MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

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MRG Spring meeting goes multi-national

Health care reformers from three countries will come together in Toronto on May 14 and 15 to share ideas and experiences.

The Medical Reform Group is holding its spring general meeting in conjunction with Physicians for a National Health Plan, the organization of U.S. doctors who favour a single-payer system.

The PNHP is holding its annual meeting in Canada this year to give its members a chance to meet Canadian health care professionals and to see Canadian hospitals and health care facilities first-hand.

A featured speaker at the meeting will be Julian Tudor Hart, the British physician-author whose book, "A New Kind of Doctor" has inspired many health care reformers.

The meeting, to be held at the Hotel Plaza II in Toronto (NE corner of Yonge and Bloor) will begin with a PNHP morning session on Saturday May 14 devoted to PNHP policies and strategies.

PNHP members will spend the first part of the afternoon touring local hospitals and other health care facilities, while the MRG will hold a two-hour session from 1 to 3 pm on "Recent Developments in Health Care Reform in Canada", with Michael Rachlis, author of Second Opinion, speaking about what has been happening in Saskatchewan, British Columbia, and elsewhere in Canada. Some MRG business, such as the budget, will also be dealt with.

A joint PNHP-MRG session on the theme "international perspectives on health care" will begin at 3 pm. Featured speakers will be Julian Tudor Hart (see profile on P. 3), David Himmelstein of PNHP, and Rosana Pellizzari and Haresh Kirpalani of the MRG. The initial presentations will be followed by questions and discussion.

On Saturday evening there will be a social for PNHP and MRG members. Details will be available at the meeting, or call 416-588-9167.

Sunday's agenda will be primarily devoted to health care reform in the United States. Representative Jim McDermitt, the sponsor of the "American Health Security Act", which proposes a Canadian-style single-payer system, has been invited to address the meeting.

Some details of the agenda are still being finalized. For more information, call the MRG at 416-588-9167.

The struggle for national health insurance in the U.S.

By Dr. Quentin Young
National Coordinator, PNHP

The debate over health care reform in the U.S. has accelerated dramatically over the past year and is now at the top of the political agenda. Some important recent developments include the introduction, and virtual collapse, of the Clinton plan; the growing support for single-payer reform within physicians' groups and Congress; and the tremendous movement towards single-payer legislation in several states, particularly in Colorado, Vermont, and California. Although none of these

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Medical Reform

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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.)

Correspondence should be sent to Medical Reform, P.O. Box 158, Station D, Toronto M6P 3J8. Phone: (416) 588-9167 Fax: (416) 588-3765.

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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.

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developments is likely to translate into meaningful reform this year, we may have finally reached, to borrow from Winston Churchill, "the end of the beginning" of the struggle for universal coverage.

President Clinton's proposal for a "managed competition" health plan was released last October. The plan evolved from the ideology of Alain Enthoven, a former Assistant Secretary of Defense, and his collaborators at the "Jackson Hole Group", a group of corporate leaders and health care power brokers. Single-payer advocates succeeded in getting the President to add a state single-payer option in his plan, but little else that reflects our vision.

Clinton's proposal would herd most Americans into restrictive managed care plans, owned by for-profit insurance companies (who are among the plan's strongest supporters). Most patients would lose the power to choose, or change, their own doctor and hospital. Since only the wealthy could afford better insurance, the plan would assure a multi-tiered health care system, separate and unequal. In essence, Clinton's plan would perpetuate the private health insurance industry, the cause of the crisis, and complete the corporate transformation of American medicine.

Public reaction to the Clinton plan was equivocal from the outset, and has plummeted more recently, despite continued high (over 85%) support for universal access to health care. Republican leaders reacted to Clinton's plan by announcing that there was no health care crisis. Democrats predictably praised their President for taking on the issue, but most expressed reservations about his blueprint. In recent weeks, the major Congressional committees working on reform have all but dismissed the plan because of its regulatory complexity. Unfortunately, the alternatives they are scrambling to pull together offer only piecemeal reforms.

The introduction of the Clinton plan presented new challenges and opportunities for national health program supporters in the U.S. Inside the "beltway" of Washington, D.C., the informal single-payer coalition split in two as some major consumer and labor groups chose to support the Clinton plan. Outside the "beltway", coalitions have generally been more cohesive; for the most part, they remain united in support of single-payer reform, and are continuing with their grassroots education, organizing, and lobbying work.

Although a much greater level of public mobilization is needed, the efforts of single-payer supporters are being felt in Congress. There are currently 93 co-sponsors of federal single-payer legislation (H.R. 1200) in the House of Representatives. There are only a handful of supporters in the Senate, however, which is likely to block any significant health care reform this year.

Help from organized medicine to change the balance of power in Congress may finally be forthcoming, albeit slowly. In recent months, three medical organizations have endorsed single-payer reform. These include the American College of Surgeons (with 60,000 members), the American Women's Association (13,500), and the National Medical Association (6,500). Single-payer has also been endorsed by prominent physicians

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such as Marcia Angell of the New England Journal of Medicine, Logan Holtgrewe, Past-President of the American Urological Association, and Andre d'Hemecourt, President of the New Hampshire Medical Association, among others. Rep. Jim McDermott, chief sponsor of H.R. 1200, is himself a child psychiatrist from Washington state.

A range of reasons are cited for the growing number of medical endorsements for single-payer. The most common are that it provides universal access, will provide better health care for the poor, preserves patients' freedom to choose their physicians, and protects clinical autonomy. Physicians are wary of the Clinton plan's emphasis on managed care and perceive single-payer as a far preferable alternative; as one American Medical Association executive put it "there is nothing like the sight of the gallows to concentrate the mind".

In Colorado, Vermont, and California, three states with large organizing drives underway for single-payer reform, physicians' groups are reacting with cautious support. In Colorado, a proposal for a state single-payer bill passed the Republican controlled Senate after garnering support from the Colorado State Medical Society and the Colorado Academy of Family Physicians. PNHP Past-President Dr. Cecil Rose and national Board member Dr. Rick Beiser report that they are inundated with requests to speak to medical audiences in the Denver area.

In Vermont, a 1993 survey showed that over 50 percent of physicians in the state support single-payer. Activists there have collected over 5,000 signatures in support of a state single-payer bill. In 20 town meetings across Vermont last month, the vote by the public was 2:1 in favor of single-payer reform.

California activists are working to beat Colorado and Vermont to be the first state to adopt a single-payer system. Supporters there have already collected 700,000 signatures to put a single-payer initiative on the ballot this fall, and expect to have the 1.1 million signatures needed to do so by the deadline of April 22. PNHP members have received a sympathetic response to the initiative from the county medical societies, and expect some formal endorsements soon.

Twenty other states have had state single-payer bills introduced in just the last two years. Such proposals have proven to be enormously useful as local grassroots education and organizing tools for our movement. Within a few years, they may well provide the same breakthrough to fundamental reform in the U.S. health system as the province of Saskatchewan's plan did for Canada. Stay tuned.▼

Introducing Julian Tudor Hart

"The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces. The market distribution of medical care is a primitive and historically outdated social form and any return to it would further exaggerate the maldistribution of medical resources."

The Inverse Care Law, Julian Tudor Hart, Lancet 27th February 1971

Despite our expenditure of 9.5% of GDP on health we wrestle with intransigent and often worsening problems in Canada. The mismatch of resources to the populations who would benefit continues. Natives, whether on reserves or in urban centres suffer excessive morbidity and mortality. Physician and hospital resources become increasingly unable to serve the basic needs in rural areas.

