
Medical Reform

Newsletter of the Medical Reform Group

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PERSONAL ATTACK, POLITICAL WEAPON

Gordon Guyatt

Whistle-blowers beware, the anguish never ends. While that isn't the subtitle that Miriam Shuchman chose for her recently published assault on Nancy Olivieri's reputation, it does capture the profoundly destructive effect that Shuchman's book could have.

Potential whistle-blowers - those who discover misbehaviour, facts, or circumstances threatening to a powerful company or institution - face great risks. Industry and institutional responses are almost invariably a professional and personal attack on the whistle-blower.

In this regard, Olivieri's story is typical. An academic investigator at the Hospital for Sick Children and the University of Toronto, Olivieri uncovered evidence of ineffectiveness, and possible serious toxic effects of a drug she was studying. The drug, deferiprone, is an iron chelator designed to prevent the adverse consequences of iron overload in patients with conditions such as thalassemia. Olivieri felt that patients, and the research community, needed to be aware of her findings. Despite threats - and subsequent initiation - of lawsuits against her by Apotex, the company involved in moving the drug toward market, Olivieri proceeded to publish her findings.

At the time the controversy developed, the University of Toronto was negotiating a large grant from Apotex. Instead of support from the university and hospital, Olivieri received harassment, including a highly publicized referral to the College of Physicians and Surgeons of Ontario for research misconduct. The College ultimately vindicated Olivieri, finding her conduct "exemplary".

Shuchman's book replays the story, and a whole host of variably related events, in a manner that is as negative as possible about Olivieri. The book focuses on Olivieri's putative limitations as a physician, a researcher, and a human being, attempting to discredit her on all counts.

The response of Olivieri and her supporters to the book has been to focus on its reliance on unnamed sources and anonymous quotes, its serious inaccuracies, the continued controversy about deferiprone (which remains unlicensed in Canada and the United States) and evidence of Shuchman's bias.

Perhaps most striking in regard to this last problem is a letter to Shuchman from a patient quoted liberally throughout her book. The letter, copied to Olivieri with permission to circulate, includes the following: "Dear Miriam: You've used a smoke and mirrors approach to spinning my statements to inaccurately portray Nancy by misquoting me, attributing quotes to me that I didn't make, omitting portions of my comments that would alter the effect, and taking these comments out of context."

Shuchman's apparent readiness to twist the truth in her attempt to pillory Olivieri is troubling. Nevertheless, the inaccuracies and distortions are tangential to the essential destructiveness of the book. That destructiveness lies in the context of two ongoing political debates in which the book's publication is set.

The first debate relates to criticisms the pharmaceutical industry has

(continued on page 2)

INSIDE

Boutique Medicine.....3-5
Home Care.....6-7
Supreme Court decision....8-10
Student Campaign.....11-12
Reproductive Health.....13-16

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1

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Editorial committee this issue:

Brad MacIntosh, Janet Maher

The Medical Reform Group 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 contribution of all health care workers is recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health is provided.

PERSONAL ATTACK, POLITICAL WEAPON(continued)

recently faced for a number of long-standing practices. These practices include extravagant gift-giving to potential prescribers of their drugs, large payments to experts in a position to make influential recommendations, withholding data from investigators involved in their research, ghost writing of manuscripts, and withholding and ignoring information concerning deleterious affects of their drugs.

The second debate relates to increasing threats to the academic freedom of university-associated clinicians and researchers. More and more, universities and hospitals are reliant on industrial partnerships, and donations from wealthy companies and individuals. This reliance has spawned a culture that puts an increasing premium on employees serving the institutional interests, an increasing intolerance of dissent and criticism, and an erosion of academic freedom. As a result, a number of clinician-scientists have brought their stories of actions against them by their hospitals and universities to the Canadian Association of University Teachers. CAUT has responded with a series of recommendations for strengthening academic freedom that medical schools have, so far, rejected.

These two debates share common elements. They reflect increasing corporatization of our society, and reactions against that corporatization. Critics are forcing large corporations and institutions to defend themselves against charges that their actions compromise the public interest. Naturally, those under attack have responded aggressively to defend themselves.

Public debates are often resolved at least as much by symbolic

and emotional arguments and presentations as by evidence and logic. Nancy Olivieri, and her story, are powerful symbols of the pharmaceutical industry, universities, and hospitals acting against the public interest, and the possibility of heroic action by individuals to defend that interest. Shuchman's book represents an apparent effort to tarnish the luster of that symbol.

If Olivieri was biased and intransigent, then perhaps we are making too much of concerns about drug toxicity, and the industry's suppressing and ignoring toxicity. If Olivieri is a harridan, self-serving and nasty, then perhaps the same is true of other clinician-scientists claiming their academic freedom is being violated. If that is the case, then our concern about the direction in which medical schools and their associated hospitals are drifting may be unwarranted.

None of us lead blameless lives. Nancy Olivieri faced a profoundly difficult choice in making her findings about desferiprone public. She courageously stepped forward, knowing she would suffer - and suffer she did. Would she have acted had she known that this suffering would include a highly public attack, devoid of objectivity, on her integrity and concern for patients, years after the event?

Faced with the same situation, would you? ♦

BOUTIQUE MEDICINE, BLOCK FEES AND OTHER STRATEGIES TO IMPLEMENT TWO TIER MEDICINE BY STEALTH: UPDATE ON THE ONTARIO COMMITMENT TO THE FUTURE OF MEDICARE ACT

Janet Maher and Brad MacIntosh

Shortly after the 2003 election, and responding to the palpable concerns of Ontarians, the new provincial Liberal government introduced Bill 8, the Commitment to the Future of Medicare Act, which was intended to codify the Ontario government's understanding of its obligations under the Canada Health Act to maintain and enhance access to high quality health care for all.

The Medical Reform Group intervened on Bill 8, agreeing with the government on the importance of pharmacare and home care, and the urgency of proceeding with primary health care reform as the cornerstone of an effective health care system. We supported the government proposal for an Ontario Health Quality Council, with some specific recommendations for a more open recruitment process for the Council. Where we diverged most from the government was on the parts of Bill 8 relating to accessibility and their approach to the issue of block fees.

