
Medical Reform

Newsletter of the Medical Reform Group

Issue 140

Volume 26, Number 4

Spring, 2007

FRIEND, ACTIVIST, ADVOCATE, MENTOR:

DR. MIRIAM (MIMI) DIVINSKY 1953-2007

Long time Steering Committee member and colleague Rosana Pellizzari has edited and provided links on the tributes we received following the untimely death of long-time Steering Committee member and activist Mimi Divinsky

Mimi was born in Winnipeg on September 24, 1953. Mimi's heritage twinned scholarly prowess with a desire for social justice. To this, Mimi added her own marvellous style and a heartfelt concern for her fellow human beings. She grew up in Vancouver and excelled in academics. From her early years, she had a passion for intellectual debate. Mimi graduated in medicine from UBC in 1977 and then completed her residency in family medicine at Women's College Hospital in Toronto.

Mimi practiced family medicine in Toronto, working during that time with several MRG members. Mimi served on the steering committee of the MRG since its inception. She was an active participant in the campaign for the Canada Health Act and in the provincial ban on extra-billing in the 1980s. She also put in many hours working on the MRG women's health committee which campaigned for the decriminalization of abortion.

Mimi was a driving force behind better services for victims of sexual assault and helped to develop

the sexual assault evidence kit now in routine use through-out Ontario.

Towards the end of the 1990s, Mimi was diagnosed with Multiple Myeloma. However, her fires just burned brighter. Occasionally slowed by her disease or her treatments she lived with purpose, style, and vigour. Mimi was a lifelong student of philosophy and dance. She read more books in a month than most Canadians do in their lifetimes.

In her last years she was intensely involved with poverty-related health issues. She was an active member of Health Providers Against Poverty and took part in special clinics targeted for recipients of Ontario Works and Ontario Disability benefits across Ontario.

At the end of 2005 as Mimi was entering the final phase of her illness, she drove to Belleville and worked all day at one of these clinics, completing the medical documentation that would result in a larger monthly allowance for food for 130 families.

Mimi suffered a fractured femur in the summer of 2006 and was confined to hospital until she died on February 4, 2007. She is survived by her parents, two sisters, and two nieces. Mimi was an intellectual superstar, a fine musician, a compassionate and skilled physician, and a wonderful friend. We in the MRG were fortunate to count her as one of the most active members. All of us who knew Mimi remain inspired by her life. ♦

Michael Rachlis

INSIDE

Tributes to Mimi.....	1-13
News Releases.....	13,16
Federal Budget.....	14
Provincial Budget.....	14-16
City on Special Allowances.....	17
Schafer Commentary.....	18-21
Kushner on block fees.....	22-23
Spring Meeting.....	24

Please visit our website at: <http://www.medicalreformgroup.ca>

(continued on page 2)

Medical Reform is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at \$60 per year. Arrangements may be made to purchase multiple copies or annual subscriptions.

Articles and letters on health-related issues are welcome--please forward electronically to medicalreform@sympatico.ca.

Contact us at:
Medical Reform
Box 40074, RPO Marlee
Toronto, Ontario M6B 4K4.
Telephone: (416) 787-5246
Fax: (416) 352-1454
E-mail: medicalreform@sympatico.ca

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

Editorial committee this issue: Norman Kalant, Rosana Pellizzari, 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 care is provided.

FRIEND, ACTIVIST, ADVOCATE, MENTOR (continued)

Mimi Divinsky was a dear friend and faithful member of the Steering Committee of the MRG. She was one of those people who never seemed to leave the steering committee, even at times of illness. She considered herself a "lifer", and, in the end, she truly was.

Those of us who joined the MRG after her tenure had already begun, remember her for many of her qualities, of which kindness and compassion, were only two. As Haresh Kirplani, a former member of the steering committee, writes, she is remembered as a "passionate advocate"

What Mimi Divinsky Meant to Me

I call myself a refugee from Thatcherite Britain. I did not come to Canada quite willingly. In this somewhat grudging immigrant way, I of course knew very little of Canada. I had some vague impressions of snow, vast spaces and the Arctic. I viewed Canada as a junior partner in imperialism, and I was not sure where the progressive movement was.

Of course I was somewhat busy, in a neonatal unit at Toronto, making it trickier to find out what lay beneath the surface of the big Gold Tower on Bay Street. Then came the OMA doctors' strike in support of extra-billing in 1986. Naturally I was horrified by this, and somehow, I found out that an apparently weird bunch of misfits calling themselves the 'MRG' – contested the premises of this strike. "Ahah!" I thought. "There is some life in this, apparently cold country.... There is hope yet!"

Making contact with the MRG was a major step in my personal 'Canadianization'. Before long, I found myself working with the Steering Committee – which is where I met Mimi. It would be wrong to say that she was the most important personal connection of mine to the MRG, but she was a very important one. Many meetings at both her flat and my various dwellings convinced me that this

was a very unusually caring individual. She always made me feel she was interested in hearing what I had to say. She seemed to think that new voices should be heard as loudly and as much as any native-born Canadian should.

With all that, she was transparently an intellectual – and was conversant with books, music, the London review of Books, and even tapestries from the Cluny Museum in Paris. While impressed that she knew of the Middle Ages Museum, the Cluny, I was rather shocked by the tapestry of the unicorns on her wall.

Why was I shocked? Well, unicorns might be called an antithesis of reality. But all this exemplified how 'un-pigeon-hole-able' she was. Anyone who knew Mimi, would readily point out that she was far from being a caricature of a Marxist or an activist.

If anything, she should be described as some sort of humanist – echoes of Petrarch and Erasmus would come to mind – slightly old-fashioned and slightly 'intellectual' in a pejorative way. So why would 'classical' activist-Marxists have a fondness of Mimi – is that a bit strange? Not really.

After all, how to describe Mimi's broad and gracious generosity? Not Marxist. And yet.... Marx once said that 'Nothing human is for-

(continued on page 3)

FRIEND, ACTIVIST, ADVOCATE, MENTOR (continued)

eign to me'. His breadth of writings and life experiences should convince even the most skeptical that this was perhaps true. Leavening the intellectual dry humanism, was her passion for social justice.

Mimi had a breadth of experience and generosity of spirit that might have also used those same words of Marx. I gather from a recent presentation by her sister Pamela, that she was fond of Spinoza. That Marx paid tribute to Spinoza might be an intellectual link between Mimi and myself. Undoubtedly she found my views too strident, yet she always listened to understand. And vice versa.

I think when the Steering Committee moderated me to 'reason', it was her and Gordon Guyatt that usually got through to me to 'convince me to see sense', or 'moderate'.

What made me fond of Mimi, was not our intellectual link, but the realization that Mimi was a passionate advocate for the defense of a publicly funded and accessible health care system. She was a co-founder of the MRG for this reason. She left any atomized, unitary, alienated single sense of being an individual, for this collective venture. She was a vital and consistent fighter for people's dignity in ill health.

Her apartment, full of esoterica such as the above named unicorns, suggested she belonged to a specific species of 'Humanists' who are often labeled 'individualists'. I have often found them to be also somewhat backward looking and isolationist, but Mimi refuted such stereotypes. Mimi recognized that collective and united actions were important in affecting social change.

In this she did not fit labels such as 'individualists'. She understood that the MRG Steering Committee was working collectively for a better society. She was a very effective member of a cooperative group, like all the other members of the steering committee. My point is that, despite her intense individuality, Mimi saw the need for collective agitation and action.

When I left the Steering Committee, losing my connection to Mimi saddened me. She left a gentle but firm touch on the MRG's actions. An untimely death has ended her struggle, but not her example of how to advocate for the ill, and the poor, and the disadvantaged. ♦

Haresh Kirpalani

Haresh speaks for many of us when we recall Mimi's steadfast contributions that spanned over two decades of MRG activism. Ahmed Bayoumi recalls his first Mimi sighting in those heated days of the 1986 doctors' strike:

Clarity of Vision

I first saw Mimi during the doctor's strike of 1986 when I was a medical student and she was one of several MRG spokespersons who weathered the scorn and criticism of their colleagues to stand up for the principles of universal health care. It was an intensely emotional time and I remember Mimi's brave commitment to her beliefs.

Coupling bravery with deep compassion was characteristic of Mimi, both in her professional career as a physician and in her activism with the MRG. Mimi was a pioneer in women's health, helping to establish

and run the first 24-hour sexual assault crisis centre in Ontario. She was also unafraid to use the privilege that came with her medical degree to fight for social justice, committing herself to help with the Health Providers Against Poverty's special diet clinics.

At steering committee meetings, Mimi was consistently concerned about the right thing to do. She had little interest in extended arguments or pointless vacillation – if there was a clear choice that should be made, Mimi would advocate strongly for that position. And yet Mimi's convictions were never reckless. At one meeting, she described to some student MRG members how, as an Intern, she would carefully look up all

drugs and dosages to ensure that her patients were getting the best possible care.

This was the key to Mimi's approach and why so many of us admired her so deeply. She possessed a truly unique and wondrous mix of qualities – intellect, caution, courage, and, above all, a deep compassion for others and a commitment to social justice ♦

Ahmed Bayoumi

(continued on page 4)

FRIEND, ACTIVIST, ADVOCATE, MENTOR (continued)

In the many years before her illness, and occasionally even in later times, Mimi could often be coerced to Co-Chair the steering committee with me, since she felt guilty for not hosting, and catering, the bi-monthly steering committee meetings that took place in Toronto. I would offer my place and broker with Mimi that she would take on the role of Chair. Although Mimi had a disdain for food preparation, she always enjoyed coming into the kitchen to ensure that the kettle was on for tea, and early on, noticed that I did not own a proper tea cozy. Being Italian, I know more about espresso than I did about the preparation of tea. Mimi gifted me with a grand tea cozy that could double for a Bishop's Mitre. I made sure to use it for every subsequent steering committee meeting, and would proudly place it next to the dish of lemons, for Mimi, of course. Obviously, I was not the sole recipient of a Mimi-treasure. Gordon Guyatt was also among the gifted:

Compassion for All

Of all the many dedicated physicians who have contributed to the work of the Medical Reform Group over the years, Mimi Divinsky cared more deeply and more intensely for the oppressed and disadvantaged than any. Her compassion was ever evident in the way she spoke, and in the way she acted. It provided the motivation for tireless work in her clinical practice, and in her political activities with the MRG. It resulted in her continuing to work with the MRG - including representing us with the Canadian Health Coalition - even during the advanced stages of her illness.