This state of affairs should not be surprising when we consider the inverse care law. Without denying the gradual changes to planned and rational health care in the various provinces, we have not moved far from the market place. It has been often observed that we have a private system publicly funded. Can we expect to solve the problems of inappropriate allocation in a system in which physicians have largely arbitrary choice of what services to provide and in what location? And at the same time we have in the background the ideologues who advocate markets as the solution to all problems and would logically end up regarding health care just as a commodity to be purchased by individuals. The breadth of Tudor Hart's reading and understanding is enormous. An understanding of the social history of medical care is evident in his book "A New Kind of Doctor" and he is fully aware of the effectiveness of changing the determi-

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nants of health. However he also writes from the perspective of someone who was in active general practice over a professional lifetime. He has no doubt of the effectiveness of appropriately applied conventional scientific medicine.

It is most opportune that Dr Tudor Hart will be visiting Ontario this May. He is an invited speaker to the annual conference of CHEPA. He will also be attending a joint meeting of the Medical Reform Group and of the (US) Physicians for a National Health Program which advocates a single payer approach for the US. It is most timely to be able to hear from someone who fervently believes in a national health service and has participated actively in it. As someone to whom the date 1948 also represents a positive milestone in health care reform I welcome the challenge of pushing North America towards its 1948.

Nobody is saying that the British National Health Service is perfect. But it is worth observing that the original model appears to remain intact beneath the complex managerial reforms that recent Conservative governments have imposed. It also appears (and we look forward to Tudor Hart's opinion) that good and necessary accountability provisions have been added of a nature that has barely been thought about in North America. It's almost amusing to read in "A New Kind of Doctor" of Britain in 1948: *"Government ministers, Ministry of Health civil servants, specialist doctors, GPs and the public at large all saw the hospitals as the only significant site for clinical growth and innovation."* We should not neglect reading history or it will repeat itself as farce.

The meeting of the MRG and our American friends and colleagues is a welcome opportunity to come together to promote humane and economical solutions, taking a lead at a time when we are constantly offered the trite and irrelevant. For my expectations of the gathering and of the future, let me again quote from "A New Kind of Doctor":

"Indignant descriptions of what's wrong with society, and the doctors' role in it, are increasingly superfluous and irrelevant; few of us need convincing that there are more and more reasons for despair, not only about our own society, but about the future of mankind. Somehow we have to find rational, historically credible foundations for renewed optimism, convincingly supported by evidence, with positive programmes for something better, which do not depend on defensive faiths in obsolete solutions."

Bob Frankford

Hart J.T. *A New Kind of Doctor*, London: Merlin Press 1988

Hart J.T. "The Inverse Care Law", Lancet 1971;i; 405412

Hart J.T. "Two Paths for Medical Practice", Lancet 1992, ii, 772775

Frankford R. Book Review: A New Kind of Doctor, Ontario Medical Review, November 1989, p42▼

Canadian Health Coalition initiates process to define principles for health care reform

By Stephen Leary
Executive Coordinator
Canadian Health Coalition

There has been a growing feeling that because of the increasing cuts to health care budgets and the resulting reduction in services that we often end up defending things we don't agree with. To address this problem the Canadian Health Coalition is proposing "Principles for Health Care Reform".

The Process

This document is an outgowth of a process that started with the Medicare Declaration which was used during the federal election to determine where the leaders stood on the major issues. The idea was expanded at a CHC Board meeting in late November which was attend by a number of national organizations and seven provincial health coalitions. Rather than always being on the defensive it was time to state a positive view of what we want the system to look like.

The Health Care Declaration would be a set of principles that groups from across Canada could unite around. It is particularly important at this time to have common goals as the federal government sets its course with the forum on Health to be chaired by the Prime Minister. If we had a document that could be used by a health coalition in New Brunswick, a nurses union in Manitoba and a health care union in Alberta then we would be the stronger for it. It would then be very difficult for a government to dismiss our concerns.

The process we are proposing is to

consider the attached set of principles. It is a combination of a number of different documents and principles that have been produced over the last few years. We are proposing these principles as a starting point and you should not feel constrained by them in any way. If your group feels that they do not represent your concerns then change them. The most important thing is that we get your vision for health care.

We Want Your Ideas

We would like your coalition, group or union to discuss what you would like to see in the way of a health care system. The areas of concern can range from federal financing, the cost of drugs, the move to the community, the effects of poverty on health

We would like to keep the finished document to one page. This would prevent a shopping list of principles, and it would also force us to try and present our principles concisely. One page could also be easily reproduced and translated.

To make the declaration a successful document we are hoping a wide discussion takes place by a lot of different groups. We would like to prepare people for the forum on health by having thinking about health and their vision of it. We do not know if there are going to be public hearings with the national forum but we will do our best to be part of the process and having a unified position will give us a head start.

A National Meeting for Organizing

Once you have a chance to work on your own version of the principles and have a finished document send them back to the Canadian Health Coalition. We will try and bring together what people have sent us and put together a synopsis for a meeting of health coalitions, and CHC members that is planned for June 11-12 in Ottawa. At that meeting we hope to deal with any contentious or outstanding principles for a final discussion and document.

We hope that people would accept this process with an element of trust. We would like a final document that would encompass all the major themes but you may not find your exact wording on the final paper but an effort will be made to incorporate everyone's ideas. This is really the key to building consensus around this difficult task.

The Health Care Declaration is only one part of a package that would be the finished product. To back up the principles we are will have research and documentation that more fully explains some of the principles and give the reasoning behind the principles. This needn't be new information but existing research that would provide the support for the principles. There would also be a set "speakers notes" produced which would give some of the reasoning behind the principles without drowning people in facts and figures. The speakers notes would give a person enough information to speak confidently about the principles.

An important aspect of the whole process is how we use the principles in an effective manner? What sort of actions locally, provincially and nationally can the principles be integrated into?

Stephen Learey
Executive Coordinator

DRAFT PROPOSALS ONLY: PRINCIPLES FOR HEALTH CARE REFORM

1) ***Encourage Prevention.*** We must increase support for the preconditions of good health. We need a job strategy, a social safety net, and other public policies that ensure shelter, education, food, full employment, peace, and a safe environment (including a safe work environment). Ignoring these needs will lead to much higher health care costs in the long run.

2) ***Preserve and strengthen the Canada Health Act.*** Reinforce the five principles of the Act: universal coverage, accessibility, portability between provinces and territories, comprehensive coverage, and public administration. The federal government can enforce Canada-wide standards by threatening to withhold cash transfers to provinces that violate the Canada Health Act. The federal government must maintain its cash transfers to the provinces for health care to sustain this power.

3) ***Don't make health care workers bear the burden of health care reform.*** Retain the skills of experienced health care workers by negotiating employment security agreements with health care unions. Employment security agreements enable displaced workers to access comparable jobs in the health care system. Allow health care workers to retain their existing rights by encouraging unionization in the emerging health care organizations.

4) ***Expand the role of non-physician health providers.*** Nurses, midwives and others can handle many procedures as effectively and efficiently as physicians, especially in areas that have been neglected by the medical profession, such as services for women. We must develop alternate models that expand

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the role of non-physician providers.

5) ***Eliminate for-profit health care.*** Public administration of health care insurance has saved Canadians billions and must be maintained and strengthened. Deinsuring services and imposing user fees is leading to a more expensive, two-tiered system. There is no room for profit and inequity in health care.

6) ***Stop fee-for-service payments.*** Most physicians (and some other health care providers) are paid on the basis of the number and type of services they provide. This form of piecework encourages over-booking, over-prescribing, and over-treating.

7) ***Put new health services in place before shutting down existing health services.*** Governments have used the rhetoric of community care to downsize institutional care without actually expanding community care. Health care reforms should increase, not decrease, the security of seniors and other health care consumers.

