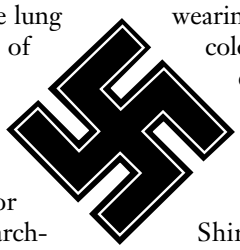
World's "last trial" involving Nazi doctor ends in Austria after suspect declared demented

The world has likely seen the last trial involving a doctor accused of killing people in the name of medicine and Nazi Germany's euthanasia program and its perverse research involving human subjects.

Dr. Heinrich Gross, who is suspected of murdering mentally and physically handicapped children at the Am Spiegelgrund Clinic, the children's section of Vienna's Neurology Institute, went on trial Mar. 21. But barely an hour into the trial of the 84-year-old Austrian physician, the judge suspended proceedings after hearing evidence that the defendant was experiencing dementia.

Although Gross may no longer be competent to stand trial, it is difficult to ignore the evidence that derives in large part from the Nazi mania for collecting and storing scientific information. Gross took photographs of the children he treated. The records are precise: 772 children died in his clinic and the professor signed the death certificates of 238.

The preserved brains, kept in jars of formaldehyde in the basement, revealed traces of a powerful sleep-inducing drug, Luminal. The death certificates bearing Gross' signature give lung infection as the main cause of death.



Survivors like Alois Kaufmann, 67, make clear why: doctors were determined to do their bit for the Nazi war effort by researching the effects of cold and malnutrition on the human body. Drugged children were put out on the balconies in the middle of winter. It was common to dunk children in ice-cold water and then wrap them up like mummies, again to test their resistance to cold.

"They would take all the bedclothes away and put the children — even babies — naked on the balcony to check how long it would be before they got pneumonia and died," recalled Kaufmann, who was sent to the clinic as a 10-year-old in 1943 after a school psychologist designated him "asocial."

Kaufmann identified Gross as the feared doctor known as The Scythe, who would stride into his Vienna clinic wearing polished boots and his crisp colonel's uniform, and point to the child patients marked down for euthanasia under Hitler's *Lebensunwertes Leben* (Life Unworthy of Life) program.

Gross joined the SA Brown Shirts in 1933, the Nazi party in 1938 and the Wehrmacht in 1943. After World War II he became a stalwart member of the ruling Austrian Socialist Party.

Almost 700 000 Austrians were members of the Nazi party, and the postwar Socialists quickly realized that they could not rule without the help of these ex-Nazis. With political protection, Gross rose to be one of the best paid forensic doctors and, helped by his clinic's unique collection of pickled brains, a respected neurologist. — *Gil Kezwer*, Toronto

MDs' bid to raise drinking age meets opposition

A recommendation from the College of Physicians and Surgeons of Manitoba to raise the province's legal drinking age from 18 to 21 is being opposed by the province's hospitality industry and some young people employed in the industry. Meanwhile, a major youth group supports the move.

The proposal is one of 22 recommendations in the college's Pediatric Death Review Committee report, which was released in early April. It suggests that raising the drinking age could significantly reduce traffic fatalities by keeping alcohol out of the hands of young drivers.

Dr. Robert Walker, deputy registrar of the Manitoba college, said the recommendation is based on American experience, which shows that every state that lowered its drinking age in the early 1980s raised it back to 21 by 1988. "Data accumulated by US officials suggested that the change helped to reduce the number of traffic deaths among teenagers and young adults," says Walker.

The college's proposed age change is tied to another recommendation calling for a graduated licensing system, in which new drivers would hone their skills under conditions that minimize injury risk. The restrictions include a prohibition against driving at night for young drivers, a copilot program and zero blood alcohol tolerance. This program is already in place next door in Ontario.

Ron Ledohowski of the Winnipeg-based Hospitality Corporation says the college recommendation would make it difficult for the hospitality industry to

(Continued on page 1600)

New rapid HIV test opens Pandora's box of ethical concerns

A new HIV test that provides results in just 15 minutes is undoubtedly more convenient and faster, but observers say it also raises concerns about appropriate counselling, administration of the test and ways to deal with false-positive results (see pages 1545, 1605).

The Canadian HIV-AIDS Legal Network has responded to the new product with a 145-page report that urges provincial and territorial governments and regulatory bodies to run pilot studies on the new tests before mass marketing takes place. The studies would assess the need for counselling, training and quality control.

The test, which was approved by Health Canada in mid-March, is the country's first rapid screening test and the only HIV test possible outside a laboratory. It is considered as accurate as the current standard, the ELISA laboratory test, but results from that take 2 weeks.

The report's coauthor, lawyer Richard Elliott, says the Legal Network's major concern is the quality of counselling, especially given the number of false-positive results. This figure varies according to the HIV seroprevalence within a population, but it can be quite high. For example, 300 000 ELISA tests were conducted in Ontario last year, and 3000 were positive. After a second confirmatory test, only 1000 of the people tested were found to be HIV positive. (Patients are not notified of their status until after the second test.)

With rapid testing, however, patients would be informed of their status on the spot, before any confirmatory test had taken place. "It's crucial in counselling that they understand they may or may not be positive," says Elliott, director of policy and research at the Legal Network, a nonprofit group that takes the lead in analysing legal and ethical issues raised by HIV testing. It is urging regulatory bodies, provinces and territories to establish practice guidelines regarding who can provide rapid testing and to ensure training and counselling specific to the new test.

Elliott says the ease of rapid testing will increase the likelihood of poor counselling and lack of proper consent. "We're concerned that people will feel pressure to have this test done without adequately considering the ramifications of a positive result," he says.