Others in these circumstances would have turned their attention inward, but not Mimi.

Unlike some people on the political left who find it easier to be caring in the abstract, Mimi's intense concern for others manifested itself on both the personal and political levels. I can provide one personal anecdote in that regard. After my divorce, my daughter, then 3 years old, was struggling with the situation. I mentioned this to Mimi. Shortly thereafter I received a number of children's story/picture books directed at children of my daughter's age trying to adjust to their parents' marriage breakup. My daughter continued to choose these stories - the only one I still remember was "Dinosaurs' Di-

vorce" - for our story times for a number of years. I believe the books played a significant role in allowing her to come to terms with the situation.

On another occasion, I mentioned the difficulties my daughter was having adjusting to many people. Mimi's action was the most considerate, thoughtful - and the most practical - of all the responses this particular life difficulty elicited.

Mimi was a remarkable person in a number of ways; to me, her depth of caring, and her constant willingness to summon the energy and initiative to respond to that caring, is the most remarkable. ♦

Gordon Guyatt

As Co-Chairs of the MRG Steering Committee, Mimi and I had the honour of co-signing a letter we sent to our Ontario College of Family Physicians (OCFP) in the early 1990's. The OCFP had sent a letter to every family physician member directing them to lobby their patients to protest against the introduction of Nurse Practitioners.

We were appalled that our College would ask physicians to use patients for political purposes and penned a letter pointing out that its actions were unethical and unprofessional. I can still recall Mimi's reaction when the Executive Director, at that time, responded with a threat aimed directly at the both of us. Although shaken by the intimidating tone of the College's response, it didn't prevent Mimi from continuing to speak out with me at a media conference. Mimi took her role as a Family Physician very seriously. For someone as dedicated and caring as Mimi, the letter's attack was probably gut-wrenching. But she didn't flinch. I was grateful for her support.

Tara Kiran writes of her own experience with Mimi as a colleague and a support:

(continued on page 5)

FRIEND, ACTIVIST, ADVOCATE, MENTOR (continued)

Work on the Health Providers Against Poverty Campaign

I had the pleasure of knowing Mimi during the last two years of her life. Mimi and I were both active members of a group called Health Providers Against Poverty – a group of health professionals determined to draw notice to the ill effects of poverty on health.

Together we sought support from professional organizations, lobbied government for an increase in social assistance rates, and staffed clinics where we would fill out forms that allowed people to receive a “special diet supplement” of up to \$250 per month extra on their social assistance cheques.

Most of the providers in our group live and work in Toronto and so, most of the special diet supplement clinics that we organized were located in Toronto. But, the need, of course, is broader. Two summers ago, our group received a desperate plea from an anti-poverty organization in Belleville, asking for a physi-

cian or nurse to staff a special diet clinic in Belleville so that social assistance recipients there too could have their forms filled out to receive extra money.

Most members of our group were reluctant to travel the distance to participate in the clinic, scheduled on a weekend no less. But Mimi volunteered. She traveled to Belleville numerous times over the following months and filled out forms for hundreds of people, making each of their lives better, one form at a time.

Although I knew of her diagnosis, I was barely aware of Mimi’s illness. She worked tirelessly and passionately to improve the health of Ontario’s poor, and rarely mentioned her own struggles with her health.

I remember attending meetings with Mimi at the Ontario Medical Association where we were lobbying to include poverty as a priority on their health policy agenda. She spoke fervently of the desperation of the families she met in Belleville and the difference a few hundred dollars made in their lives.

I only recall her mentioning her own struggles twice. Once, to apologize that she could not make an earlier meeting time because of her daily treatments at the hospital. And once, nearer the end of her illness, when she revealed her frustration at the slow pace of progress. She wanted to see something tangible done before she died.

It is amazing to me that in her last months, Mimi chose to spend her time and energy fighting to improve the health of the poor. When I try to put myself in her shoes, I can only come up with more selfish ways that I would want to spend my time if I knew that I would not have long to live.

Mimi was continually humble, selfless, and determined in her work to improve the lives of others. While there is always more work to be done, I hope that Mimi knew how many people she helped in her own lifetime.

Thank you, Mimi. We will miss you. ♦

Tara Kiran

The Medical Reform Group was blessed to have Mimi as a member. Truly, she was a fixture at MRG events and meetings. Those of us who had the honour of working with her, side by side, will never forget her honest and humble manner, her preference to work behind the scenes, the smiles and giggles that would constantly erupt across her face. Melissa Melnitzer has this to say of her time with Mimi:

A Woman with a Sense of Humour

I only knew Mimi for a short time, but will never forget her. Her quiet but palpable strength will remain an inspiration to me.

I met Mimi through the Raise the Rates campaign in 2005 and was immediately drawn to her enthusiasm and her commitment to helping others in the face of her own struggles.

She was often very anxious, which was always a mystery to me given all she had to feel confident about—she was smart, sensitive, courageous, and had such an easy smile.

Despite her anxiety and her exhaustion, she prepared intensively for a presentation to the Toronto Board of Health and got up in front of a room full of people to deliver her deputation. She dragged herself out

to Belleville to fill out countless special diet forms when they were in a pinch for a provider there, and she continues to be revered in that community for her efforts and for her kindness.

She attended every Health Providers Against Poverty (HPAP) meeting she could, and endlessly offered to do anything to get poor people their money. When the rest of us hesi-

(continued on page 6)

FRIEND, ACTIVIST, ADVOCATE, MENTOR (continued)

tated, Mimi always jumped forth fearlessly.

When Mimi got sicker again, she still tried to be involved as long as she possibly could...and when she couldn't, we would always hear of her requests for updates from HPAP. Again, despite her growing physical

frailty, her mind and heart couldn't stop caring about others. I tried to visit her, and weak as she was, she remembered me and all we had done together, and was grateful for all we continued to do.

When I heard Mimi had died I was, of course, sad and yet relieved,

too, for her that her struggle was over. Even though I didn't know her well, I miss her and think of her often. And every time I really put my heart into an HPAP issue I feel that she is part of my heart and carries me forward. ♦

Melissa Melnitzer

There is no doubt that Mimi cared deeply about her own patients and about the sick and the disadvantaged in general. Many of us had the opportunity to work with her and none would dispute the authenticity of her devotion. Shelly Sender recalls the following:

Teacher and Mentor

I first met Mimi during medical school, during my clerkship at the Wellesley hospital in the early 90's. I can't remember the exact circumstances of our meeting but I do remember what a warm, grounded,

sensible and reassuring presence Mimi was during that rather stressful (for me) time.

I remember in particular one conversation I had with her in which I asked if I could do an elective in her clinic. Mimi answered that, much as she enjoyed teaching, she felt it was unfair to her patients to bring students

into her office as it would interfere with the special relationship she had with her patients.

I didn't know Mimi terribly well but I surely feel that the world is a poorer place without her. ♦

Shelly Sender

One of our Steering Committee members, Ted Haines, tells us that there is one word that best sums up, for him, what Mimi was, and that word is "Steadfast". She was steadfast until the end, as a friend, a physician, and a great soul. That is how she lived her life, and how she cared for her patients. I can remember visiting a patient of hers that had been admitted to St Joe's in Toronto for a serious pregnancy complication one weekend. I was on call and when I went in to see the woman, I learned that Mimi had already been in to see her. Mimi tried hard to accommodate her work and her patients as her health failed.

She was not prepared to give up easily something that defined her very core. Mimi, as Chris Cavacuiti writes, was an inspirational physician.

An Inspiration and a Mentor for Life

Mimi is one the big reasons I made it through medical school. While I love being a doctor and couldn't imagine anything I'd rather do, I have to confess that I spent much of my training wondering if I'd made a big mistake. I wasn't sure the endless hours of work preparing for a career in medicine were worth it.

Mimi helped me realize that the effort was worthwhile. Her

warmth and caring were exactly what I needed at that time. When I saw how much support Mimi gave to me, my fellow students, and her patients, I knew I wanted to be try to be like her one day.

I can probably count on one hand the number of teachers I've had that I would consider true mentors, but Mimi would be on that list. She was the kind of person who didn't just teach you, but filled you with enthusiasm and made you want to be

better than you are. I will always remember Mimi for that.

Now that I'm a doctor and medical teacher myself, I appreciate all the more the tremendous gift she gave me back when I began this path. If I can make half the difference that she did to the lives of the students and patients I see, then I will have had a very successful career indeed. ♦

Chris Cavacuiti

(continued on page 7)

FRIEND, ACTIVIST, ADVOCATE, MENTOR (continued)

It was easy to make Mimi laugh. My last visit with her, in Mount Sinai, was delightful. It was October and I was on my way to catch a flight that was to begin a four and a half-month holiday with my husband. I knew I would not see Mimi again. She pointed out her pathology in great detail. "Look at this clubbing" she smiled, as she placed her hands in mine. Some-how, we found lots of things that were funny and we thoroughly enjoyed ourselves. As her close friends reminded us at the memorial, her hospital room was transformed into her salon, where she held court. On behalf of all of the Medical Reform Group, I salute our beloved Mimi and cherish her memory. Our work for justice was better because of Mimi. We were better because of her. We miss her terribly.

Janet's predecessor, Ulli Diemer forwarded copies of several items authored by Mimi in the early 1990s. We reproduce several which are as valid now as when she wrote them.

DRUG BENEFIT CHANGES HAVE CONSEQUENCES FOR LOW-INCOME PATIENTS

In the last issue of *Medical Reform* (Vol. 12, No. 5, December 1992), there was an article by Dr. Mitch Levine on the Drug Benefit Plan reforms. Many of the evaluation criteria of the Drug Quality and Therapeutics Committee have had long-standing support from the MRG – reducing costs without changing benefit or risk and encouraging physicians to amend ill-considered prescribing practices.

Nevertheless, as a GP in a downtown Toronto practice I have had a chance to see some of the consequences to patients living on social assistance incomes, since these changes were implemented at the end of August 1992.