8) ***Health care reform should not mean more unpaid labour for women.*** The shift to community care (especially home care) has meant shifting the burden of care onto the shoulders of unpaid family members, especially women.

9) ***Reduce dependency on prescription drugs and make them more affordable.*** Transnational drug companies are adding millions to our health care costs by driving up prices. We need to repeal Bill C-91 (which extended drug patent protection) and enact genuine patent law reform that promotes lower drug prices.

10) ***Make the health care system more democratic.*** Health care is a vital part of Canadian public policy. Decisions on health care should not be left to private corporations or unaccountable boards. We need to expand the role of the public at large and health care workers. There should be genuine and ongoing public consultation on health care reform. Elections to hospital and health care boards should be encouraged. Employer-sponsored "total quality" schemes that circumvent workers' elected representatives must be replaced by bona fide moves to involve workers in workplace decision-making.▼

HSOs and CHCs: Divide and conquer?

The last several issues of ***Medical Reform*** *have featured discussions and exchange about HSOs and community health centres. The following letter by Bob James responds to a letter by Rosana Pellizzari in the February issue.*

Dear Rosana: I was disappointed by your letter published in the February issue of *Medical Reform*. I felt that you had responded to Fred Freedman's comments in a way which lessened, rather than expanded, the understanding between the HSO and the CHC physicians. And this surprises me, given your other role as past president of the AOHC (which is supposed to represent both groups).

To call the HSO program "disastrous" and "a virtual cash cow for the unscrupulous" is to engage in the spreading of unsubstantiated rumours. You must have known that this is hurtful and harmful to any meaningful dialogue between our two groups of physicians. I would not consider a personal communication with Jim O'Neill "substantiation". And the figure you quote, if it is correct, is well out of date. All HSOs have had cuts in the order to twenty to thirty percent in their budgets over the past year. And your figures give the number of dollars per doctor, not taking into account the numbers of other staff that the clinic may have.

Your figure [$375,000] is the number of dollars per physician for the North End Community Clinic in Hamilton as well — and it is not clear how many patients that clinic looks after.

I am using this only to point out that the HSOs, like the CHCs, use other staff than physicians, and the figure quoted is thus a misrepresentation of the take-home income of the physician.

The Ministry of Health has indeed now set up quite strong, and very bureaucratic, rules for accountability. They are beginning to look at outcomes. We are now penalised if we do not provide direct patient care for forty hours per week, as well as on-call service; we are penalised if our patients go elsewhere, whether we have control over that or not; we are being expected to do extra work for no extra money (in fact, less money). You cannot blame us for wondering why the HSOs are singled out for this treatment, when the fee-for-service docs and the CHCs are not.

The government has thus far been quite good at dividing the CHCs from the HSOs, and have succeeded in planting the idea generally that the CHCs are good and the HSOs are bad. Their strategy is to divide, and conquer. I am sorry that you seem to be taking the same position. I am afraid that the time for "review" (read: cutting) of the CHC program will come, and you cannot expect cooperation or support from HSO physicians if you treat them like this now.

I hope we can continue to talk about this.▼

Bob James

Budget consultation with Ontario's Treasurer

By Gordon Guyatt

Minister of Finance Floyd Laughren is conducting a series of "prebudget consultations" with representatives of community groups. The Medical Reform Group was asked to participate in one such consultation in Hamilton, and I attended as the MRG representative.

Mr. Laughren began with a picture of where he sees the province is economically. Inflation was anticipated to be 1.5% for the current year, but with the decrease in tobacco taxes will be zero. Mr. Laughren anticipates that the economy will grow by 4%, but because output is increasing more than employment, unemployment will remain over 10%. An additional point is that most of the growth has come in production related to export.

Mr. Laughren presented the provincial government as continuing to face lower-than-expected revenues and desperately keeping at bay what he sees as a disastrous deficit. As efficiency-increasing measures, Mr. Laughren cited the movement of health care from institutions to the community, electronic kiosk service for license plate renewal and similar functions, closing foreign trade offices, public-private partnership for endeavours such as building Highway 407, and streamlining social assistance administration. At the same time, pressures on the budget continue. Mr. Laughren highlighted the Drug Benefit reimbursement, legal aid, and student assistance as growing expenditures to which the government is committed. In the face of these pressures, the Minister sees continued reductions in funding to a variety of programs as a requirement to keep the budget deficit at a target of 9.5 billion. With regard to taxation, he noted attempts to make the system fairer by reducing taxes for those with low incomes, the introduction of the minimum corporate tax, and reducing corporate tax loopholes.

Following the Minister's presentation, the community representatives had a chance to make comments. Those presenting included the Mayor of Hamilton, Bob Morrow; Ann Sloat, representing the Regional Chairman; and representatives of the Hamilton Construction Association, the Hamilton and Region Arts Council, the Labour Council, Dofasco, the Social Planning and Research Council, and a member of the McMaster Department of Economics. The questions and answers highlighted the difficult position in which the government finds itself in which there is a large debt with very substantial interest payments and community representatives talking of "tax fatigue" and the need to have a tax structure that draws investment to the province. With respect to the debt, Mr. Laughren made what I thought was a compelling point when he said that payment of interest to wealthy foreign bond holders was not a very desirable resource transfer.

In addressing health issues, I stressed the importance of avoiding user fees, and pointed out that focusing on community care may not be more efficient, and that money apparently saved may come simply as a result of withdrawal of services. I stated that, in contrast, the cap on payments to physicians was a truly effective and appropriate way of restraining expenditures. I then suggested other ways of increasing efficiency which the MRG's resource allocation group has suggested. The most important is a restructuring of primary care with a shift from a fee-for-service to a capitation-based system. Other suggestions I mentioned included concentrating laboratory and diagnostic testing in public institutions and minimizing the extent to which individual physicians benefit financially from ordering diagnostic procedures, and shifting from for-profit laboratories to not-for-profit laboratories in public institutions.

The Minster of Finance replied to these comments by agreeing that user fees were not a good idea (though he did mention that he had asked for how much money would be collected by charging $5 for each hospital admission and each doctor's visit). He acknowledged the need for caution about savings when resources are transferred from institution to the community. He noted the problems that result when physicians create a public outcry over reductions in health expenditures. Finally, he noted that he had seen figures both that suggest private laboratories are less expensive than public laboratories, and the reverse.

My impressions of the meeting were the Minister was a genuine and well-meaning individual and that I gained some sympathy for the government's dilemma. I wasn't given any sense that the government would take on major restructuring, or that they would necessarily refrain from further damaging health care cutbacks. For now, however, we can consider that full public funding of hospital and physician care will continue.▼

CMA's 'anti-doctor bias' angers some doctors

By Matt Borsellino

From the Medical Post, February 1994

Ottawa – The agenda of this year's Canadian Medical Association leadership conference has "a definite anti-doctor bias," according to a handful of high-profile Ontario physicians.

Dr. Killian de Blacam, spokesman for the group, says the agenda of the meeting is top-heavy with health economists whom doctors know to be collaborators with government efforts to reform Canadian medicare.

He feels "there should be no place in policy-making for those without some clinical acumen," and believes "some sort of balance might have proved more useful" than having just one side of the equation at the conference.

Dr. de Blacam, who is not a member of the CMA, will not be attending the conference.

Headlining the event scheduled to take place here March 3 to 5, will be Dr. David Naylor, head of Ontario's Institute of Clinical Evaluative Sciences.

Dr. Gordon Guyatt, chairman of McMaster University's evidence-based working group and a founder of the Medical Reform Group, will be joining him. Dr. Jonathan Lomas (PhD), co-ordinator of the university's Centre of Health Economics Policy and Analysis (CHEPA), is among those slated to speak.

