Venous Thrombosis and Pulmonary Embolism

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AS long as twenty years ago, the long femoral veins of the legs were coming under suspicion as the source of most pulmonary emboli. The more courageous surgeons of that time undertook sporadically the interruption of these veins to prevent further emboli in a situation where venous thrombosis was obvious.[1], [2]. Through the years, more and more attention has been attracted to these veins, chiefly through the anatomical work of Hunter and associates[3] and the clinical pioneering of Homans.[4] Over the past five years, a welter of literature has appeared, the result of a better understanding of the mechanism of a catastrophic syndrome which is remediable by a relatively simple form of treatment. Much is still to be learned about thrombosis and embolism, but with the intelligent use of the therapeutic weapons available, anticoagulants and femoral vein interruption, and vigilant prophylaxis against thrombosis, fatal embolism should become less conspicuous in any group of mortality statistics.

It is not amiss at this point to mention that at the Massachusetts General Hospital there are as many post-operative fatal emboli seen on the autopsy table to-day as there were fifteen years ago. The reasons for this apparent lack of progress become obvious, however, when we consider surgery to-day as against fifteen years ago. Perhaps the chief factor in this apparent discrepancy is the fact that patients are kept alive longer following major surgery. The liberal use of blood transfusions, chemotherapy, antibiotics, and other modern adjuncts have resulted in patients living 10 to 12 days following major surgery to the time when fatal embolism is most likely to occur. As pointed out elsewhere,[5] increasing age, magnitude of operations, and incidence of cancer have been other factors responsible for the persistence of frequency of post-operative embolism. Another reason, is the reluctance of many of the staff to institute prophylactic measures in their highly vulnerable private patients. In the lifetime of the average surgeon unheralded fatal embolism occurs not too frequently, and it is difficult to learn from experience of the group as a whole. Finally, the frequency of autopsy permissions has risen, particularly in the private wards of the hospital, where embolism from quiescent phlebothrombosis is apt to occur.

We admit an accurate comparative study is difficult from year to year, and only an estimate of the value of measures of prevention available today is possible. Yet certain definite facts are becoming established.[6] The *age* of the patient is probably the one important factor often ignored. Age in years can often be considered a fairly accurate guide as to the frequency of embolism. Infirmity with its influence on muscular activity plays an important role in initiating phlebothrombosis, although it is obvious that some patients relatively young may be more deteriorated than those of an older age. *Trauma* involving the lower extremities has also become established as a predisposing factor to thrombosis of the veins. A simple sprain or an abrasion in an ambulatory patient may initiate a particularly malignant and persistent type of thrombosis. As interest in embolism has increased, fatal catastrophies in postpartum patients seem to be less frequent. This may be a relative decrease

or may be due in part to earlier ambulation on the part of attending obstetricians

Then there is a group of surgical post-operative conditions influenced by the patients' disease and the magnitude of the operation, which are becoming recognized as potentially susceptible to death from embolism. In general, *malignancy*, itself is an important predisposing factor, even in its inoperable phase. Abdominal visceral malignancy, particularly of the stomach and colon, carries a relatively high likelihood of embolism. In the past five years, nearly 50 per cent of the fatal emboli at the Massachusetts General Hospital were in patients harboring cancer. *Acute abdominal infections* particularly with ileus, are often associated with thrombosis and embolism. It is possible that the abdominal distension itself with resulting distal venous congestion, may be the mechanism here; although it is obvious that depleted patients from any cause whatsoever are more subject to thrombosis than are those in good general condition. Patients undergoing partial leg amputation, low thigh amputation in particular, and operative or unoperative treatment of fractures of the leg and hip region have been found most susceptible to insidious thrombosis and fatal embolism. It has been found that cardiac patients, as well as other medical patients with circulatory congestion resulting from sedation and bed rest in a sitting position, are common victims of this disease. [7]

