Medical Reform

Newsletter of the Medical Reform Group

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ORAL TESTIMONY TO ONTARIO FINANCE AND ECONOMIC AFFAIRS COMMITTEE

Presented by Steering Committee Member Ritika Goel on June 6, 2012

Members of the Standing Committee on Finance and Economic Affairs, thank you for this opportunity to speak to you about the 2012 Provincial Budget. I am here representing the Medical Reform Group, a volunteer association of physicians and medical students which has advocated for over 30 years to improve the health of people in Canada. My name is Ritika Goel, I am a public health professional and one of Ontario's 11,000 family physicians serving Ontarians on the frontlines. I'm here to talk to you today, not just about the budget, but about the health and well-being of people in Ontario and a vision for the kind of society we want to live in. I want to talk to you today about the difficulty Ontarians have accessing medications. The need to use our health care providers to their full potential. The need for a discussion on revenue generation. And, finally a conversation about our democracy.

I see patients regularly who cannot access medications. When Medicare was founded in Canada, we decided physician and hospital services were medically necessary, but not medications. This no longer fits with today's reality of chronic diseases, which require medications for us to treat patients appropriately. Almost 1 in 5 Ontarians have NO drug coverage. This means that my patients ration their medications so their treatment doesn't work properly. This causes unnecessary complications, which are costly to the system. On top of that, such practices lead to problems like antibiotic resistance meaning the drugs we already have become less effective.

What we need is a national pharmacare program. Not only would this be the fair and equitable way to ensure all people in Ontario have access to medicines, it's also the smart thing financially. Canada's spending on drugs is second only to the US. Most other industrialized nations have included medications as part of their universal healthcare systems, and we should too. The United Kingdom has substantially lower healthcare expenditures than Canada, and the major difference is their lower spending on drugs. The two countries use the same amount of drugs per capita.1 But the UK has included medicines as part of its universal healthcare plan. This means they can take advantage of widescale price negotiation, bulk

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Editorial committee this issue: Ritika Goel, 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.

EDITORIAL NOTES

Janet Maher

As I was preparing this issue of MEDICAL REFORM, it has been almost impossible to get the image of Lewis Carroll's Tweedle Dum and Tweedle Dee out of my mind.

In Ottawa a majority government persists in alienating important communities in our country by throwing its weight around at every opportunity. The omnibus finance bill recently passed and sent to the senate is much more than the usual budget bill which promised to cut 20,000 federal civil servants from the payroll over the next 3 years without affecting front line service.

In some 425 pages, that bill amended over 70 pieces of existing legislation—amendments that will not only reduce inspection of food and drugs and 'rationalize' environmental regulation, devolving it for the most part to provincial governments who had not foreseen this turn of events, but will also limit the availability of Employment Insurance to perhaps 1 in 5 of the Canadians who will lose their jobs this year. Although the government has stuck with its commitment to provide modest health transfers to the provinces and territories until at least 2015, it refuses to participate in any federal-provincial planning or innovation which might improve quality and access.

What struck most MRG members, however, was a regulatory change that did not even get debated in the House of Commons—that is the radical reduction, effective June 30th this year, in the Interim Health Benefit, a federal emergency health coverage that has been available to newcomers until they become eligible for provincial health insurance. You will see in this issue reference to debates, demonstrations, rallies and study sessions focused on drawing public attention to this short-sighted move.

At Queen's Park a minority government conveniently forgets that it is a minority, operating all too often with the arrogance of a majority government. Although their omnibus budget bill was only slightly less ambitious than the federal tome, it may turn out to have more lasting consequences for health care in the province and in the country.

Our members have also been active over the spring on that front, working with the recently formed Doctors for Fair Taxation campaign to lobby for increasing rather than decreasing provincial revenues through a surtax on those most able to pay. Some members undoubtedly cheered quietly when the Minister of Health announced the budget allocation for OHIP would not increase this year. However, many have been appalled by the ham-fisted approach to negotiation of both the government and the OMA. At press time, the Steering Committee is preparing to seek clarification from the College of Physicians and Surgeons of Ontario on the professionalism of physicians asking patients to lobby government in their favour on the fee question. ♦

purchasing and a common formulary. For the same patented brand name drug, the UK pays 10% less and for the same generic drug, 20% less than we pay in Canada.1 A report entitled 'The Economic Case for Universal Pharmacare' explores these very points and found that a national pharmacare program would lead to $10.7 billion in savings for Canada.1

While the provinces and territories are currently working to set a common price for medicines on the public provincial drug plans, this is not national pharmacare. It does not reach the same purchasing power for price negotiation or bulk purchasing. It also does not address the administrative issues of having multiple payers. It also does not help the 1 in 5 Ontarians who do not currently have access to medicines. We support the Drummond Commission's recommendation for bulk purchasing, and agree with the Senate and various Royal Commissions in declaring our support for a national pharmacare program.

Second, we support the Drummond Commission's recommendation to use our healthcare providers to their full potential. I have worked in excellent interdisciplinary teams where patients are seen by nurse practitioners or registered nurses and I am available as a consultant. In rural Ontario, this is commonplace. We should permit our highly skilled health professionals to do all that they can do. While this does mean a culture change in the health sector, I can say as a recent graduate that the current training in our professional schools encourages team-based interdisciplinary care. These models work. They make sense, and they save money.

Third, we wish to applaud the NDP's contribution to this budget in introducing a 2% increase in personal income tax for all those earning over $500,000. More such conversations must be had. By now we all know that income inequality has been growing over the past few decades in an unprecedented manner. Between 1980 and 2009 controlling for inflation, the top 20% of earners saw a 38.4% increase in their incomes as the middle fifth saw a 0.3% loss and the bottom fifth saw an 11.4% loss. We also know now that income inequality is bad for your health. The poorest fifth of people in Canada are two to four times as likely to suffer from chronic diseases like heart disease, chronic lung disease, or mental health problems than the richest.2 We are living in times when average people in Canada are told they must endure cuts to their public services and an austerity agenda while governments successively cut corporate and personal income taxes. Canada's corporate tax rates are the lowest of the G7 countries and Ontario's corporate tax rate is the fourth lowest in the country.3 We recommend eliminating the planned further corporate tax cuts, saving $800 million. We also recommend building on the 2% increase for those making over $500,000. This is a start, but we can do better.

