of Seven to pursue their art and exhibits. In fact, in his time he was considered the most outstanding ophthalmologist in Ontario. His first position at the university was as lecturer in pharmacology and therapeutics, and he also assisted the professor of gynecology. He then did postgraduate ophthalmic study in London, England, before returning to work at the Toronto General Hospital and the Hospital for Sick Children. He was professor of ophthalmology at the University of Toronto from 1914 to 1929, published widely on ophthalmologic conditions and represented the university on the council of the College of Physicians and Surgeons of Ontario.[1] His patronage of the Group of Seven was without a doubt his major legacy.

Wilton's article on corneal transplants alludes to the university but neglects the important role it played in establishing the Eye Bank of Canada (Ontario Division) in conjunction with the Canadian National Institute for the Blind (CNIB). The concept of a Toronto eye bank arose during a discussion between Col. E.A. Baker and Professor A.J. Elliot in May 1950.

The CNIB contributed $500 to the university's Department of Ophthalmology to help establish the eye bank. Its first medical director was Dr. Hugh Ormsby, who obtained funding from the federal health department in 1955 and established research programs in corneal transplantation under Elliot. In 1959 Elliot appointed Dr. P.K. Basu Stapells director of ophthalmic research. Anne Wolfe, who managed the eye bank and built up the donor system, eventually handed management responsibility to Dr. Marilyn Schneider, and Fides Coloma succeeded Schneider in 1996. Dr. David Rootman has been responsible for directing the bank since 1991, and Professor William Dixon, the senior medical adviser, maintains close links between the bank and the CNIB. Since 1966 the eye bank has been funded by a Ministry of Health contract grant and an operational grant from the CNIB. It is the only transplantation program housed on site at the University of Toronto.

The ophthalmology department is proud of its historical links to the Group of Seven and its continuing links, via the Eye Bank of Canada, with the CNIB and the provincial government.

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The other side of the great divide

After reading "MD crosses great divide when moving between practices in Canada, US" (*Can Med Assoc J* 1996;155:1599-600), by Charlotte Gray, I feel obliged to respond. The article dealt with a plastic surgeon who practises on both sides of the Canada–US border. For the past 5 years, I have practised on both sides as a general practitioner.

In the winter I work part time for a nonprofit corporation that operates community clinics in 3 counties in South Central Florida. They provide care to low-income Americans. In the summer I do part-time work as a locum in my former practice in Ontario, where I spent 35 years in general practice.

In Florida, medical care is excellent if you can afford it. The community clinics have excellent providers, including board-certified specialists, general practitioners and nurse practitioners. Although primary assessments are reasonably complete, progression to more sophisticated studies such as echocardiograms, contrast studies of the gastrointestinal tract and endoscopic examinations require a cash outlay that most patients cannot afford. Even recipients of Medicaid, which provides care for destitute Americans, encounter difficulty, since specialists often refuse to accept these patients. For emergencies, hospitals make all modalities, such as MRI and CT, available.

For the patient population I serve in Florida, my treatment decisions are almost always severely restricted by the patients' poverty. Although great publicity is given to campaigns encouraging women to have an annual mammogram after age 50, for most of our patients the fee of $60 or more is a real financial strain.

When I see patients in Canada, I know they will be seen by a specialist regardless of their income. A mammogram can be ordered without cost. In Ontario, patients are required to wait for bypass surgery due to overburdened facilities. In the US this procedure can be done promptly, but I have treated patients whose delay in having the surgery was due to their inability to pay. Meanwhile, they remained cardiac cripples. As a Canadian physician, I cherish the freedom to treat patients without concern for their ability to pay.

As a provider and a user, my plea is that the beleaguered Canadian health care system does not become Americanized into a two-tier system.

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Revisiting Rick: more bad news on the HMO front

Last year, during one of my periodic visits to Los Angeles, my friend Rick (as I have been calling him), a primary care physician, recounted some of the difficulties he ex-

perienced while working for one of California's largest health maintenance organizations (HMOs). I wrote a letter to the editor of *CMAJ* concerning his warnings about the risks of corporation-style health care ("US physician warns Canadians about privatization," *Can Med Assoc J* 1996;154:142-3), and a series of letters followed.

I just returned from Los Angeles, where Rick updated me about further developments in the world of US managed care. He resigned his HMO staff position after his role as chief of staff at his health care centre was eliminated and supervisory responsibility was relegated to department heads who worked from a central location, and not at the branch level.

The final impetus for his resignation was the untenable decision that the scheduling of his patients, many of whom were elderly, would be done centrally. He therefore had no control over how his clinical practice was scheduled. He discovered that expectations concerning his "productivities" — the managed-care term for patient encounters — were ever increasing. However, no one in administration was sympathetic to his concerns about the negative impact on patient care of the common practice of double-booking the allotted 15-minute appointments. He learned after his resignation was submitted that appointment times were being reduced to 10 minutes.

Soon after Rick tendered his resignation, Dr. Gigi Hirsch, director of the Centre for Physician Development at Boston's Beth Israel Hospital, reported in *AMNews*, the weekly newspaper of the American Medical Association, that many managed-care physicians were experiencing work-related stress syndromes due to lack of control over scheduling.[1] As Hirsch wrote, "this inflexible scheduling system made it extremely difficult and unnecessarily stressful to take good care of patients," and "adverse working conditions may be undercutting one of the core strengths of American medicine — the high quality and personal commitment of its physicians."

Rick's experience is common and reflects the result of the "corporatization" of US health care, the natural consequence of privatization in a free-market economy.[2–5] Although many in Canada believe that we can develop a system that avoids the pitfalls that exist in the US, they must consider the strong pressures the US health care industry will bring to bear on Canada, and the fact that the North American Free Trade Agreement may make protection from US influence impossible.[6,7]

We should be able to find solutions to our health care challenges without sacrificing the principles of equity and justice for patients and autonomy of practice for physicians that are embodied in our single-payer system. It would be shameful if Canadians were exposed to the possibility of risk to our medicare system, however remote, as an illusory solution to the financial and structural problems that we will face in years to come.

Rick's real name is Vic Wylie. He did not want his name used in my original letter because of his concern that divulging it could result in his dismissal, an occurrence that is not uncommon because of the "gag-clause" mentality in the managed care industry.[3]

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