Prophylaxis

In the future more attention will become directed at prevention or prophylaxis against thrombosis and embolism. With the accumulation of data, our prognostic accumen should become more accurate and adequate measures undertaken before the disease begins, or at least has progressed to the stage of disastrous embolism. At the present time interest in most clinics is directed at the treatment of the disease once established, rather than at the more remunerative and life-saving measure of prevention. The Scandinavian countries in particular have been more progressive in this phase of the problem and have reported effective results. [8,9]

Only in the past eight or ten years have preventive measures been stressed in this country. A definite lowering in the incidence of embolism has resulted from the utilization of the many well known pre- and post-operative general measures. Elimination of statis in the leg veins by bandages and posture, muscular activity in bed and early walking are all helpful and generally practised. In 1943, superficial femoral vein interruption was introduced as a prophylactic measure. This resulted from the previous observation of the relatively innocuous results from routine interruption of the well leg in patients who had unilateral established thrombophlebitis. Early in the era of thereapeutic vein interruption for obvious phlebitis, it became evident that some patients with unilateral interruption died from embolism from the well leg. Bilateral femoral vein interruption became the established practice in this group, and in the well leg it was considered a prophylactic measure. With the accumulation of information concerning thrombosis susceptibility, it became clearer that in certain groups, chiefly dependent on age, disease, and operation, if any, a preventive femoral vein interruption was not only rational but also a safe procedure. As can be noted in Table I, this procedure has gained increasing popularity, and will probably comprise fifty per cent of the vein operations in this Hospital in the future.

TABLE I

INCIDENCE OF THERAPEUTIC AND PROPHYLACTIC FEMORAL VEIN INTERRUPTION IN 2131 CASES

Massachusetts General Hospital

1937-1947

	Therapeutic	Prophylactic		Total
1937-1942	202	0	0%	202
1943	150	15	9%	165
1944	208	72	26%	280
1945	214	178	45%	392
1946	259	289	53%	548
1947	227	317	58%	544
Total	1,260	871	....	2,131

We realize the inadequacies of any such comparative series as shown in Table II. Search through the hospital files for cases comparable as to age, sex, hospital division, disease, and operation, has given an indication of the value of this prophylactic measure. It has not always been possible to compare similar cases in the same years, particularly in the leg amputation or hip fracture groups, as in later years the practice of femoral vein interruption has become universal in these diseases, and it was necessary to search back in the files prior to the year 1943.

TABLE II

COMPARATIVE INCIDENCE OF POSTOPERATIVE THROMBOSIS AND EMBOLISM

Older Age Group of Patients

1943-1947

	Number of cases in each group	With Prophylactc Vein Interruption		Without Prophylactic Vein Interruption	
		Phlebitis	Fatal Embolus	Phlebitis	Fatal Embolus
Fractures Hip Region	130	3	0	23	10
Leg Amputation	92	1	1	6	8
Colon Operatons	111	5	1	16	6
Gastric Operations	94	7	1	9	4
Resection Rectum	52	2	0	11	2
Genito-Urinary Surgery	50	4	0	3	2
Biliary Surgery	74	2	0	8	1
Pelvic Surgery	46	0	0	4	1
Hernioplasty	41	2	1	3	1
Sm. Bowel Obstruction	21	3	0	2	1
Neuro Surgery	7	0	0	0	1
Appendectomy	24	1	0	2	0
Heart Disease	23	0	0	4	0
Radical Mastectomy	20	0	0	1	0
Pancreatic Surgery	15	2	0	4	0
Esophagectomy	12	0	0	2	0
Miscellaneous	59	3	0	4	0
Total	871	35	4	102	37

Because of medicolegal jurisdiction, autopsy was not possible in all deaths following hip fractures.

In 4 of these 871 particularly vulnerable patients treated by prophylactic femoral vein interruption, fatal embolism occurred. In three of these there was no past or present evidence that thrombosis was already established before femoral vein interruption was undertaken. The embolism in one of these may have originated in the proximal segment of the superficial femoral vein left in situ. Deflnite extension into the profunda femoris was found in one and this we believe led to the large propagating thrombus in the iliac veins of sufficient magnitude to cause death. We feel that the dangers of interruption of the common femoral is greater than that of fatal embolism orginating in the profunda femoris. Also it seems clear that the superficial femoral should be interrupted as close to the profunda as is technically possible, so as not to leave a nidus for thrombus formation.