Finally, on the point of democracy and accountability, we are very concerned by Schedule 28 in this bill. Schedule 28 seeks to give the province sweeping powers to privatize Ontario government services, which could include public hospitals or OHIP itself. We denounce this section of the bill both in support of public sector workers, whose rights must be protected, and to maintain the accountability of public services to the public. There is a large body of evidence that shows private funding and for-profit delivery of health care is more costly, of poorer quality and worsens inequity. I also say with some disappointment, that this provincial budget has gone through an extremely undemocratic process. We have had no pre-budget consultations. The Drummond Commission was hired to give recommendations on cuts to our public services, and revenue generation was considered 'off the table'. Even now, this opportunity to present to the committee comes for only 4 and half days, in one city only, with extremely short notice. While we are grateful for this opportunity, this is not how our democracy should function.

So I ask you now, why is it that in Canada, a country with supposedly universal healthcare, I see patients who are unable to access the medications I prescribe to them? Why are we not using our health professionals to their full capacity? Why are we not having a discussion about raising revenues given growing income inequality and increasing tax cuts, and finally, How do we ensure that these decisions are being made in a democratic and accountable fashion? ♦

Thank you.
Ritika Goel, MD, CCFP, MPH
Medical Reform Group

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2. Organization for Economic Co-operation and Development. OECD Health at a Glance 2011. Web. 4 June 2012. <http://www.oecd.org/document/11/0,3746,en_2649_37407_16502667_1_1_1_37407,00.html>
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ONTARIO BUDGET 2012: SHOULD THE PROVINCIAL GOVERNMENT CONTINUE TO ACT AS IF IT HAS A MAJORITY?

As noted in MEDICAL REFORM 157, the McGuinty Government has revised the process for seeking the input of Ontarians in the budget process. Despite its position as a minority government, the government is only seeking input after the budget has been released rather than standard pre-budget consultations. On April 3rd, 2012, Steering Committee Member Ritika Goel sent letters to the Premier and Ministers of Finance and Health, as well as to each of the party leaders, and their finance and health critics, reiterating the concern we expressed in our March 16th brief to the Standing Committee on Finance and Economic Affairs. Each of the letters took the format of this one to the Premier.

Hon. Dalton McGuinty
Premier of Ontario
Room 281, Main Legislative Building
Queen's Park
Toronto, Ontario M7A 1A1

Dear Premier:

I am writing on behalf of the Medical Reform Group to follow up on the brief we had prepared earlier in March in anticipation of a meeting of the Standing Committee on Finance and Economic Affairs, regarding the budgetary choices facing Ontario residents. At that time we urged a healthy skepticism of an approach which focused only on spending cuts to answer the current imbalance between revenue and expenditures in the provincial budget.

Now a scant week after Minister Duncan presented his proposal, we continue to be concerned. As many, including our members, recommended, we were pleased that the rollbacks in income tax scheduled for this year were rescinded. However, we think there would be value in reconsidering the resource pie—not only in the 'smarter' allocation of current resources, but also in seeking additional revenues for programs and services which are valued by Ontarians.

While the essential flat-lining health budget and salaries of many of the province's professional public servants (including physicians and other health providers paid from the public purse) was also a good sign, we believe that the government could do a great deal more to shape change in this sector. Part of that shaping would be in much more precise allocation of resources to address directly some of the most notorious bottlenecks in the system. For example, while the focus of federal funding while it lasted was on eliminating waitlists in some designated areas, little was accomplished in a more permanent sense in addressing the base issues—of being able to discharge acute care patients to home or other community facilities because of the lack of such facilities and resources.

This situation has not changed since your government took over from the Conservatives in 2003; it leaves many families under pressure at time of crisis, and creates an environment where some would argue there needs to be event more private sector involvement to eliminate the bottlenecks. Our view is that health care is not like any other commodity—there is and should be no room for profit in this sector. Moreover, where such for profit activity already exists, government must play a role in regulating minimum service standards.

We have two very serious disappointments in the 2012 budget. One relates to your government's reluctance to address the issue of resources by adding to them, by increasing rather than seeking to decrease taxes and other revenues for programs and services that have demonstrated their effectiveness—like full-day kindergarten and high quality day care, for example. In the past several months we have heard suggestions from many well-paid professionals who value the programs and services that have made Ontario a good place to live—to the extent of urging a review of the tax regime to make it fairer and more progressive.

The other major disappointment, in view of the plenty in which those well-paid professionals live, is the halving of the scheduled increase in the child tax benefit and the freezing of social assistance rates at 2011 rates—even though with the cuts of the mid-1990s, they represent a decline in buying power to just over half of

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ONTARIO BUDGET 2012 (continued)

what the most vulnerable had to manage with a generation ago.

Our members can help in two important ways, and we look forward to the opportunity to discuss how needed improvements can begin to be made this year with regard to:

1. Better resource allocation within the health care system can improve programs and services for all; and
2. The evidence base for addressing the social determinants of health, including income, housing and social supports for all Ontarians.

I look forward to an opportunity to share some of our deliberations with you and your cabinet colleagues.♦

LETTER FROM PREMIER MCGUINTY TO RITIKA GOEL

Ontario Premier responded in record time to the MRG letter

April 11, 2012
Ritika Goel, MD
Medical Reform Group
PO Box 40074 Toronto, Ontario M6B 4K4

Dear Dr. Goel:

Thank you for your letter regarding the 2012 Ontario Budget. Your views and concerns and those of your members are important to me, and I appreciate your taking the time to share them.

As you know, places around the world have felt the effects of the global economic slowdown. Ontario's government took action to help families through the global recession by protecting public services and stimulating the economy to protect and create jobs. Ontario's economy is growing stronger, although at a more modest rate than we would like to see. Right now, the most important thing we can do to strengthen our economy is to balance the budget. We are taking strong action for a better Ontario. A stronger economy will create more jobs and continue to protect the gains Ontarians have made together in our schools and in health care.