Our position on block fees followed some months of discussion with the College of Physicians and Surgeons of Ontario (CPSO) which had begun a routine review of their block fee policy near the end of the term of the previous government. The initial interest of steering committee members was to react to reports that in a context of scarcity of family doctors, some physicians appeared to be taking advantage of the so-called block fee to limit their practice.

Block fees represented one response of physicians to requests for a range of services which were not directly insured services. Typically these included filing of forms for third parties (sick notes for employers, certificates of physical fitness for school and other uses), as well as forwarding of clinical information to other physicians, telephone consultations and prescription renewals and the like.

To reduce the administrative burden, some physicians proposed to charge an annual fee, generally in the range of \$50 to \$100 per patient per year. When this practice became an issue in the early 1990s, the Ontario Medical Association and the College of Physicians and Surgeons of Ontario had devised a protocol which regularized the fee by requiring that patients be informed of the range of services to be included and given the option of continuing to pay for such services on an as-used basis.

The summer before the 2003 election, some steering committee members began to be concerned at the increase in reports of some family physicians who appeared to be taking advantage of substantially increasing the block fee, adding some services which were arguably insured services, and requiring patients to pay the fee as a condition of service, or be dropped from the physician's roster. The assumption in these cases was that a physician could generate sufficient income from a higher fee (often \$300 to \$500 annually, although

Globe and Mail columnist Margaret Wente reported one group of family doctors in Toronto seeking \$2,500 per patient in the summer of 2003 for a 'customized health plan') to maintain a much smaller patient roster than the average.

Steering Committee members Irfan Dhalla and Gordon Guyatt argued (see **Medical Reform** issues 124ff for copies of correspondence, briefs and reports of meetings) with representatives of the College of Physicians and Surgeons of Ontario that the existence of block fees of any amount were effectively an invitation to give preferential service to those who opted to pay the fee as requested.

We recommended to College staff and the Registrar that they return to the plan which provided for administrative fees to be charged for uninsured services only individually as they are provided. Not surprisingly when the government sought input on their Bill 8 provisions, we recommended abolishing block fees, or at the very least providing both more patient education on the issue of fees and implementing and publicizing a more effective complaints procedure.

While the final version of the bill made some minor amendments to the section on access, the item on block fees remained as originally drafted, with the assurance that the issues we had raised might be dealt with either by government in accompanying regulations or via the CPSO

(continued on page 4)

BOUTIQUE MEDICINE, BLOCK FEES AND OTHER STRATEGIES TO IMPLEMENT TWO TIER MEDICINE BY STEALTH (continued)

policy which would be completing its review process in early 2004.

The CPSO review took a little longer than anticipated and so the revised policy was only published in college publications and the website in April, 2005. Although there have been some minor amendments in their policy, the college council did not feel evidence provided by the Medical Reform Group and others was sufficiently compelling, and so the only substantial change was some facilitation of third party complaints as a result of their discussions with the government. We again took our case to the government, who counselled us to await the ministry review process—as noted in Minister Smitherman's letter of March 18th, published in our last issue.

We have continued to meet with ministerial staff to discuss ways to minimize the impact of block fees on people at what is often their most vulnerable time of need. Meanwhile, as we see in this issue, some medical practices seem to be prepared to continue to test the limits of the government's attentiveness/interest/sensitivity to different strategies to accommodate what is perceived as patient demand for access to timely service. Late in 2004, rumours began to surface that a new kind of user fee might expedite more timely access to some services.

As noted in our April 14th letter to Minister Smitherman below, there seem to be emerging a few variants of this. As one of our members found when seeking a referral for a patient, the Life Screening clinic charges a substantial fee for mandatory nutrition counselling, an uninsured service, with the implicit promise that should other services be

indicated, for example, a colonoscopy, these would be expedited through the normal public system. The Wasser Pain Clinic at Mount Sinai uses an introductory fee of \$150 (similar to a one-time version of the block fee charged by some family doctors) to cover non-OHIP services as a condition of being accepted to the clinic.

We are investigating some further items relating to reproductive health and orthopaedic services, and expect that members may be aware of additional strategies being used or contemplated by colleagues.

On May 20th, 2005, we met with Ministerial policy assistant Abid Malik at his invitation to discuss our concerns. Malik noted that following the passage of Bill 8 they had set up a 1-800 'snitch line' for patient complaints, but it had been so little used that it was discontinued. He confirmed that they are still considering regulation on Bill 8 regarding block fees, and that our input might yet see the light of day. He also noted that the two cases we had featured in our April 24th letter were already under investigation in the ministry and offered to facilitate a further meeting with the senior bureaucrats.

That offer led to a further meeting on June 16th with Dr. Chester Brown, the ministry's medical consultant in charge of the enforcement of Bill 8, and Ms. Suzanne McGurn, Director of Provider Services. Brown explained that in addition to collection of data consistent with current privacy legislation, their investigation process also includes due diligence to determine both facts and intent, and would include consultation with practitioners/services com-

plained about to attempt to resolve the issue informally if possible.

Brown noted that in the majority of cases, they determine that there has been a miscommunication which would generally result in a repayment or refund for the patient. McGurn noted that for all the light shed already on this issue, greater clarity on what are insured and uninsured services would assist them in their work. She also observed that in many of the cases they investigate, physicians end up amending their policies to be more explicit about the uninsured services they offer so as to avoid in future the grey areas which had led to ministry requests to reimburse patients.

Although neither Brown nor McGurn could imagine a quick resolution of the issue, they invited our advice to their ministerial committee on provider billing practices and education. The meeting ended with Brown expressing some concern about the implications of the latest OMA deal which allows physicians to incorporate, and McGurn encouraging our continuing involvement in policy development both at political and bureaucratic levels. ♦

BOUTIQUE MEDICINE, BLOCK FEES AND OTHER STRATEGIES TO IMPLEMENT TWO TIER MEDICINE BY STEALTH (continued)

On April 14, 2005, Steering Committee member Irfan Dhallal wrote the Minister to summarize our concerns on new user fees:

Dear Minister:

I'm writing on behalf of the MRG to register our concern that several large medical practices in Toronto are violating the Commitment to the Future of Medicare Act by charging patients illegal fees for insured services. We believe this is an important matter that the Minister needs to address urgently. I will provide you with details regarding two of the practices that are in violation:

1. The Wasser Pain Clinic at Mount Sinai Hospital. As noted on the Wasser Pain Clinic's website, the clinic requires patients to pay a "one-time administrative fee of \$150 for services not covered by OHIP" before patients are accepted into the practice. Since the services the Wasser Pain Clinic provides are insured by OHIP, this kind of fee is clearly "extra billing" and as such, is a violation of both the Canada Health Act and the Commitment to the Future of Medicare Act.

