Huge class-action settlement worries neurologists

A recent $27.5-million class-action settlement involving a Toronto-area physician has left some neurologists concerned about potential damage to the specialty's reputation. The December settlement, the largest of its kind in Canadian medicolegal history, will see payments made to up to 15 000 patients who underwent electroencephalograms (EEGs) at 6 Toronto-area clinics between January 1990 and March 1996; about 75 of them subsequently developed hepatitis B. The clinics were operated by Dr. Ronald Wilson.

A subsequent investigation determined that the outbreak was caused by an infected technologist and inadequate infection control practices (see *CMAJ* 2000;162[8]:1127-31). That study concluded: "There were no written infection control procedures for any of the clinics. The technician reported that he did not wear gloves when conducting EEGs and … although [he] indicated that the use of needle electrodes rarely resulted in bleeding, patients' reports of bleeding were common."

"Absolutely, we've been damaged by this," said Dr. William Murphy of Calgary, a past president of the Canadian Society of Clinical Neurophysiologists. "Our profile is certainly harmed."

Murphy says the case has also given many neurologists reason for pause. "I can't believe how one person can contaminate so many individuals."

The case first gained public attention in 1996 after Toronto public health officials traced a hepatitis B outbreak to the EEG clinical technician employed by Wilson. He performed all EEGs done at the 6 clinics.

The infection rate among Wilson's patients was 600 times greater than normal. About 15 000 people who

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Investment in international health will pay massive dividend: WHO

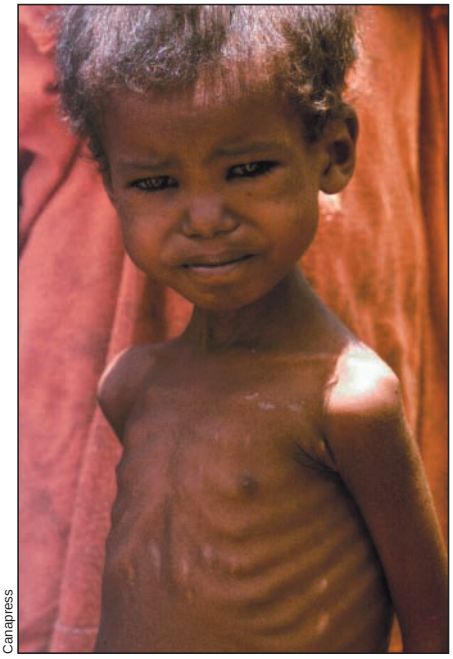
Increased spending of $66 billion per year to improve the health status of developing nations will provide a sixfold return on the investment, a group of leading economists and public health experts says.

In a report prepared for the World Health Organization (WHO), the Commission on Macroeconomics and Health concludes that the increased investment — half to come from developed countries like Canada and the rest from "reprioritizing" the budgets of underdeveloped nations — would provide the large returns because healthier people would live longer and be more productive (see p. 293). Under the plan, "official development assistance" from countries like Canada would increase from its current level of $6 billion per year to $27 billion by 2007. The rest of the money would come from the developing countries themselves. The commission concludes that the additional spending would save about 8 million lives a year.

"The commissioners use clear scientific evidence to challenge the traditional argument that health will automatically improve as a result of economic growth," says WHO. "Their report shows that the opposite is true: improved health is a critical requirement for economic development in poor countries."

Under the plan, countries like Canada would make annual contributions to the health of developing nations that would amount to 0.1% of their gross national product — in Canada's case, about $1 billion annually. Developing countries would also aim to raise budgetary spending on health by an additional 1% by 2007 and 2% by 2015. "With bold decisions in 2002, the world could initiate a partnership between rich and poor of unrivalled significance offering the gift of life itself to millions of the world's dispossessed," the report states.

But how well will this message go over in wealthy countries like Canada, where international concerns usually take a back seat to national issues? "The problem of winning public support is indeed a large one," commission Chair Jeffrey Sachs told *CMAJ*. "Europe and Canada are much further along on the aid-health-development linkages than the US, which has become the stingiest of the 22 donor countries when aid is measured as a percentage of GNP. Since Canada is host of the G-7 summit this year and Africa is high on the agenda, I believe Canada is likely to accept the challenge of advocating for and contributing to greater aid."



Canapress

Time to invest in the future?

Sachs says the United Kingdom and European Union have both made promising comments about the need for increased aid, "but so far I haven't seen much progress with the US administration."

The commission was created in 1999, with Sachs, director of Harvard's Center for International Development, as chair. Its report, *Macroeconomics and health: investing in health for economic development*, is available at **www.cid.harvard.edu**. — *Patrick Sullivan*, CMAJ

How did the situation at the Queensway–Carleton get so nasty?