The fourth death in this group is definitely questionable from a prophylactic point of view, as the surgeon felt in retrospect that the thrombus was present in the iliac vein at the time of operation. The patient had been bedridden for twelve weeks with peripheral arteriosclerosis and died eight hours after simultaneous low thigh amputation and bilateral superficial femoral vein interruption. The pathologist felt that the clot was of a much older vintage than the time elapsed from operation to death from massive embolism.

TABLE III

EMBOLIC DEATHS SUBSEQUENT TO FEMORAL VEIN INTERRUPTION
Prophylactic

Age	Sex	Disease	Operation	Interval Between Vein Interruption and Death
67	M	Ca Sigmoid with Obstruction	Cecostomy, later Resection	16 days
54	F	Ca Stomach	Total Gastrectomy	34 days
63	F	Ventral Hernia	Repair	15 days
78	M	Arterio-sclerotic Gangrene	Thigh Amputation—12 weeks after Admission	8 hours

Within the last year or two there has been a marked increase in the use of the anticoagulant Dicumarol in the prophylaxis of thrombosis and embolism. Bruzelins[9] and others have reported brilliant results, and in this country E. V. Allen, et al,[10] and Smith and Mulligan[11] have come to champion its use. It is a cheap drug, in comparison to Heparin, it is easily administered, and its effect is fairly accurately measured by the Prothrombin content of the blood. It is a specific liver poison, however, and like any ingested drug it has dangers in that it cannot be readily retrieved, once administered. Certainly laboratory facilities for measuring its activity must at all times be at hand. Specific effective antidotes are found in large doses (72 milligrams) of Vitamin K and in whole blood transfusions.

We have come to rely more and more on the use of Dicumarol as a preventive to thrombosis in the last three years. In older patients, over the age of 65 or 70, who are more likely to bleed uncontrollably from arteriosclerotic vessels, particularly of the brain, we have elected the safer procedure of femoral vein interruption. Similarly, in hypertensive individuals, those with liver disease or diabetes, and those undergoing thoracic operation, we have forgone the

use of the anticoagulant in favor of vein interruption. Finally we are influenced somewhat by the likelihood of thrombosis relative to the primary disease, electing the surer prophylaxis of vein interruption in those patients with the greatest chance of embolism; namely those with hip fractures, those requiring thigh amputations, and some gastro-intestinal malignancies regardless of age. According to present day trends, Dicumarol may supplant the more laborious vein interruption in some of these groups.

It is of first importance that none of the 496 patients between the ages of 40 and 65 receiving prophylactic Dicumarol, died of fatal embolism. Phlebitis and infarction have occurred in a small percentage, and these have been protected by subsequent femoral vein interruption. In an earlier report it was possible to demonstrate in a controlled study of two similar groups of patients of middle age treated by small doses of Dicumarol post-operatively, that this drug was effective in reducing the incidence of thrombosis by 80 per cent.[12] More intelligent use of the drug, more frequent small doses, and the use of Heparin in resistant patients will result in a further reduction in the future.

TABLE IV

COMPLICATIONS OF PROPHYLACTIC DICUMAROL IN 496 PATIENTS
Massachusetts General Hospital

1945-1947

	With Response	Without Response	? Response	Total
*Minor Bleeding.....	12	0	0	12
*Major Bleeding.....	1	0	0	1
**Phlebitis.....	2	5	4	11
**Infarct.....	6	0	5	11
Fatal Pulmonary Embolus.....	0	0	0	0
Deaths from Delayed hemorrhage...	1	1	0	2

*Requiring Vitamin K or Transfusion.