2. Life Screening Centres (984 Bay Street, Suite 502). This clinic is expediting access to colonoscopies for a fee of \$395. Our research has revealed that patients who need a colonoscopy and are referred to the clinic are told they can have it done in a publicly funded hospital, after a 6-8 month wait, or immediately in the clinic. They are told that the clinic does not charge for the colonoscopy but that there is a mandatory visit with a nutritionist, and that the charge for this visit is \$395. This is clearly queue jumping. We have also been told by staff at the clinic that if the colonoscopy uncovers a problem that requires surgery, this will occur in a much more timely fashion than if the patient goes through the usual channels.

We are aware of several other practices that are charging similar fees for medically necessary services. The passage of the Commitment of the Future to Medicare Act reassured Ontarians of the government's intent to eliminate extra billing, user fees and queue jumping. We believe you should now use your authority under the Act to stop these egregious practices. Furthermore, to dissuade other health care practitioners from charging illegal fees, we believe that your actions should be public.

We are thus requesting an urgent meeting with you to discuss this issue further. I look forward to your reply. ♦

GET WITH THE PROGRAM

Gordon Guyatt responded April 4, 2005 to Blatchford's April 2 Globe and Mail column, "Deadly Decisions in a Damaged System"

When Christie Blatchford completes her mission to report anecdotes of catastrophes in Canadian health care delivery, perhaps she'll begin to address possible solutions. If she does, she will need to decide whether she wants to solve the problems only for the affluent who can pay extra, or for all Canadians.

If Ms. Blatchford wants a system of high quality care for all of us,

she will find a road map in a number of thoroughly researched and carefully considered reports. The National Health Forum of 1997, and the Senate Kirby and Romanow reports of 2002, all point the way.

We require stable, adequate public funding for hospitals and for diagnostic equipment; an adequate supply of well-trained health professionals; expansion of publicly funded home care and drug benefit pro-

grams; and a move toward multidisciplinary chronic disease management with adequate quality monitoring.

Canadians are well aware our system has deficiencies. If Ms. Blatchford gets onside with the first report of the Canada Health Council, and exhorts governments to move quickly in implementing reforms, she will be making a valuable contribution. ♦

HOME-FREE? HOME-BOUND? OR HOMELESS? PUTTING HOME CARE BACK ON THE NATIONAL AGENDA

Janet Maher

On the eve of an anticipated provincial announcement on home care, health policy analyst Carol Kushner provided the educational background for a review of home care at the spring members meeting on May 11, 2005. Her presentation led to a lively discussion, which reaffirmed that a comprehensive and integrated approach to home care is central to the long-term sustainability of health care in this country. Carol began with a discussion of the objectives of home care, which she thought should aim at maximizing individual autonomy for as long as possible.

While high quality medical care is certainly important, she counseled a broader social approach which situated medical services in the context of maintaining health and mobility and recognized the value of social supports such as assistance in the activities of daily living. Kushner highlighted the recent history of interest in home care, from the National Forum on Health, a federally sponsored national consultation to give direction to the modernization of health care, under the leadership of a score of prominent Canadians.

The 1997 Forum report recommended public funding for a full range of home care services, and recognized, perhaps as poignantly as any policy undertaking in the past decade the burden of care on caregivers. The 1997 Speech from the Throne—the federal government’s signaling of its intentions—gave way to a National Conference in 1998, and a range of options and models. However, most

of the energy marshaled for this event dissipated pretty quickly, and the prospects for introducing new cost-shared social programs for pharmacare and home care faded.

In Ontario, as in many other parts of the country, provinces under pressure to “do something” in health care, made two major decisions which have continued to compromise a more comprehensive approach to home care.

In Ontario, toward the end of the hospital restructuring process, and arguably to facilitate the closure of that process, the 20,000 new long term care beds promised by the Harris government began to come on stream. As well, the establishment of a provincial network of Community Care Access Centres (CCACs) introduced a process of competitive bidding among providers for home care services.

By 2000, Canadians were justifiably fed up at declining access despite the promise of the National Forum, and former Prime Minister Chretien appointed former Saskatchewan Premier Roy Romanow to devise a blueprint for action. Romanow reported in November of 2002, and on the whole made recommendations which had the potential to address many of the most critical issues facing the health care system. It is not clear, and Kushner, among others, wonders how clearly he understood the centrality of or agreed with the incorporation of home care in the health care mandate, since the Romanow home care recommendations are essentially limited to short-

term acute mental health care and post-hospital care with little recognition of the much longer term needs of those with chronic conditions for home care supports.

What was of greater interest however was the response of the federal government which had commissioned Romanow’s work. While the rhetoric was considerable and vehement, and the response of the newly-elected Martin government in the September 2004 First Ministers’ meeting marked a significant improvement over the Chretien era, in that it provided for the restoration of some \$42 billion of federal funding (largely eroded at the hands of Martin when he was Chretien’s finance minister), the promise to “buy change” by making the transfers to the provinces conditional on the provinces’ spending on the agreed-upon priority areas, was largely neglected in the implementation.

Moreover, no sooner had the ink dried on the September meeting than several of the premiers, including Ontario’s McGuinty, renewed campaigns to improve their treasuries at the expense of Ottawa. In Ontario, despite McGuinty’s 2003 election promise that Ontarians could choose to receive care at home provided the costs did not exceed nursing home or hospital costs, these policy changes have yet to be realized. While there was some modest increase in the budget for home care in the spring budget, the Minister has asked Ontarians to withhold their judgment pending the Review by

(continued on page 7)

HOME-FREE? HOME-BOUND? OR HOME-LESS? (continued)

former Health Minister Elinor Caplan on the Competitive Bidding Process at CCACs. (Caplan's report was finally released May 31).

In discussion, Kushner spoke at length of some of the models, particularly OnLok and PACE which have now almost a generation of experience of integrating the health and social needs of elderly who are frail enough to qualify for nursing home admission, but are maintained in home through a mix of in-home and day care. She cited recent OnLok spending patterns where nearly 80 per cent of program budgets were devoted to family physicians, day programs, home care and transportation and just 22 per cent on hospital, nursing home, lab and other diagnostic tests, medication and specialist care.