Our plan to build the most highly skilled and educated workforce includes fully implementing full-day kindergarten by 2014 to give our youngest learners the best start, keeping a cap on class sizes in the early grades, maintaining the 30% Off Ontario Tuition grant for families, and integrating employment and training programs to help Ontarians become more responsive to today's job market.

Ontario now has the shortest wait times in Canada for key surgeries. Reforms to health care will enhance community-based care and help ensure Ontarians continue to receive quality, timely care.

Our five-year plan will keep Ontario on track to balance the budget. We will keep our focus on building a stronger, more diversified economy. The new Jobs and Prosperity Fund will consolidate many business support programs and focus on increasing productivity and creating jobs. In addition, planned infrastructure investments of more than $35 billion over the next three years will create or preserve over 100,000 jobs on average each year. And the proposed mine developments in Northern Ontario's Ring of Fire are expected to create over 1,500 permanent jobs.

We are making the right choices and, by strengthening our economy and protecting the gains we have made so far, we will be able to continue to provide the services that Ontarians need and value the most.

I note that you have sent copies of your letter to my colleagues the Honourable Dwight Duncan, Minister of Finance, and the Honourable Deb Matthews, Minister of Health and Long-Term Care. I have asked that they take note of your views.♦

Thanks again for writing. Please accept my best wishes.
Yours truly,

Dalton McGuinty Premier
cc: The Honourable Dwight Duncan
The Honourable Deb Matthews

OMA ENCOURAGING COERCIVE BEHAVIOR, SAYS DOCTORS' GROUP

The Medical Reform Group, a doctors' organization that advocates for high quality universal health care in Canada, has accused the Ontario Medical Association of encouraging coercive behavior among its members.

A recent communication from the president of the OMA, Dr. Doug Weir, included the following:

In response to requests from members, we have developed a generic petition that can be printed and placed in a prominent area in the office or clinic waiting area or a suitable high-traffic location for patients to sign (https://www.oma.org/Member/Resources/Documents/Petition.pdf>

"The doctor's office is no place to encourage action by patients in response to cuts to doctors' remuneration," said MRG spokesperson Dr. Gordon Guyatt. "The action violates fundamental principles of the doctor-patient relationship. Doctors are there for the patients' well-being, not to persuade patients to support their political positions."

In relation to their physicians, patients are in a dependent and vulnerable position. Any doctor who posts the petition offered by the OMA is taking advantage of this dependency and vulnerability to achieve their political goals.

"Essentially, the OMA has crossed the line," said a second MRG spokesperson, Dr. Ritika Goel. "Physicians hold the balance of power and patients may feel coerced, or obliged. We believe this is unethical and ask the OMA leadership to reconsider."

The doctor-patient relationship is essentially fragile, and trust is crucial. Using the context of the doctor's visit for political purposes seriously undermines that trust.

"We are confident the doctors who are parents would be uncomfortable with teachers considering industrial action posting petitions supporting their cause at parent-teacher evenings," Dr. Guyatt added. "Patients visiting a doctor are more vulnerable than parents at a parent-teacher evening."

"We understand the strong emotions that the current dispute has generated. Nevertheless, the OMA's action represents poor judgment," Dr. Guyatt concluded. "Dr. Weir should make it clear to the doctors of Ontario that they should not be recruiting patients to their political causes during patient visits to their offices."♦

Released by the Medical Reform Group June 18, 2012

EVIDENCE AND EFFICIENCY SHOULD GUIDE FEE SCHEDULE CHANGES, SAYS THE MEDICAL REFORM GROUP

A group of Ontario doctors today called for the Ontario Medical Association to accept that the OHIP fee schedule for physicians' billings should be based on evidence and efficiency.

"The Ontario Ministry of Health and Long-term Care has implemented several changes to the fee schedule," said Medical Reform Group spokesperson Dr. Ahmed Bayoumi. "Although the process by which these changes were made is problematic," said Bayoumi, "the principles behind the changes make sense. And change is long overdue."

"The Ontario public health insurance plan should not pay for services when evidence suggests they are unlikely to improve health," said another MRG spokesperson, Dr. Gary Bloch. He cited the example of pre-operative echocardiograms, a test of heart function, for patients without known heart disease undergoing surgery. "Physicians will no longer be able to bill for such tests," said Bloch, "but that is appropriate given that they have not been shown to improve health. This is an example of how the health care system can save money without worsening health. The medical profession should be promoting such changes."

"Fees should also reflect changes in efficiency," noted Bayoumi. "Prices for almost all goods fall as technology advances. Because of the regulation of the health care system, such changes have to come about through changes in the fee schedule, which needs to be updated periodically. For example, a

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EVIDENCE AND EFFICIENCY (continued)

decrease in cataract fees makes sense."

"Physicians have a duty to be stewards of the health care system," said Bloch, "and that means accepting some hard decisions, even if there is some financial cost to ourselves."

The MRG was also critical of the approach used by the Ministry in imposing these changes. "The Ministry's actions were heavy handed and rushed," said Bayoumi. "While we urge the OMA to accept the principles that the fee schedule needs to be changed, we also urge the Ministry to accept mediation to determine the specific nature of those changes." Bayoumi noted that physicians are privileged and can mobilize resources to fight back, a position that is not be shared by many other groups facing funding cuts. "We remain firmly opposed to the austerity agenda," noted Bloch, "and unilateral government decisions about funding only increase our concerns about the governments' processes." ♦

Released by the Medical Reform Group
May 15, 2012

DOCTORS DEMAND REPEAL OF CUTS TO REFUGEE HEALTHCARE

A group of Ontario doctors today has added its voice to calls for Jason Kenney and the Conservative Government to withdraw ill-considered reforms to the Interim Federal Health (IFH) program. This is the insurance program through which refugees and refugee claimants receive health benefits.