At the end of December I wrote to the committee requesting "Special authorization" for a patient of mine, age 67, who reports that he cannot afford to have a telephone in his subsidized rental apartment. He suffers from a severe form of neurodermatitis which finally, after skin biopsy, second opinions, numerous emollients, and other antihistamines finally responded to twice daily Atarax (hydroxyzine) 25 mg. A prescription of 200 tablets (this antihistamine is not available OTC) would cost either ODP or the patient approximately

\$25. What amazed me were the arguments used in the 'refusal' letter I received, dated January 26, 1993:

"For all products removed as benefits, the primary issue is not whether the products are themselves valid therapeutic agents, but rather whether it is a necessary and effective use of public funds to pay for products that are available without a prescription, at modest cost to the consumer for use in self-medication.

"Since the removal of hydroxyzine from the Formulary as of August 25, 1992, the DQTC has received a number of individual requests for coverage of antihistamines under Section 8(1) of the Ontario Drug Benefit Act. The committee has given full consideration to requests to redesignate antihistamines as benefits and to individual requests for coverage and it has concluded that hydroxyzine should not be covered under the ODB program."

I know that other physicians are concerned about the deletion of Gravol (dimenhydrinate), alternatives for which Dr. Levine suggests prochlorperazine or metoclopramide (with reservations). I have no 'scientific' proof, only 10 years in practice

to confirm that Gravol is effective against nausea, with sedation as a common side-effect.

Dr. Levine supports the deletion of multi-vitamin preparations with the valid argument that a well-balanced nutritious diet precludes their necessity: "Thus a more efficient use of resources would be to spend government funds to provide food to the needy rather than paying for prescriptions of vitamin pills."

To quote Tevye, from *Fiddler on the Roof*, "If they would agree, I would agree."

I would appreciate hearing from readers of the newsletter regarding their own experiences and suggestions for 'lobbying' on this issue. I find this contradiction between policy and practice a difficult one to sort out. ♦

*Mimi Divinsky, MRG Newsletter
Volume 13, Number 1 - March 1993*

TAKE A STAND AGAINST DELISTING

We need to be critical of the recently announced possible OHIP “delisting” of certain medical and surgical procedures as posing a serious threat to medicare.

Although these procedures have been described as “cosmetic” or “borderline cosmetic” there are, except for neonatal circumstances, appropriate medical indications for each and every one. Delisting means that once outside the OHIP fee schedule, physicians may continue to provide the treatment described, but there will be no limit on the fee that can be charged. Once again we face what we have fought so hard to prevent – a two-tiered medical care system in which the wealthy have continued access and those who cannot afford to pay are denied. We need to call on the NDP government to

see this contradiction of their long-standing commitment to three of the principles of the Canada Health Act – that it be universal, accessible, and comprehensive.

We ask that consultation and discussion be initiated in order to assess the medical indications for each of the proposed treatments and that compassionate consideration be given to the inclusion of ‘emotional’ as well as physical needs in our definition of ‘health’. We have a commitment to include in our definition of ‘comprehensive’ all treatments of proven medical benefit – those that improve quality of life as well as those that prolong it. The serious effects of morbid obesity, deep cystic/scarring acne, sexual dysfunction, and unwanted pregnancy from contraceptive failure, to name a few, cannot be beyond our arena of concern and

care. Patients involved in long-term psycho-analysis cannot be abandoned in the midst of an intensive treatment. We erred in not protesting the delisting of electrolysis – there are patients with endocrine diagnoses for whom this treatment is valid and important.

The argument that those delistings will save the health care system a significant amount of money is unconvincing in a fee-for-service system. That is, most of these procedures are only one of many that a surgeon or specialist is able to provide. Time will be spent providing other ‘listed’ services within OHIP, perhaps more quickly and efficiently from the point-of-view of the patient, but not, in this way, decreasing health care cost. ♦

Mimi Divinsky, MRG Newsletter Volume 12, Number 2, May 1992

DRUG REFORM MISTAKES

One can no longer keep silent about the serious mistakes continuing to be made by Ontario’s Drug Quality and Therapeutics Committee in its attempt to make substantial changes to the Ontario Drug Benefit Plan.

Many of the evaluation criteria it adopted have had our long-standing support – reducing costs without changing benefits or risk and encouraging physicians to amend ill-considered prescribing practices.

Yet as a GP in downtown Toronto I have had a chance to see some of the adverse consequences of changes introduced in August 1992.

Now (September 1993) a new Ministry of Health Fact Sheet noti-

fies us of further deletions – calcium tablets, antacids, and digestive enzyme supplements will be added to antihistamines and vitamins, deleted last summer.

The fact sheet informs us that patients with cystic fibrosis will be able to obtain enzyme supplements through ten designated hospital pharmacies in the provinces. But what about those patients with proven need, caused by other diagnoses?

The fact sheet also informs us that there are alternative “covered” medications for the treatment of allergic reactions, neurodermatitis, gastritis, and osteoporosis. Yet all these alternatives are more expensive, ‘second-line’ drugs known to be effec-

tive, but at the ‘price’ of increased side effect risks.

The primary issue is not whether the deleted products are valid therapeutic agents – there is no contradiction here.

But the Ministry believes that the burden of cost should fall to the patient – “Products removed as benefits are available without prescription at retail drugstores and most are relatively inexpensive.”

But “inexpensive” is of course relative to income: Here then is one contradiction – that a physician must choose between alginic acid (Gaviscon) and ranitidine (Zantac), between dimenhydrinate (Gravol) and prochlorperazine (Stemetil).

(continued on page 9)

USER FEES LEAD TO TWO-TIERED HEALTH CARE

*The following letter was sent to the **Globe and Mail** newspaper by Mimi Divinsky on behalf of the Medical Reform Group Steering Committee. An edited version of the letter was printed.*

If “A majority of Canadian support the idea of imposing user fees to fight rising health-care costs” (front page, *Globe and Mail*, November 5, 1991) then it’s time, once again, to re-iterate what we as physicians working in diverse areas of the province have known for decades and what researchers have been confirming, certainly since 1980. In that year Stoddard and Woodward published their study on “The Effect of Physician Extra-billing on Patients’ Access to Care”.

In 1985 Health and Welfare Canada published Stoddard and Labelle’s report on “Privatization in the Canadian Health Care System” in which assumptions about the effect of charges to patients on reducing alleged “frivolous” use of the system were challenged and critiqued.

In fact, the research reveals that the introduction of user fees does not result in a more rational use of the

system, nor does it save health-care dollars. Rather, rich people use the system more and poor people use it less — regardless of the urgency of the diagnosis, and even if it involves not seeking care for an ill child. It is, however, guaranteed to create a two-tiered health care system — in complete contradiction to the five principles of the Canada Health Act:

that it be accessible, universal, portable, comprehensive, and publicly administered. The Act was passed by a unanimous vote of support by Parliament in 1984, unequivocally reflecting the views of Canadians that health care is a right, not a commodity in the market place. ♦

M. Divinsky, M.D., MRG Newsletter Volume 11, Number 5, December 1991

MRG CRITICAL OF PROPOSED DELISTING

The following brief was submitted by the Medical Reform Group to the Joint Management Committee Panel reviewing the schedule of benefits.

The Medical Reform Group is critical of the proposed delisting of 19 medical and surgical procedures from the OHIP fee schedule. When the original list of 14 was made public in 1992, we believed this approach to be a serious threat to medicare in the province. Even with the new and more rigorously defined categories, we are still convinced that any focus on delisting continues to risk the creation of a two-tiered system, with no guarantee of any significant decrease in health care costs.

The Medical Reform Group was established in 1979 out of a commitment, by its founders, to the principle of health care as a right, and a recognition of the basis of health as social and political in nature. We agree that the Ministry of Health should consider deletion of services for which there is no proven benefit and applaud their responsiveness to public participation in these discussions and decisions. But it is clear from the

‘qualifications’ of the JMC list that almost every considered procedure has ‘medical’ indications, if by that we mean that we understand health to have a broad definition which includes emotional well-being and quality of life, not just its prolongation. We are alarmed that the ‘bureaucratization’ of these distinctions will have several effects:

1. Delisted services will have no limit on the fee that the physician can charge. This was our initial fear of a two-tiered system for those who can pay and denial of services to those who can’t, but for whom there may be a legitimate need.
2. Delisting encourages direct charges to patients. Third-party billing has essentially delisted the annual health examination (Item 12), which in the absence of any ‘diagnosis’ is most often done at the request of an insurance company, school, summer camp, etc. Many of us in general practice know that ‘sick note’

(continued on page 10)

DRUG REFORM MISTAKES (continued)

The latter are four to five times as expensive and have significantly more potential side-effects, but are “covered” by ODP for other reasons.

The other contradiction is that between NDP policy and practice — what has happened to its condemnation of user fees and its commitment to universality? ♦

Mimi Divinsky, MRG Newsletter Volume 13, Number 5, November 1993

MRG CRITICAL OF PROPOSED DELISTING (continued)

charges are rarely passed on to the employer, but are 'out-of-pocket' expenses for the patient. We are also aware of excessive charges to patients for services such as the transferring of records (e.g. a patient was charged \$30 for photocopying of an obstetrical ultrasound report: personal communication, Dr. Rosana Pellizzari). Mr. Bill Mindell, of the City of York Health Unit reported that children were prevented from attending school because parents could not afford to pay a \$40 physician fee to complete a Tuberculosis Control form required by public health officials. These are clearly the equivalent of "user fees".

3. Physicians will use their "OHIP-allotted" billings to provide other insured services, challenging the argument that health care costs will, by this approach, be lowered in any significant way. In a fee-for-service system physicians have every opportunity to maintain their incomes.

4. The other possibility is that physicians will be tempted to provide more delisted services, for two rea-

sons – they are more lucrative and they promise an easier 'physician lifestyle'. To quote a Chief of Surgery: "If doctors can set their own fees for these (delisted) services and in a sense work outside the system, why would they continue to treat trauma patients? This way they make good money and don't have to get up at 2 am." (Dr. Girotti, Ontario Medicine, 20/9/93).

5. The notion of patient responsibility lives on the borderland of victim-blaming for illness. If we consider travel malaria prophylaxis to be an expense to the traveller (Item 14) what do we do if the prophylaxis 'fails' and our patient returns to Canada with malaria? What about suspected dysplastic nevi – they are benign but potentially malignant – will they be 'covered'? (Item 9). We are very concerned that we will see a repetition of the 'therapeutic' abortion committees which presumed to judge the 'medical necessity' of a woman's choice.