She also cited Peter Coyte's 2002 review of the recent Ontario hospital restructuring exercise where he concludes that rather than the projected 20,000 nursing home beds proposed by the previous (Harris) government, a more modest 8,000 would likely be adequate. His 2004 recommendations to integrate post-acute home care funding and delivery with hospital care and to shift chronic home care into a system of integrated primary care have, it appears, been shelved by both government and the institutions involved.

Kushner concluded her presentation by noting that home care still needs a secure home in public policy and encouraged members to persist in the many evidence-based projects they are already undertaking to assist citizens in campaigning for integrated not for profit care. ♦

ONTARIO HEALTH COALITION CALLS FOR VIGILANCE ON CAPLAN

Toronto - In response to large protests in Ottawa, St. Catharines and Toronto, the Minister of Health announced a review of competitive bidding in homecare last fall. Elinor Caplan has been appointed to conduct the review. However, she has stated that her mandate is to review "procurement procedure" not competitive bidding, despite the Minister's announcement. Her review is scheduled to be delivered to the Ministry of Health tomorrow, April 1.

In response, the Ontario Health Coalition has conducted its own review of the competitive bidding system that has ushered in for-profit privatization in homecare. The results were released in a press conference today.

Among the findings:

- ♦ 6 large corporations now hold 76% of homecare nursing contracts, compared to 8 agencies holding 66% of the contracts in 1995. Small community-based agencies have been virtually eliminated in the sector.
- ♦ 1,050 workers have been laid off as contracts were lost in recent months.
- ♦ Over 22,000 clients have been affected as their careworkers were laid off in contract losses.

"Unfortunately, the Caplan review process is another exercise in rearranging the deck chairs on the Titanic," stated Pat Armstrong Professor of Sociology and Women's Studies at York University. "As this report clearly indicates, what is sinking homecare is competitive bidding and not simply the procurement

process that is the sole focus of Ms. Caplan's review. Only a thorough, public and evidence-based review of competitive bidding can ensure Ontario residents get the quality of care they need at the price that respects care providers and care recipients."

"If they adopt a long-term strategy to continue competitive bidding, the Liberal government will embrace long-term privatization," stated Ross Sutherland, registered nurse and coalition spokesperson. "We are extremely concerned that the government is refusing to consider the poor performance of the profit-system. We are paying the price through poor working conditions, high administrative costs, disruptions in care, and a climate of fear for nurses, clients and support workers."

"Needed now is a more open review that asks fundamental questions about how to build a stable and sustainable system of homecare that is responsive to patients discharged from hospitals and to elderly and disabled citizens living in the community," concluded Jane Aronson, Professor and Director of Social Work at McMaster University. ♦

Released by the Ontario Health Coalition March 31, 2005. The report was finally released on May 31.

SUPREME COURT THROWS A CURVE ON CHAOULLI

We reproduce here for members copies of the Canadian Health Coalition Fact Sheet, released June 28, 2005

Issue: Jacques Chaoulli, a Quebec doctor and George Zeliotis, his patient, challenged sections in the Quebec health and hospital insurance laws that make private health insurance illegal. They claimed that because delays in the public system place their health and security at risk, they should be allowed to take out insurance to permit them to access private services. The Quebec trial judge dismissed the claim. The Quebec Court of Appeal agreed.

Decision: The Supreme Court of Canada split 4 to 3 on the issue, giving 3 separate sets of reasons. The majority of 4 justices held that the appeal should be allowed and that the Quebec prohibitions on private health and hospital insurance are inconsistent with the Quebec Charter.

Justice Deschamps held that the Quebec Charter protection of life and personal security had been violated and the provision banning private health insurance is not justified. Chief Justice McLachlin and Justice Major (with Justice Bastarache concurring) held that the Quebec laws also breach s. 7 of the Canadian Charter of Rights and Freedoms. They held that delays in treatment could breach the right to life and security of the person. The laws prohibiting private insurance were contrary to the principles of fundamental justice because they were arbitrary and not justified under s. 1 of the Charter.

The majority ruling dismissed expert evidence accepted by the trial judge as well as the evidence of the Romanow Commission. Instead, they cited evidence from Senator Kirby's interim report (selectively citing OECD countries out of context) and

Dr. Erwin Coffey of the Montreal Economic Institute, a libertarian think tank funded by the Donner Foundation. These two 'experts' form the basis of Justice Deschamps' assertion that a private parallel health insurance system does not impact negatively on the public system. [Senator Kirby, a senior director of Extendicare Inc., and Dr. Coffey have a combined total of zero (0) peer-reviewed publications to their credit.]

In a blistering dissent, Justices Binnie and Lebel (with Justice Fish concurring) held that waiting times could violate the right to life or security of the person. Even so, they held the prohibition on private health insurance is not arbitrary because it is intended to protect equality of access to the health care system:

"...the proposed constitutional right to a two tier health system for those who can afford private medical insurance would precipitate a seismic shift in health policy for Quebec. We do not believe that such a shift is compelled by either the Quebec Charter or the Canadian Charter." (para. 176)

The dissenting judges also criticized the majority for selective use of the evidence:

"The appellants' argument about 'arbitrariness' is based largely on generalizations about the public system drawn from fragmentary evidence, an oversimplified view of the adverse effects on the public system of permitting private sector health services to flourish and an overly interventionist view of the role of the courts..." (para 169)

They found that on the legal issues raised, the appeal should be dismissed:

"The public cannot know, nor can judges or governments know, how much health care is 'reasonable' enough to satisfy s. 7

of the Canadian Charter of Rights and Freedoms." (para 163)

Implications: This judgment raises important legal and political questions. While it applies in Quebec, the reasoning could be used to challenge similar laws in other provinces on the basis of the Canadian Charter.

It is not clear how other provinces can meet the test the court applies for Charter compliance. There is no standard to measure against. The implications for other provincial health insurance regimes have to be carefully reviewed. In addition to the legal uncertainty, there is a major political challenge, especially because of the ideological commitment to privatize health service delivery by the current governments in Quebec, Alberta and British Columbia.