"It is a cruel move on the part of the government to cut health care for refugees, who are often traumatized by war and persecution," said MRG spokesperson Dr. Michaela Beder. "Refugees are among the most vulnerable people in Canada and cuts to their health care services are unacceptable."

On Friday May 11, a group of approximately 90 doctors, including members of the Medical Reform Group, entered MP Joe Oliver's office asking for a meeting to discuss the cuts. Similar protests occurred across Canada, including a rally on Parliament Hill.

"Health care providers are in the best position to see that this population is not abusing our health care system. In fact, they are accessing much-needed services like pregnancy care, well-baby checks and cancer screening, which likely prevent downstream costs," said Beder.

"Under the changes, refugees will be denied access to essential medicines," said MRG spokesperson Dr. Andrew Pinto. "People with diabetes will not get insulin, people with heart attacks will not get beta-blockers after discharge from hospital, and people with arthritis will not be treated for their pain. These changes will create a new class of people living in Canada without basic health insurance."

The proposed changes would also introduce a two-tier health care system for refugee claimants, whereby people from designated countries of origin (so-called "safe countries") will be denied medical care. These changes are based on false notions that individuals from these countries are bogus claimants.

"I have patients from around the world who are persecuted for their ethnicity, sexual orientation or political affiliation," said Pinto. "The Canada I know welcomes those who have faced tremendous hardship, provides them a home, and offers them the health care that they need." Pinto noted that the changes come into effect on June 30. "The time to act is now. The reforms must be withdrawn immediately." ♦

Released by the Medical Reform Group
May 14, 2012

THE PHYSICIAN AS ADVOCATE

Member Philip Berger provided evidence for the Discipline Committee of the College of Physicians and Surgeons of Ontario in the form of the following letter on June 27, 2011. The College has now completed its hearings but not yet rendered a decision. Portions of the letter have been edited for space reasons. Please contact the editor at medicalreform@sympatico.ca or Dr. Berger himself if you would like a copy of his full submission.

Mr. Peter Rosenthal
ROACH, SCHWARTZ
688 St. Clair Ave. W.
Toronto, ON. M6C 1B1

Dear Mr. Rosenthal,

Re: College of Physicians and Surgeons of Ontario and Roland Chee Kong Wong

I am responding to your request for an opinion on the allegations of the CPSO against Dr. Wong and the referral of the Inquiries, Complaints and Reports Committee of the College to the Discipline Committee of the College.

I was in full-time community-based practice from July, 1978 to December, 1993. I was appointed Chief of the Department of Family and Community Medicine at the Wellesley Hospital in January, 1994 and held that position until October 31, 1997. On November 1, 1997, I was appointed Chief of the Department of Family and Community Medicine at St. Michael's Hospital – a position which I still hold. I held the position of Lecturer from 1984 – 1994 in the Department of Family and Community Medicine, Faculty of Medicine, University of Toronto. In 1994 I was promoted to the rank of Assistant Professor and since 2000 have been an Associate Professor in the Department of Family and Community Medicine, Faculty of Medicine, University of Toronto. I have attached a copy of my Curriculum Vitae which outlines my educational background and professional activities.

Since 1978, when I began a permanent medical practice in Toronto, I have treated hundreds of patients who have received social assistance benefits. Since the implementation of the Special Diet Allowance (SDA) for persons receiving social assistance, I have completed hundreds of these forms. My practice has always included many people living in poverty who rely on social assistance benefits for housing, food security and general support.

In the Notice of Hearing of the Discipline Committee of the College, the College has alleged that Dr. Wong "has committed an act of professional misconduct:

1. under paragraph 1(1) 2 of Ontario Regulation 856/93 made under the Medicine Act, 1991("O. Reg. 856-93"), in that he has failed to maintain the standard of practice of the profession; and

2. under paragraph 1(1) 33 of O.Reg. 856/93, in that he engaged in conduct or an act of omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional."

Further, under Schedule "A" of the Notice of Hearing, the College alleges that

"1. Dr. Wong has committed acts of professional misconduct with respect to completing Special Diet Allowance forms for patients between approximately 2004 and 2009. Specifically:

(a) Dr. Wong failed to maintain the standard of practice of the profession and is incompetent in his care and treatment of 15 patients, whose identities have been disclosed to him, between January 2008 and February 2009, including, but not limited to, in his record-keeping, failure to take proper histories and failure to perform appropriate medical examinations, including diagnostic testing.

(b) Dr. Wong completed and signed Special Diet Allowance forms between approximately 2004 and 2009 without confirming dietary restrictions, allergies, etc., as reported by patients, and continues to do so.

(c) Dr. Wong submitted billings to OHIP for completing Special Diet Allowance forms between approximately 2004 and 2009 without confirming dietary restrictions, allergies, etc., as reported by patients, and continues to do so."

In providing this opinion, I have reviewed several documents (list available upon request). I also interviewed Dr. Wong on May 25th, 2011 in order to fully understand his activities respecting completion of the SDA forms. My review of Dr. Wong's SDA patient records is similar to that of Dr. Bloom's review as outlined in the third full paragraph on page 3 of his September 8th, 2009 report. Any opinion or conclusion as to whether Dr. Wong "failed to maintain the standard of practice of the profession and is incompetent in his care of the treatment of 15 patients" requires a determination of the community standard of practice of physicians who complete the SDA forms. Further, it requires a determination of the standard of practice specific to completion of the SDA forms by all health professionals approved for completing the form. That is, the standard of practice for any approved health professional completing the SDA form must be clear and explicit.

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THE PHYSICIAN AS ADVOCATE (continued)

I have been unable to find any published documents or any communication from any source which describes the current standard of practice for community physicians completing SDA forms or for other approved health professionals completing the SDA forms. No such information appears to exist. It is impossible to judge whether Dr. Wong fell below the standard of practice of the profession in the absence of any information on the standard of practice of his colleagues who complete SDA forms.