**Requiring Femoral Vein Interruption.

Two fatalities are recorded, and in both cases criticism of the use of the drug is justifiable. They only serve to emphasize the dangers inherent in its use. One patient aged 57 was known to have a moderate hypertension, and on this basis alone probably should not have received prophylactic Dicumarol. He had a simple partial colectomy with primary anastomosis for a constricting carcinoma of the sigmoid. Two hundred milligrams of Dicumarol was given on the first post-operative day and fourteen hours later he had a large subarachnoid hemorrage. The prothrombin time eight hours later was only 20 seconds over a normal of 18 seconds. Vitamin K was given in 72 milligram doses as an antidote and daily prothrombin determinations carried out thereafter. His prothrombin time immediately fell to normal, but sixteen days later it was found to be 27 seconds. He continued to bleed into his subarachnoid space and, in spite of a carotid artery ligation, died. It seems very doubtful that the 200 milligram dose of Dicumarol with its usual delayed action could have influenced the original cerebral hemorrhage within fourteen hours after its administration.

The other fatality occurred in an 82 year old man who through error was given 200 milligrams of Dicumarol on the day following repair of an incarcerated hernia. A week previously he had had a transurethral resection of a hypertrophied prostate gland. There was a prolongation of prothrombin time to 26 seconds on the day following Dicumarol, and five days later he bled massively from the prostatic bed. In spite of blood transfusions and Vitamin K his prothrombin time was not reduced below 22 seconds. He bled on two other occasions in the next two weeks. The non protein nitrogen level of his blood reached 80 milligrams per cent, and 37 days after the single dose of Dicumarol, he succumbed. This patient represents the oldest to have received the drug, and like many of the older group his tolerance to it undoubtedly was low. To-day, Dicumarol is rarely given prophylactically to any individual over the age of 65. We feel that any patient in this age group who is going to be confined to bed rest for more than 48 hours following an operative procedure is most safely protected by prophylactic bilateral femoral vein interruption.

In general, to the group of patients between 35 or 40 to 65 years of age we have administered Dicumarol post-operatively as a preventative. Too little attention has been given to the details of use of the drug. We have found 200 milligrams to be safe initial dose, and 75 per cent of the patients have responded satisfactorily, as evidenced by the prothrombin time determinations.

TABLE V

RESPONSE TO 200 MGM. PROPHYLACTIC DICUMAROL

1947—254 CASES

	Good	Poor	Undetermined	Total
Single Dose	78	21	20	119
Multiple Dose	113	20	2	135
Total	191 (75%)	41	22	254

In all patients a pre-operative prothrombin time levelshould be recorded. On the morning following operation 200 milligrams of the drug is given by mouth. If a gastric tube is in place, the capsules are given about the tube, and suction is eliminated for two to three hours. Administring the powdered drug via Levine or jejunostomy tube is unsatisfactory because of its low solubility and the inevitable loss, and it is more effective to give the capsules by mouth. A prothrombin determination is taken in the morning two days later, and drug resistance will make itself evident on this reading. On the evening of this same day, providing there is a poor response, an additional 200 milligrams is given. Most patients, however, respond. Subsequent prothrombin time tests are carried out at 48 hour intervals, and an attempt is made to keep the prothrombin content of the blood between 50 to 30 per cent of normal until the patient is fully ambulatory at will. Most patients are wholly or partially bedridden for only a matter of four to six days, so that in the majority a single dose of 200 milligrams gives adequate protection. After considerable experience with the use of the drug, we have given up the expensive and time consuming daily prothrombin determinations, and feel that we can satisfactorily maintain a level between 50 and 30 per cent of normal by following the blood content every other day. This has made the project practical from a laboratory stand-point.

Treatment

As far as therapy of established thrombophlebitis with or without pulmonary embolism is concerned, we have developed the greatest confidence in superficial femoral vein interruption. Anticoagulants in treatment of thrombophlebitis at the Massachusetts General Hospital have been reserved for those few patients admitted to the hospital with a history of acute deep phlebitis dating back three or four days and with thigh swelling as evidence of extension of the process to the common femoral and iliac veins. Another small group of patients who have had pulmonary infarction following vein interruption, indicating the presence of thrombosis above the tie or phlebitis elsewhere have been given Heparin and Dicumarol.