"Pre-test counselling is the standard of care that must be met in any HIV testing," concurs Dr. Phil Berger, the chief of family and community medicine at Toronto's St. Michael's Hospital. "My worry is that [counselling] won't occur if testing is being done by a range of professionals who aren't necessarily trained in counselling."

The Health Canada licence stipulates that the test, which is marketed by BioChem ImmunoSystems Inc. of Montreal, can only be used by health care professionals at the point of care. However, each province and territory has its own definition of "health care professional," and in some cases it includes dentists and registered massage therapists. Many of these professionals are not currently trained to provide counselling, says Elliott.

There is also some concern that the test could make its way to the black market and be used for unscrupulous purposes by employers. Elliott argues that these people should be prosecuted. "I don't want to see circumstances where someone takes this kit and forces a spouse or child or employee to take it," he says. "It raises concerns about informed consent." US regulators have already approved home test kits for HIV that cost about US$40. — *Barbara Sibbald*, CMAJ

Fewer traffic deaths?

(Continued from page 1599)

find enough restaurant workers.

"This age group [18 to 20] is very important to the industry. Restaurants and bars are already competing with each other for the same employees. If this group is prevented from working, it's going to really hurt us."

Allan Pond, a 19-year-old bartender at a Winnipeg restaurant, says that without the income from his job, he would be forced to withdraw from a BSc degree program he hoped would lead to medical school. "If you're too young to serve liquor or work as a bartender, then who is going to hire you?" Pond asks.

Many young people called a local radio station to voice their disapproval of the proposed age change, saying that it is already easier to purchase illicit drugs than alcohol. However, the president of the Winnipeg Students Association came out in support of the change.

"If you ask me, it's too easy for kids age 15 and 16 to get their 18-year-old friends to buy them alcohol," says Andrew Morrow. "At 21, a person is more responsible for his behaviour."

Diane McGifford, minister responsible for the Manitoba Liquor Control Commission, said the government has no immediate plans to raise the drinking age, but there will be public consultations on the Liquor Control Act this spring and the drinking age is likely to be discussed. "I expect the college and many others will attend the hearings," says McGifford.— *David Square*, Winnipeg

Return to May 30, 2000
Table of Contents

Feds honour Dr. Maude

The oak-panelled shelves and display cases containing Dr. Maude Abbott's pathology slides were a fitting backdrop for unveiling a Historic Sites and Monuments brass plaque and oil portrait in honour of one of Canada's first female physicians. The unveiling took place Mar. 10 at McGill's Osler Library.

A pathologist who became world renowned for her pioneering work in abnormalities of the heart, Abbott obtained her medical degree in 1894. At the time, few women pursued medical careers in Canada or elsewhere. Abbott, one of the first women to teach medicine at McGill, also became curator of the university's pathology museum. She was the first to use its specimens to teach medical students, a practice that Dr. Abraham Fuks, McGill's dean of medicine, said continues to this day.

"When I first read the story of that woman, I found it unbelievable," said federal cabinet minister Lucienne Robillard, who attended the unveiling. "How did she succeed at that time?"

Abbott, who was called "the beneficent tornado" by one of the speakers, helped found the Federation of Medical Women of Canada, which began as a meeting of 6 women sitting on the grass after a CMA meeting. The group now has more than 2000 members.

Some of the retired physicians present at the standing-room only ceremony remembered not only her achievements but her travails. "Her work studying congenital heart malformations formed the basis of the initiation to cardiac surgery," said Dr. Sean Moore, professor emeritus of pathology, "yet she had a problem getting a clinical clerkship."

Federal cabinet minister Lucienne Robillard unveils plaque honouring Dr. Maude Abbott at McGill's Osler Library

"It's a pity she couldn't get into medicine at McGill because she was a woman, and had to go to Bishop's," added Dr. H.J. Scott, a retired cardiac surgeon who was on McGill's faculty of medicine for more than 35 years. — *Susan Pinker*, Montreal

Shocking, graphic cigarette packages are a deterrent: study

A University of Guelph study on cigarette packages has concluded that strong emotional statements on packages, such as "Smoking causes mouth cancer," along with pictures of rotting gums and blackened teeth, are huge deterrents to both smokers and nonsmokers.

The study, conducted by John Liefeld of the University's Department of Consumer Studies, was commissioned by Health Canada and was part of the reason the federal government proposed increasing the size of health warnings, printing them in colour and including a graphic image on the package.

"The content of the message is most important," Liefeld said. Some of the other messages he used in his study included: "This year, smoking will kill off the population of a small city." It was combined with a picture of a bar graph showing projected deaths from motor vehicle accidents, suicides, smoking and heart disease. Another message, "Smoking kills babies," is accompanied by a graphic of a baby lying on its back.

Liefeld studied a sample of 617 people in Ontario and Quebec. "It can be concluded from these results that the immediate impact of larger, stronger warning messages with pictures on one's thinking about smoking would be strong," he said.

Approximately one-third of the study sample were teenage smokers and another third were teenaged nonsmokers. An estimated 90 percent of all smokers begin smoking before age 20. The remaining participants were adult smokers.

The study also found that even warning messages that covered 60% of the package surface did not prevent smokers from recognizing their brand in a simulated store display. Liefeld said that for 95% of smokers, there was no difference in the time taken to locate their brand in the display.