Dr. Bloom opines that "The standard of practice for a general practitioner/family physician is to illicit (sic) a complete history and perform a relevant physical exam for each patient complaint or concern. Such inquiries should illicit (sic) how long the patient has had the problem… treatment". Dr. Bloom further reports that "Completion of a full, relevant assessment is required in order for a physician to sign an attestation to the patient's condition such as the application for a Special Diet Allowance". And that signing the SDA form "…without further assessment…", "…falls below the standard of practice reasonably expected of a competent family physician/ general practitioner."

A reasonable and competent physician is required to elicit and confirm a history, perform a relevant examination and conduct investigations only in relation to the purpose of the patient visit. Physicians generally presume that patients are being truthful and honest when reporting their history. It is nearly impossible in most circumstances to verify a patient's history and this would not be required unless it was relevant to the presenting problem and purpose of the visit. The requirement to verify a history when possible must also account for the risks and benefits, to the patient and to society, of any physician action, including treatment recommendations.

For example, if a patient presented with a history of being prescribed opioid medications for chronic pain by another physician, a competent physician would be required to obtain the previous physician's records or current pharmacy records to confirm that the patient has indeed been receiving the opioids. The reason for such confirmation is because of the risk both to the patient and to the public of opioid prescribing. Nonetheless, patients without a previous history of taking opioid medications regularly present with a history of acute pain (for example, as a result of an injury) for which little or no physical examination evidence exists to confirm the history. Physicians have no way of verifying the history as related by the patient and rely on the truthfulness of the patient. In this situation, a reasonable physician, after assessing the risks and benefits both to the patient and to the public, could prescribe opioid medications and could do so in the absence of the physician's capacity to confirm the patient's history.

Another example of circumstances in which it would be impractical and unachievable for a physician to secure a complete history and perform a relevant examination occurred during the H1N1 Mass Vaccination program. At the St. Michael's Hospital Department of Family and Community Medicine, patients were administered the H1N1 influenza vaccine based on the self-reported and patient-completed screening questionnaire, in the absence of any history, physical exam or investigations to confirm the patients' answers.

The risks to patients of providing inaccurate information and then receiving a contraindicated H1N1 vaccine is far greater than the non-existent risk to the patient of providing inaccurate information for the purpose of a physician completing a SDA form. Yet no confirmation of the veracity of the patient's history was routinely conducted for the purpose of receiving the H1N1 vaccine. If the standard of practice as described by Dr. Bloom was applied during the vaccination of patients, the vaccination program would have ground to a complete halt.

Numerous other circumstances exist in the day-to-day practice of medicine in which physicians rely on the integrity of the patient's history and do so without confirming or proving that the information provided by patients is accurate. So-called patient "sick notes" to employers or school authorities are written daily by Ontario physicians based wholly on the patient's history. Even securing an MRI examination relies on the patient's history of reporting no possibility of metal in the periorbital area of the skull – routine screening x-rays are not done on all patients seeking an MRI. Such x-rays are only done if the patient reports a suspicion or history of a metal object in the periorbital area.

In my judgement, the extent to which a physician must obtain a history, perform a physical examination and order necessary investigations is determined by the reason for the patient visit, the parameters of the relationship established between the doctor and patient, and the risks and benefits to the patient and society arising out of any actions or treat-

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ment by the physician.

In the case of Dr. Wong, the terrain of his relationship with the patient was extremely narrow. He enunciated clearly to the patient that "the purpose of the program is for the professional to identify the medical conditions listed in the Ministry sheet". Dr. Wong did not undertake any commitments to the patient for the purpose of providing ongoing care or investigation of current medical problems. The sole purpose for which Dr. Wong engaged with patients (and patients understood this) was to complete the SDA form. Dr. Wong relied entirely on information provided by the patient and presumed the patients were being truthful and honest. Within the limited and singular purpose domain of Dr. Wong's relationship with his patients (that is, to complete an SDA form), no risk to the individual patients arose because of Dr. Wong's reliance entirely on the patient's history. Further, only benefit could accrue to the patient in the form of additional income to secure adequate food and other necessities of living.

On a population health basis, it has been well established that socioeconomic status is directly related to health status and providing additional income to the poorest people in society could only improve their health status. Therefore, Dr. Wong's completion of SDA forms would be expected to benefit the entire society by collectively improving the socioeconomic status and health of his patients seeking completion of SDA forms. In my judgment, the health benefits of an increased income would be greater than any additional cost to society of SDA forms completed in a fashion deemed less than satisfactory by the MCSS.

Some physicians routinely complete SDA forms for some conditions based solely on the patient's history. For example, patients who report symptoms arising from the ingestion of dairy products are presumed to have an "allergy to milk/ milk products" or "lactose intolerance" (both medical conditions that require a special diet). I know of no physician (and I include myself in this category) who would conduct any investigations to confirm these diagnoses solely for the purpose of completing an SDA form and it would be unreasonable to do so. If the modus operandi and standard of practice described by Dr. Bloom were applied to the day-to-day practice of physicians, it would produce gridlock in Ontario's health care system and an enormous increase in health care expenditures.

Mr. David Carter-Whitney, in his February 11th, 2011 letter, states that "The Ministry is reliant on physicians and other approved health care professionals to complete the SDA application form based on sound medical assessment and professional standards." Yet neither the MCSS nor any other body has enunciated the specific standards of practice expected for the completion of SDA forms. The MCSS does not require physicians to substantiate with any documentation the "medical condition that requires a special diet". Yet the same Ministry requires detailed supporting evidence for the completion of the Ontario Disability Support Program forms and the transportation subsidy forms available to people on social assistance. Further, many private insurers, employers and even the federal government for Canadian Pension Plan purposes, require detailed evidence of medical diagnoses reported by physicians. If the MCSS desires evidence in support of the existence of the medical conditions listed in the SDA form, then the MCSS should ask physicians and other health professionals to provide such documentation, as it does with other forms.