The diagnosis of the thrombo-embolic syndrome is made on the basis of one or more of the following: chest symptoms, leg signs, or occasionally a "clinical chart sign."Chest symptoms often masquerade as intestinal disturbances, such as indigestion, or other minor complaints. Calf swelling, tenderness and positive Homans' sign need not be present. Mild distension of the ankle or fulness of the calf tissues on the affected side have occasionally fixed the diagnosis. Finally, we have come to look upon an unexplained simultaneous rise in temperature, pulse, in particular and respiration in an otherwise flat convalescent chart as a warning that a small pulmonary infarction may have occurred. It appears that in this group of patients, chest and leg signs as the earliest signal of disease occur in the ratio of three to five respectively.

TABLE VI

INDICATIONS FOR FEMORAL VEIN INTERRUPTION
Massachusetts General Hospital

1937-1947—2,131 CASES

	1937-42	1943	1944	1945	1946	1947
Chest pain as first symptom	41.0%	34.5%	32.5%	23.0%	16.4%	14.0%
Leg signs as first symptom	59.0%	56.3%	41.8%	33.7%	30.5%	24.6%
Positive Clinical Chart Sign	0	0	0	0	0.4%	3.1%
Prophylactic Interruption	0	9.2%	25.7%	43.3%	52.7%	58.3%

In 1260 cases of established thrombophlebitis treated by femoral vein interruption there have been six proven fatalities from embolism, a mortality of 0.47 per cent. This figure compares favorably with those reported elsewhere from clinics employing various anticoagulants as therapeutic agents. Bauer[13] in Sweden reports a mortality of 1.4 per cent using repeated intravenous administration of Heparin, and Evans and Dee[14] employing Heparin in Pitkins menstruum in combination with Dicumarol have reduced their mortality to 1.6 per cent.

TABLE VII

EMBOLIC DEATHS SUBSEQUENT TO FEMORAL VEIN INTERRUPTION
Therapeutic

Age	Sex	Disease	Operation	Interval Between Vein Interruption and Death
47	F	Intract. Facial pain	Lobotomy	23 days
74	F	Diabetic gangrene	Thigh amputation	2 days
74	M	Ca Stomach Inoperable	Peritoneoscopy	38 days
66	M	Ca Stomach	Subtotal Gastrectomy	9 days
76	F	Cataracts	Enucleation	8 days
77	M	Phlebitis and Pulmonary Infarct	Medical patient	13 days

The net salvage in terms of lives in this therapeautic group is difficult to determine. In those patients presenting initial chest symptoms in particular, the diagnosis of sublethal pulmonary embolism in former years was often overlooked. [15] Symptoms were ascribed to pleurisy, pneumonia, or cardiac disease. To-day, a large group of these, presenting a warning pulmonary infarct are saved. The salvage in the group presenting thrombophlebitis as the initial sign is probably less dramatic. In an earlier series at the Massachusettes General Hospital, one patient in twenty-five with thrombophlebitis, treated by the old conservative measures succumbed to pulmonary embolism. [16]

TABLE VIII

SUMMARY—THROMBO-EMBOLIC DISEASE
Massachusetts General Hospital

1937-1947

	No. of Patients	Fatalities
Prophylactic Dicumarol	536	2
Prophylactic Sup. Fem. vein interruption	871	4
Therapeutic Phlebotomy, Thrombectomy, and Femoral vein interruption	1,260	6
Total	2,667	12 (0.45%)

It must be borne in mind, finally, that patients are also saved much of the prolonged convalescence formerly seen in the treatment of thrombophlebitis. Moreover, the late sequelae of deep thrombophlebitis are greatly reduced. Jorpes [17] found sequelae in 90 per cent of the patients treated under old conservative measures. Post-phlebitic varices, edema, and ulcer do not occur in patients treated specifically early in the course of thrombophlebitis.[18]

Conclusions

1. Up to January 1, 1948 over 2,600 patients at the Massachusetts General Hospital have had specific efforts made to prevent or treat thrombosis and embolism.