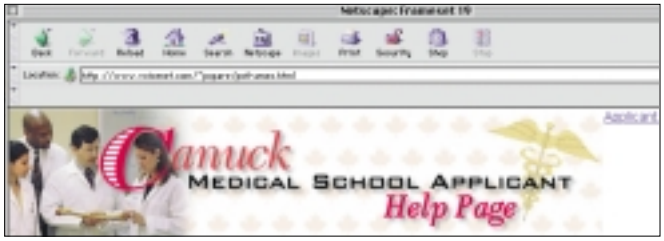
"The incidence of smoking has decreased over 20 years because of the weight of combined actions from many agencies, including the CMA," he said. Because of those actions there has been a decrease in the smoking population — except among teenage girls. — *Ken Kilpatrick*, Hamilton

On the Net

Online lifeline for med school applicants

Students looking for a leg up in the competition to get into medical school can turn to the Internet for help and guidance, because several Web sites offer services ranging from tips on interview techniques to doing well on the ever-intimidating MCAT.

The Medical Education Ring page (http://nav.webring.org/cgi-bin/navcgi?ring=mededrg;list) lists 194 sites that offer help to medical school applicants. While most of these target Americans and American medical schools, a few Canadian sites are worth checking out.



Ian Wong, a medical student at the University of British Columbia, serves up advice by outlining his personal experiences. His Web site, Admissions Advice Page for Canadian Pre-Meds (www.geocities.com/HotSprings/Oasis/8998/), also helps potential applications survive PMS — pre-med syndrome.

"I like to define pre-med syndrome as the overly obsessive and unhealthy desire to do whatever it takes to enter medical school," says Wong. "Stressing out over my exams and midterms throughout the entire semester definitely didn't make for a fun time, and it doesn't make you fun to be around."

Another Canadian site is the Canuck Medical School Applicant Help Page (www.voicenet.com/~popare/poframes.html), which was created by John Po, a Canadian attending medical school in Philadelphia. It is geared toward helping Canadian students apply to American medical schools. He offers general advice regarding the interview process, and for a fee he will give applicants personalized preparatory training for the all-important interview.

The Medical School Interview Feedback site (www.interviewfeedback.com) is another interesting site. It asks applicants to complete a questionnaire after their medical school interview. Anonymity is guaranteed, with results sorted by school and posted for other potential applicants to read.

People completing the questionnaire can comment on the interview process, the number and type of interviewers, and what the hardest questions were. Applicants are also encouraged to give their impressions of the interviewers' attitudes and the friendliness of the faculty.

Graham Redgrave, editor of the site, says some admissions personnel are "uncomfortable" with the content of some of completed questionnaires. "The opinions and narratives here are meant to be useful in as broad a sense as possible," he tells admissions officials. "I hope the feedback contained within the questionnaires is of as much utility to you in your professional roles as it appears to be to the applicants in their pre-professional ones." — *Michael OReilly*, mike@oreilly.net

Doctors in South Africa becoming gun-shy

Trauma caused by guns and knives is keeping South Africa's doctors busy. "A significant number of casualties are trauma related," notes Dr. Deon Stoltz, senior medical supervisor at Stellenbosch Hospital. "In 84% of cases alcohol is a factor. You can see the spike [in the number of cases] at the end of the month, when people have money to spend on alcohol."

On average, Stoltz and his colleagues at the 100-bed hospital, which is about 45 minutes outside Cape Town, treat about 60 victims of common assault on Friday and Saturday nights. Most of these emergencies now involve stab wounds; the number of gunshot wounds has declined in recent months. This is not unusual. Indeed, hospitals throughout the country are dealing with an epidemic of violent injuries. Stab wounds are common and in some areas the number of gunshot victims is soaring.

In fact, the number of gunshot wounds was so high last year at the Groote Schuur Hospital in Cape Town — 981 patients in total — that doctors and nurses in the trauma unit embarked on an awareness campaign that included placing posters throughout the hospital to increase understanding of the seriousness of the problem. Part of the problem is that firearms are easily available and legal to obtain in South Africa, where Uzi sub-machine guns and AK-47 assault rifles are common.

The problem also extends outside the trauma unit. Doctors at the Stellenbosch Hospital have found themselves caught in the middle of all-out warfare between rival gangs. If a gang member failed to die in a shootout and doctors were lucky enough to be able to save his life, opposing gang members often show up to finish the job, says Stoltz. (For the security of these patients, they are routinely and randomly moved within the hospital.)

The threat of violence also extends to medical staff, particularly nurses who live in the townships where many of the patients, their families and their "visitors" also live. "Staff get threatened that they will be 'gotten' in the community," says Stoltz. — *Donalee Moulton*, South Africa

Return to May 30, 2000
Table of Contents

Pulse

Boys and girls and healthy behaviour

The Canadian component of a multinational study that gathers information on the behaviour of schoolchildren when it comes to health risks has found some significant differences between boys and girls.

The Health Canada report Trends in the Health of Canadian Youth, based on data collected through the 1989/90, 1993/94 and 1997/98 survey cycles for the World Health Organization, found that in 1998 Canadian boys in Grade 10 were more likely than girls to drink soft drinks daily (60% versus 44%). Boys, however, were also more likely to eat breakfast daily (55% versus 41%), and far less likely either to be on a diet or to feel that they needed to lose weight (18% versus 45%). Grade 10 students of both sexes were roughly equally inclined to eat fruits or vegetables daily (62% of boys, 65% of girls).

Although Grade 10 boys were much more likely than girls to exercise outside of school at least twice a week in 1998 (75% versus 54%), they were also slightly more inclined to watch more than 4 hours of television a day (23% versus 19%), and much more likely to play computer games for more than four hours per week (35% compared with 5%). Sixty-six percent of Grade 10 girls had tried smoking, compared with 61% of boys, and 23% smoked daily, compared with 17% of boys.