"No cap on babies" read the placard of a demonstrator marching outside Ottawa's Queensway–Carleton Hospital last fall. The marchers, who included 4 of the hospital's 7 obstetricians, were outraged by the 201-bed community hospital's attempt to cap the number of deliveries in its birthing centre. The hospital said it had no choice but to set limits if it was to avoid a deficit, but when it comes to motherhood issues — and there are none bigger than this one — that was a hard message to sell. By the time the matter was settled, "brown envelopes" had been sent to local papers and relations between physicians and the hospital board had suffered. And in the end, the board never did get its message out to the public.

So how did things turn so bad so quickly? It probably started with a letter reminding the hospital's 215 physicians that the renewal of privileges depended on their agreement to practise within "fiscally prudent" parameters.

Dr. Douglas Cochen accused the hospital board of trying to "blackmail physicians, telling them they have to choose which patients to look after."

No matter that June Lemmex, the board chair, had always insisted that "we have not and will not turn mums-to-be away." No matter that the hospital was deeply in the red and that budgetary chaos at the Ottawa Hospital had recently resulted in the suspension of that hospital's board. And no matter that the Queensway–Carleton's chief of staff had been pressing the obstetrics department to estimate how many deliveries it expected to handle in 2001/02. Dr. Paul Legault, its chief, would not provide a figure. The obstetricians insisted that because the birthing centre had been built to accommodate 2700 births annually, that figure should be used. However, births are nowhere near this level and the board felt that the hospital had neither the staff nor the money to handle that number.

The situation deteriorated throughout the fall, and in late November confidential hospital documents began appearing in the *Ottawa Citizen*, sparking the public demonstration. "Once those pregnant mums began demonstrating, the board had lost the media battle," admits Dr. Ron Vexler, the chief of medical staff. "No hope of dialogue with the obstetricians was left."

This debacle raises important national questions about whether hospital boards filled with volunteers and focused solely on their own institutions should decide where services are provided and funded. "All the hospitals need to work together to decide how to allocate resources," says Lemmex. "We've got to stop the turfing. But at present, we don't have those mechanisms."

How did this situation get so nasty? The story begins with the wrenching changes demanded by the province's restructuring commission in 1997. The shake-up included closure of the Grace Hospital, which had handled 1600 deliveries annually; that obstetrics department was then absorbed by the Queensway–Carleton, a full-service community hospital. "There was a culture clash," explains Lemmex. "I think the obstetricians had difficulty understanding that there are other services here, such as surgery, which are of equal importance."

The hospital was also facing acute fiscal pressure. Opened in 1976 to serve a local population of 125 000, it now served 400 000 area residents. Emergency room visits had doubled to 60 000 a year, and by early 2001 the hospital was heading for a deficit of $14.5 million on its identified revenue of $60.1 million. Since the problems were caused by patient volume and not poor management, the province allotted an extra $12.5 million, but the board still had to bridge the remaining budget shortfall. The obstetricians remained adamant that they could not forecast the number of deliveries. "We had 7 eager obstetricians, and obstetrical programs in community hospitals elsewhere in the Ottawa Valley were collapsing," explains Vexler. "The board felt we must control growth of the programs. But the obstetricians refused to engage in dialogue."

He responded with a letter indicating that renewal of privileges would depend on a written statement agreeing to whatever number of deliveries "is determined to be sustainable by the Board according to our financial situation."

This implicit threat lit the fuse. Internist Charles Shaver collected ethical opinions from 3 separate sources, and all suggested that the obstetricians faced "a serious ethical dilemma" because their duty to their patients' best interests conflicted with the hospital's fiscal policies. Vexler withdrew the letter in December, and he and Lemmex now concede that it was a mistake to have sent it. However, they say there are few levers available to boards struggling to stay within budget if physicians will not consider the fiscal health of the whole institution.

"Physicians should not have to make decisions about allocation of resources," responds Shaver, who suggests that the ministry must provide adequate funding at whatever level physicians and their patients deem necessary. And if the dollars simply aren't there? "Well, they'll just have to raise taxes, I guess. Or maybe introduce a mixed public-private system for certain tests and procedures."

In the meantime, the furore has simmered down, with the Queensway–Carleton projecting 2460 deliveries for 2001/02. But morale has suffered, and issues of trust and confidentiality within the once tight-knit medical staff worry Vexler, whose 7-year term ends in March. "Where will the brown-envelope routine stop? Will it spread from confidential discussions on policy to confidential patient care records?" — *Charlotte Gray*, Ottawa

CMA membership soars

Active membership in the CMA stood at an all-time high of 52 950 members at the end of 2001 — an increase of 4.6% during the past year and a 21% increase since December 1997. The CMA ended the 20th century with 50 630 members.