Dr. Ian Warrack, chairman of the 10-person committee, said in a phone interview the agenda is partially designed to recognize the 30th anniversary of McMaster's medical school and its "influential" role in the area of evidence-based medicine over the past few years.

On January 14, Dr. de Blacam sent CMA president Dr. Richard Kennedy an open letter outlining some of his concerns. He expressed concern about Dr. Naylor's role in heading a group that has concluded that hundreds of appendectomies could be forgone without harming the health of Ontarians while more mastectomies are being done than is probably warranted.

Dr. Guyatt also comes under some criticism. According to Dr. de Blacam, Dr. Guyatt believes Ontario's social contract should target doctors.

"Fairness dictated that doctors should take the biggest hit (since) physicians have long been spared," Dr. Guyatt is quoted as saying in Dr. de Blacam's letter.

Further, Dr. Lomas, in Dr. de Blacam's opinion, is yet another frequent critic of both the profession and fee for service medicine.

"Physicians across Canada are struggling to cope with government funding cutbacks," Dr. de Blacam's letter concludes.

"As self-employed professionals, we are looking to our national association to defend our interests. The policies of the CMA must reflect the membership. I am concerned that the organization which you represent may be leading many of us into bankruptcy and public ridicule."

In a phone interview, Dr. de Blacam, a Sudbury family physician, admitted that he is not a CMA member because he considers it "a waste of time." He added that the only major speaker with an "anti-doctor bias" he could think of who is not on the agenda of the CMA event was controversial author Dr. Michael Rachlis.

Joe Chouinard, the CMA's director of corporate affairs, said he tried to get Dr. Rachlis too. The whole idea of the leadership conference, he noted, is to give the profession an opportunity to grill people, who some in the profession believe have an effect on developing policies they deem to be detrimental.

"Just because they're on the agenda doesn't mean the CMA promotes their ideas," Chouinard said.

"These people are influential with government. What we're trying to do is expose the profession to what they're all about while being a bit provocative as well. We didn't expect everyone to be supportive and happy with what we're trying to do."

The conference focuses on "renewed emphasis on evidence-based approaches to health care," Dr. Warrack said.

"It's our hope many doctors will go there and put some pointed question to these people that will end up either exposing them for what they are or allaying the profession's fears.

"It's our attempt to get the profession to debate whether evidence-based medicine is the way to go in the future. We know government is certainly listening to this approach with much interest."

Gordon Guyatt adds: Dr. Chouinard subsequently wrote to the speakers, and along with Dr. Warrack to the Medical Post, to clarify their "misrepresentations about the leadership conference." Their letter put the conference in a more positive light, while reiterating that it provided the participants with an opportunity to challenge the conference speakers.▼

Academic Medicine and the Pharmaceutical Industry: A Cautionary Tale

By Gordon Guyatt

The following article appeared in the March 15 Canadian Medical Association Journal. It presents the events that followed our internal medicine residency program's introduction of guidelines for interaction with the pharmaceutical industry. The CMAJ publication was accompanied by a response from the Pharmaceutical Manufacturers Association of Canada.

Before I submitted the paper for publication, I informed the senior administration of the departments with which I'm associated, and the Health Sciences faculty at McMaster. They asked, appropriately enough, why I was doing this. I argued that industry intimidation is analogous to political corruption. It can continue only so long as it is kept quiet, and tacitly accepted by the all the players in the game. The industry behaviour would not be acceptable to the general public, the academic community, or just about anyone else. As soon as some one stands up publicly and says what is going on, and there is a risk of other people reporting similar incidents, the behaviour becomes much more dangerous for the industry. Its frequency must decrease.

I also presented a second reason, my belief that people in other academic institutions, when they encounter similar threats (as they inevitably will) are liable to respond differently having read the paper. They will see they are not alone, and that it is possible to refuse to be intimidated.

Despite these arguments, the administrators were unanimous in trying to dissuade me from publishing the paper. They presented a variety of reasons why it wouldn't be a good idea (and different people offered different reasons) but possible retaliation by the industry was prominent. Ultimately, each of the senior administrators graciously accepted that what I was doing in publishing the paper was not unreasonable. Personally, I suspect there will be no adverse consequences, either for me personally (my research is, to a considerable extent, funded by the industry) or to the institution. I think the leadership in the industry is too smart to retaliate. However, the final outcome remains to be seen.

Recently, our medical residency program adopted formal guidelines for interactions with the pharmaceutical industry. In this paper, I describe how the pharmaceutical industry responded to these guidelines by intimidating the academic leadership at our institution, and how we handled this intimidation. The paper is not about individual culpability, but about social forces which I believe exist in academic medical centres throughout the industrialized world. I have therefore done my best to protect the identity of a number of participants in the drama.

The story

The Guidelines, which were adopted after extensive debate by internal medicine residents and faculty, include proscription of residents being the beneficiary of non-educational benefits (including drug lunches) from the industry, and exclusion of industry representatives from residency educational events. When resources for educational activities are not readily available from the department, faculty members and residents can seek industry support, and acknowledge the support. If a company insists on participating in choosing the content of an educational event or having an industry representative attend, we decline funding. The Postgraduate Education Committee responsible for all residency programs at our institution subsequently adopted similar guidelines.

To ascertain industry reaction to the Guidelines, we conducted a poll of 24 companies with which the residency program had interacted. Approximately half of the 18 who responded found the guidelines unacceptable and stated that funding for the program would decrease as a result. The other half found the guidelines acceptable.

On May 20, 1992, a senior official of the Marketing Section of the Pharmaceutical Manufacturers' Association of Canada (PMAC), a group that represents the interests of multi-national pharmaceutical companies with Canadian subsidiaries, visited me in my role as Director of the Residency Program in Internal Medicine. The initial discussion highlighted our different perspectives. The senior official then suggested that industry funding for not only educational activities, but also research, could be compromised by the Guidelines. I stated that this was a threat, and that threatening statements were not acceptable. The Senior Official denied that he had made a threat, and repeated a simile he had already presented about the interaction between academic medicine and the industry being like a marriage in which both partners had to compromise. The day after the meeting,

Continued on Page Ten

Academic Medicine...
Continued from Page Nine

the Senior Official wrote me a polite note in which he "sincerely hoped that the guidelines of McMaster can be brought much closer to the Canadian Medical Association guidelines both in spirit and form." This last hope was offered despite my making it clear that the Guidelines were not a subject for negotiation with the industry.

This Senior Official also held a senior position with a Canadian subsidiary of a multinational pharmaceutical company. The Director of the General Internal Medicine residency subspecialty program, Dr. David Sackett, requested funds from the Senior Official's company to sponsor resident research. In his reply, the Senior Official wrote:

(Our company) has always had mutually beneficial relationships with many physicians and health care professionals in your institution. Recently, access to many of these key people has become limited, including the medical residents. Without this contact, it is very difficult for a partnership to develop. Consequently, it is not easy for (our company) to justify philanthropic donations to research, where there is limited or no access to researchers, and no hand in the type of research project selected for support. Unfortunately, at this time we will have to decline your request.

Shortly thereafter, contacts in the industry told Dr. Sackett that the PMAC had an "unwritten but official policy of non-cooperation with Guyatt," and that some of them saw the Senior Official's letter as an unfortunate "power play" and "flexing of muscles." Dr. Sackett told me that he was left with the impression that some companies still wanted to support educational events, but did not want this support to be construed as condoning the Residency Guidelines.

