Confusion surrounds MedicAlert services

Litigation surrounding MedicAlert services, which was established in 1961, restructured services for members in January 2003. The organization shifted to an annual fee structure, with 2 membership levels because the cost of maintaining the central database could not be sustained on the basis of monies generated from a flat fee for a MedicAlert bracelet, necklet or watch and lifetime membership, Blais says, adding that lifetime members have the option of paying the annual fee, on a “voluntary” basis or ignoring the invoice. “Obviously, we’re still going to provide information” about the member’s health record if contacted by emergency medical personnel on the MedicAlert 24-hour Emergency Response Hotline. That record includes information on medical conditions, allergies, implants, devices and medications, as well as emergency contact information for the member’s physician and family. Enrolment in the “Advantage” membership category includes notification to a member’s physician and family contacts when a call has been made to the Hotline, as well as 2-year parts and labour warranty on jewelry.

Among the most common medical conditions engraved on MedicAlert bracelets are allergies and diabetes. — Wayne Kondro, CMAJ

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No blame — No gain

The Supreme Court of Canada has urged its implementation, calling it an “excellent thing” to do. Ontario Superior Court Justice Mary Anne Sanderson went even further, arguing that “the road to public health should not be paved with individual victims.”

Provinces, meanwhile, have talked for decades of establishing programs, yet only Quebec has done so.

The harsh reality, though, is that no-fault compensation for people suffering from serious adverse side effects of vaccines remains a distant prospect for most Canadians. By contrast, the United States, Britain, Japan, Singapore, New Zealand, Germany, Switzerland, Denmark and more have implemented plans, some as early as 1961.

Proof of injury requirements vary, as does compensation. Most countries have tables of 10–80 questions, the answers to which are reviewed by experts. Britain pays a once-only amount of between £40 000 and £100 000 for 60% disability. In Japan, compensation includes a caretaker’s allowance in additional to a pension and medical allowance.

In Canada, what compensation is offered is restricted to Quebec and can be traced back to a youngster named Nathalie Lapierre, who contracted acute viral encephalitis while being vaccinated for measles at the age of 5 and was left permanently disabled.

Her parents sued the Quebec government as well as the vaccine’s manufacturer and distributor, seeking roughly $3.1 million in damages. The suit was eventually tossed as Supreme Court Justice Julien Chouinard in 1985 rejected arguments that damages suffered by an individual for the benefit of the community must be borne by society. In the absence of faulty administration, which would make a physician liable, vaccinations are but part of the “pitless game of chance. ... Fortuitous events are not the cause of obligations, they merely occasion them,” Chouinard wrote, later adding that although “recognition of the existence of an obligation independent of any fault would be an excellent thing, no such obligation exists in Quebec civil law.”

A year later, Quebec became the only province to have a no-fault insurance plan for those who suffer vaccine-related injuries. Over a 15-year period, 20 claimants out of 117 were compensated, with awards averaging $135 000. In a similar period in the United States, where compensation is based on predetermined amounts depending on the nature of the injury, 1390 out of 5335 claims were settled for awards ranging from $250 000 to $1.4 million, paid from a national vaccination injury fund to which pharmaceutical firms must make a 75-cent contribution for every antigen contained in every vaccine they sell. Those compensated waive their rights to sue manufacturers.

In Quebec, claimants can still sue, but if successful, must repay provincial compensation. To date in Canada, no one has won a civil claim.

“It’s hard to prove cause or liability,” says David Scheifele, lead investigator and co-founder of the Canadian Paediatric Society’s Canadian Immunization Monitoring Program. Approximately 75 000 children are admitted to hospital each year, less than 10 of which have had recent vaccinations. “In about 5 of those cases, an alternative cause for their sickness is identified, and 5 might potentially be suffering from post-immunization vaccine-related injuries. Most kids recover.”

Although heavyweights like the National Advisory Committee on Immunization has not taken a stance on no-fault compensation, Schiefele says a “safety net” is needed. “It won’t be
used very often. We also need to reassure politicians that severe harm is extremely uncommon.”

Cost fears appear to be at the root of political reluctance to implement no-fault compensation for the vaccine damaged. BC was “reluctant to write a blank cheque as there were no statistics on how frequently there might be claims,” Scheifele says.