Dr. Wong relied on the history provided by patients to complete the SDA application forms. The MCSS is asking the College to "investigate whether Dr. Wong knew or ought to have known that his completion of SDA application forms was false or misleading…". In the narrowly defined parameters of Dr. Wong's relationships with patients seeking completion of an SDA form and in the absence of any risk to patients or society of Dr. Wong's relying on the patient's history for the purpose of completing an SDA form, Dr. Wong accepted the patient's report of their medical condition as truthful. It is not Dr. Wong's job to conduct an investigation as to whether patients were providing false or misleading information. Nor would the risks and benefits of such investigations ever be justified or defensible if they were conducted solely for the purpose of completing an SDA form.

Indeed, the MCSS, in its most recent revision to the SDA form (dated 2010/12) requires the patient or SDA applicant to sign the form and state that: "I declare to the best of my knowledge that the information on this form is true, correct and complete…". The MCSS is placing the onus of truthfulness on the patient/ applicant, in the same fashion that Dr. Wong has done. If the MCSS takes the position that Dr. Wong was completing forms which were "false or misleading", then it is the patient/applicant who should be held accountable, not Dr. Wong. And the MCSS's requirement for the

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applicant to sign the SDA form is evidence of where the responsibility for truthfulness lies – and that is with the patient/applicant.

The SDA forms themselves are ambiguous and provide for a range and latitude of opinions by physicians and other health professionals as to the existence of a medical condition that requires a special diet. For example, some physicians will confirm that a patient has extreme obesity if a patient has ever met in the past the criteria for such a diagnosis, even though the criteria may not be met at the time that the patient is seeking completion of the SDA form. Similarly, some physicians would confirm the diagnosis of unintended weight loss if the patient has ever in the past experienced a weight loss which satisfies the criteria for confirmation of a medical condition that requires a special diet. And in the case of unintended weight loss, physicians must rely on the patient's report of a baseline weight. Physicians attempting to provide greater financial benefits to their patients will interpret these criteria in the broadest fashion, and therefore err on the side of the patient securing additional benefits. It is the ambiguity and lack of clarity of the forms which give rise to this possibility.

Dr. Wong's position, and one with which I agree, is that his allegiance is to the patients, not the MCSS. It is not Dr. Wong's job to preserve "the integrity of a program intended to assist people with special diet needs" – that is the job of the responsible Ministry, in this case the MCSS. In the case of a collision between the physician's loyalty to the patient's interest and the public good, physicians must make determinations as to which is paramount. In some circumstances, laws and statutes require physicians to opt for the public good even if it is detrimental to the patient's interest – a good example being the suspension of a driver's license due to a medical condition. In the case of Dr. Wong's completion of SDA forms, no such conflict exists between the patients' interests and the public good. Both are achieved by the provision of greater funds to the poorest people in society.

Finally, although no information or evidence exists as to the community standard of practice for physicians completing SDA forms, I have conducted a literature search, with the assistance of St. Michael's Hospital Library staff, in order to determine the standard of practice in completion of other types of forms. The search revealed articles which address deception, fraud and misrepresentation by physicians and other health care professionals, mostly in relation to health care insurers in the United States. The conduct and attitudes of physicians and others surveyed for these articles crossed a boundary never reached by Dr. Wong. Dr. Wong did not meet the threshold of deception or other dishonest action as described in any of these articles. Dr. Wong simply accepted the patients' report as truthful. Nonetheless, the literature review provides a general sense of physicians' attitudes and practices when physicians are attempting to protect the best interests of their patients and secure required services. (Available upon request).

Each of these articles generated major controversy within the medical profession. But regardless of the views held on this matter, it is clear that deception, misrepresentation, and so-called "gaming the system" is widespread among medical professionals in the United States trying to secure care for their patients. The literature review may reflect the ethical behaviour and community standards in other jurisdictions where the practice of medicine is similar to that of American physicians. If that is the case in Ontario, then Dr. Wong has established a higher standard of practice than his peers.

As mentioned above, Dr. Wong's conduct did not meet the threshold for deception or misrepresentation as described in any of the articles. Dr. Wong simply chose to believe his patients, as many physicians do. No harm, and indeed only benefit, accrued to the patients from Dr. Wong's conduct. And providing increased income to the poorest people in Ontario can only collectively improve their health – thus benefiting all of society.

The key and distinguishing difference between Dr. Wong's professional practice and those of many of his colleagues is the numbers of patients for whom he provided the service of completing SDA forms and the number of forms he actually signed. In the absence of any information or evidence which can demonstrate that Dr. Wong has diverged from the community standard of practice in completing SDA forms, the number of forms he completed is not a sufficient basis for deducing or concluding that he fell below any standard of practice.

The MCSS's questions whether Dr. Wong's "…completion of SDA application forms was false or misleading…". Dr. Wong did not misrepresent any information provided to him by patients. He relied on the histories of the patients and reported that information to the MCSS.

Dr. Wong's completion of

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THE PHYSICIAN AS ADVOCATE (continued)

SDA forms exemplifies the long-established role of the physician as a health advocate. Dr. Wong's activities, including consideration of the economic determinants of health, advocacy for individual patients in a population of poor patients, and promoting the health of individuals and communities all exceed the standard of practice for a physician as health advocate.

The MCSS does not require supporting evidence for the physician to complete the SDA form. Dr. Wong did not acquire or provide such evidence. Dr. Wong simply assisted patients using the means available under the SDA application process and system for the benefit of his patients which is his duty as a health advocate. His actions are not "disgraceful, dishonourable or unprofessional" – they should be praised by his colleagues.♦

Yours sincerely,

Philip B. Berger, MD

FOLLOW-UP ON ONTARIO GOVERNMENT HOTLINE

Janet Maher

In a Steering Committee meeting in late March, concerns were raised about rumours about the re-emergence of extra-billing by some Ontario providers. In discussion with staff of Minister Deb Matthews, we were referred to the office of the Minister's Senior Communications Advisor, Ms. Joanne Woodward Fraser, who responded by e-mail on May 4, 2012 to a series of questions we had posed. The exchange, focused on the government's 2011 ***Protecting Ontarians' Access to Public Health Care****, is reproduced here verbatim.*

Here are the responses to questions from the Medical Reform Group in follow-up to the Minister's June 21, 2011 news release on Protecting Ontarians' Access To Public Health Care.

