We will consider for publication only letters submitted in duplicate, printed in letter-quality type without proportional spacing and not exceeding 450 words. All the authors must sign a covering letter transferring copyright. Letters must not duplicate material being published elsewhere or already published. We routinely correspond only with authors of accepted letters. Rejected letters are destroyed. Accepted letters are subject to editing and abridgement.

Seules peuvent être retenues pour publications les lettres reçues en double dont la longueur n'excède pas 450 mots. Elles doivent être mécanographiées en qualité “correspondance” sans espace proportionnel. Tous les auteurs doivent signer une lettre d’accompagnement portant cession du copyright. Les lettres ne doivent rien contenir qui ait été présenté ailleurs pour publication ou déjà paru. En principe, la rédaction correspond uniquement aux auteurs des lettres retenues pour publication. Les lettres refusées sont détruites. Les lettres retenues peuvent être abrégées ou faire l’objet de modifications d’ordre rédactionnel.

CMA’s response to abortion bill

Patrick Sullivan’s summary of the CMA Board of Directors’ discussion of the abortion legislation, “CMA board finalizes response to federal abortion bill” (Can Med Assoc J 1990; 142: 147-149), would have made me laugh if it hadn’t made me so sad. It is ironic that the board members think they can change the reality of abortion by disguising it in euphemisms.

Sullivan states that the CMA brief on Bill C-43 “will restate physicians’ opposition to the placement of abortion — a medical procedure — in the Criminal Code. The CMA says abortion is the only medical procedure accepted such treatment.” The fallacy in this argument results from lumping together acts that cannot be considered equivalent. Most medical procedures are morally indifferent. They are good if performed well, on the right patient, for the right reasons; they are bad if performed carelessly or unnecessarily. The case of abortion is not so simple, no matter what one’s moral beliefs are.

In the past, in the laws of most countries, abortion was classified with other acts that terminate an innocent human life. It was therefore included in our Criminal Code. For reasons that are beyond me, society has made a complete about-face in the last few decades: abortions are now done in the open, by physicians, in hospitals, and they are paid for by the government. This change in attitudes does not change the intrinsic nature of the procedure.

Abortion should remain in the Criminal Code where it belongs.

Catherine Ferrier, MD
257, rue St-Jacques
Ville St-Pierre, PQ

The recent decision of the CMA Board of Directors to approach the House of Commons legislative committee in regard to the proposed abortion law is not a bad idea; it’s just that the reasoning is unimaginable, and the conclusion the board has reached is outrageous.

The board’s decision to regard abortion as a medical procedure and therefore free of any criminal activity is nonsense. This statement alone is completely contradictory to what the CMA taught only 20 years ago.

It is true that no other “medical procedure” is mentioned in Canada’s Criminal Code, but then again there is no other “medical procedure” like abortion. Abortion remains what it has always been: the destruction of innocent life. As a medical procedure it shares company with the foulest of deeds.

That an “ethicist” should have the nerve to say that the bill “threatens the nature of the doctor–patient relationship” without addressing the right of such an act is a disturbing comment about our present-day ethics. If such reasoning were followed, any act, no matter how horrific, could be guarded in the “sacred” rooms of the physician. What will be done when counselling for suicide is seen as a right to be protected in a physician’s office or when a child wants to know what pills should be given to his or her elderly parent to end the parent’s life? Will such information and transactions become acceptable and protected merely on the basis of the doctor–patient relationship?

And that a former head of a provincial medical association could state that “a lot of us don’t like abortion, but we recognize it is better done [by a physician]” is incredulous. Does the insanity of such a thought escape everyone? Are Canadians to believe that abortion should become an acceptable procedure in hospitals because physicians kill best?

Is there anyone left thinking clearly at the CMA? Can there be any intelligible argument for abortion? Must it now be thought that even an official body of the medical establishment sees abortion as a given? If the mother won’t protect her child, and if the doctor

* For prescribing information see page 673

CAN MED ASSOC J 1990; 142 (6) 515
won't protect the child, who will?