In a parallel development, the Chair of Continuing Education came under industry pressure. Attributing the Guidelines to the institution (and thus to the Continuing Education program as well as the Residency Program) several companies indicated that if cooperation with the industry were withheld, funds would be donated elsewhere. The Chair eased the misunderstanding with the industry, clarifying that the Continuing Education guidelines had not changed. In addition, the Chair of Continuing Education sent a memo to a senior Administrator, identifying the serious deleterious effect of the Guidelines on his program's relationships with the pharmaceutical houses. In the memo, he suggested that all educational programs adopt a uniform approach to this issue. Accompanying the memo were suggested guidelines for interaction with the industry that sanctioned input from the industry in planning educational events and a much greater access to and opportunity for dialogue with physicians by industry representatives.

The Administrator wrote back to the Chair of Continuing Education concurring that a more uniform policy across educational jurisdictions was desirable. The Administrator's note included the following reflections:

"I share your concern that our relations with the drug industry are a bit like a marriage, where the relationship has to be nurtured to avoid the alternative of constant conflict.

All of us endorse the general principle that we should not be held hostage by drug companies but we also have to recognize the hard fact, that the drug companies are becoming increasingly the only likely source of external funds to support some of our educational operations."

To me, the activities of the Senior Official and the PMAC, and the pressure that had been brought to bear on the Chair of Continuing Education, represented attempts by industry representatives to intimidate the faculty leadership. In response to the Senior Official's rejection of funding, Dr. Sackett and I sent him a letter on June 8 saying that, as we understood it, he had withheld funding on the basis of the residency Guidelines. We suggested that this was not in his company's or the industry's best interests, and that we would be happy to meet with him to discuss the issue further.

When, by August 11, we had not received a reply, Dr. Sackett sent a further letter. The letter began with the following sentence. "Because this letter, and your response to it, may receive rather wide distribution, I begin it with a chronology of the pertinent events". The letter suggested that if there was no confirmation or refutation of his impression of a link between refusal of funding and the Guidelines, that Dr. Sackett would feel obligated to bring the issue forward to the Royal College of Physicians' Committee on Health and Public Policy, of which he was then the Chair. The letter also asked for clarification of PMAC policy with respect to the Guidelines.

The Senior Official replied on August 24. His letter stated, "My decision...to respond negatively to your request for funding of research projects was in no way linked to the new guidelines."

In subsequent correspondence, Dr. Sackett and I asked the Senior Official to clarify the PMAC attitude toward the guidelines. Ultimately, we explicitly asked if there was, or had ever been, PMAC policies to withhold funding because of the Guidelines, or to not cooperate with me in my role as Residency Program Director. The re-

ply came not from the Senior Official, but from the President of the PMAC, and stated that there had never been any such PMAC policies.

I also felt compelled to deal with the Chair of Continuing Education's concerns about his deteriorating relationship with the industry. In a widely distributed memo addressed to the Administrator, I first noted that the deleterious effect of the Department of Medicine Guidelines suggested that the industry saw the Guidelines interfering with their ability to exert influence on the attitudes of physicians-in-training. Second, I suggested that industry representatives believed that by putting pressure on organizers of another program they may indirectly influence policies of the postgraduate training programs. I noted that, were the Administrator to engineer a modification of the Guidelines, the industry's belief that they could indeed exert influence in this fashion would be vindicated. I suggested that proceeding in this fashion would be a major error. The Administrator decided that with the current differences in attitudes and guidelines, there was little to be gained through an attempt to develop a uniform policy.

Our residency program did not rely heavily on funding from the industry, even prior to the Guidelines. Overall industry funding for the internal medicine residency program has remained more or less constant since the Guidelines were adopted.

Discussion

There are lessons in this story both for the pharmaceutical industry and for academic medical leaders. The industry must accept that we are in an era in which ethical standards of conduct for the medical profession are in flux. A number of organizations have delineated standards of conduct that are quite different from practices that have become commonplace over the last decade. Some physicians present compelling arguments that suggest that any industry gifts to physicians, or physicians' organizations, are a form of bribery. According to these standards, our Residency Program Guidelines are still too permissive. This most rigorous standard is currently an extreme minority viewpoint, but that may change as the debate continues.

The industry must let the discussion within the profession evolve. As the evolution proceeds, institutions and organizations will take different approaches to the problem. Industry attempts to influence the debate by intimidating those responsible for setting standards or guidelines will not serve its long-term interests. Attempts to intimidate provide ammunition for those who see accepting any gifts as a breach of ethical standards.

Academic leaders considering policies restricting industry donations and access to physicians and to physicians-in-training will face worries about industry reprisals. During the internal debate that was part of our Guidelines development, faculty members expressed concern about possible reductions of industry funding. Misguided industry representatives may exert subtle or overt pressure on academic leaders to refrain from instituting or enforcing restrictions on industry interaction with physicians. Academic leaders may be tempted to bow to this pressure.

Academic leaders should, however, note that industry can not carry out major reprisals, because doing so would be too damaging to its image. Indeed, the whole reason for subsidizing educational programs is to present a picture of socially responsible, generous corporate bodies. Threats of withdrawal of support are a bluff, and will evaporate if the bluff is called. If they are seen as intimidating academic policy makers, industry representatives realize that they will provide too much ammunition to those whom they see as their enemies.

This is not to say that more subtle reprisals are not still possible. There may be many reasons to reduce funding, and excuses are easily found. On the other hand, industry has little to gain by restricting funding in a fashion that leaves uncertainty about the causal connection with faculty policies. Ultimately, however, the most compelling reason to resist intimidation is that it is an abuse of power and influence. Succumbing to industry inducements, or the threat of withdrawal of these inducements, reinforces the behaviour and is likely to compromise our ability to make ethical stands in a variety of areas.

The verdict about the appropriate ethical standards that should guide individual physicians and publicly funded institutions in their relationship with the pharmaceutical industry is not yet in. Leaders of both academe and the industry must prevent industry intimidation from being a hidden or explicit factor in the ongoing debate.

Acknowledgements

I wish to thank David Sackett for sharing the challenges in dealing with the difficult issues we faced, and for his wise counsel in the preparation of this manuscript. I also wish to thank David Davis for sharing his insight into the events, and for his help in ensuring a balanced presentation of the story.

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Doctors and drug companies in France

By Jean-Michel Normand

In these last couple of months some of France's biggest pharmaceutical companies have given up organizing lavish banquets to present their latest product to the medical profession. Several conferences to which laboratories invited general practitioners have been only sparsely attended — or else cancelled. And the various handouts doctors used to get if they took part in "research" (read: prescribing certain drugs) have virtually dried up.

This chill wind has nothing to do with France's economic situation, but results from new legislation — by the previous Socialist majority — which restricts rewards, cash or kind, made by the medical supplies industry to members of the medical and paramedical professions.

In the face of a soaring national insurance deficit, it was urgent to stop inducements to doctors to prescribe more and more — or dearer — drugs. It was widely accepted in the medical world that pharmaceutical laboratories and certain doctors had got into bad habits and it was high time to end practices contrary to medical ethics.

There has, on the other hand, been an outcry against the law's stipulation that doctors must systematically draw up written agreements with the laboratories specifying "the explicit purpose and real aim of the research or scientific evaluation" involved and submit them for review by the French medical association's local branch.

The stiff penalties specified have been widely criticized: offenders may be fined up to 500,000 francs, or two years in prison or banned from practising for ten years.

The laboratories are alarmed that the new legislation — brainchild of the economy ministry's competition and anti-fraud department — will dent their brand image, while doctors refuse to be publicly pilloried and accuse the government of disrupting the system whereby laboratories keep them abreast of advances in treatment.

Official representatives of both the medical profession and the pharmaceutical laboratories are determined to pull together in an attempt to persuade France's new government to amend the legislation.

"Everyone is caught in a cleft stick," says Sylvain Visconti, head of Rhone-Poulenc-Rorer's pharmaceutical division. "We agree with the spirit of the law, but its formulation is so repressive it virtually prevents us from keeping doctors informed — they've been completely terrorized."