What seems to be a benign plan on the first glance is not. It may be tempting to 'cut and slash' what ap-

pear to be the offending agents of our health care system, but our precious energy needs to be re-directed to substantial reform of a primary care system that has revealed its weaknesses.

The Medical Reform Group has repeatedly called on provincial governments to reform the delivery of primary health care. We have strongly supported alternative methods of physician remuneration and have called for the recognition of other health care workers in the system. We advocate that the fee schedule apply only to specialists, laboratories, and diagnostic imaging services and that primary care be based on a salary or capitation system which includes monitoring and accountability. We ask the NDP government to abandon this misguided and hazardous project to 'delist' services, and renew its commitment to the principles of the Canada Health Act – that it be universal, accessible, and comprehensive. ♦

Dr. Rosana Pellizzari and Dr. Mimi Divinsky, MRG Newsletter, Volume 14, Number 1, February 1994

NOT JUST TOURISTS TORONTO

Friends of Cuba in the Toronto Area who wonder what they can take to help out when they travel to Cuba have a practical possibility. A non-profit, volunteer-run organization called "Not Just Tourists Toronto" will send you on your way with a suitcase of medicines and medical supplies destined for a medical facility in the area you plan to visit. Not Just Tourists Toronto collects medicines and medical supplies and

sorts them under the supervision of health care personnel. (No narcotics or controlled drugs are handled and opened medicine containers are not accepted.) Donated second-hand suitcases are packed so that they weigh no more than the ten kilograms of humanitarian aid that Cuban law permits for tourists. Each suitcase of medicines is inspected by a doctor

and includes a letter from a Canadian doctor (in both English and Spanish) addressed to a Cuban medical facility, and travellers are given detailed instructions for contacting the Cuban facility.

In its first year of operation, project volunteers collected, packed and sent more than 1,000 kilograms of medicines and medical supplies
(continued on page 17)

ACTIVISTS LOBBY TORONTO BOARD OF HEALTH

Mimi Divinsky was among the deputants to the Toronto Board of Health on September 26th, 2005.

I have been a family doctor working in downtown Toronto for over 20 years and I'm here representing the Medical Reform Group, an organization of physicians founded in 1979, whose three fundamental principles are:

1. Health care is a right, not a commodity in the marketplace.
2. Health is political and social in nature.
3. The hierarchical structure of the delivery of health care needs to be challenged, so that it acknowledges the expertise of other health care professionals.

Dr. Melnitzer, who was the first physician signing Special Diet Forms for clients and patients at the Parkdale Community Health Centre, has outlined the history of this aspect of OCAP's "Raise the Rates" Campaign. When she and Dr. Gary Bloch alerted the MRG to the issue they had the support not only of individual doctors who were willing to work at Special Diet Form (Hunger) clinics (signing forms for patients who either hadn't known they were eligible or had no family doctor to appeal to) but a strong endorsement from the Steering Committee, who which has now sent letters to Mayor David Miller, Councillor Joe Mihevc and the Honourable Sandra Pupatello, Minister of Community and Social Services, making it clear that the solution to the problem lies with the provincial government.

My brief presentation today hopes to make two points.

First, Dr. McKeown's report on the cost of the 2005 Nutritious Food Basket confirms what others will reiterate, that the current social assistance rates 'support' or main-

tain inadequacy in Toronto) and that many recipients are having to choose between paying the rent and buying enough food to see them through the last 10 days of each month.

I have here some old postcards that I found in my files, left-over from an anti-poverty campaign in 1996, at the time the provincial Conservative government cut welfare payments by over 20 per cent. It was called "Pay the Rent and Feed the Kids" and the postcard face declared "1 in 3 children in Toronto lives in poverty." It's now ten years later and things are no better.

In fact, they're much worse. In 2004 there was a small increase in the welfare rates, of 3 per cent. But since 1999 there has been a 17 per cent increase in the cost of food alone, never mind the increased costs of housing and transportation.

The Medical Reform Group supports the Board of Health in endorsing the 2005 Nutritious Basket. We recommend that the Board advise Toronto City Council to lift all obstacles to administering the Special Diet Forms. And we strongly recommend that until the provincial government raises the woefully low social assistance rates, every OW and ODSP client should be granted the maximum Special Diet benefit of \$250.

Secondly, the point of the Special Diet Form is to increase income. There is abundant evidence that poverty is a risk factor for ill health; that it affects both pediatric and adult morbidity (there is an increased incidence of low birth weight, inadequate nutrition, poor school performance, injuries, and disabilities

among children and higher-risk adult illnesses include heart disease, type II diabetes, respiratory diseases, and some cancers) and mortality - even with universal access to health care, being poor shortens your lifespan.

Dennis Raphael, a York University professor in the School of Health Policy and Management (and many others) conclude:

It is documented that the primary factor (my emphasis) that determines whether people are able to maintain health and avoid illness is the amount of income available to them.

So this short-term remedy, of getting the maximum \$250 per person to everyone on OW and ODSP, is a preventive medicine intervention.

The famous 19th Century physician and pathologist, Rudolph Virchow, wrote "Medicine is politics writ large", an insight that inspired the MRG's second principle (as above), that health is social and political in nature.

Despite all the spectacular advances of 20th Century medical science it's clearly just as true now as it was then. ♦

Mimi Divinsky, Reprinted From MEDICAL REFORM, Volume 25, No. 3, Issue 136, Winter 2006, pp.13-14

MEMORIES OF MIMI DIVINSKY

"Charity should be abolished; and be replaced by justice." — Norman Bethune. Sam Kuhn Tenant Action Group Organizer in Belleville sent this tribute to the doctor who appeared to help in the fall of 2005.

The circumstances which brought a group of single moms living in a Belleville Non-Profit Housing project together with Doctor Mimi Divinsky is one that ought not to be lost down the memory hole.

Since the Harris cuts in 1995 people living in poverty in Ontario have seen their incomes slashed by at least 40 per cent.

The spring of 2006 brought hope to hundreds of low income Belleville families after surviving ten years of relentless Tory and Liberal cuts to social assistance. The Ontario Common Front (OCF) has been fighting first the Tories, and now the Grits, in demanding governments build affordable housing, increase minimum wage, impose free tuition, increase funds for healthcare and immediately implement a 40 per cent increase to social assistance rates.

Despite years of militant actions, TAG and other OCF groups found while we could stop individual hydro cut-offs and evictions, we were ineffective in impacting on government social policy.

The good news was that the Ontario Coalition Against Poverty (OCAP), our Comrades in Toronto, had discovered a little known loop-hole under social assistance legislation which could reverse decades of neoliberal poor bashing in Ontario. This "special diet" benefit gave health care professionals the ability to grant poor people thousands of extra dollars in emergency relief effectively ending legislated starvation in one fell swoop.

In Belleville, a bus load of people (mostly moms and kids) suffer-

ing on welfare and Ontario Disability and wanting to take advantage of this loop hole, attended OCAP's "Hunger Clinic" in Toronto.

The group who organized the Belleville bus for the OCAP Hunger Clinic in Toronto was the Tenant Action Group (TAG); a small anarchist tenants' collective in this city of 40,000 in eastern Ontario. Our "shadowy" group of local rural and urban anarchists filled the free bus to Toronto with a load of skeptical moms and kids from the Marsh Drive housing project. The police refer to this community as "Kraft Dinner Row" and seemed an appropriate place to begin.

Once our first contingent of moms arrived home with the signed forms and the money started rolling in everything changed; whereas in the past TAG meetings attracted three or four members, now we saw ourselves grow into meetings numbering twenty five...thirty people. For an anarchist collective having lost members to arrests, harassment and burn-out these new found members that the "special diet" campaign brought were a godsend.

This is where Mimi enters the scene:

We had organized our first clinic with the help of a dietician in Oshawa, but at the very last moment the dietician backed out. In response to an emergency call-out, Doctor Divinsky responded immediately from Toronto with the news that she would fill the gap.

Finally after months of work we had our own Hunger Clinic and Doctor Divinsky made that possible!

We had decided that the Hunger Clinics must be organized in and by the low income community themselves. We were also determined that people would be fed by us while they waited to be assessed at the clinics and that no money would be charged to the victims in this unorthodox humanitarian relief effort.

When Doctor Divinsky pulled up amongst our huge crowds of anxious, desperate and skeptical social assistance recipients on Marsh Drive, Mimi was treated like a movie star. Very quickly, "Memes" settled into the kitchen table of one of our mom's homes and started assessing the masses of social assistance recipients waiting outside.

We had primed the anxious crowds not to "pester" the doctor with too many questions; that the objective was to get people in and out and get as many forms filled out as possible. We had no idea that Doctor Divinsky was terminally ill. I remember being told by one of the mom's helping to process the forms with Mimi, that Meme's would sometimes stop, overwhelmed by the sheer numbers of people to see her, and lay down momentarily on the couch only to revive herself with a cup of tea before forging through the masses again.

On that first day, Doctor Divinsky assessed over 120 people with every last person being seen by her; and working over five hours straight! Ultimately our group hosted over seven Hunger Clinics assessing over 920 individuals for the "special diet" benefit.

For example, Mimi's efforts meant a single mom with three kids

(continued on page 13)

MEMORIES OF MIMI DIVINSKY (continued)

getting an extra thousand dollars a month above and beyond her normal monthly welfare cheque for a year.

Mimi inspired our group to issue her the Norman Bethune Medal for her work in bringing back dignity to our community.

I remember “Memes” competing with another doctor at one of our clinics to see who could sign the most forms...

I think Mimi won. That day we assessed over three hundred people! When our group met with the local welfare office to discuss our Clinics we soon discovered that protecting the “integrity of the (welfare) legislation” was the bureaucratic pri-

ority and mantra of Hastings County. Mimi held up people and families as more worthy of protection than the “integrity” of legislation that enshrines destitution in Ontario.

The self appointed “Mayor” of Marsh Drive penned the following poem in honour of Mimi:

There are many miracles in life.
Like my Seven Children and my wife.
The one that we remember first
was the day that we met Dr Mimi.
She helped our Family and many more.
She helped us be rich and yet we were poor.
She came to us with good intent.