2. Insufficient emphasis has been placed on the rewards of prophylactic measures, as it is in the group of patients without signs of thrombo-embolic disease that the salvage is by far the greatest. General prophylactic measures are sufficient for the younger patients, Dicumarol is most practical for the middle-age group, and bilateral superficial femoral vein interruption is safest for the more inactive and aged.

3. Patients with proven thrombophlebitis and in particular sublethal pulmonary infarction are saved in less striking numbers by superficial femoral vein interruption.

4. Deaths from sudden massive embolism still occur in our hospital. These are often without warning and in patients who have had no specific prophylactic measures instituted.

5. The increase in geriatric surgery, in surgery of malignancy, in the magnitude of surgical procedures, and finally the decrease in mortality from shock, infection, and pneumonia in recent years have resulted in thrombosis and embolism as a more prominent potential cause of death than formerly. Actually, in spite of an increase in autopsies, the number of deaths from embolism at the Massachusetts General Hospital has remained unchanged.

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An assistant is wanted for a gold mining district in Northern Ontario, salary $325 a month, plus 7c mileage. Further information may be secured by writing to the Secretary.

Study and Treatment of the Neuroses

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THE complexity of modern civilization throws an increasing strain on man's attempt at gratification of his primitive instincts in relation to the conformity with the mores and rules of his cultural group. The study of the personality in its struggle to find adequate satisfaction in his environment leads to the problem of the cause and treatment of the neurosis.

Psychoneurosis may be defined as the failure of the individual to deal successfully with a given situation, a failure to find socially acceptable gratification for his subjective needs. The failure depends upon the balance between his adaptability and the difficulty of the confronting situation. When the difficulty demands greater powers of integration then the personality has, the neurosis develops. Thus the cause of the neurosis may be due to an abnormal environmental strain or a lowered threshold of personality integration. The problem then in treating the neurosis is to cure or at least arrest further progression of the illness. This can be done by helping man find his spiritual and material place in the complex social order.

The developed neurosis leads the personality in a repetitive and vain effort to solve a problem in the present by means of behavior patterns that failed in the past. The sterotyped behavior patterns which incapicitate the individual in his relations with other people then develop.

The patient must be treated so as to find a solution to his present problems by correcting his unsuccessful patterns, by showing him the futility and irrational quality of his behavior. Attention must be focused upon the dynamic potentialities of the patient's personality for healthy development, upon the forces that can be utilized for the therapeutic process. Main conflicts in present society lie between the balance of social and asocial behavior, between aggression and dependence and upon the solution of the sexual drive.

Anxiety, a feeling of unpleasant emotional tone is an important factor in the neurotic personality. It is a result of an effort at controlling inward conflict and serves as a warning to the personality of the necessity of seeking a better solution of his difficulties

The stereotyped behavior pattern of the neurotic personality leads to increasing difficulties in handling problems. Further failure in adaption increases feelings of failure and inadequacy which progressively paralyzes the personality. The process of disintegration and regression then occur and the patient develops psychotic symptoms of delusions and hallucinations. Reality becoming so unpleasant and unbearable, the personality plunges into the dangerous whirlpool of phantasy. This loss of capacity of the individual for reality testing is characteristic of psychotic states as schizophrenia.

The importance of early treatment of the acute neurosis cannot be overemphasized. It is at this phase that a complete recovery can be made with adequate treatment. The breaking up of the sterotyped behavior patterns will give the individual a chance to make a satisfactory adaption. Without

treatment the personality continues in his undesirable path that leads either to a stubborn chronicity or to a serious psychotic state.

The study of the neurosis is an all embracing investigation of the individual in his growth and development and in his relationships to the present environment. A history must be a detailed and thorough search of emotions and modes of reactions from infancy to maturity. It must include a careful analysis of the people who have influenced him in his emotional development. Thus a study of the family and his cultural group is necessary. Social service facilities are important in this respect.