Jean-Francois Sfarti, chairman of Sanofi-Winthrop, says that his company has suspended all such promotional operations because it is impossible to distinguish between what is legal and what is not. "The pharmaceutical industry, no doubt unintentionally, over-stepped the mark. But the law goes too far the other way. We must work together to come up with balanced rules compatible with medical ethics."

How exactly did the industry "overstep the mark"? The practice of giving handouts to doctors or paying their fares to conferences or seminars can be justified when such perks are kept within reason. On the other hand, it expressly violates medical ethics when it results, directly or indirectly, in some sort of return favour from doctors, such as the prescribing of certain medicines. That is what apparently occurred.

Over the last two years things have got out of hand," says one medical sales representative. "The best-known technique involves asking the doctor to prescribe a particular drug for several dozen patients over a period of a month, as part of a sham, post-launch therapeutic study.

"In fact the aim is to place a maximum quantity of our products with doctors and to get them into the habit of prescribing. In return, we occasionally reward them with a cheque, but on the whole we tend to hand out telephones, fax machines, medical textbooks or invitations for a weekend in often quite distant places, sometimes under cover of a humanitarian mission."

It would seem that the doctors most often asked to take part in such "research" — which qualifies as unfair competition and results in the cost-effectiveness of drugs going by the board — happen to be those with the largest practices.

A GP in the Greater Paris area says he is asked at least once a month to carry out bogus research in return for a gift worth anything up to 1,500 francs. "As for the very numerous dinners sponsored by the drug companies as part of their policy of keeping us up to date, they sometimes do actually serve a professional purpose. I think the new law aims above all to clamp down on certain scandalous practices verging on extortion — which are fortunately very rare — such as when a doctor approaches a lab and offers to prescribe one of its drugs in return for various kickbacks such as pleasure trips, for example,

through an association set up specifically for that purpose."

Gifts fly especially thick and fast when several similar products are in competition. The most commonly cited are drugs for veinous congestion, anti-hypertensive medicines, antibiotics and tonics of various kinds — markets which total several billion francs.

"The new law is a blessing for me," says the head of a small laboratory. "I was sick of the way certain doctors were 'put under contract' by my competition, who offered them hospitality at bogus conferences or gift vouchers in proportion to the volume of drugs they prescribed. Mind you, I'm not saying that all doctors gave in to the temptation — far from it."

Hospital doctors are also constantly solicited. One of them says: "Rather than fight tooth and nail to get funding to attend a symposium of genuine interest — but which is taking place in New York — it's much simpler to phone a lab!

"This is an area where pharmaceutical companies, especially the smaller ones, are able to invest in the future: when a junior hospital doctor moves into the private sector, he or she will have got into the habit of prescribing their products. I wish the advantages granted by labs went to university hospitals, as they do in the States, rather than to doctors."

The American Medical Association has adopted a charter which specifies that gifts made to doctors may be accepted only if they are directly connected with the doctor's work. It also forbids the reimbursement of conference-related expenses and bulk buys of prescribed drugs.

Dr. Gilles Bardelay, who runs *Prescrire*, a medical monthly with 22,000 subscribers that does not accept pharmaceutical advertising, takes a more radical line: "Several doctors including myself have set up a network which keeps an eye on medical sales reps. We've no qualms about citing specific cases of abuse. I don't think doctors should allow themselves to be visited by reps. If they need information, they should approach the laboratories directly."

He feels that the new legislation, which confirms legal principles already established in 1953 but provides for stiffer penalties, has been introduced not so much with a view to being implemented as to giving the profession a salutary scare.

Most doctors, while regretting that colleagues' behaviour has cast suspicion on the whole profession, would prefer to see a concerted drive to raise moral standards rather than a divorce with the pharmaceutical industry.

"Of course there is abuse," says Dr. Hubert Wannepain, a leading doctors' union official. "The new law was drawn up without consulting us, and although its principles are sound it nonetheless remains impractical: the number of medical association officials would have to be quadrupled, and even then they would be snowed under with requests for authorizing the smallest promotional events.

"The best guarantee of a good medical training is pluralism. The pharmaceutical industry has a role to play alongside the in-service training financed by doctors themselves and the health service."

The medical association regards the law as "imprecise and restrictive" and has urged doctors to be "extremely prudent". Clearly reluctant to play the policing role expected of it, the association claims that the legislators, "under pretext of avoiding scandals, have paralyzed partnerships" with the pharmaceutical industry.

The industry would like to see "a strict code of ethics" governing relations with doctors which would "strongly discourage possible abuse". It regrets the government did not take into account the draft European directive which allows the industry, under certain conditions, to finance events whose purpose is to keep doctors informed of new developments.

To avoid abuse, says Visconti (Rhone-Poulenc-Rorer), "we must ensure that our generosity towards doctors is reasonable and periodic." Although flawed, the new law has drawn attention to and challenged unethical practices. In so doing, it may have harmed the brand image of the pharmaceutical industry and the medical profession. But it was no doubt the price they deserved to pay for having taken so long to clean up their act.▼

Reprinted from the Le Monde section of the Manchester Guardian Weekly, May 2, 1993.

Reform of Canada's Primary Health Care System

Introductory comments by Rosana Pellizzari:

John Forster, Walter Rosser and Maggie Grogan, in their paper "Reform of Canada's Primary Health Care System" (see below) have based their recommendations on both a critique of the existing problems in primary health and an endorsation of Ontario's Health Goals as priorities for any restructuring. The model borrows heavily from the British experience of registering every citizen with a primary health care organization. Citizens have the right to change but would be restricted to receiving all services from one organization at any one time. These organizations could be either private practices, HSOs or CHCs.

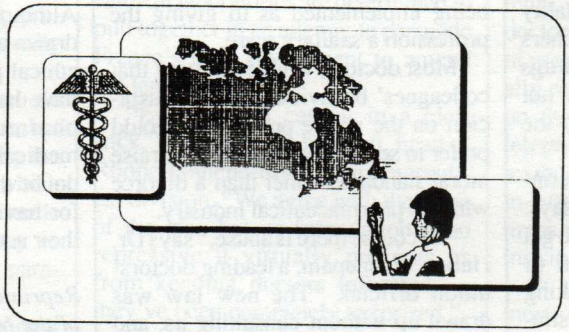
Whatever the organization, it would be accountable to a local authority. These authorities would set and enforce standards for care and "targets" based on the needs and demographics of the population. Funding would be a blend of capitation, fee for service and program funding.

The authors propose that primary care be provided by a "team of professionals working in a coordinated way". Organizations would be required to provide 24 hour care, seven days a week. They would keep computerized patient records. All records of a patient would be centralized in one place. The local authorities would ensure quality control.

The model has several attractive features. It promotes an understanding of health which is population based, but is built on the provision of co-ordinated, comprehensive care to the individual. It respects client choice and allows for the possibility for more consumer input, through CHCs or at the level of the local authority. It introduces accountability and evaluation into our current non-system of care. It removes the financial incentives to provide unnecessary services.

Where more work is needed is in the interface between primary care and both consultants and institutions. The model makes no mention of referrals and hospitalizations, common occurances for primary care. Britain is now experimenting with "fundholding" where primary care physicians can purchase services from consultants and hospitals.

I believe the MRG should endorse the Forster, Rosser and Grogan paper as a valuable contribution to the health reform debate. It is hoped that the College of Family Physicians will recognise their work and use it as a discussion tool for its members. In contrast to much of the profession, it represents an attempt to be thoughtful and proactive in its recommendations for change.