Actions: The Canadian Health Coalition is calling on the federal government to:

- ◆ Recommit to defend the right of all Canadians to universal and equal access to health services regardless of ability to pay
- ◆ Develop benchmarks for waiting times and strategies for applying them to ensure timely access and to conform with the Canadian Charter and other human rights law
- ◆ Work with provincial and territorial governments to ensure their Medicare laws protect equality of access with equal terms and conditions and shield health insurance and service delivery from commercialization and international trade rules
- ◆ Enforce compliance with the Canada Health Act and stem the tide of privatization that undermines the objectives of the Act and threatens the viability of Medicare. ◆

CANADIAN HEALTH COALITION ACTION ALERT ON CHAOULLI DECISION

The recent Supreme Court ruling struck a blow to the heart of Canada's Medicare system. Four of seven Supreme Court justices ruled that the remedy to waiting times in the public system is to grant a constitutional right for those who can afford private medical insurance the jump the queue. The majority decision argues forcefully for the rights of private health insurers while at the same time arguing that the poor have no constitutional right to health care. The decision is a perversion of Canadian values and is likely in violation of international human rights law.

Canadians don't believe in the values expressed in the Supreme Court's Chaoulli v. Quebec decision. Waiting time problems need to be fixed in the public system so that all Canadians have equal and timely access. Health is a human right.

We agree with Prime Minister Martin's recent comments:

"The way you avoid all of the problems of a two-tier system, which we see in the United States, for example, every single day, is to make sure your public health care system is very, very strong.... Health care should not be based on your pocket-book, it should be based on need." (Canadian Press, June 21, 2005)

But words are not enough. Faced with the Supreme Court intervention, concerted action is urgently required.

Strategic investments are needed to reduce wait times and increase the number of health care providers. Other essential reforms include:

- ◆ Improved access to safe and effective drugs

- ◆ Improved primary care
- ◆ Expanded home care
- ◆ A national strategy on health human resources

Public funding for health care must be invested in the public system and not for private care. These new investments much, in the words of Roy Romanow, 'buy change.'

Wait time reduction strategies will fail without a plan to stem privatization of delivery.

Two-tier health care siphons scarce human resources from the public system. We have a shortage of nurses, physicians, radiologists, technicians, etc. in the public system, increases wait times and erodes the public system.

The obligation is on governments to fix what they broke through previous funding cuts. Canadians want the problems in the public health care system fixed. They don't want the system dismantled.

In light of the serious threats to Canada's public health care system, the government of Canada must:

- ◆ Recommit to defend the right of all Canadians to universal and equal access to health services, regardless of ability to pay. This includes tracking public funds to ensure they are invested in care not profits.
- ◆ Develop benchmarks for waiting times and strategies for applying them to ensure timely access and to conform with the Canadian Charter and other human rights law.
- ◆ Work with provincial and territorial governments to ensure their Medicare laws protect equality of access with equal terms and conditions and shield health insurance and

service delivery from commercialization and international trade agreements, including NAFTA and the GATS.

- ◆ Enforce compliance with the Canada Health Act and stem the tide of privatization that undermines the objectives of the Act and threatens the viability of Medicare.

Send messages urging action to your representatives: Right Hon. Paul Martin, Prime Minister, 80 Wellington Street, Ottawa K1A 0A2. Telephone: (613) 992-4211; Fax: (613) 941-6900; e-mail: pm@pm.gc.ca; Hon. Ujjal Dosanjh, Minister of Health, House of Commons, Ottawa K1A 0A6. telephone (613) 957-0200; Fax: (613) 952-1154; e-mail: minister_ministre@hc-sc.gc.ca. For detailed contact information for premiers, provincial premiers and health ministers and individual members, visit: www.medicare.ca ◆

CORRECTION

In the last issue we carried a fact sheet, **Tips for Health Care Providers on Completing Special Diet Prescriptions/Forms for Clients on Ontario Works**, but credited it incorrectly. In fact the tips were prepared by Regent Park Community Health Centre and the Ontario Coalition Against Poverty (OCAP). The fact sheet has been an important resource as several Toronto agencies supported clinics over the spring and summer to assist clients. For more information, please contact OCAP at 10 Britain Street, Toronto M5A 1R6, phone 416 925-6739 or e-mail at ocap@tao.ca. ◆

CHAOULLI DECISION PROTECTS ONLY THOSE WHO CAN PAY

The Medical Reform Group of Ontario today criticized the Supreme Court of Canada's decision for putting the rights of wealthier Canadians ahead of those of the majority.

"Two tier medicine violates the rights of those on the lower tier," said MRG spokesperson Dr. Gordon Guyatt. "The way private medicine will play out in Canada, as it has in Australia and Britain, most of us will be in that lower tier."

In contrast to the majority, the minority opinion in the court paid attention to the evidence, and acknowledged that a parallel private system will actually worsen care, and waiting

times, for those covered only by public insurance.

"Private insurance threatens publicly funded care," said a second MRG spokesperson, Dr. Ahmed Bayoumi. "We have a shortage of both doctors and nurses. Many, and perhaps the best, will be drawn into the private sector, leaving greater shortages in the public system."

There are other reasons that a parallel private system will compromise publicly-funded care. Private insurance is associated with large administrative costs, and money that could be spent on delivering health care is wasted. When private insurance arrives, the most powerful political

constituency - those with power, education, and money - leave the public system. The political pressure to maintain the system - the only thing that ensures public health care remains high quality - decreases.

"This decision has scared Canadians, and with good reason," Dr. Guyatt concluded. "The right wing wants to deny it, but the Supreme Court ruling has started us down the road toward US-style two-tiered care. Canadians must insist that their politicians set up an effective road block - which will include ensuring timely care for all of us." ♦

Released June 20, 2005 by the Medical Reform Group

RECENT MESSAGE IN OUR MAIL BAG: EXAMPLE FOR MEMBERS

Reader Rita Pollock of Coquitlam copied us on her letter of concern to the Prime Minister at the Chaoulli decision

I read with dismay the Quebec decision on allowing private insurance coverage for the rich. How does allowing the rich to bypass the Medicare system provide timely medical treatment to the poor and middle class? Our system has been eroded for decades as subsequent governments have bled money from our health care system. But this is not the only reason our system has been devastated. The ongoing reduction of training hospitals for doctors and nurses over the past decades has brought us to the place we are today. Please provide ample funding to reinstate thousands more spaces for training nurses and doctors. At the present rate of training we are not even replacing the staff that are retiring. Where does this make sense if you really believe in a public health care system?