The CMA ought to be going to the Commons committee not to influence a law so as to protect itself from pressure groups or because it fears the law "standing in the wings" but in the tradition of medicine. It ought to go to protect the mother and the child. At least then such a pursuit would be noble and right, if not popular.

Donald Jansen, MD
Ile du Grand Calumet, PQ

Medical care is not fully portable for Quebecers

Fully portable medical care in this country was guaranteed by the Canada Health Act in 1984, but over 6 million residents of Quebec and recent immigrants from Quebec are deprived of this because of the unwillingness of the Quebec government to comply with the federal law.

Of the three main groups affected the first consists of patients in west Quebec seeking medical services in Ottawa. The problem has been partially resolved by an agreement effective Nov. 1, 1989, that provides for specialized services such as cardiac catheterization and dialysis and for emergency services. However, it fails to cover elective visits to general practitioners or most internists as well as work done in private laboratories. The unfairness of this situation has been exacerbated by the new employer health tax (which replaces Ontario Health Insurance Plan [OHIP] premiums), to be paid to Queen's Park on behalf of all employees working in Ontario, even the thousands who reside in Quebec.

The second group consists of Quebec patients travelling in other parts of Canada who unexpectedly become ill. Private insurance companies usually will not cover a person over age 71 years or those with complications from a previous illness, such as a heart attack in a person with previous hypertension or angina pectoris.

The third group consists of Quebec patients who move to other provinces. Last year nearly 28 000 people moved from Quebec to Ontario, and 41 600 moved to all parts of Canada. During the initial 3-month waiting period these people would be covered only by Quebec insurance and thus would have to pay out of their own pockets and await partial reimbursement — unless they could find a physician or laboratory that would accept 30% to 60% of the normal fee. Many of these people would need to see a physician during the first 3 months, if only to renew a prescription. In Ontario the employer of a new arrival from Quebec would pay the new employer health tax from day 1, although the employee would not be covered by OHIP until day 91.

This situation is absurd, illogical and unfair to both patients and physicians. Quebec patients will increasingly feel that they are second-class citizens who have to beg for charity in order to receive medical care outside their province. Physicians justifiably expect to be paid the normal fee in their province and would resent being shamed into giving a discount, particularly with the knowledge that this would indirectly be subsidizing the Quebec government.

I have suggested to premiers McKenna and Peterson that Quebec's signature on the Reciprocal Medical Billing Agreement should be one of the preconditions for the Meech Lake Accord. Such a symbolic concession by Premier Bourassa might begin to resolve the present stalemate. The medical care problem has nothing to do with language rights, and its solution would entail about a dollar a year in extra taxes for each Quebec citizen.

Should Bourassa still refuse to bring his citizens into the national medicare program, then I believe that he would be sending a very loud message to English Canada — that perhaps the divisive forces in Sault Ste. Marie and other Ontario communities are right.

Charles S. Shaver, MD
205–3029 Carling Ave.
Ottawa, Ont.

"Clawback" on medicare benefits: Solution to underfunding?

For some time now it has been apparent that the funding of our health care system is totally inadequate. This has resulted in a number of unreasonable delays due in part to shortages of new equipment and facilities and inadequate maintenance or lack of replacement of older equipment. One of our local radiotherapy machines is affectionately called "old wheezy" by cancer patients, who are frequently sent home because it is out of order.

The greatest stumbling block to additional funding is the need to maintain the universality of medicare. Fortunately, we have a precedent for maintaining universality and increasing funding: the "clawback", by means of which universal benefits such as pensions are taxed back at the recipient's marginal tax rate.

Suppose that the value of all goods and services provided by medicare were to be considered as a taxable benefit. The data would be readily available on government computers. Medicare benefits could be taxed at the individual's marginal tax rate. People who do not pay taxes, such as the poor, dependent children and spouses, and certain pensioners, would not be affected. To prevent financial hardship there would have to be a