Q: How many callers have you had in the fiscal year 2011-12?
A: In fiscal year 2011-12, the Program received 651 calls. Most calls are not about extra-billing. Many are misdirected or it is clear from the initial call that the charge is for an uninsured service. Calls also include requests for the ministry to provide letters to a private insurer that a specific service is not insured.

Q: How many complaints resulted in investigations?
A: Not all investigations arise from patient complaints. The ministry opened 156 investigations in fiscal year 2011-12.

Q: Can you make any comment on the types of services which seem to be attracting complaints most often?
A: Of the 154 investigations closed in fiscal year 2011-12, the ministry conducted multiple investigations of charges associated with:

- Cataract surgery—none were determined to be extra-billing
- Colonoscopy—2 of 6 investigations were determined to be extra-billing
- IVF—none were determined to be extra-billing
- Removal of skin lesions—4 of 8 were determined to be extra-billing
- Various uninsured vision assessments and eye tests

Q: How many complaints resulted in recoveries for complainants?
A: Of the 154 investigations closed in fiscal year 2011-2012, 47 were found to be extra-billing. In each case, the patient was reimbursed or the provider withdrew the charge.

Q: Of those, how many were single complaints, and how many multiple complaints, as described in your release?
A: Ten individual providers, (e.g. physicians, optometrists, dental surgeons, hospitals, clinics, laboratories) were the subject of more than one investigation. Of these, the ministry found that 3 of the providers made a single extra-billing charge.

Q: When the campaign was launched, the government declined to consider third party complaints. Has this changed?
A: Complaints that originate from third parties, such as patient representatives, providers, College of Physicians and Surgeons of Ontario, insurance companies, etc., and those about charges for third party services, have always been accepted and investigated if there is a possible violation.♦

REFUGEE HEALTH: DEBATE ON GUTTING OF THE FEDERAL INTERIM HEALTH BENEFIT

Dr. Philip Berger has been prominent among the resistance to the spring announcement of Federal Immigration Minister Jason Kenney that most of the temporary benefits which have been available to refugees will cease as of June 30, 2012, leaving many of the most vulnerable in the lurch. On May 13th, about 150 Toronto Area physicians, led by Dr. Berger and Dr. Meb Rashid of the Crossroads Clinic at Women's College Hospital, briefly occupied the constituency office of Toronto Minister to seek an audience (refused) with the minister on the issue. On June 18th, in collaboration with health providers across the country, the second demonstration on the refugee health issue, took place in front of the Citizenship and Immigration offices on St. Clair Avenue in Toronto and attracted 500-600 protesters. The response from the public, driving by as well as trying to get in and out of the public library, was excellent.

As part of the related media campaign, Philip Berger was a guest on the CBC Radio show, As it Happens, on Monday June 11th, in which he outlined the issues of the campaign. At least one of his listeners had some trouble with his approach and complained to the CBC. Here is Philip's open letter to Dr. Danielle Grondin, Director General for Health at the Canada Immigration and Citizenship, and the link for his interview with As It Happens: www.cbc.ca/asithappens/episode/2012/06/11/the-monday-edition-30/. On June 19th, As It Happens again interviewed Dr. Grondin to seek her explanation for inconsistencies in her public statements. That interview can be listened to at www.cbc.ca/asithappens/popupaudio.html?clipIds=2247862895,2247865473,2247875135

An open letter Dr. Grondin

Re: Dr. Grondin's letter to Carol Off, Co-host of As it Happens, CBC Radio about my interview on the pending cuts to the Interim Federal Health Program

Dear Dr. Grondin,

I read your comments to my interview with profound disappointment. I would expect such a response from a member of political party but expect more from a physician who is familiar with the health consequences of the pending cuts to the Interim Federal Health Program (IFHP).

In your letter to Carol Off, you make a number of comments that suggest that I have exaggerated or misunderstood the impact of the IFHP cuts. For example, you state that the immigrant health exam is sufficient to diagnose tuberculosis. This is the exam that is done either pre-migration or in the case of refugee claimants, soon after they put in their refugee claim. I am certain you are well aware that many immigrants often develop tuberculosis after their arrival in Canada and after their immigrant health exam. As you also know, the first year is a particularly high risk period for the emergence of active TB. As a matter of fact, in the first year of the recent migration of resettled Burmese refugees from Thailand where there was considerable emphasis on tuberculosis screening, 40% of tuberculosis was diagnosed well after the immigration medical examination by doctors in the communities where these groups settled.

Since the health coverage that will be available for refugees will now be based on specific diagnosis and not on actual symptoms, many refugees, and for that matter physicians, will not be able to determine if the patient has health coverage until after investigations are undertaken and a diagnosis is determined. Given the risk of not having insurance, it would be very likely that a refugee with a cough would wait in the hope that their symptoms would resolve before seeking out health care. Certainly, the IFHP will cover the costs of TB once it is diagnosed. Will it cover the costs of all the patients that present with cough, chest pain and shortness of breath that could have TB? Apparently not.

The best way to diagnose TB before it becomes a public health risk, is by doing a skin test for tuberculosis and treating positive individuals at that stage. This is not part of the Immigration medical examination and will no longer be covered by the IFHP.

In your letter you speak of resettled refugees and failed refugee claimants. We should be very clear that these cuts do affect resettled refugees. These are refugees that Canada has already accepted as people in need of protection. They are in the process that will lead to them being Canadian citizens. As of June 30th, such refugees, many who have originated from Iraq and Afghanistan as well as refugee camps across the world, will no longer have access to medications. As you are well aware, the vast majority do not have the means to pay for medications upon arrival in Canada. They will go without. As you yourself said from your presentation with Albert Deschamps to the Citizenship and Immigration Parliamentary Committee on Feb. 3, 2011 regarding issues with the uptake of the IFHP by Quebec pharmacists:

"This was an important concern for CIC, since refugees do not have the means to pay for their prescriptions without the assurance of this program"(http://openparliament.ca/committees/immigration/40-3/40/dr-danielle-grondin-1/).