How can anyone truthfully champion a privatized system when it means more tax dollars go to these profit companies instead of into much needed public resources? It is time your minister's stop writing letters to the provinces that have been creating privatized services, allowing the rich to jump the line in waiting lists and draining doctors and nurses needed in the public system, and stop these private clinics from operating privately but instead bring them into the public system.

You and your colleagues have touted that we have a Universal Medicare System but this is in too many cases false. As I have written to you before with no reply, Universal Medicare would mean no Canadian citizen would have to pay extra insurance to travel to another prov-

ince or territory to receive essential medical services. Our original Medicare also was paid through our taxes yet now several provinces have imposed premiums and unjust deductibles on the hard working middle income earners.

Slowly but surely private insurers, usually from the United States, which has an abominable record of providing affordable medical service to the general population at twice the cost, are infiltrating the Canadian system with the acceptance of the public having to pay separate medical insurance for visiting their relatives or touring the rest of our great country. Stop this privatization by stealth and implement true Universal Medicare across Canada having this administered through one insurance plan with total oversight to ensure the care

STUDENT MRG HEALTH INITIATIVE: WHERE IS CANADA?

Cathy Nangini and Brad MacIntosh

It's a good time to talk about Africa. The Make Poverty History campaign is out in full force, Bob Geldof is turning up the volume in Live 8 performances, and feel-good initiatives like Tony Blair's commission for Africa was full of promising talk.

Only problem is, when push comes to shove, nobody is taking any action.

This is a theme from which our own Canadian government is not exempt. As organizers of the student MRG initiative to provide medical aid to rape survivors in the Democratic Republic of Congo, we have experienced Canadian political inertia first hand.

Our aim has been to bring awareness at the local, national and international level regarding the use of sexual violence as a deliberate, merciless tool of war. The situation in the DRC, especially in the eastern regions, is extremely violent and unstable. The rape of tens of thousands of women and girls—some as young

as three years old—terrorizes them into silence, puts too many of them in urgent need of medical treatment which isn't available, and decimates communities with shame.

A UN peace-keeping mission (MONUC) is underway; however, some of these troops have themselves been implicated in acts of sexual violence. As recently as early June, a UN human rights team was fired on by militia while investigating reports of rape and abduction of women in the eastern Ituri province.

While all this occurs, Canada continues to enjoy the benefits of the politically weak but vastly rich country, chock-full of gold, diamonds, and minerals like coltan for cell phones and copper. Eight Canadian mining companies were implicated in the UN's 2002 hot list of corporations violating a code of ethics established by the Paris-based Organization for Economic Cooperation (OECD). The code is voluntary and unenforceable by national or international law.

That Canada should siphon off Congolese riches with one hand and sit on the other when it comes to instigating effective human rights action is unconscionable. We believe that addressing the current health crisis in the DRC is not only feasible and well within Canada's means, but also necessary in order to restore humanity and dignity—the cornerstones of any well-functioning society.

The student campaign kicked off in January with two main goals. One involved raising money for the Panzi Hospital in the eastern province of South Kivu, where Director Dr. Mukwege performs fistula surgery on hundreds of females to repair their damaged vaginas. He needs sutures, antibiotics and basic surgical equipment, and is the only doctor in the province that can provide this treatment.

The other objective was to kick-start the Canadian government, through CIDA, into supplementing an additional \$12,000 in funds to support the Panzi Hospital.

To date we have raised over \$2500 in donations by the sale of postcard petitions addressed to Aileen Carroll, Minister of International Cooperation, which call upon the Canadian government to take a stand on the issue of sexual violence as a weapon of war through immediate and direct action..

These postcards, along with a concept paper outlining our plan for implementing medical aid through CIDA based on the resource needs of the Panzi hospital, were presented to Parliamentary Secretary Paddy Torsney in early June.

(continued on page 12)

FROM OUR MAIL BAG (continued)

is economical, efficient and effective. Private insurers in the United States spend millions and millions of dollars looking for ways to prevent people from being covered. Money that could be used to help people and as I'm sure you know, does not cover at least 40 million citizens.

It is time for your government to get off the fence and implement real change. If this means changing the constitution to outlaw private insurers and disallow provinces from opting out of their responsibilities to

provide Universal Medicare, then so be it.

I am forwarding this letter to the opposition parties urging them to talk to you also about protecting Medicare and enhancing its equal availability to all. As a citizen of Canada for my whole life I expect you to personally reply to my letter.

Sincerely,

Rita Pollock

Coquitlam BC ♦

STUDENT MRG HEALTH INITIATIVE: WHERE IS CANADA? (continued)

The meeting was a grand disappointment. Ms. Torsney's attitude can be distilled into two points: the first being that Canada is already an exemplary world-leader on the humanitarian stage, and secondly, the kind of project we propose is better suited to partnership with an NGO. In other words, governments are not in the business of being world citizens.

Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa, would be the first to rain on Ms. Torsney's Canadian cheerleading parade. At a Rights & Democracy conference in Ottawa a few weeks ago, he called the failure to commit to the 0.7% foreign aid target "a scar on the reputation of Canada."

The game of political "pass the buck" is not new. Madelaine Drohan's book *Making a Killing* takes a look at numerous companies—Canadian mining companies included—who position themselves between war lords and world mar-

kets to secure profit in unstable countries like the DRC. Bill Graham, who was Foreign Minister when the UN report was released, responded to these concerns by declaring that there was nothing he could do. He suggested that perhaps some other country like France could raise the issue at the next G8 summit.

That summit is just around the corner, and not even Bob Geldof can get anyone to commit to a plan of action.

Certainly CIDA will not be at the helm leading the way. Our meeting with CIDA officials directly following the morning conversation with Paddy Torsney gave us another dose of political impotency. In contrast to Torsney's message, however, CIDA told us that our project is exactly the kind of thing they are looking for. Unfortunately, they could not find a funding mechanism for it. Our budget was too small.