Reform of Canada's Primary Health Care System

By John Forster, Walter Rosser, and Maggie Grogan

Concerns to be addressed

- The type of system we need
- Accountability
- Population Health
  - Determinants of Health
  - Intersectoral Collaboration and Integration
  - Health Promotion
  - Disease Prevention
  - Access
  - Mental Health
  - Long Term Care
  - Community Service Development
  - Equity of Opportunity for Healthy Living
- Drug utilization

Health goals

(Developed by the Premier's Council on Health Strategy)

- Shift the emphasis to health promotion and disease prevention
- Foster strong and supportive families and communities
- Ensure a safe, high-quality physical environment
- Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death
- Provide accessible, affordable, appropriate health service for all

Characteristics of proposed reform

- Practice registration
- Local Authority Coordinating Care.
- Community Health Authority Linked to a Regional Health Service Authority.
- Primary Health Care Through Multidisciplinary Agencies.
- The Mandatory Use of Health Targets.
- Central Health Records.
- Computerized (informatics primary care services)
- A managed system
- Balance between preventative, curative, and palliative services
- A rationalized and blended system of funding

Practice Registration

- Everyone registered with an organization that provides primary care
- A variety of types of organization
- Population health provided for as a result of having a defined patient base
- Outreach programs
- Choice would be maintained
- Access would be guaranteed

Local Authority Coordinating Care

- "Community health service authorities"
- Coordinate primary care service within a particular neighbourhood or district.
- Part of a larger regional district
- Approximately 50,000 - 75,000 people.
- under the auspices of district health councils.
- composed of professional and non-professional people
- selected through an appropriate non political mechanism.
- Responsible to regional health authority or district health council for the provision of a range of services for each citizen.
- Control and authorize primary health care services within their district.
- Include medical services as well as others.
- Practice organizations within each district accountable to the community health service authority.
- responsible for such matters as the setting of health targets and the provision of continuous care.
- Primary care services must be linked to the health care needs of the community in which it exists.
- services set up with a clear accountability to a community agency

Community Health Authority Linked to a Regional Health Service Authority

Regional municipalities, through their district health councils, would be empowered to articulate the primary health care needs of the people within their borders. They would set priorities based upon economic and other circumstances within their region. They would obtain their authority directly from the provincial Ministry of Health, delegate that authority to the District Health Service Authority as described above.

Primary Health Care Through Multidisciplinary Agencies

We propose that primary care be provided by a team of professionals working in a coordinated way. Family physicians would work alongside nurses and other non-physicians in the provision of care for their community. In this way, more effective services can be mobilized and savings realized.

The Mandatory Use of Health Targets

- Inability in primary care to articulate the needs of our community of patients
- Inability to create or realize health targets.
- Impossible for a current practice to determine immunization rates, smoking rates, suicide rate, the level of hypertension, etc. within the practice community.
- Mandatory for each practice organization to set and to meet health targets for their patient population.
- Based upon epidemiological studies of the district or region in which the practice is placed.
- Provincial agencies' (such as the Premier's Health Council) objectives and targets could be implemented at a practice level.

Central Health Records

- Current system of health records chaotic.
- As many health records as they have seen doctors in their lifetime.
- Little attempt made to coordinate and centralize the health records of any one individual.
- Fragmented and disorganized care can and does occur.
- Standardized and central health record maintained by the practice to which registered.
- Property of the province
- Portable from one practice organization to another
- All records pertaining to that patient would be centralized in one place.▼

NEWS BRIEFS

MEETINGS AND CONFERENCES

MRG Steering Committee

The Medical Reform Group Steering Committee meets on Monday **April 18** in Toronto. MRG members are invited to attend Steering Committee meetings to observe, take part, or raise issues the MRG should be addressing. For details on times and places, call 416-588-9167.

'Picture of Health' forums

The Ontario Federation of Labour is sponsoring a series of two-day regional forums on the theme "A Picture of Health". The forums will bring together OFL affiliates, local unions, health workers, labour and community activists, and researchers to share visions for the health system; explore the connections between good quality, humane care and employment security; and assess the effects of the current restructuring of health care on local health services. The dates and places for the forums will be Sudbury April 19-20, London April 21-22, Dryden April 25-26, Oshawa May 3-4, St. Catharines May 5-6. For more information contact the Ontario Federation of Labour, 15 Gervais Drive, Suite 202, Don Mills, Ontario M3C 1Y8, (416)441-2731, fax: (416)441-1893.

Gerontology conference

The Ontario Gerontology Association's annual conference — The Challenge of Change — will be held **May 5-6** in Toronto. Contact Ontario Gerontology Association, 7777 Keele Street, 2nd floor, Concord, Ontario L4K 1Y7.

Reception for Julian Tudor Hart

Dr. Bob Frankford, MPP, is hosting a reception for Julian Tudor Hart on Friday **May 13**, 6 - 8 pm, in Room 247 of the Ontario Legislature, Queen's Park, Toronto. For more about Julian Tudor Hart, the author of *A New Kind of Doctor*, see Page 3. Call (416)325-9923 for more information.

Health Care Reform in Canada: Recent Developments

The Medical Reform Group's Spring General meeting will be held on Saturday **May 14**, 1 pm to 3 pm, in Toronto, at the Hotel Plaza II (NE corner of Yonge and Bloor). The meeting will focus on "Recent Developments in Health Care Reform in Canada". Michael Rachlis will kick

off the discussion by surveying recent developments across Canada. The meeting is being held in conjunction with the annual meeting of the U.S. group Physicians for a National Health Plan. A joint session with the PNHP on the theme "International Perspectives on Health Care Reform" will begin at 3 pm (see below for details).

International Perspectives on Health Care Reform

The U.S. group Physicians for a National Health Plan is holding its annual meeting in Canada this year on the weekend of **May 14-15** in Toronto at the Hotel Plaza II (NE corner of Yonge and Bloor). A joint session with the Medical Reform Group, on the subject of "International Perspectives on Health Care Reform" is planned for the Saturday afternoon, from 3 to 5:30 pm. Speakers in that session will be Julian Tudor Hart (see profile on Page 3), David Himmelstein, Rosana Pellizzari, and Haresh Kirpalani. For more information on the meeting, see Page 1.

MRG members who would be able to provide a billet for PHNP members attending the meeting are asked to call the MRG office at 416-588-9167.

MRG/PNHP social

Physicians for a National Health Plan and the Medical Reform Group will be holding a get-acquainted social on Saturday evening, May 14, in Toronto. MRG members are invited to attend. For details, come to the meeting on May 14 at the Hotel Plaza II, or call 416-588-9167.

Helping the bereaved male

The twelfth King's College conference on Death and Bereavement will take place on **May 16-18** in London. The topic is "Helping the Bereaved Male". Contact King's College Centre for Education about Death and Bereavement, 266 Epworth Avenue, London Ontario N6A 2M3, fax: 519-433-0353.

Rethinking Primary Care

The Centre for Health Economics and Policy Analysis at McMaster University (CHEPA) is devoting its seventh annual policy conference to the topic of "Rethinking Primary Care". The conference will be held **May 19-20** at the Nottawasaga Inn in Alliston. Among the speakers are Julian Tudor Hart, a Welsh physician and an internationally known authority on alternative models of primary care, who will speak on Visions of Primary Care (see profile of Julian Tudor Hart on P. 3); Linda McQuaig, author of *The Wealthy Banker's Wife: The Assault on Equality in Canada* and *Behind Closed Doors: How the Rich Won Control of Canada's Tax System*...

Community Physician

Women's Health in Women's Hands – A Community Health Centre for Women, is in need of a part-time female physician. We are a pro-choice, antiracist, multilingual centre, committed to working with women with diverse needs and backgrounds, particularly teenaged women, older women, disabled women and women from different racial, cultural and linguistic groups. The successful candidate will be providing a full range of primary care services to women who access the Centre. She will need to be flexible and able to work cooperatively in a multidisciplinary team setting. Some evening, on-call and outreach duties will be required. Salary $85,648 - $117,776 prorated plus benefits package.