Grade 10 boys and girls were equally likely to have tried alcohol (93% and 92%), and to have been "really drunk" at least twice (43% for both sexes). Boys, however, were almost twice as likely as girls to drink beer at least once per week (18% versus 10%). Boys and girls were almost equally likely to have tried marijuana (44% and 41%). The latter numbers are substantially higher than they were in 1990, when only 26% of boys and 24% of girls admitted to having tried marijuana. — *Shelley Martin*, martis@cma.ca

Fifteen-year-olds who smoked daily, by country, 1988 (%)

Huge study questions HRT's role in heart health

The assumption that hormone replacement therapy helps prevent heart disease may be false, according to preliminary results made available in the midst of a US study of 27 000 healthy postmenopausal women.

Investigators with the National Institutes of Health (NIH) Hormone Replacement Therapy Study found that women taking estrogen were having slightly more heart attacks, strokes and blood clots in their legs and lungs than those taking the placebo. Less than 1% experienced these problems and the initial increased risk seemed to go away after the first 2 years of hormone treatment.

The acting director of the trial, Dr. Jacques Rossouw, said that even though it is too soon to say whether the increased risk of heart attacks and strokes will hold up as the trial continues, he felt morally obliged to inform participants of the findings. Each study participant received a letter informing her of the initial findings. The NIH recommends that the trial continue fully and that women in it remain and continue taking therapy.

Ten million American women take HRT, which has long been touted for its heart-protecting qualities. Studies comparing heart attack rates in women taking HRT with those who did not have consistently found lower rates of heart disease in those taking the hormones. However, these studies didn't consider the fact that women who take hormones tend to have a lower risk of heart disease anyway. They are also less likely to smoke and more likely to exercise and have a healthy diet.

Participants in the Women's Health Initiative study, who are being followed for 8 to 12 years, have clinic visits every 6 months to assure safety and assess their health. The study tests whether long-term HRT reduces coronary heart disease and fractures without increasing the risk of breast cancer.

A study published by *JAMA* in August 1998 found that HRT for postmenopausal women with heart disease did not prevent further heart attacks or death from coronary heart disease. The Heart and Estrogen-Progestin Replacement Study (HERS) involved 2763 women, who were treated for about 4 years. — *Barbara Sibbald*, CMAJ

Research Update

Pinpointing the genes at work in osteoarthritis and cardiovascular disease

Several diseases thought of as age- or lifestyle-related have strong genetic components, according to research in progress presented at the Human Genome Meeting held in Vancouver in April. Dr. Elina Slagboom of the TNO-PG Gaubius Laboratory in Lieden, The Netherlands, presented her findings from genetic research into osteoarthritis and cardiovascular disease.

As a late-onset disease, osteoarthritis (OA) has a strong genetic component, says Slagboom. But is the genetic influence detectable, and which genes are involved? One of the difficulties in determining the genetic factors influencing OA is that risk factors for the disease also have genetic components of their own.

In her recent work, Slagboom looked at radiographic evidence of OA in subjects enrolled in the "Rotterdam" study, which included 1000 subjects aged between 55 and 65. Only 18% of the subjects, however, had OA changes on radiographs.

Slagboom's next step was to look for candidate genes in cartilage damage and repair. The presence of the type II collagen (*COL2AI-5*) gene has been shown to correlate with a fivefold increase in the risk of OA. The angiotensinogen (*AGN*) gene has been associated with OA in both hands. However, the search for genes "could go on forever," says Slagboom, who then turned her attention to autosomal dominant families with generalized early-onset OA. She is now trying to find a gene associated with early-onset OA and more common OA phenotypes, using sibling pairs with OA demonstrated on radiographs. She will look for associations between these pairs and the subjects in the Rotterdam study.

In her work on cardiovascular disease (CVD), Slagboom is looking at 500 twin pairs to find the heritability of risk factors. Forty genes are associated with arteriosclerosis, and she is trying to discover if any 1 gene is linked to the risk of death from CVD. In a study of 650 patients over age 85, Slagboom examined the hypothesis that mutations in the methylenetetrahydrofolate reductase (*MTHFR*) gene contributed directly to death. The patients were followed for 10 years; 89% of them died during that decade, 38% from cardiovascular disease. The male gene carriers had 4 times the risk of dying from cancer than from cardiovascular disease, which Slagboom concluded was due to their high rate of smoking — 50% smoked, compared with 4% of the women in the study.

Slagboom is currently replicating the study with a second sample of subjects aged 85 and older, whom she will test for the *MTHFR* gene. In another study of 900 men aged 65 to 85, preliminary results show no significant relation between the presence of the gene and risk of death, but almost twice the risk of CVD and cancer among gene carriers. — *Heather Kent*, Vancouver

Turning T cells to the task of fighting cancer

In addition to their essential role in fighting infection, T lymphocytes are proving their use in eliminating cancer cells. This ability is at the heart of recent research into immunotherapy for cancer. Now researchers at the Memorial Sloan-Kettering Cancer Center in New York have developed stable, artificial cells that stimulate T cells to fight cancer (*Nat Biotechnol* 2000;18:405-9).

"There are cells in the body that are specialized in the function of presenting antigens to T cells," says lead researcher Dr. Michel Sadelain. "These cells, termed 'antigen-presenting cells,' naturally express a cohort of molecules that render them effective in this task. However, the generation of such cells for the purpose of inducing specific T cells is labour-intensive and time-consuming. We therefore examined what are the minimal components needed to make genetically engineered cells that are potent activators of T cells that are able to recognize and destroy tumour cells."