However, they reassured us that, perhaps within one year they may

have drafted a plan of action to help sexual violence survivors in the DRC. One year of planning and at least three full-time salaries far exceeds the budget of our proposal, a project that would immediately cover supplies for a year's worth of fistula repair surgeries at the Panzi Hospital

Despite our failure to obtain government support for the Panzi Hospital, we are committed to implementing our proposal. We are pursuing fruitful interactions with organizations like Montreal-based Rights and Democracy, and we continue to involve individual Canadians through public awareness activities. ♦

Cathy Nangini and Brad MacIntosh are graduate students in the Department of Medical Biophysics at the University of Toronto. Nangini is founder of S.A.F.E.R.—Student Aid For the Elimination of Rap—and a member of the MRG Student Chapter. MacIntosh is founder of the MRG Student Chapter. For more information on supporting the campaign, please see www.medicalreform.ca/congo.htm.

WORKING GROUP ON REPRODUCTIVE AND SEXUAL HEALTH

Janet Maher

As noted in our spring newsletter the Steering Committee endorsed the formation of a working group to review the situation of reproductive health in Canada in 2005. The group met for the first time April 9th and dealt with a very full agenda.

The meeting started by recalling the original resolution (No. 11) passed by the Medical Reform Group on Women and Health Care in the spring of 1980, and which is repro-

duced below. The comprehensiveness of the resolution is a credit to the founding members:

WHEREAS the medical profession is not adequately meeting the needs of women, particularly in the areas of obstetrics and gynecology, counselling on sexuality, parenting, contraception, abortion, role conflicts, and health education,

WHEREAS we recognize that the medical profession has historically regarded women's physical symp-

toms with less rigor than those of men, and has tended to treat their psychological problems with psychotropic drugs rather than working with them to increase coping skills,

WHEREAS the medical profession has taken from women control of child-bearing, abortion, and birth control,

BE IT THEREFORE RESOLVED THAT:

(continued on page 13)

WORKING GROUP ON REPRODUCTIVE AND SEXUAL HEALTH (continued)

1. Centres be made available and easily accessible for primary care including contraception, abortion, pre-pregnancy counselling, prenatal counselling, natural childbirth classes and childbirth education, minor gynecologic problems, Pap smears, and breast examination;

2. Abortion be removed from the criminal code and be recognized as a matter of a woman's personal conscience;

3. Free-standing (i.e. non-hospital) abortion clinics be established in which women can obtain first trimester abortions quickly, safely, and in a sympathetic environment;

4. Any physician unwilling to be involved in abortion or abortion counselling be obligated to promptly refer a woman desiring these services to another physician of agency who will help her;

5. Safe alternatives in childbirth be made available to women including in-hospital birth centres, out-of hospital birth centres, and adequate supports for home birth;

6. Breast-feeding and natural childbirth be actively supported by physicians involved in birth, and family-centred birth become the norm,

7. Gynecologists, general/family practitioners, and health care workers receive more training in office gynecology, sexuality, marital and sexual dysfunction;

8. Family physicians, psychiatrists, and other health care workers receive more training in women's problems, women's roles in society today, and the conflicts women face in regard to their roles as mothers, wives and workers;

9. All sexist material in medical journal advertisements and in medical textbooks be eliminated

(Passed May 24, 1980)

Discussion ensued on abortion services. It was agreed that, aside from Toronto and Ottawa, access for women was very uneven. Some new providers are being trained, but an increasing issue even in major centres are fees charged to women at centres outside hospitals and the 5 original independent health facilities sanctioned in the NDP days.

A major difficulty seems to be that many hospitals have avoided providing services, and so there is pressure for additional clinics; a committee member reported that the Mississauga clinic where she has seen patients claims to have gotten Ministry of Health approval for a fee of \$60. The fee operates like the so-called block fee in that patients can elect to pay on invoice or in block—with ultrasound, RH and some more complex situations, the fee could be well in excess of \$60. The fee can be waived for some patients.

A related issue for services performed outside public hospitals and the original clinics might be quality control. Working group members generally did not have significant concerns with hospital based abortions, although it was noted that many hospitals seem to be using the recent budget situation as a rationale for limiting abortion services. After some discussion the working group agreed to take up the issue with the Ontario Women's Health Council and/or Public Health Departments across the province to follow up on a 2002 survey of reproductive health services in public hospitals done by CARAL.

The working group had concerns about the implementation process for emergency contraception. Although everyone cheered the recent announcement that emergency contraception was to be made available directly in pharmacies, on closer inspection the announcement appears to raise at least as many questions as it solves.

The product will not be on open shelves, and pharmacists expect to counsel potential users. Moreover, in the early days following the announcement, a number of pharmacists indicated they will not be stocking the product. As well, no protocols are yet available on the kind and extent of counselling. As will be seen in Rosana's article on emergency contraception (following in this issue), it seems likely that the fees will be nearly double what was available previously by prescription, and that the fees are unlikely to be covered by existing insurance plans. Other concerns mentioned include the extent to which this will become an additional pressure for more direct to consumer drug advertising.

Provider training has always been a concern of the Medical Reform Group. The general assessment of those at the working group meeting was that some quality provider training continued to be available. Some working group members noted that they would be attending a National Abortion Federation conference in Montreal later in the month and should have a better idea of relative supply following the conference. They also expect to share information with US providers on training family physicians for early termina-

(continued on page 14)

WORKING GROUP ON REPRODUCTIVE AND SEXUAL HEALTH (continued)

tions, to ease some of the expected service gaps as the current generation retires. At the same time, there are many services, for example, emergency contraception and early terminations that could be much more accessible if available at the primary care level.

The working group agreed to return at its next meeting to the issue of medical education and planning around women's, reproductive and sexual health, including at the new northern medical school. As well, we will canvass members and friends to see if there is support for wider use of mifepristone or methotrexate.

The final issue for the first working group meeting was a review of a Canadian Press report on Manitoba's decision to appeal a Superior Court ruling which held that abortion was a medically necessary procedure, and the Manitoba government's refusal to pay costs of abortions performed at the Morgentaler clinic in Winnipeg—free-standing but for profit, offended the Canada Health Act. It seems that the Minister of Health announced they will not reimburse patients and will appeal as they expect provincial health insurance to pay for full service in hospital, not in for-profit clinics. Debby Copes referred members to the BC Pro-Choice Action Network at www.prochoiceactionnetwork-canada.org ♦

PLAN B FIASCO (continued)

At a recent meeting in Perth County, with local pharmacists, there was no clear consensus on whether a counselling fee was being charged, but in some cases, a fee of \$12 was being added to the cost of the drug. One pharmacist reported that, with a prescription, he sold Plan B for \$24.78. As a behind the counter sale, he charged \$32.99 plus taxes. The pharmacists expressed discomfort with the screening form. Many reported that their pharmacies did not have private counselling rooms and so they had been put into situations of asking intimate and personal questions when confidentiality was compromised and privacy violated.