A strong commitment to women's issues, antiracism, community-based medicine, health promotion and prevention is essential.

C.C.F.P. Required. Ability to speak more than one language an asset.

Please apply in writing to:

Joan Grant-Cummings, Executive Director
Women's Health in Women's Hands —
A Community Health Centre for Women
344 Dupont, Suite 402
Toronto, Ontario M5R 1V9
Deadline for resumes: May 6, 1994

Family Physician

Position in a downtown Toronto Community Health Centre. Replacing female physician in a diverse, multicultural community. Must be flexible and able to co-operate with a multidisciplinary team that is committed to serving the needs of marginalized people. Some evening, on-call, teaching and outreach duties. Generous salary and benefit package. Additional languages an asset. C.C.F.P. preferred. In accordance with the guidelines of Section 24(1) of The Ontario Human Rights Code, we are hiring a woman for this position.

Please apply in writing by April 29, 1994, to:

West Central CHC
c/o Physician Hiring Committee
674 Queen Street West
Toronto, Ontario M6J 1E5
Fax: (416)363-6190

And Ended up Richer; and Julio Frenk, Director General of Mexico's National Institute of Public Health. Brian Hutchison, an MRG member, is the chairman of this year's conference. Registration is $220. For more information, contact Conference Administrator, CHEPA, McMaster University, 1200 Main Street West, Rm 3H26, Hamilton L8N 3Z5, (905) 525-9140 x22135, fax: (905) 546-5211.

Baby Friendly Initiative

Humber College, INFACT Canada, and Women's College Hospital are co-sponsoring "The Baby Friendly Initiative: A National Plan for Action" — a workshop for health professionals and policy makers to be held Thursday **June 9** at Humber College, 205 Humber College Blvd., Toronto. Contact Sylvia Segal, Humber College, 416-675-6622, fax: 416-675-2015.

Canadian Peace Alliance

The Canadian Peace Alliance will hold its 1994 convention June 10 through 12 in Montreal. For more information contact the Canadian Peace Alliance, 555 Bloor Street West, #5, Toronto, Ontario M5S 1Y6, (416)588-5555, fax: (416)588-5556.

Canadian Health Coalition

The Canadian Health Coalition is hosting a country-wide meeting on June 11-12 in Ottawa to adopt a set of health care principles and plan actions around a National Forum on Health. Contact the Canadian Health Coalition, 2841 Riverside Drive, Ottawa K1V 8X7, (613)521-3400 for more information. See Page 4 ("Principles for Health Care Reform") for information about the proposed Health Care Declaration/Principles for Health Care Reform.

Community Health Centre Physician

Barrie Community Health Centre is seeking a full time physician to provide community-oriented primary health care and health promotion within a multi-disciplinary setting.

BCHC is a resource for the citizens of Barrie to enable them to assert control in their own lives in order to improve their health and the health of the community. This is a general practice which emphasizes service to those having difficulty accessing necessary care.

The successful candidate will have:

- demonstrated ability to work as part of a team
- knowledge of and commitment to community based health care
- an understanding of the determinants of health
- strong clinical skills
- knowledge of and sensitivity to women's health issues
- license to practice in Ontario

Please apply in writing or call to inquire:

Carla Palmer
Executive Co-ordinator
Barrie Community Health Centre
80 Bradford St. Unit 117
Barrie, Ontario L4N 6S7
Tel. (705) 734-9690

Law and Mental Health

The twentieth Congress of the International Academy of Law and Mental Health will be held in Montreal **June 15-18**. Contact Karyn Wager, International Scientific Committee, 30 St. Joseph Blvd. E., #520, Montreal, Quebec H2T 1G9, 514-847-0782, fax: 514-843-5415.

Alternative Media Conference

The Alternative Press Center is hosting an alternative media conference on the weekend of July 22-24 in Baltimore. The purpose of the conference will be to discuss the problems confronting alternative media and to strategize solutions. Discussion will look at questions of audience for the alternative media, the political climate, new technology, funding, and organizational forms. For more information contact the Alternative Press Center, P.O. Box 33109, Baltimore MD 21228 U.S.A., (410)243-2471, fax: (410)235-5325.

MRG Fall General Meeting

The Medical Reform Group's fall general meeting has been scheduled for Thursday **September 29**.

It's Never OK

The Canadian Health Alliance to Stop Therapist Exploitation Now (CHASTEN) is holding a conference on sexual exploitation by health professionals, psychotherapists and clergy on **October 13-15** in Toronto. Contact Temi Firsten, c/o CHASTEN, P.O. Box 73516, 509 St. Clair Avenue West, Toronto M6C 4A7, (416) 656-5650.

Caring for a Nation

Caring for a Nation is a film project being developed by Erudite Cultural Products. The film is described as an important tool in the battle for a decent and equitable system for health in Canada. The documentary would critically examine the delivery of health care in Canada and the United States as seen by two community health clinic doctors, one in Ottawa and the other in San Francisco. Filmmaker Linda Gouriluk is looking for support for the project, in the form of endorsements, distribution of publicity, and financial support. For more information contact Erudite Cultural Products, Box 3997, Station C, Ottawa K1Y 4P2, (613)722-8512.

PUBLICATIONS

Women with Disabilities

The DisAbled Women's Network Ontario (DAWN) has published *Women with Disabilities: A Guide for Health Care Professionals*. The 33-page Guide outlines and discusses issues such as "How can health care professionals make their offices more accessible?", "How can health care professionals provide better health

care to women with disabilities?", and "How can health care professionals improve their procedures for clients with specific disabilities?" Available from DAWN, 180 Dundas Street West, Suite 210, Toronto, Ontario M5G 1Z8.

Mental Health Reform

The Ontario Ministry of Health has released a report, "Implementation Planning Guidelines for Mental Health Reform", which is supposed to provide a planning framework for the transformation of mental health services across Ontario. The guidelines see District Health Councils leading the implementation planning process at the district and regional levels. Available from the Ontario Ministry of Health, Hepburn Block, Queen's Park, Toronto M7A 2C4, ISBN 0-7778-2573-2, Cat. #4226131.

Patent Folly

Patent Folly: Behind the Jargon on Intellectual Property Rights: A Layperson's Reader, by P. Sainath of the Indian School of Social Sciences in Bombay, dissects the debate on "intellectual property rights" and draws out the implications for pharmaceuticals, agriculture, and other fields. Sainath argues that in every "invention" there is a significant public element in that every patented product or process rests on many previous discoveries and insights, and that what marks the recent drive for "intellectual property rights" is not the desire to guarantee a reasonable return to people for their work, but the desire to establish monopolies at the expense of the rights of the public. The people of the Third World, he says, are particularly victimized by this process, which benefits no one except a few multinational corporations.

Available from P. Sainath, Indian School of Social Sciences, Bombay 5-E, ENSA Hutments, Mahanagarpalika Marg (Near Azad Maidan), Fort, Bombay 400 001 India.

A Gentle Death

A Gentle Death, by Marilynne Seguin, explores the moral and legal implications of euthanasia. Seguin offers advice on working with doctors and other health-care professionals, dealing with unresolved personal conflicts, involving family members and friends in the decision-making process, and coping with present legal realities.

Key Porter Books, 1994, 250 pp, ISBN 1-55013-553-8, $19.95.

40+ Guide to Fitness

A Physician's Exercise and Sports Program, Edited by David R. Stutz and the Editors of Consumer Reports Books. Distributed in Canada by McClelland & Stewart. 1994, $23.50, 166 pp, ISBN 0-89043-578-2.