Sadelain and his colleagues used mouse cells to stimulate the expansion of human tumour-reactive T cells in the laboratory. They found that introducing just 6 genes was enough to create a cell that efficiently stimulates and amplifies human cytotoxic T lymphocytes that break down melanoma cells in vitro. Three genes are used to generate the peptide complex that directly engages the T cell receptor. The other 3 genes enhance T cell activation by engaging other receptors expressed by the responding T cell.

"To our surprise, these artificial antigen-presenting cells worked at least as well as dendritic cells, the most potent naturally occurring antigen-presenting cells, under the experimental conditions used so far," says Dr. Sadelain.

The next step, he adds, is to confirm that artificial antigen-presenting cells can be generally applied to induce tumour-specific T cells in the laboratory. "We will initially focus on antigens found in lymphomas, leukemias and prostate cancer. We also plan to assess the efficacy of these T cells in animal studies. We intend to develop a system that could also permit stimulation of T cells against more than 1 antigen at a time." — *Donalee Moulton*, Halifax

Return to May 30, 2000
Table of Contents

Public Health

Rapid HIV testing

Epidemiology

Rapid HIV test kits are now available in Canada.[1] Their use is currently restricted to "point-of-care" sites — testing sites where appropriate HIV counselling is available. The kits are designed to screen for the presence of HIV-1 and HIV-2 antibodies in a sample of whole blood, using an enzyme immunoassay. Results are produced within 15 minutes, which means that a person can learn of his or her HIV status during a single visit.

All rapid-test kits approved by Health Canada must meet performance standards for sensitivity of at least 99.0% and a specificity of at least 99.5%. These are the same standards set for HIV screening tests used in approved laboratories. The rapid test provides a reliable negative test result that permits the health care professional to complete HIV testing and counselling during a single visit. False-positive results will occur with rapid HIV tests, particularly among patients from populations with a low rate of HIV infection. In cases of positive or equivocal screening results, a venous blood sample must be sent to an approved laboratory for confirmatory testing (such as the Western blot). The time for results of confirmatory testing varies by laboratory but is between 3 and 14 days.

Clinical management

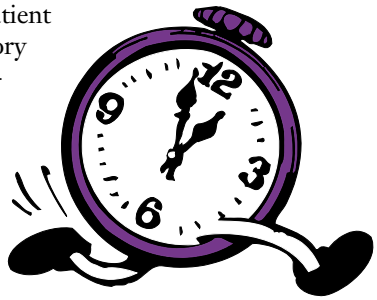
Typically, capillary blood is collected using a pipette. The blood is incubated in the testing device for a specified period (usually several minutes), after which a precise amount of buffer is added. The mixture is then incubated again for several minutes. If HIV antibodies are present in the patient's blood in sufficient concentrations, a colour reaction occurs along a test strip. Several of these steps are time-sensitive and must be adhered to for accurate results.

As with all HIV testing, the use of rapid HIV test kits requires the specific, informed consent of the person being tested. Given the rapidity of results and the possibility of false-positive outcomes, counselling must be provided for those receiving point-of-care testing. Health Canada has produced a guide for health care professionals that shows how to administer the test and counsel.[1]

Pretest counselling must include informing patients of the possibility of false-positive results and should stress the importance of confirmatory testing of all equivocal or positive results and advise patients of the cost of point-of-care testing, such as the purchase price of a test kit. Post-test counselling after a positive or equivocal result should include the provision of support and follow-up during the interval required to complete confirmatory testing.

Prevention

HIV infection is reportable under public health legislation in Canada. Health care professionals are required to report identified cases of HIV infection to the public health system to maintain accurate HIV epidemiologic information and to assist in contact tracing. In the event that a patient does not complete confirmatory testing, the health care professional should seek advice from a public health official on reporting requirements. HIV testing may not be reliable in patients who are in the HIV "window period" during seroconversion. Patients who have engaged in risk activity in the 3 to 6 months before testing should be counselled on the need for appropriate repeat testing.



The faster results and simpler testing technology make it easier to reach high-risk, hard-to-reach populations, such as intravenous drug users who may not use health care services regularly. Despite these benefits, concerns have been raised about the potential for harm.[2] Ease of testing might lead to people being tested without their voluntary, specific, informed consent. Prospective situations where this might happen include the testing of pregnant women in labour, the testing of patients before medical care is provided and the testing of patients to avoid the necessity of postexposure prophylaxis. — *Erica Weir*, CMAJ

References

1. Point-of-care HIV testing using simple/rapid HIV test kits: guide for health-care professions. CCDR 2000;26(07). Available: www.hc-sc.gc.ca/hpb/lcdc/publicat/ccdr/00vol26/index.html (accessed 2000 May 1).
2. Canadian AIDS Society and the Canadian HIV/AIDS Legal Network. *Rapid Testing for HIV: What are the Issues?* Ottawa: The Society; 1999. Available: www.aidslaw.ca/elements/Testing/rapidtest.html (accessed 2000 May 1).

Alberta ignores vocal opposition, presses ahead with law to expand role of private clinics

Richard Cairney

Warm weather brought out more than the tulips in Alberta this spring, as thousands of demonstrators — including a well-known Hollywood actor — took to the streets to protest the province's controversial legislation to regulate the contracting out of surgical services to private, for-profit clinics.

Not that the demonstrations did any good. Bill 11, the Health Care Protection Act, was expected to become law by mid-May after Premier Ralph Klein invoked closure on debate in the legislature May 1. The bill, which expands the role of private-sector clinics within the public system, not only drew fire from opponents across the country but also divided physicians and had protesters describing Klein as "a fascist."