And stood her ground with Government.

The nutritious meals, great outings and some toys.

The Children’s lives were full of joy.
With time and age and as they grow.
It’s Dr Mimi they will know.

There was change and things were great.

It’s Dr Mimi we will always appreciate.

Mimi made so many lives so good.
If there was a way we could help her.
We hope and pray someone would.
May our thoughts and Prayers be with you ♦

Mayor of Marsh Drive

BRIAN DAY’S ACTIVITIES “SHAMEFUL” SAYS MEDICAL REFORM GROUP

Dr. Brian Day is using his position as President-elect of the Canadian Medical Association to fight desperately needed health reform in the United States,” MRG spokesperson Dr. Ahmed Bayoumi said today. “His behaviour is shameful.”

After years of disastrous experimentation with a variety of private-pay options, many people in the U.S. are waking up to the benefits of single-payer, universally accessible health care.

In particular, Governor Arnold Schwarzenegger of California is proposing a move in the direction of universality. While still limited and inadequate, the Schwarzenegger plan would nevertheless benefit a large number of currently uninsured Californians.

The plan threatens those who benefit from bloated and inefficient American health care, including insurance companies and private for-profit health care delivery organizations.

Dr. Brian Day is contributing to a conference designed to fight moves toward publicly funded care. “Dr. Day,” an advertisement for the conference says, “will discuss at length the disadvantages of providing and receiving care in a government-run delivery system.”

The advertisement continues saying “Dr. Day refers to his election as evidence that doctors there are ready to give private health care a bigger role in the Canadian system.”

“Following his election, Brian Day started to tone down his anti-Medicare rhetoric,” said another MRG spokesperson, Dr. Gordon

Guyatt. “This shows he’s back to his old tricks.”

While Canada’s health care system is far from perfect, every authoritative report in the last 40 years has concluded that the best solutions will come within a publicly funded structure, with care delivered by not-for-profit providers.

“What is outrageous about Day’s activities,” concluded Dr. Bayoumi, “is that he is undercutting proposals for positive and urgently needed reform in the United States. Using his position as CMA president-elect for this purpose is truly shameful.” ♦

Released January 29, 2007

HEALTH CARE AND THE NEW FEDERAL BUDGET

Since health care is under provincial jurisdiction, the role and the influence of the federal government rest on the transfer of money to the provincial governments, either as cash or as revenues from taxation in areas ceded by the federal government to the provinces.

The major transfers are the Canada Health Transfer (the federal contribution to “medicare”), the Canada Social Transfer (the federal contribution to post-secondary education and other social programs), and Equalization Payments and Territorial Financing (redistribution of revenue from wealthy to poor provinces, to be used for purposes determined by the provinces). In the field of health care there are several additional minor transfers for specific purposes; the amounts and goals of these transfers indicate the commitment of the federal government to the present public health care system and the direction any major changes.

The budget for 2007 provides for an increase of 5.76% in the Health Transfer, to \$21.3 billion, \$400 million toward the development of health information systems and electronic health records, \$612 million for

the implementation of wait time guarantees, and an increase of \$22 million in the annual budget of the Canadian Institute for Health Information. For the past 3 years provincial government expenditures for medicare have increased at a rate of 5.3% per year. Assuming that this rate continues through 2007, the increase in expenditures will balance the increase in the transfer, and there will be virtually no leeway for innovation or change in health care delivery.

Two new programs have been proposed repeatedly but not initiated: a national pharmacare program, and a plan to diminish the rate of poverty and the growing gap in income between the most and the least affluent members of society. The Alternative Federal Budget, prepared by the CCPA, proposes that a pharmacare program be started on a 50/50 cost-sharing basis with the provincial governments, the federal government to provide \$2.5 billion this year. The total contributions would need to be increased in subsequent years.

Can we afford such expenditures? In principle money can be obtained by reducing expenditures on present

programs and by reducing “tax breaks” to specified individual or corporate revenue earners. A few examples are the following:

- ◆ a decision that henceforth the armed forces will be assigned only to peace-keeping and disaster relief activities; much equipment to be used for combat duties is now on order and cancellation would save several billion dollars.
- ◆ eliminate tax and other subsidies for the oil and gas industries
- ◆ tax reduction on capital gain and dividend income

Of particular interest to health care is the plan to establish a Patient Wait Times Guarantee Trust fund, with an initial investment of \$600 million. The underlying concept is illogical and ill-conceived; on the basis of experience in other countries it is doomed to failure. It would be a far better to forget the idea of a wait time guarantee and to use the money to help pay for Pharmacare.

Thus a careful review of current and proposed expenditures will lead to a reassessment of priorities and to the reallocation of substantial funds. ◆

Norman Kalant

ONTARIO BUDGET 2007—THE MCGUINITY POVERTY BUDGET DISAPPOINTS THE POOR MOST OF ALL

For all the fanfare in the first part of this year on addressing the social deficit now that the fiscal deficit is near resolution, the March 22 provincial budget seemed strangely out of synch with the prospect that we will be heading shortly to a provincial election and that the

Liberals might have done a little more to meet their 2003 election promises to the most vulnerable Ontarians.

Despite the spin and kudos from many advocates in the days following the budget, there is little reason for low income Ontarians to hope for any relief from increasing costs and dwindling resources.

What's in the Budget:

- ◆ Two per cent increase effective November 2007 or about \$83 million annually for the 400,000 Ontarians on Ontario Works and Ontario Disability Support Program

(continued on page 15)

THE MCGUINTY POVERTY BUDGET DISAPPOINTS THE POOR

MOST OF ALL (continued)

- ◆ New Ontario Child Benefit, spending over \$2 billion over 5 years

- ◆ Nearly \$400 million to support municipal housing programs, aboriginal housing off-reserve, and some 27,000 rent allowances for low income renters

- ◆ Enhanced property and sales tax credits for seniors for the fourth time in four years

- ◆ Extension of pension income-splitting to provide tax savings of \$170 million annually to Ontarians with eligible pension income

- ◆ \$25 million to enhance child care in 2007, rising to \$50 million annually in subsequent years

- ◆ \$150 million in new green economy initiatives, tree-planting and energy audits

- ◆ Increase to health care spending to \$40 billion represents a 29 per cent increase over the McGuinty years

- ◆ Increase in education spending to nearly \$20 billion represents 17 per cent increase since 2003-04

- ◆ Cut in Business Education taxes of \$540 million in 2007

- ◆ No new funding for post secondary education and deregulation of tuition fees mean university fees will average over \$10,000 annually, and students in professional programs can expect to pay \$15,000 annually for tuition alone.

- ◆ A commitment not to tax or clawback the recently announced federal working income tax benefit

- ◆ Increase in the minimum wage to \$10.25 an hour in 2010

The Promise to Address Poverty

The McGuinty Liberals committed when they came to power in 2003 to restore welfare spending to pre-Harris levels, but predictably found the cupboard nearly bare and the Ontario economy in a difficult situation, with the result that the best they could manage up to this year were two small increases which have not kept pace with inflation since 2003, let alone address the 22 per cent cut of the Harris government in 1996 and the legacy of 10 years of 'clawback' in the National Child Benefit.

As noted many advocates hailed the new Ontario Child Benefit, which is expected to begin in 2007 by providing the equivalent of \$250 annually per child under 18. The benefits would include all children, including those of social assistance recipients; with a phase-out of benefits for those with net incomes between about \$20,000 and \$27,000 annually. This is instead of ending the so-called clawback of the National Child Benefit which amounts to \$122 monthly for most categories of social assistance recipients.

On closer inspection, therefore, it is difficult to see just how this benefit will, in the words of the provincial finance minister, 'mean that parents would be able to move off welfare without worrying about losing support for their kids.' Not only does the province not eliminate the clawback, but it has also launched yet another restructuring of welfare benefits that will mean that by 2011, the much vaunted benefit will compensate for only \$50 of the \$122 clawback, according to the Income

Security Advocacy Centre's Sarah Blackstock.

What can be done?

While some believe 'the poor will always be with us,' the facts don't bear out that adage. Indeed, when the Canadian Parliament passed the famed 1989 all party resolution marking the first retirement of Ed Broadbent, committing to eliminate child poverty by 2000, poverty rates for seniors were almost equally abysmal, particularly for women. In the intervening 20 years (since the parliamentary resolution) incomes of families headed working age adults have lost purchasing power, according to the Canadian Council on Social Development poverty among those over 65 has been halved.

Through the second half of 2006, the National Council of Welfare polled Canadians on their solutions to the persistence of poverty in our country and earlier this year, published a report, called *Solving Poverty: Four cornerstones of a workable national strategy for Canada*.

It highlights that Canada in general is out of step with important developments in preventing and reducing poverty. Many other countries, and two Canadian provinces, have had the same debates about the same issues, including how to measure poverty, but they have found ways—remarkably similar ways—to move on to action and to achieve measurable progress. They are bringing poverty levels down, replacing human misery with opportunity and building stronger societies in the process.

(continued on page 16)

THE MCGUINTY POVERTY BUDGET DISAPPOINTS THE POOR MOST OF ALL (continued)

The National Council of Welfare has a strategy with four cornerstones focus, as follows:

- 1 creating a national anti-poverty strategy with targets and timelines;
- 2 developing a coordinated plan of action;
- 3 ensuring accountability; and
- 4 establishing official poverty indicators.

Quebec began in 1995, with legislated poverty reduction targets, and Newfoundland began a similar process in 2005. A few weeks ago, we heard that Nova Scotia is about to debate a comparable strategy. While we know that legislation needs political will and enforcement mechanisms, a similar approach in Ontario would at minimum serve to focus

public attention on the need to address preventable health conditions in the context of income adequacy among the most vulnerable and may be a strategy worth pursuing with a government committed to improving the health status of poor people in Ontario. ♦

Janet Maher

HEALTH PROVIDERS CALL ON PREMIER AND FINANCE MINISTER TO ENSURE PROVINCIAL BUDGET RECOGNIZES LINKS BETWEEN POVERTY, FOOD SECURITY AND HEALTH

Health Providers Against Poverty expressed dismay at the what the current Liberal government has characterized as an anti-poverty budget. “For a group who were the first to take a hit when the previous government wanted to balance the provincial budget, an increase of 2 per cent from November, 2007 for social assistance recipients neither makes up for inflation this year alone nor recognizes the loss in buying power of the most vulnerable Ontarians,” said Dr. Gary Bloch.