Active members include medical students, residents and practising and retired MDs, and there were increases in all these categories in 2001. The largest increase was in the practising-physician category, which rose by 1156 doctors and surpassed the 35 000 mark for the first time (35 459). The association also attracted 624 more medical student members in 2001 (5273) and 115 more residents (4033). Overall, Ontario supplies the most active members (21 060), with British Columbia second (8619) and Alberta third (6709). — *CMAJ*

Hospitals leaving huge "ecological footprints": report

A family physician who assessed the size of a Vancouver hospital's "ecological footprint" says her findings show that hospitals have a "huge" impact on the environment. The footprint is a calculation of how much land is needed to support the consumption of resources and production of waste by a person, nation or other entity. Dr. Susan Germaine determined that the Lions Gate Hospital in North Vancouver has an ecological footprint covering at least 2841 hectares — 739 times its actual size. The city of Vancouver's footprint is 180 times its total area.

Germaine, a member of the Canadian Association of Physicians for the Environment (CAPE), conducted the assessment for her thesis in environmental science. She says her estimate is conservative because there is no way to gauge the total impact of toxins, chemicals, new medical equipment and supplies used at the hospital.

Despite these limitations, Germaine says the notion of a footprint provides a clear illustration of hospitals' environmental impact and allows comparisons among facilities and over time.

For example, the hospital uses 1.75 million pairs of gloves per year — 8.2 pairs per patient per day. "Who knows how many gloves are used across Canada," says CAPE chair Dr. Trevor Hancock. "It's an apt symbol of the problem. We have to ask ourselves: 'Is there a way of reducing this and maintaining safety?' "

The footprint experiment is featured in North America's most comprehensive report on the greening of health care, *Doing less harm: assessing and reducing the environmental and health impact of Canada's health care system*. It was funded by Health Canada and published by the Canadian Coalition for Green Health Care (**www.greenhealthcare.ca**), a group of 12 health and environmental organizations, including the CMA. The report documents the impact of hospitals' solid and liquid wastes and air emissions on the environment (see page 354) and looks at ways to reduce the impact.

Canapress

Big feet: A hospital's ecological footprint is based on the land required to absorb the waste produced and provide the resources consumed.

The coalition is lobbying governments to help hospitals switch to more environmentally friendly practices. Hancock thinks most health care institutions will "be green" within 5 years. "There's growing awareness, but the bigger challenge will be to get people to appreciate the economic, legal, community and health benefits of going green."

Copies of *Doing less harm* are available for $10 from **tea@web.net**. — *Barbara Sibbald*, CMAJ

Neurologists worried

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received EEGs during the 6-year period are expected to receive amounts ranging from $1000 to $130 000. Under the settlement, Wilson denied any responsibility for causing the problem. He still faces a hearing before the Ontario college.

Writing in *CMAJ* in 2000, the public health team that investigated the case concluded that guidelines were not followed at the Toronto clinics. "As stated in the guidelines," it concluded, "it is preferable to use noninvasive techniques (e.g., disk electrodes) rather than invasive ones (e.g., subdermal electrodes)."

Dr. Gerald Tullio, a community neurologist at the William Osler Health Centre in Brampton, Ont., considers the case a wake-up call. He said he makes a point of opening new packages of electrodes in front of patients to help dispel any fears that products are being reused.

Tullio said many neurologists are worried about the impact the case will have on their malpractice fees, but Françoise Parent of the Canadian Medical Protective Association (CMPA) thinks the impact will be small because "assumptions [were] made about the cost of [this] class-action suit 6 years ago." Ontario neurologists will pay $7116 for coverage in 2002. — *Brad Mackay*, Toronto

Last chance for input on new herbal regulations

Five years after the federal government decided it needed some control over the sale of natural health products, new regulations are almost ready to be put in place. Canadians have until March 22 to voice their concerns about the regulations, and an updated version should be published in the *Canada Gazette*, Part II, by this summer. Afterwards, manufacturers will have 2 years to have their products assessed and receive a product licence and product identification number, the equivalent of the drug identification numbers used for prescription drugs.

The Natural Health Products Directorate will have to assess an estimated 25 000 to 30 000 products, including herbal preparations, vitamins, minerals, traditional medicines, plants and homeopathic preparations.

Under the regulations, labels will include directions for use, a list of medicinal and nonmedicinal ingredients, and any cautions, contraindications or known adverse reactions associated with the product. Manufacturers will also be allowed to make evidence-based health claims.

To comment on the proposed regulations, contact the Natural Health Products Directorate, 171 Slater St., 9th Floor, Ottawa, ON K1A 0L3; nhpd_general@hc-sc.gc.ca. — *CMAJ*