Critics say the bill brings Canada closer to a two-tiered health care system, sets a precedent under the North American Free Trade Agreement that would allow American health care firms to set up in Canada, and does nothing to address the underlying problems that are causing long waiting lists for surgery. The bill's vociferous opponents said the bill would, in effect, allow the formation of private hospitals. And they accused Klein of playing loose with language: the legislation refers to approved surgical facilities, but critics say these are, in fact, hospitals.

Canapress photos

Actor Kiefer Sutherland addresses Bill 11 protesters during mid-April protest in Calgary

Bill 11 (www2.gov.ab.ca/healthfacts/index.cfm?PnM=Legislation) proposes a new regulatory structure for private surgical facilities. The province's 17 regional health authorities will have to follow the new rules when establishing contracts for private surgical services. The bill also expands the role of private-sector clinics, allowing them to perform more complicated procedures that require overnight stays. At present, only relatively minor day procedures, such as cataract surgery, are permitted.

The bill would prohibit queue jumping and charging patients extra for enhanced services; the private firms would charge the province itself for any extra costs. And the act would allow such contracts to exist only if they improve access to health services or if they are cheaper than in the public system. Surgeons are allowed to work in the public and private sectors but would be paid the same fees in either system.

Opposition has come from groups as diverse as the Consumers' Association of Canada, Alberta's Catholic hospitals, the Raging Grannies, unions, municipal governments, grass-roots organizations like Alberta's Friends of Medicare (www.savemedicare.org), the Canadian Health Coalition (www.healthcoalition.ca) and the Alberta Medical Association (www.amda.ab.ca).

Dr. David Bond, president of the 6000-member AMA, says the province needs to focus on providing the public health system with adequate resources. He argues that contracting for services doesn't make sense when a shortage of medical staff is at the heart of surgical waiting lists.

"We are saying that we don't believe this bill actually protects anything and that it does not get to the root of the problems we have in terms of providing services to our patients," says Bond. Those problems, he adds, have more to do with a lack of infrastructure: nurses, physicians, operating rooms. And the bill focuses only on one small area — facilities outside of the hospital.

Many of the bill's critics, including the AMA, are worried about conflicts of interest. In particular, some opponents point to the strong connections between government-appointed members of the Calgary Regional Health Authority board, the region's medical staff and the ownership of private surgical facilities. Bill 11 makes no mention of conflict of interest, the premier says, because each of the province's health regions has its own conflict guidelines.

Bond says this isn't good enough. "This is a provincial health plan. Why should we have 17 different rules in 17 different regions? If you are an Albertan and you are covered by Alberta Health and Wellness, you get the same service and support whether you are in Edmonton or Lethbridge or Calgary."

Bond also argues that there's no way of knowing whether the surgical contracts are cheaper. With Bill 11, the surgical contracts will not be protected under the province's freedom-of-information legislation. This means that anyone can request the financial details. However, it is impossible to "price out" services in a public hospital because of confidentiality rules, meaning that it is also impossible to compare prices within the 2 systems. "If we don't know

what lab services cost in the public system, how the heck are we supposed to make a decision about whether it costs less to have it done in the private system?" Bond wonders.

Although he makes a strong case, some members of the AMA disagree with the association's opposition to the bill. Dr. Dennis Modry, head of the AMA's section of cardiovascular and thoracic surgeons and a longtime critic of medicare, says the province's 20 cardiovascular and thoracic surgeons disagree with the AMA and may quit the association over the issue.

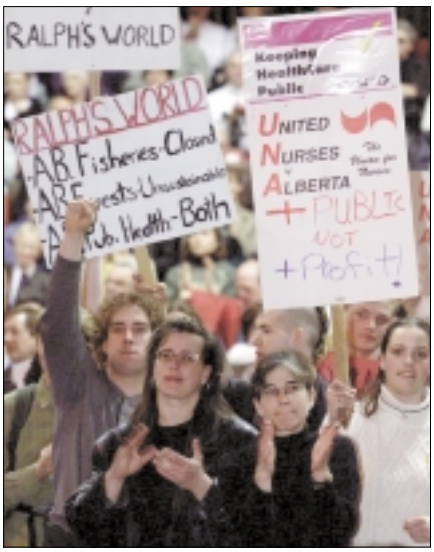
"With respect to Bill 11, we applaud the way in which the provincial government is looking for new, creative and innovative solutions to improving our health care system, in response to the federal health minister's challenge to the provinces to develop new ways of improving health care within the constraints of the Canada Health Act," Modry said in a statement issued shortly after the AMA criticized the bill.

However, such public expressions of support for Bill 11 have been few and far between. In Edmonton and Calgary, public rallies against the bill drew thousands of people, who flocked to hear speeches by Shirley Douglas; her father, the late Saskatchewan premier Tommy Douglas, is considered the father of Canada's medicare program. Her son, actor Kiefer Sutherland, also appeared at the rallies to fight the bill.

In an interview with *CMAJ*, Sutherland said the federal and provincial governments seem to have abdicated responsibility for health care by cutting funding. "We have to take responsibility for the welfare of others," he said. "We have evolved to a level of society, I hope, where that is true. We have a health care system in this country that exemplifies that and I've watched it slowly, over the last 20 years, be stripped down to the bare minimum and to the point where people are now saying it doesn't work. Well of course it doesn't work — it's not being funded properly. I have a huge problem with politicians who have been going against the wishes of their constituents and have been bloodletting the system for 20 years and now say it doesn't work and that we have to go private."