At that time, you correctly understood that almost universally, resettled refugee will not be able to purchase their medications. What has

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changed since then for you to suggest that not having access to medication represents "little change to their health coverage"? This inability to provide medication access for chronic diseases such as heart disease, diabetes, asthma and the treatment of Post Traumatic Stress Disorder is not addressed in your letter. Surely you recognize the need for such treatment options to alleviate the suffering of refugee populations. This will not be available to them.

Given your considerable time working with migrants, I find it astonishing that you minimize the impact of such limitations to treatment on the health of refuges and their surrounding communities. You choose to pass over the tremendous number of refugees that will no longer have any coverage under the governments "designated country of origin" or safe countries list. These are not failed refugee claimants . These are refugee claimants who are awaiting their due process of a refugee hearing. This includes sick children and pregnant women. This also includes those who are suffering from Post-Traumatic Stress Disorder and other mental health issues as I cited in my interview. In a chilling document from CIC, the denial of care for pregnant women and people having a heart attack is clearly articulated (http://www.cic.gc.ca/english/refugees/outside/coverage.asp). This is simply inhumane.

I think the need to continue to provide the existing services to refugee populations was most clearly articulated by your submission to a parliamentary committee on immigration:

"In some countries, they had no access to medical services and, because of epidemiological conditions and infectious diseases, their health status has deteriorated. It is very important for Convention refugees to receive treatment. In any event, they are eligible for those services under our provincial and territorial health plans. We cover them for the waiting period, which is normally three months, but as soon as they are eligible, our program no longer covers them.

It is also important to cover those groups for what we call supplementary coverage, for medication and all those things that may not be covered by health plans; though the plans cover them for people on social assistance, for example. We take all the provincial social assistance programs already in place and we adapt them. That allows us to reach some degree of parity in what is offered to those groups in the provinces and territories.

That is important for three reasons. First, it is important for the refugees themselves, whatever category they are in, that we are concerned about their state of health and provide the necessary care. Second, it is important for public health, especially if they show signs of infectious diseases that can be spread to those close to them and to the community. We have to provide treatment for that. Third, by assuming the costs, we ease the strain on the resources of the provincial and territorial health systems, at least with regard to the costs. That all must be seen as positive."

You have also suggested that I have overstated the impact of the pending IFH cuts. Is so, I would not be alone. The list of health care organizations that have opposed the cuts is a prestigious one and includes the following among others:

- Canadian Medical Association
- College of Family Physicians of Canada
- Royal College of Physicians and Surgeons of Canada
- Canadian Association of Optometrists
- Canadian Association of Social Workers
- Canadian Dental Association
- Canadian Nurses Association
- Canadian Pharmacists Association
- Canadian Association of Community Health Centres
- Canadian Association of Midwives
- Canadian Paediatric Society
- Canadian Psychiatric Association
- Association of Medical Microbiology and Infectious Diseases Canada
- Canadian Federation of Medical Students

It should be stated that this is an unprecedented response from health care organizations and an obvious response to the tremendous hardship that will result because of these cuts.

In your letter to Ms. Off you ask for a counterpoint to provide a balanced perspective. You have suggested that I, and perhaps the organizations listed above are misinterpreting the consequences of the cuts. I would welcome such a discussion. As such, I invite you to join me or one of my colleagues in a public discussion, perhaps on "As It Happens" or some other forum. I look forward to your response.♦

Philip B. Berger, MD
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PUT FOOD IN THE BUDGET CAMPAIGN

Statement by member Philip Berger, April 19, 2012 as allies gathered at Queen's Park to urge the government to make a significant investment in the health of Ontario's Social Assistance Recipients

My name is Philip Berger. For 35 years, I have been the treating physician for hundreds of patients receiving social assistance. I know how they live. I have visited their homes, inspected their empty food cupboards, seen their limited clothing supplies and poorly-furnished rooms.

Over 870,000 Ontario residents – the poorest of the poor – are so-called "beneficiaries" of our welfare system. In 1995, the Conservative government put them down – hard – with a 22% reduction in Ontario Works welfare rates, which remained in place for 10 years. Ontario Disability Support Program rates were frozen from 1993 – 2003. The Liberal government then

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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:

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Name _____
Address _____
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Province _____
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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

You may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and **enclosing a blank 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 _____ 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 (Please Print) _____ Account holder's signature _____ Date _____

PUT FOOD IN THE BUDGET CAMPAIGN (continued)

ground them down hard with sub-inflationary increases to welfare rates and a freeze in the current budget. Meanwhile the NDP, in this budget debate, maintains a complicit silence with a muted call for a beggarly 1% increase in welfare rates, but only for those with disabilities.

Health care workers have known for decades that the poor suffer a higher prevalence of any disease you can name, and die younger from those same diseases: heart disease, diabetes, cancer, HIV/AIDS. Make no mistake about it: no matter the condition – it is the poor who are disproportionately affected. But nothing new here.

Canada's iconic physician, Dr. Norman Bethune, declared 80 years ago that, "There is a rich man's tuberculosis and a poor man's tuberculosis. The rich man recovers and the poor man dies. This succinctly expresses the close embrace of economics and pathology. The poor man dies because he cannot afford to live."

What is it with our political parties? Afraid to increase taxes on the wealthy and on corporations, but no reluctance to keep the poor down. It has become tedious to recite the dramatic increase in wealth of those few at the top and boring to speak of the deteriorating circumstances and dire tabulations for those at the bottom.

But the Ontario Liberal government, and especially the allegedly social democratic NDP, cannot dismiss as mere statistics the single mothers who trudge to food banks to secure sustenance for their hungry children. The crushing health consequences of poverty and the demoralization of welfare families whose children, believe you me, know by age 8 that their lives are being driven into the territory of permanent disadvantage: this is all a matter of public record right now. It is the record of the over 870,000 who have been continually put down by all three political parties with welfare rates having lost up to 37% of their value in the past 20 years.

Now is the time to act. Raise - and raise substantially – welfare rates and pay for it by raising taxes on people like me – those who can afford to pay.♦

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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:
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