Even now, the statistics are hazy, although the federal government is creating a national registry for health professionals to report adverse vaccine effects and this spring will establish a “hotline” for parental reporting.

Experts say no-fault compensation would be invaluable and justified. “It would be an important reassurance for parents,” says Scott Halperin, director of the Canadian Centre of Vaccinology at Dalhousie University. “It’s a social contract, it makes a strong statement, ‘if something does go wrong, we’ll take care of you.’”

But a Canadian program would have to be carefully thought out, says Dr. Monika Naus, associate director, epidemiology services at the BC Centre for Disease Control. “Compensation would have to be beyond a shadow of a doubt.”

As well, Naus adds, “what events would be covered, what level of confidence do we require to compensate an individual and to establish that causality is associated with a vaccine.”

Kumanan Wilson, a researcher and assistant professor in the Department of Medical and Health Policy at the University of Toronto, says it’s impossible to project the cost of a program without knowing its parameters.

But the US program (at 75-cents per dose) has a projected surplus of US$6-billion, Wilson notes. Compensation “makes sense. If there’s no problem with vaccine safety then it won’t be expensive since there will not be many compensation claims. If there is even a small problem with vaccine safety, then we should have been compensating families of vaccine-injured children all along and the program is clearly justified.” — Anne Tempelman-Kluit, Vancouver, BC

**Dispatch from the Medical Front**

**Obstructed labours**

Somalia is a beautiful country at the horn of Africa. Ravaged by war and without a functional government for 15 years, it lacks basic health infrastructure and rates as one of the world’s worst health performers. As field nurses at the Médecins Sans Frontières (MSF) health centre in Dinsor, we dealt with the usual array of problems: cholera, tuberculosis, lack of nutrition.

Yet, it is young, pregnant women that I recall, like the one I’ll call “L,” who’d been in obstructed labour for 2–3 days. She presented with cephalopelvic disproportion (the baby’s head was too big to pass through her pelvis) and type 3 female genital mutilation, making vaginal delivery difficult and extremely painful. L seemed exhausted. The surgeon recommended a cesarean section.

In Somalia, consent for any manner of medical treatment must be given by a male relative. We had difficulty locating L’s family and once we did, they refused permission to perform a C-section. Although warned about the risk to both baby and Mom, they took L home.

I thought about her that night as we unsuccessfully fought to save another young woman in her first pregnancy, who’d arrived semi-conscious and convulsing, presenting with obstructed labour and eclampsia.

The following day, looking frightened, L returned. Her contractions had stopped. By then, she’d been sleepless and in labour 5 days. The baby was dead in utero. The surgeon decided to perform craniotomy, in hopes crushing the fetus’ skull made it deliverable vaginally. The 4.5-kg baby was macerated, the smell awful. L asked me if she had twins and whether the baby was a boy or a girl.

Post delivery, L’s perineum was examined. It was a complete mess. She had a large tear and a fistula. Her vagina and rectum were one. She also required blood transfusion but again, in Somalia, blood is donated by male relatives, which often proves a challenge.

While L was slipping in and out of consciousness, we were chasing donors. Some were finally found and she was transfused.

L made it through the night, and survived, but faced ongoing complications of fistula. If unrepaired, her stool would leak into her vagina, making her an outcast in the community, like another 18-year-old who presented to our outpatient clinic with urinary incontinence. A year earlier, she’d had prolonged obstructed labour and a C-section to deliver a stillborn baby. Urine was leaking into her vagina. She had vesicovaginal fistula. Her husband wanted to leave her.

When I think of her tears and the number of times consent for c-section was refused and a woman left to suffer chronic complications, or die, I feel hopeless, frustrated and demoralized. More so, when I recall that more urban parts of Somalia are less intransigent.

We need a deeper investigation and understanding about why emergency obstetric care is anathema to some in the community. To that end, MSF proposes to engage an anthropologist, and until then, a specialist to repair fistulas.

— Joli Shoker MSN, Vancouver, BC

CMAJ invites contributions to Dispatches from the medical front, in which physicians and other health care providers can provide eyewitness glimpses of medical frontiers, whether defined by location or intervention. The frequency of the section will be conditional on submissions, which must run a maximum 350 words or be subject to our ruthless editorial pencils. Forward submissions to: Wayne.Kondro@cma.ca

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