloomfield . Financial Post

July 14, 1989. p.16

"The moral of the table accompanying this table is that 1989 will go down in the record books as one of the best -if not the best - fiscal years Canadian corporation have had this decade ...moreover some of the more spectacular returns on equity don't even feature in this table. For instance Inco Ltd returned 68.9% on equity last year. It isn't in the list because Inco didn't have an earnings base five years ago- being in the red at the time. In short 1988 was a great, great year for Smokestack Canada. Average profit growth over 1987 for all top 500 companies was 20% -on a much more modest revenue increase of 9%"

From "Tax Burden of poor too heavy, study says". Sean Fine. Globe and Mail

21 July 1989

"Despite increasing child poverty the federal government is forcing poor and middle -income families to lead the fight against the national deficit, an analysis of the tax impacts from 1984-1990 suggests. In 1990 working -poor households will pay more than $1000 in additional taxes compared to what they paid in 1984. That constitutes a bigger bite of their income than will be taken from any other group says the Canadian Council for Social Development. In homes where $5 can mean the difference between regular meals and going hungry, the analysis says the loss of $1000 is "enormous and devastating. It is unconscionable that households scraping by on poverty incomes should be asked to help reduce the deficit", David Ross and Richard Shillington say in their report. The authors say that the system may be even more regressive than their report suggests, since they chose not to include tax breaks - such as higher limits on contributions to registered retirement savings plan - that favour the well to do. As well, they say, unless sales tax credits are raised substantially for the poor the system will become more regressive when Ottawa's proposed goods and services tax is introduced in 1991."

TOPS OF THE TOP 500

Company	Net income $000	Return on equity	5-year EPS growth
St. Lawrence Cement Inc.	86,602	28.8%	1970.8%
Malette Inc.	15,940	28.0%	1661.3%
Alcan Aluminium Ltd. *	1,145,800	22.8%	1503.0%
Doman Industries Ltd.	20,231	30.5%	1436.1%
Sherritt Gordon Mines Ltd.	56,491	24.3%	1068.1%
Sodisco Inc.	12,621	29.1%	716.9%
Donohue Inc.	68,691	21.3%	632.8%
Weldwood of Canada Ltd.	68,414	22.4%	615.0%
CGC Inc.	47,064	55.4%	584.7%
Guillevin International Inc.	6,898	25.1%	471.0%
Celanese Canada Inc.	48,904	28.4%	443.4%
BC Sugar Refinery, Ltd.	23,563	34.1%	414.0%
Slocan Forest Products Ltd.	11,887	24.7%	390.4%
Jannock Ltd.	52,339	25.9%	354.6%
Finning Ltd.	37,067	22.0%	333.3%
Quebecor Inc.	32,887	20.3%	329.4%
Connaught BioSciences Inc.	35,000	20.7%	268.4%
Leon's Furniture Ltd.	14,822	23.3%	221.8%
Cara Operations Ltd.	26,645	26.2%	186.4%
Du Pont Canada Inc.	99,910	21.9%	183.7%
Nova Corp.	424,000	24.1%	181.3%
Ford Motor Co. of Canada Ltd.	269,800	21.1%	125.0%
Thomson Newspapers Ltd. †	254,875	22.7%	102.1%
Sico Inc.	7,462	25.8%	70.9%

* Converted from US$ † Now merged with Thomson Corp.

From Ingersoll Times

5.7.89

"The temporary suspension of a prominent Oxford County doctor's licence is raising questions about the public's right to know information. Dr. Town's licence was suspended on May 29 and is in effect until Sep 19. Rumours about the reason for Town's licence suspension have been circulating. The College of Physicians and surgeons ...have not given any explanation ... Draft legislation released last year called:" Striking a New Balance: A Blueprint For The Regulation of Ontario's Health Professions", calls for the discipline process to be made more accountable...the Medical Reform Group... had input into the draft legislation. Their position falls in between that of the present system and the total opening of the discipline hearings recommended in the draft legislation." We favour them (discipline hearings) being open but we also recommended that for the protection of doctors and the public ... names not be published unless there is a finding of guilt," said Dr. Don Woodside. This would parallel the system now in place for sexual abuse cases in which the name is not published because it may identify the victims, Woodside said. One concern that the College has... Franklin (a spokeswoman) said is that hearings might deter some patients, particularly those with a complaint of sexual assault , from coming forward.Another concern that both Franklin and Woodside raise is there must be some protection for doctors who are wrongfully accused. If a complaint is made in public and is it is proved unfounded, a doctor's reputation remains damaged. Still, Woodside said it is important for the public to have confidence in the system and see it as a fair and public process."

Spadina Health Centre

Fred Freedman, Mirian Garfinkle, and Lea Rositer are looking for a new partner for friendly, downtown community practice. We have just become a HSO. The new partner would do fee-for-service until his/her practice is built up. If interested contact Fred Freedman, 928-0920 (day), or 531-2861 (evening).

Woolwich Community Health Centre

St. Jacobs

A family physician is needed for a newly organized Community Health Centre, located in St. Jacobs, Ontario, close to hospitals and universities in the cities of Kitchener and Waterloo. This physician will work in a team setting providing primary health with another physician, nurse practitioner and office nurse. There is a strong focus on outreach, health education and promotion and working with other professionals in the area. Please contact Clint Rohr, Executive Director, Woolwich Community Health Centre, P.O. Box 419, St. Jacobs for more information.

LAMP Health Service

Full Time Family Physician Required

A community health centre requires a full time family doctor beginning in September '89 to work as a member of a health service team, with other professionals and with a volunteer community Board and Committees. Family Practice residency an asset. Salary commensurate with experience. Attractive benefit package. If interested, send resume to:

Mr. Joe Leonard
Executive Director
Lakeshore Area Multi-service Project Inc. (L.A.M.P.)
185-5th Street, Toronto, Ontario
M8V 2Z5
(416) 252-6471

LAMP

Occupational Health Physician Wanted Half-Time

A half-time position for an occupational health physician is available in the west-end Toronto community health centre LAMP. Responsibilities include diagnosis of work-related illness and injuries, community education, report writing and some epidemiological research. Requirements include a diploma in occupational health and/or extensive related experience, knowledge of epidemiology, willingness to work with non-English speaking clients and as a member of a team responsible to a Community Board of Directors. Remuneration pro-rated to 17.5 hours per week. Some flexibility with hours may be required. This position is available immediately until March 30, 1990 with chance of renewal.

Apply to: Bonnie Heath, Program Co-ordinator
LAMP Occupational Health Program
185 Fifth Street, Toronto, Ont.
M8V 2Z5
252-6471