Listening to their concerns, it is possible that the pharmacists are being asked to violate Ontario's privacy legislation (PHIPA) by completing the form produced by the Canadian Pharmacists Association. Health information custodians must collect only the information necessary for us to do our job as health care providers. Do pharmacists really need to know the customer's name and address, and the dates and times of other episodes of unprotected sex PRIOR to the episode in question in order to dispense Plan B? Why do pharmacists need to ask for the name and address of a woman purchasing Plan B but not of a woman purchasing an antifungal cream to treat a vaginal yeast infection? Since there are no contra-indications to ECP, except for pregnancy, do they really need to ask about other medical conditions?

Ontario's PHIPA requires that steps are taken to safeguard personal health information. It is unclear what happens to these forms, where they are stored, how long they are retained and what happens to the informa-

tion collected. Before asking for personal information, the patient or client must be provided with a written description of the practices used to protect information, and the name of the person to contact with questions or concerns about personal health records. In reviewing the "How to Use Emergency Contraceptive Pills" fact sheet developed by the Canadian Pharmacists Association, there was no reference made to the collection of personal information by pharmacists, nor to the fate of the information being collected.

It is clear that emergency contraception has become less accessible, more costly and more problematic for women in Ontario who will request it without a prescription. For these reasons, the MRG Steering Committee should consider the following actions:

1. Write a letter to the Canadian Pharmacists Association requesting that they withdraw the Screening Form and instead, request that pharmacists provide Plan B to clients without counselling, but with information for the client to read prior to taking the medication. This would also make the charging of a counselling fee unnecessary.
2. Write a letter to Health Canada lobbying for a change in status of Plan B from a Schedule II drug to an over the counter product. This step would be the most effective in reducing cost and improving access at the same time.
3. Write a letter to the Ontario Women's Health Council to express concern over the excessive cost and barriers to access being experienced by Ontario women requiring emergency contraception.

(continued on page 15)

PLAN B FIASCO (continued)

4. Encourage physicians in Ontario to continue writing prescriptions for emergency contraception for all of their patients who rely on barrier methods for birth control. Prescriptions may provide women who have drug coverage to obtain Plan B at no, or reduced, cost. It will also avoid the necessity for

pharmacists to make any enquires of a personal or intimate nature at the point of sale.

MRG members in general practice may also want to consider purchasing Plan B to sell to their patients at cost. Alternatively, local public health units will sell contraception, including emergency contraception at

little or no cost to low-income women. There is certainly much we can do to ensure that women in Ontario have as many options as possible to reproductive health services. ♦

MRG MEMBERSHIP APPLICATION

I would like to ☐ become a member ☐ renew my support for the work of the Medical Reform Group

Membership Fees

- \$195 Supporting Member Physician
- \$50 Affiliate (out of province) physician Intern / Resident / Retired / Part-time Organization
- Free Newsletter Subscriber Medical Student / Medical Research Student

Please specify membership category:

Please specify areas of interest and expertise:

Name _____
Address _____
City _____
Province _____
Telephone _____
Fax _____
E-mail _____

Please charge my MasterCard/VISA in the amount \$ _____. My credit card account number is: _____
Name of Card holder: _____
Expiry Date: _____

Mailing Address:
Medical Reform Group
Box 40074
Toronto, ON, M6B 4K4

If you prefer, you may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and enclosing a black cheque, marked "VOID" from your appropriate chequing account.

I authorize my financial institution to make the following electronic payments directly from my account:

The amount of \$ _____ on the first day of each month, beginning _____, 20____.

Please credit the payments to the METRO Credit Union account (No. 1148590) of the Medical Reform Group.

I understand that these electronic payments will continue until I give notice in writing to the Payee to stop doing so; that I must notify the Payee in writing of any changes to the information in the authorization; and that I must notify the Payee within 90 days of any error in the electronic payment.

Account holder's name (print)

Account holder's signature

Date

THE PLAN B FIASCO: HOW CANADA HAS MADE EMERGENCY CONTRACEPTION HARDER TO GET

Rosana Pellizzari

Since the 1960's, hormones have been used post-coitally to prevent pregnancy in women who have had unprotected sexual intercourse.

The use of oral contraceptives, or Yuzpe method, became the standard of care in the 1970's, and consisted of 2 doses of Ethinyl Estradiol and Levonorgestrel, taken 12 hours apart. The development of a progestin only emergency contraception, Levo-norgestrel or Plan B, represented a major advance, as it was more efficacious, better tolerated, and safe to use in women who had contra-indications for estrogen. In 2001, the makers of Plan B applied to Health Canada to have their product changed to non-prescription status. This was seen as a major advance in improving access for women,

given research findings that demonstrated pharmacist-access as being effective at promoting better access.

The change to non-prescription status for Plan B occurred early in 2005. Although endorsed by groups such as the Society of Obstetricians and Gynecologists of Canada (SOGC) and the Canadian Women's Health Network (CWHN), the latter warned that this move could in fact create a "needless barrier, increase costs and reduce a woman's privacy".

Discussions with the SOGC have revealed similar concerns. The CWHN recommended that the only action necessary by pharmacists was the provision of information at the point of sale. Many professionals, researchers and activists in Canada point out that the drug is very safe and should be available over the counter, as it already is in countries like France.

By changing Plan B's status to a "Schedule II" product, Health Canada has made it necessary for a pharmacist to provide professional intervention at the point of sale. The Canadian Pharmacists Association has advised its members to complete a "Screening Form" on every woman who requests emergency contraception and to charge an additional counselling fee for the service.

The screening form asks for the woman's name, address and date of birth. It also asks very intimate questions, for example "Since your last menstrual period, have you had any other episodes of unprotected sex that might put you at risk of pregnancy?" If the client answers yes, the pharmacist is to ask for dates and times and document these on the form.

(continued on page 14)

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Please visit and comment on our web-site at <http://www.hwcen.org/link/mrg>

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