“Countless studies have highlighted the costs to the health system of failing to address the preventable causes of illness and chronic disease, including lack of access to good quality nutrition at home and in schools, as reported most recently by the Health Council of Canada in February of this year. As health providers who serve some of the most marginalized communities in the city, we see the human costs on a daily basis,” Bloch continued.

Nurse practitioner and advocate Kathy Hardill added, “Poverty is a serious social problem *and* a critical health issue and the shortsightedness of this strategy defies logic, as we watch health care costs continue to increase. This government promised to raise the rates to reflect the real cost of living in Ontario in 2007. Instead, the paltry rate increases we have seen in the McGuinty years mean that the average family on social assistance is forced to make do on less than they had in 1995, once inflation is taken into account.

This is some \$200 less a month than the Toronto Board of Health recommended in fall 2006 as ‘basic adequacy’ for a family and nearly \$400 less a month than they calculated would be needed by a one-person household.”

Bloch and Hardill have spoken frequently on behalf of Health Providers Against Poverty, including at pre-budget consultations at the end of January, calling for an immediate

40 per cent increase in social assistance rates.

Health Providers Against Poverty, a group of local physicians, nurses, and dietitians, has joined forces with other community advocates to focus public attention on the growing gap between the government’s promises to provide a healthy level of social assistance and the dire poverty in which social assistance recipients are forced to live. ♦

Released by the Health Providers Against Poverty, March 23, 2007

KEEPING AN EYE ON CITY HALL

MRG wrote to city councillors on February 19th to remind them of earlier commitments on the City's Nutritious Food Basket. We heard back from the City Clerk on March 14th that the Council endorsed Board of Health recommendations to increase social assistance to include a basic allowance which meets daily nutritional needs AND other basic needs including transportation, clothing and personal care items, and that details be published annually. Further the council reaffirmed its request to staff to ensure all recipients get all benefits related to their condition; endorse Ontario Bill 150 [which would raise the minimum wage to \$10 an hour], and publicize all its recommendations to all Ontario municipalities with a population of 50,000 or more.

To The City Community Development and Recreation Committee:

I am writing on behalf of the Medical Reform Group, a voluntary association of physicians and medical students, many of whose members work with low-income individuals and families on social assistance, people living in poverty in Toronto and many of the other major cities in Ontario. Our member have also been active in providing health-related information for Toronto councilors at the Board of Health and Community and Neighbourhood Services.

We write today in support of the request of Health Providers Against Poverty (HPAP), to seek a resolution to the inconsistent approach used by city social assistance workers with regards to the allocation of the Special Diet.

Social assistance recipients are entitled to particular benefits depending upon their eligibility. With regards to the Special Diet forms, it is the responsibility of the welfare worker to provide the social assistance recipient with the form when requested. It is the responsibility of a designated health care provider (physician, nurse practitioner, dietitian, or midwife) to complete the sections of the form relating to the client's health conditions. The decision as to what constitutes a health condition for a particular individual lies solely with the designated health provider, in consultation with the client.

What happens inconsistently, but all too frequently, is that individuals and/or families are denied the special diet form by their worker when requested or denied certain funds allocated by their health provider on their Special Diet form. We believe these seemingly arbitrary practices are inconsistent with the spirit of council instruction on this matter. In particular, in November 2005, City Council passed a resolution calling for all entitlements under the Special Diet to be provided and for welfare staff to be trained to ensure this happens. Sadly, we continue to witness and hear of so many gaps and inconsistencies by welfare offices throughout the city, that we now have serious concerns as to how the 2005 resolution was implemented.

Therefore, we are asking that this matter be addressed by this council and that the 2005 resolution be reviewed and re-implemented as needed. Thank you for your attention to this important matter. ♦

NOT JUST TOURISTS TORONTO (continued)

abroad with tourists. In 2005, the United Steelworkers donated space for the group and the amount of donations sent more than doubled to 2161 kilos. In 2006 the figure more than doubled again – to more than 4200 kilos.

For the past two years Not Just Tourists Toronto has offered an e-mail course designed to help people in other Canadian cities and abroad to develop Not Just Tourist groups in their own communities. As a result, NJT projects have started in

Vancouver, Calgary, Edmonton, Winnipeg, Ottawa and Kingston. Links to groups in these cities can be found on our web site: www.njttoronto.ca. Visit the site for more information or contact NJTT by e-mail at: njttoronto@gmail.com

The Toronto-area group is also looking for additional volunteers to help with a full range of activities. Contact them and they'll find a volunteer task that matches your skills and interests. In the Toronto area, you can call (416) 234-9658. From else-

where in Canada, call the toll-free number 1-888-898-8246. Just download the form on the website and send to: njttoronto@gmail.com. If you're retired and you want to make a meaningful contribution to people who need help, this is the project for you. ♦

A message from former Ontario Social Justice Coalition Chair Bill Howes.

COMMENTARY: SCIENCE SCANDAL OR ETHICS SCANDAL? OLIVIERI REDUX

Arthur Schafer

Nancy Olivieri is famous for refusing to suppress doubts about an experimental drug with which she was treating thalassemia patients. Her principled stand, and the resulting scandal, led universities to offer researchers some protection against illegitimate drug company pressure. Medical journals changed their publication rules. Research hospitals changed their policies. She became an international icon.

By contrast, Apotex, the drug company which tried to silence her, has attracted international opprobrium. The company repeatedly threatened to sue Olivieri if she publicly revealed her fears about the inadequacy of their drug, deferiprone, and later it publicly questioned her sanity.¹ She sued them for libeling her; they sued her for 'slander of goods [their drug]'.² The actions have not yet gone to trial.

Apotex claims still to believe in the virtue of deferiprone, but the company has been heavily criticized for conduct which many interpreted as placing profits ahead of patient safety. Apotex is not alone in the dock of public opinion. Every month seems to bring some new scandal involving drug company suppression of negative data: think Prozac (Eli Lilly),³ Paxil (GlaxoSmithKline)⁴ and Celebrex (Pfizer).⁵ Big Pharma is facing a crisis. Public trust in drug company sponsored research is plummeting.

Olivieri's hospital, The Hospital for Sick Children, and her university, the University of Toronto, have also taken a public drubbing for failing to provide her with effective support as she struggled with Apotex.⁶ Actually, not only was Olivieri denied effective support, she was fired from her position as the director of the

Hospital's hemoglobinopathy programme, and both she and those colleagues brave enough to support her experienced harassment of many kinds. In the words of the CAUT Report: 'Neither HSC nor the University... took effective action to defend principles of research ethics, clinical ethics and academic freedom.'⁷ When it was discovered that the university was negotiating with Apotex for a huge financial donation, well, some people drew their own conclusions, and these were not flattering to the university.

Miriam Shuchman's recently published book *The Drug Trial* is the fourth book to be published on the Olivieri affair and the most troubling.⁸ The first was commissioned by the Hospital.⁹ It singled out Olivieri for special criticism but was later shown by two independent inquiries to be based upon misinformation.¹⁰ Next, the Canadian Association of University Teachers (CAUT) commissioned a report from three eminent academics.¹¹ Their extensively documented book exonerates Olivieri, while sharply criticizing the conduct of Apotex, the U of T, and Sick Kids. Then spy novelist John le Carre joined the fray with a murder mystery, *The Constant Gardener*, casting an Olivieri-like character as heroic victim of drug company machinations.¹²

Shuchman's book, by contrast with the CAUT Report, pays little attention to the central moral issues of academic freedom and drug company censorship. She concedes that Olivieri was right to go public with her data and that Apotex was wrong to threaten her. Shuchman's focus, however, is on Olivieri herself, as researcher, physician and person. The book attempts to demonstrate that Olivieri is a bad

scientist, a bad doctor and a bad person to boot.

Shuchman, a psychiatrist and medical journalist, goes to great lengths to discredit Olivieri, portraying her as a scientist who is blind to the truth about the drug she once favoured but now criticizes. As Shuchman tells the story, the real scandal is not that a wealthy drug company attempted to suppress negative data but that Olivieri's scientific doubts about deferiprone are not well-founded. Because of Olivieri's allegedly irrational opposition to deferiprone and because Olivieri purportedly exercises near-mythical powers over drug licensing authorities in the United States and Canada, she is blamed for having prevented patients from gaining access to this 'life-saving' drug.

In effect, Shuchman accuses Olivieri of personal responsibility for the deaths of many thalassemia patients, deaths which allegedly could have been avoided if Olivieri had not denied them access to deferiprone.¹³ Perhaps Shuchman is unaware that thousands of requests for unlicensed drugs are granted annually in Canada and the USA and that patients are not being denied access to deferiprone if they seek it.

Relying on quotations from anonymous sources, Shuchman also manages to portray Olivieri as a doctor who is so busy doing medical research and accepting humanitarian awards that she neglects her patient care duties. In case these scientific and moral sins are not deemed sufficiently wicked to warrant banishment to Siberia, Olivieri is also, Shuchman reports, a person who swears frequently at hospital administrators, is tough on col-

(continued on page 19)

COMMENTARY: SCIENCE SCANDAL OR ETHICS SCANDAL? OLIVIERI REDUX (continued)

leagues and much too demanding of subordinates.

The veritable cornucopia of discredit which Shuchman heaps on Nancy Olivieri is, I'm sorry to say, standard punishment for those who have the temerity to challenge powerful vested interests. In the popular imagination David bravely slays Goliath. Alas, in the real world, the whistle-blower's issue of principle is easily re-described as an act of private disloyalty and, worse, as evidence of professional incompetence and psychological disturbance.

For every Erin Brockovitch, rewarded with fame and fortune (when Julia Roberts was cast by Hollywood to portray her brave struggle), there are a dozen other whistle-blowers consigned by employers and colleagues to professional oblivion. Typically, those who challenge authority find that their professional competence, personal lifestyle and mental stability are all brought into question. Most whistle-blowers are also labeled malcontents and publicity seekers, as Shuchman stigmatizes Olivieri. They are duly punished with demotion, suspension, and/or dismissal. The case of Dr. Aubrey Blumsohn, recently suspended from his job by Sheffield University after he blew the whistle on one of that University's major research funders, Proctor and Gamble, fits the same pattern.¹⁴ Few whistleblowers escape this fate. Olivieri certainly didn't, though she fought back with admirable tenacity and won some notable victories over the company, the hospital and the university.