The rallies in Alberta's 2 largest cities were followed by growing protests at the provincial legislature in Edmonton. Although for the most part peaceful, Edmonton police showed up in force to monitor the impromptu rallies. As politicians debated the bill inside, some protesters entered the building through a ground-floor window, another window was smashed and a police van had a tire slashed. More legislature gatherings were held in early May. Elsewhere, the Raging Grannies — a vocal group of social activists — held a funeral for Bill 11 outside the office of Health Minister Halvar Jonson.

Despite the vocal opposition, Klein was determined to pass the bill — even if it meant invoking closure to end the debate. Bond said the AMA wouldn't have a problem with that, as long as a few key amendments were made first.



Protesters rally at legislature in Edmonton

"The split isn't quite as big within the profession [as it is among the public]," he said. "As soon as the word private is in there, and contracting out, people have concerns. Contracting is an integral part of the system, and we do it now for all sorts of services. I am sure the minister of health wants regulations over private clinics because there aren't many now. But we are hoping that what this will do is make sure these facilities meet the standards that are set for everything else. More importantly, we want to be assured the money that goes to these facilities is being spent in reasonable, rational ways."

Richard Cairney is an Alberta journalist.

Will litigation become part of public health arsenal in Canada's war against smoking?

Barbara Sibbald

Mammoth US legal settlements against the tobacco industry, such as a recent $6.9-million award in Florida that opens the door to a $300-billion payout for 500 000 smokers, are good news for Canada antismoking advocates. Why? Because the US lawsuits have pried loose some 39 million pages of internal tobacco company documents (**www.cctc.ca/ncth/guildford**) that are essential to a Canadian class-action suit and suits brought individually. As a result, the law may eventually become as big a weapon in the public health war against smoking in Canada as it is in the US.

These internal documents include 7 million pages from the British-American Tobacco Co. Ltd. (BAT), which owns Canada's leading cigarette manufacturer, Montreal-based Imperial Tobacco Ltd. Imperial controls about 70% of the Canadian market with brands such as du Maurier and Player's.

These documents show, among other things, that cigarette manufacturers deliberately engineered cigarettes to be the most efficient "nicotine delivery device" possible. According to a 1995 Health Canada report, nicotine levels in Canadian cigarettes have increased by 53% since the early 1970s.

Barbara Sibbald photo

MDs should tell patients they diagnose with terminal, smoking-related diseases that they have a right to compensation from the tobacco industry.

Although US courts award settlements based on these kinds of facts, Canadians are just starting to adopt the litigation process. Andreas Seibert, a lawyer with Sommers & Roth (**www.sommersandroth.com**) of Toronto, devotes all his time to a smoking-related class-action suit and 2 private lawsuits that dovetail with the class action.

Seibert is "very confident" about the ultimate success of the class-action suit. *Caputo et al* v *Imperial Tobacco Limited et al*, filed in 1995 and maintained by 4 plaintiffs, including David Caputo, could ultimately benefit about 2 million Ontario smokers and their families. (Everyone who fits the definition and is approved by the court will automatically benefit from the decision at trial. There is no need to contact the law firm.)

A number of pre-trial procedural hearings have already taken place, and a judge is expected to decide by year's end whether to certify the lawsuit as a class action. The defendants, Imperial Tobacco Ltd., RJR-MacDonald (now JTI-MacDonald) and Rothmans, Benson & Hedges Inc., are all controlled by foreign tobacco multinationals.

Seibert is also counsel for 2 individual liability lawsuits for the same party. *Spasic* v *Imperial Tobacco and Rothmans, Benson & Hedges Inc.* was Ontario's first individual tobacco-products liability lawsuit when it was launched in May 1997; a second suit was brought against British-American Tobacco and its Montreal subsidiary, Imperial Tobacco, in September 1997 after new evidence was revealed about the relationship between the companies. Mirjana Spasic died of smoking-related lung cancer in February 1998 but her estate is pursuing the lawsuits. Seibert says Spasic launched the suit because she was in poor health and didn't want to wait for the class action to proceed.

In all 3 cases, the plaintiffs are alleging negligence, negligent misrepresentation, deception, conspiracy and strict product liability (which means that the product used was defective). Seibert doesn't expect the defendants in any of the cases to settle without a trial. And if he proves liability, it will set a "strong Canadian precedent."

He plans to rely on the tobacco documents, which he says suggest that cigarette manufacturers had "sophisticated understanding of their product and its risks . . . and that they failed to disclose to their customers.

"From what I've seen, they've misleadingly stated the state of affairs regarding their knowledge and internal beliefs about the product. They knew, they've known [about the dangers] for a long time."

The tobacco companies deny this. In fact, their principal argument in the US cases was that they do not know of proof that smoking causes disease. At the same time, they also argued that the complainants knew smoking caused disease so they shouldn't be allowed to take action.

"We intend to hold them to this duality," Seibert said in an interview. "We don't intend to let them get away with this argument. I find it repugnant."

His cases aren't the only Canadian civil actions being brought against cigarette manufacturers. Quebec courts are

looking at a potential class-action suit, *Fortin* v *Imperial Tobacco*, and provincial governments in BC and Ontario are also trying to win civil suits against cigarette manufacturers (see *CMAJ* 162(10);2000:1468). The BC case against 3 Canadian tobacco companies was recently relaunched.

The federal government is also gathering information. Last November federal Health Minister Allan Rock hired Dr. Jeffrey Wigand, former head of research at the US subsidiary of British-American Tobacco Co. Ltd. and the famous whistle-blower in the movie *The Insider*, to interpret the tobacco documents.

Imperial Tobacco's profit per pack of cigarettes increased from 32 cents in 1991 to 60 cents in 1998.