To persuade us that Olivieri got the science disastrously wrong, which is the main thesis of her book, Shuchman quotes a large number of Apotex-funded scientists, who claim that deferiprone is safe and effective.

However, Shuchman omits to inform readers of her book that the published results upon which she relies have been criticized in the scientific literature, either because the efficacy test used had not been validated, or because the investigators did not report all of their data pertaining to efficacy and safety.¹⁵

Moreover, Olivieri is far from being the isolated Jeremiah of Shuchman's portrait: The world's leading researchers on genetic blood disorders, David Nathan, former President of the Dana Farber Cancer Institute at Harvard and David Weatherall, Regius Professor of Medicine Emeritus at Oxford, both think that Olivieri got the science right.¹⁶ That is, both agree with Olivieri that convincing evidence does not yet exist for the safety and efficacy of deferiprone. Two subsequent studies¹⁷ – neither mentioned by Shuchman – have provided support for Olivieri's published finding that patients being treated with deferiprone are at risk for progressive liver scarring.¹⁸

Although desferol, the current standard treatment for thalassemia patients, requires uncomfortable nightly infusions (unlike deferiprone, which comes as a pill), desferol is both safe and effective. The course of prudence would, therefore, seem to be in the direction favoured by Drs. Nathan, Weatherall and Olivieri. Nathan and Weatherall also agree with Olivieri that it would be imprudent to license deferiprone until better evidence is available. Thus, the reluctance of licensing authorities to give approval to deferiprone would seem to be based upon legitimate scientific concerns rather than, as Shuchman suggests, the malign power of Nancy Olivieri. Indeed the European licensing authority restricts use of deferiprone to 'exceptional circumstances' because, to date,

'comprehensive information on the safety and efficacy of the medicinal product cannot be provided'.¹⁹ The licensing authorities in the United States and Canada have not issued even a restricted license for deferiprone.

Since the liver scarring associated with deferiprone is a gradual process, we may not know for years which side of this scientific controversy is correct. Because Apotex cancelled (on 24 May 1996) the pivotal randomized comparison clinical trial which could have provided the long term data necessary to resolve the scientific dispute – a trial for which Nancy Olivieri was Principal Investigator – the risk-benefit ratio of this drug remains uncertain.²⁰

One of the many relevant features of the controversy not reported by Shuchman is that Apotex tried to discredit not only Dr. Olivieri, but also the monitoring procedure, liver biopsy, essential for assessing the efficacy and safety of iron chelation therapy.²¹ It was in data derived from this procedure, established in the medical literature and an integral part of the trial protocols (designed by Olivieri, approved by the hospital's Research Ethics Board and agreed to by Apotex), that the unexpected risks of deferiprone were identified.

To fill out her story, Shuchman compiles a lengthy charge sheet against Olivieri. The most serious accusation is that Olivieri negligently delayed the implementation (at Sick Kids Hospital) of proper guidelines for the treatment of sickle cell patients. Shuchman claims that this delay led directly to the death of a young patient, Sanchia Bulgin. Shuchman is unmoved by the fact that Olivieri was not one of the physicians treating this patient, and that the responsible physicians were found

(continued on page 20)

COMMENTARY: SCIENCE SCANDAL OR ETHICS SCANDAL? OLIVIERI REDUX (continued)

(by two official inquiries) to have violated established guidelines which had been in place for years. It's a bizarre accusation.²²

Many of Shuchman's other allegations of ethical misconduct, directed against Olivieri, rely on the testimony of Olivieri's leading foe at Sick Kids, Dr. Gideon Koren.²³ Koren, then a senior scientist and scientific administrator at the Hospital, has been found guilty of and severely disciplined for both professional and research misconduct, first by the hospital and the university, and later by the Ontario medical licensing body. The hospital and the university found that his actions, including persistent 'lying' in connection with his efforts to discredit Dr. Olivieri, 'constitute gross misconduct and provide sufficient grounds for dismissal'.²⁴

The CAUT Report found that Dr. Koren 'attempted to discredit Dr. Olivieri by dishonest means'.²⁵ In the words of the Discipline Committee of the College of Physicians and Surgeons of Ontario, Dr. Koren was guilty of 'conduct unbecoming a physician'. 'His actions were childish, vindictive and dishonest', authoring 'vicious diatribes' contained in anonymous 'poison pen letters' against Dr. Olivieri.²⁶ Koren was stripped by the University of his Endowed Chair, required to arrange that his ethically suspect research be deleted from the scientific record, publicly reprimanded by the licensing body, and required to pay substantial fines by the hospital, the university and the licensing body.²⁷

Shuchman has great admiration for Koren and devotes almost a full chapter of her book to trivializing his misconduct and praising his stellar virtues and research accomplishments. Unfortunately, she omits to inform her readers of the full extent of Dr.

Koren's publicly reported misconduct. Shuchan doesn't admire Olivieri and so, in sharp contrast, spends many pages describing the serious charges of unprofessional conduct which the Hospital made against her, charges that were based on allegations by Koren and persons closely associated with him.²⁸

Then, almost *sotto voce*, Shuchman briefly acknowledges that the Ontario College of Physicians and other independent bodies investigated the matter and cleared Olivieri of all the charges brought against her. Indeed, the College found that Olivieri had acted in the best interests of her patients and commended her for 'exemplary conduct'.²⁹

The heavily biased manner in which Shuchman assembles her material seriously undermines The Drug Trial's credibility. Credibility is an especially important issue when evaluating the claims made in this book, because most of the hostile quotations are attributed to doctors and patients who are not identified. One of the few clearly identified patients, 'Howard', has now gone on record as saying that his words, as quoted in the book, were twisted beyond recognition. He insists that, so far from being critical of Olivieri's patient care or ethics, he considers Dr. Olivieri to be a highly ethical doctor who is utterly dedicated to her patients. A brief excerpt from Howard's letter of protest to Shuchman, which has now been made public, raises deep ethical concerns about the integrity of Shuchman's journalism:

'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.'³⁰

My confidence in Shuchman's journalistic reliability, already shaken by numerous factual errors³¹ and skewed descriptions of key events was further eroded when I came across a passage in which she 'quotes' from a commentary I published in The Globe and Mail.³² I wrote none of the words she attributes to me.

Reading The Drug Trial I was repeatedly struck by how often Shuchman's account of events is contradicted by the findings of a series of independent inquiries – all public documents, all easily obtainable.³³ Almost all of the anti-Olivieri 'revelations' presented in Shuchman's book are warmed-over allegations already disproven by one or more of these impartial inquiries, and the others are undocumented hearsay. In short, Shuchman's way with well-established facts would have brought a smile to the face of Procrustes.

In the end, what really matters is that once Dr. Olivieri scientifically identified deferiprone's unexpected risks, she was ethically obliged to inform her research subjects, who were also her patients. Every research subject has a fundamental right to give or withhold informed consent to participation in a clinical trial. If information about potential risks is deliberately withheld then the right of informed consent becomes hollow. Put quite simply: patient safety is a value which trumps all others. Olivieri fulfilled her duty to warn her patients of possible risks. She did so in the face of company threats and hospital harassment. For this she is rightly honoured. Her hospital and university saw the battle as a mere 'scientific dispute'. In consequence, they failed in their obliga-

(continued on page 21)

COMMENTARY: SCIENCE SCANDAL OR ETHICS SCANDAL? OLIVIERI REDUX (continued)

tion to defend her academic freedom and her patients' right to informed consent. They just didn't get it. Shuchman still doesn't. ♦

Reprinted with the permission of the author from Bioethics, Volume 21 Number 2 2007 pp 111–115

Endnotes

- 1 CBS Television. 60 Minutes. December 19 1999.
- 2 Actions filed in Ontario Superior Court in 2000, as yet unresolved.
- 3 D. Healy. 2004. Let them eat Prozac. New York: NYU Press; D. Healy & G. Aldred. Anti-depressant drug use and the risk of suicide. *Int J Psychiatry* 2005; 17(3): 163–172.
- 4 W. Kondro & B. Sibbald. Drug company experts advised staff to withhold data about SSRI use in children. *CMAJ* 2004; 170: 783.
- 5 S. Okie. Missing data on Celebrex. *The Washington Post* 2001. August
- 6 J. Thompson, P. Baird & J. Downie. The Olivieri Report: Report of the Committee of Inquiry on the case involving Dr. Nancy Olivieri, the Hospital for Sick Children, the University of Toronto and Apotex Inc. 2001. Toronto. James Lorimer: 29. Also available on the Canadian Association of University Teachers Web Site: <http://www.caut.ca/en/issues/academicfreedom/olivierireport.asp> [Accessed 16 Oct 2006].
- 7 Ibid: 8, 155–158, 211–280.
- 8 M. Shuchman. 2005. The Drug Trial: Nancy Olivieri and the Science Scandal that Rocked the Hospital for Sick Children. Toronto: Random House Canada: 451.
- 9 A. Naimark, B.M. Knoppers & F.H. Lowy. 1998. Clinical Trials of L1 (deferiprone) at the Hospital for Sick Children: a review of the facts and circumstances. Toronto: Hospital for Sick Children.
- 10 J. Thompson, op. cit. note 6, pp. 281–327; The College of Physicians and Surgeons of Ontario. 2001. Complaints committee. Decisions and reasons. Claimant Dr. Laurence Becker; respondent Dr. Nancy Olivieri. December 19: No 44410.
- 11 J. Thompson, op. cit. note 6.
- 12 J. Le Carre. 2001. *The Constant Gardener*. Toronto: Penguin.
- 13 M. Shuchman, op. cit. note 8, pp. 370–379.
- 14 P. Baty. 2005. Inaction fuels research row. *Times Higher Education Supplement*.
- 15 G.M. Brittenham et al. Deferiprone versus desferrioxamine in thalassemia and T2* validation and utility. *Lancet* 2003; 361: 183. G.M. Brittenham et al. Deferiprone and hepatic fibrosis. *Blood* 2003; 101:5089–5090.
- 16 D.G. Nathan & D.J. Weatherall. Academic freedom in clinical research. *NEnglMed* 2002; 347: 1368–1370.
- 17 V. Berdoukas et al. The Sydney Children's Hospital experience with the oral iron chelator deferiprone (I1). *Transfus Sci* 2000; 23(3): 239–240. A. Maggio et al. Deferiprone versus deferoxamine in patients with thalassemia major: a randomized clinical trial. *Blood Cells, Mol. Dis.* 2002; 28(2): 196–208.
- 18 N.F. Olivieri et al. Long-term safety and effectiveness of iron-chelation therapy with deferiprone for thalassemia major. *NEnglMed* 1998; 339: 417–423.
- 19 European Public Assessment Report. Committee for Proprietary Medicinal Products. European Agency for the Evaluation of Medicinal Products. Commission of the European Communities. August 25 1999.
- 20 Thompson, op. cit. note 6, pp. 103–123; 438–447; 452.
- 21 Ibid: 2–13, 373–391.
- 22 Report of the Internal Review Committee Investigating the Death of Sanchia Bulgin, Hospital for Sick Children, Toronto. Released October 20, 2000. As the Report makes abundantly clear, the death of this young patient resulted from a failure of communication between the key physicians and surgeons caring for Sanchia. The existing guidelines for pre-operative blood work and other investigations were simply not adhered to by those responsible. Shuchman's baseless suggestion that the guidelines were inadequate and that this was due to failures on the part of Dr. Olivieri is explicitly contradicted by the Committee's Report, and is further disconfirmed by the subsequent Coroner's Report.
- 23 Shuchman, op. cit. note 8, e.g. p. 332, pp. 393–412.
- 24 Disciplinary letter from the presidents of the University of Toronto and the Hospital for Sick Children to Dr. Gideon Koren, April 11 2000, cited in Thompson, op. cit. note 6, p. 401.
- 25 Thompson, op. cit. note 6, p. 30.
- 26 The Discipline Committee of the College of Physicians and Surgeons of Ontario Re: Koren. May 1 2003. Available from the CPSO. See also: Thompson, op. cit. note 6, p. 401, for a description of the penalties against Koren imposed by The University of Toronto Disciplinary Proceedings Against Dr. Gideon Koren for Research Misconduct [Only a brief press release summary of these Proceedings has been made public, but Thompson quotes from it].
- 27 Thompson, op. cit. note 6, pp. 401–402; *Nat Med* 2000; 6:6: 609–610.
- 28 Ibid: pp. 320–321, 336–341, 364–365, 377–385.
- 29 The College of Physicians and Surgeons of Ontario. Complaints committee decision and reasons. Claimant: Dr. Laurence Becker; respondent: Dr. Nancy Olivieri. 2001 Dec 19: No. 44410.
- 30 N. Olivieri, *The Toronto Star*, Letters, June 9 2005.
- 31 Two illustrative examples of factual errors from Shuchman, op. cit. note 8: (1) p. 14: 'They did blood tests and discovered that his liver was near the point of cirrhosis'. Cirrhosis cannot be identified by blood tests; (2) p. 172: 'Olivieri was planning to keep studying L1 [deferiprone] surreptitiously.' This incorrect statement, based upon testimony from Drs. Koren and O'Brodovich, has been disproven by two independent inquiries: The College of Physicians and Surgeons of Ontario, op. cit. note 10 and Thompson op. cit. note 6.
- 32 A. Schafer. *Medicine, morals and money*. *Globe and Mail*, December 11 1998. p. A 27.
- 33 Inquiry on the death of Sanchia Bulgin; the Hospital for Sick Children and University of Toronto's disciplinary findings against Dr. Gideon Koren for professional versions of The Hospital for Sick Children Internal Review Committee's Report on the Death of Sanchia Bulgin; the Coroner's misconduct; the Report of the Committee of Inquiry commissioned by CAUT into the entire dispute; the Ontario College of Physicians and Surgeons report exonerating Dr. Nancy Olivieri of charges brought by the Hospital for Sick Children; the Ontario Health Professions Appeal and Review Board Inquiry into Complaints against Dr. Gideon Koren; the University of Toronto's disciplinary findings against Dr. Gideon Koren for Research Misconduct; and the Ontario College of Physicians and Surgeons disciplinary findings against Dr. Gideon Koren for Professional and Research Misconduct.

SUBMISSION TO THE STANDING COMMITTEE ON GOVERNMENT AGENCIES RE: THE HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

Carol Kushner, Health Policy Consultant Toronto, February 28, 2007

I want to begin by thanking you for the opportunity to participate in this consultation. I will try not to take up more than five minutes with my presentation.

By way of introduction, my name is Carol Kushner and I work in Toronto as a health policy consultant and media commentator. I have co-authored two best-selling books and numerous articles focused on improving the quality of care available in our health care system and on ensuring that Canadians continue to have access to health care based on need.

In other words, I am particularly interested in how we go about protecting the public interest. I believe that HPARB's role in providing an avenue for appeal and review of the decisions made by the regulatory bodies for health professionals is an important aspect of public protection. And so I looked at the Standing Committee's review of the HPARB as an opportunity to address one particularly troublesome issue: and that is the fact that some physicians in this province are charging their patients block fees – in effect asking them for a prepayment — for uninsured services they might or might not ever need.

I believe you have already heard submissions on this issue today including concerns about the potential for abuse, the possible harms to the physician-patient relationship, and the extreme difficulty and high cost of monitoring actual practices to ensure strict compliance.¹ To reassure you, I don't intend to cover the same ground.

In reviewing materials about block fees to prepare this presentation, I came across what I believe is an

anomaly – in Ontario Regulation 856/93 (Amended to O. Reg 53/95) to the Medicine Act 1991.² As far as I know this regulation is up to date as of two days ago when I downloaded the file from the Internet. It clearly defines professional misconduct, including the following:

“1. (1) 23. Charging a block or annual fee, which is a fee charged for services that are not insured services as defined in section 1 of the Health Insurance Act and is a set fee regardless of how many services are rendered to a patient.”

And yet, the College of Physicians and Surgeons of Ontario, charged with protecting the public interest, has a policy specifically permitting doctors to charge such fees.³ This is despite their own findings of violations including doctors charging fees as a condition of being accepted into a practice, making patients pay for OHIP covered services, terminating patients who refused to pay the block fee, and not responding to telephone messages from patients who refused to pay the block fee.⁴

Curiously, the Government's Commitment to the Future of Medicare Act (2004) also endorses the practice of doctors charging their patients block fees for uninsured services.

My question is why doesn't the government's original regulation under the Medicine Act prevail? If the answer is that the medicine is a self-regulating health profession — then we have to wonder why the CPSO permits block fees given their potential for harming the public interest. I can readily understand why block fees might be attractive to doctors. I can-

not understand their appeal to the vast majority of patients.

As I tried to move beyond newspaper clippings and anecdotal reports about how block fees might interfere with access and good quality care, I found very little. Certainly no research findings on the prevalence or impact of block fees have appeared in the pages of the Canadian Medical Association Journal or Canadian Family Physician. There appears to be no monitoring of potential harm at all apart from that done by the Medical Reform Group.

Which brings me back to HPARB – I looked through your annual report – the most recent available on line dates back to 2004 to see if by chance any requests for a review concerned the issue of block fees. I was surprised that your annual reports provide only the sketchiest information about the numbers of cases handled – there is virtually nothing revealed about the subject matter of the cases you review.

So again — why the anomaly between the regulation in the Medicine Act 1991 and the CPSO policy? And what, if any, role has HPARB played in addressing the issue of block fees within its review and appeal processes?

My own perspective is the same as that set out by the Medical Reform Group in 2004. Block fees are counter to the public interest and should be banned. Regulatory bodies should define their use as “professional misconduct” consistent with Regulation 856/93 and penalties for non-compliance should be stiff. Thank you for your attention. ♦

(continued on page 11)

SUBMISSION TO THE STANDING COMMITTEE ON GOVERNMENT AGENCIES (continued)

(Endnotes)

¹ See Intervening on Ontario Bill 8. Medical Reform Group Newsletter #129, 2004, page 6; Brief to the Standing Committee on Justice and Social Policy on Bill 8: Commitment to the Future of Medicare Act. Medical Reform Group Newsletter #129, 2004, page 6

² Medicine Act (1991). Regulation 856/93 currently defines block fees as unprofessional

conduct under 1. (1) 23. Web page accessed Feb. 26, 2007

http://www.e-laws.gov.on.ca/DBLaws/Regs/English/930856_e.htm

³ College of Physicians and Surgeons of Ontario. Policy #4-04. Block Fees and Uninsured Services. Web page accessed February 26, 2007.

<http://www.cpso.on.ca/Policies/blockfees.htm>

⁴ Block fees undermine accessibility to health care; doctors group calls on government to ban patient charges. MRG Newsletter #132. page 1.

MRG MEMBERSHIP APPLICATION

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

Membership Fees

- \$245 Supporting Member Physician
Affiliate (out of province) physician
\$60 Intern / Resident / Retired / Part-time Organization
Newsletter Subscriber
E-Newsletter Subscriber
Free 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 Alterna Savings and 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

**JOINT MEETING
THE MEDICAL REFORM GROUP & CANADIAN DOCTORS FOR MEDICARE**

PROTECTING MEDICARE - 2007-2009

Moderator: Dr. Rosana Pellizzari

Speakers:

Dr. Danielle Martin, CDM Board Chair &

Dr. Ahmed Bayoumi, MRG

Monday, April 30, 2007

7 p.m. - 9 p.m.

Room 3171, Medical Sciences Building

University of Toronto

Physicians, Med Students, Health Care Providers & Public Welcome

For more information: (416) 787-5246 [voice]; medicalreform@sympatico.ca [e-mail]

**Medical Reform Group
Box 40074, RPO Marlee
Toronto, Ontario M6B 4K4**

Please visit and comment on our web-site at <http://www.medicalreformgroup.ca>

Please also make a note of our current contact information as follows:

(416) 787-5246 [telephone]; (416) 352-1454 [fax]; medicalreform@sympatico.ca [e-mail]