The US government and 47 states sued the industry to recover Medicaid costs for treating sick smokers, and reached a settlement worth $246 billion in 1998. "The fact that they settled, and that it was the biggest settlement ever in business history, indicates they didn't want to be exposed at trial," says Garfield Mahood, executive director of the Ottawa-based Non-Smokers' Rights Association.

He says the lower awards in Canada is one reason fewer resources are put into this type of litigation. The massive US government case involved 50 law firms, which put up $100 000 each per year, thus "leveling the playing field" with the profitable tobacco industry. He says Canadians haven't made litigation a priority; instead they've focused on increasing tobacco taxes, controlling advertising and other ways of addressing smoking behaviour itself, rather than the results of that behaviour. Recent cases indicate, however, that Canadians may be getting more litigious. "If [Seibert] is successful [litigation] could attract a lot more attention as a public health strategy," says Mahood.

He urges physicians to tell their patients who are diagnosed with terminal smoking-related diseases that they have the legal right to compensation from the tobacco industry. "For years the tobacco industry had common law duty to warn customers of all the risks of tobacco — 20 terminal diseases — and the magnitude of that danger," he added. The RCMP are currently investigating several possible charges of criminal negligence against the tobacco industry.

Meanwhile, Canada's $3.8 billion tobacco industry continues to profit. Imperial Tobacco had annual sales of $1.7 billion in 1998 and profits of $815 million. Its profit per pack of cigarettes increased from 32 cents in 1991 to 60 cents in 1998.

Barbara Sibbald is CMAJ's *Associate Editor, News and Features.*

Dr. Martin pushes private medicine, but not even Reformers appear to be listening

Charlotte Gray

"If you really want to ruin your health," Dr. Keith Martin remarked facetiously, "try a political campaign. Bad food, not enough sleep, too little exercise, different motels every night."

So why is he doing it? Why did the 39-year-old MP from British Columbia, who still does the occasional stint in a BC emergency room, decide to enter the race for the leadership of the Canadian Reform Conservative Alliance, which is replacing the Reform Party? Particularly when 3 of the other 4 candidates in the race have political machines behind them that are so powerful that they keep knocking Martin's tired old jalopy off the track.

"Without this reform, we're going to slam into a brick wall."

But Martin insists that he is in the race to win. "I'm a pragmatist. I recognize that other machines are bigger than mine, but this is a marathon, not a sprint, and things may look quite different after a 2-and-a-half month campaign."

Few observers believe that Martin, who had raised only $100 000 by late April, can overtake his opponents. But they are taking a serious look at the centrepiece of his electoral platform, which makes him a more policy-oriented candidate than his rivals. Martin is pressing for health care reforms that would allow physicians to develop private practices as long as they commit 30 to 40 hours a week to the publicly funded system. He insists that if doctors' hours were regulated this way, medicare would not become the home of second-rate medicine.

In recent appearances before editorial boards, he argued that only dramatic structural change can save the existing system. "A parallel system will free up resources within the public system. Without this reform, we're going to slam into a brick wall."

Martin is convinced that his campaign has already had an impact in 2 provinces: Alberta Premier Ralph Klein has introduced legislation to permit private hospitals, and Saskatchewan Premier Roy Romanow has called for a national dialogue on what services medicare should provide. "Premier Romanow is even using the same language as me, about slamming into a brick wall if we don't make changes," says Martin.

But it is doubtful that either premier actually took their cue from the little-known Alliance candidate — their solutions for the funding crisis are quite different from those proposed by Martin. However, he is not discouraged because he sees the medicare debate finally breaking out of the old boundaries. "All the 'politically incorrect' stuff I've been saying for months about a parallel private system is now becoming part of the mainstream. Everyone else is getting beyond the idea that more money from Ottawa can fix our current system."

If Martin is elected leader of the Canadian Alliance, he would be the first physician to head a federal party since Sir Charles Tupper led the Conservatives in 1896. He would also give his own party a very different image from that presented by the other contenders. Martin does not share the fundamentalist religious views of his Alberta rivals, Stockwell Day and Preston Manning, and he does not have the go-for-the-jugular instinct of his Ontario competitor, Tom Long.

Most important, a Martin-led Alliance would offer Canadians a real choice in terms of what health care system they want. But if the recent noisy demonstrations in Alberta are any indication, his is a choice resoundingly rejected by most Canadians. In fact, his policy platform reflects how out of touch he is with both voters and his own party.

Talking to Martin, it quickly emerges that he defines his constituency somewhat differently from his competitors. He talks of attracting "disaffected Liberals and New Democrats, who want to see government living within its means, but who also want strong social programs." Meanwhile, his Alliance competitors want to attract Ontario Tories and deliver Canada's largest province to the new party. And strategic thinkers among their supporters know that Martin's health care proposals may be interesting, but they won't sell politically. "He's talking about a totally private system, privately funded, where the rich people can go off and do their own thing and, [with] poorer people left with poorer doctors and poorer facilities," says Bob Mills, the Alliance health critic. "I could not sell that politically — I wouldn't even try."

At his campaign Web site, Martin invites visitors to support his proposals. "It takes brave Canadians to stand up to the status quo and support brave new ideas for the Confederation." By mid-campaign, Martin had a scattering of supporters across the country, but he had not gathered much momentum because none of his fellow Alliance MPs had endorsed him. Meanwhile, whoever does emerge as leader of the Canadian Alliance will never adopt Martin's proposals for medicare reform. Politically, they're too dangerous.

Charlotte Gray is a contributing editor at CMAJ.