Psychological tests are essential in detecting the pathological and the healthy components of the personality. A study of Free Association and Dreams are valuable keys to his personality structure. Psychometric tests such as the Wechsler-Bellevue Intelligence Tests supply his intellectual endowment. The Rorshach and Minnesota Multiphasic Personality Tests are valuable in exploring subconscious structure. Further analysis of the personality can be made through the use of drugs elaborated during World War II. Narcoanalysis using pentothal or amytal are dramatic and searching methods that yield abundant data on repressed thoughts and memories. Synthetic therapy can be used when the patient is under these drugs for the purpose of building up the personality components. Drama yields information on the patient's reactions to his relatives and occupational associates. Consequently, a use of the above methods of study and investigation provides information upon which the individual therapy is based.

A thorough study of neurosis leads to a knowledge of the pathological factors in its development. The psychotherapeutic treatment must lie in the realm of the emotional reeducation which will enable the individual to cast away his stereotyped behavior patterns. Thus the function of therapy is one of facilitating a learning process.

The treatment of each neurotic patient is necessarily an individual psychotherapy. The patient himself must be studied thoroughly and from this an appraisal made of his individual problems. Generalizations are helpful but each therapy must be a flexible one suited exactly to each patient.

Psychotherapy in a wide sense embraces any effort to influence human thought or feeling or conduct by precept or by example, by wit or by humor, by exhortation or appeal to reason, by distraction or diversion, by rewards or punishment. However scientific psychotherapy may be defined as any therapy based on psychodynamic principles which attempts to bring the patient into a more satisfactory adjustment to his environment and to assist the harmonious development of his capacities.

A variety of psychotherapy techniques exist, ranging from the long drawn out psychoanalysis to a few short therapeutic talks. The success of psychotherapeutic treatment of the neurosis however depends largely on the patience, interest and knowledge of the psychiatrist. Much is said about the elimination of psychic infantile trauma by bringing the repressed memories to the conscious mind. However it is doubtful whether one or two isolated psychic trauma in infancy or early childhood can be as important as the continual traumatic experience that the neurotic personality lives through every day. Although past problems should be studied to understand the stereotype neurotic behavior, therapy should be focused upon the patient's problem in adjusting to present external reality.

The physical health of the neurotic patient must be kept in mind and treated if necessary. Manipulation of the environmental situation may also help in adjustment and cure of the neurosis Advice should be given on occupational activities and outside interests. Subcoma insulin treatment is often a great help in conjunction with the intensified psychotherapy. If depressive features are present electro-shock therapy may be necessary. The use of sodium amytal may be of use also in the synthesis of the personality by suggestion when the patient is under the influence of the drug. Sedatives may be necessary at the commencement of therapy.

The patient must experiment with his emotional relationships in real life after treatment has started. Many disturbed emotional relationships can be worked out in the daily life of the patient, for instance, hostility. Every success encourages new trials and decreases the inferiority feelings and resentments. Thus the therapy of neurosis is a complex one which must be suited to the individual patient. It may include a variety of techniques all of which may have some part in the successful integration of the neurotic personality.

There is no doubt that in the future many new dramatic advances will be made in the treatment of the neurosis. At the present time the extensive use of prefrontal lobectomy has cured many neurotic reactions, especially of the psychosthenic type. Refinement of technique in psychosurgery will undoubtedly lead to greater advances in this field. The use of pentothal and amytal during World War II were notable advances in abreactive technique so important in the treatment of a neurosis. Further research in this matter may help to provide the bridge of experimental research between modern psychotherapy and the physical methods of treatment. Pavlov's experiments on conditioned reflexes in animals gave valuable information in understanding neurotic behavior. Recent experiments on producing neurosis in animals have been very interesting. Physiological experiments on adrenalin reactions and desentization may prove more useful in the future. Research on constitutional inheritance of nervous systems—the balance between excitation and inhibition and the effect of drugs on this balance may lead to noteworthy results.

The goal of psychiatry must be the active study and treatment of abnormal functional nervous states with the purpose of the prevention of the neurosis and psychosis. Mental hygiene work is now at this problem with the aim of prevention by the building up of a healthy attitude and outlook in our cultural group. A more widespread help for emotionally disturbed people becomes possible with the more rational attitude towards psychiatry which is emerging in the general public.

Blue Shield, or Compulsory Government Insurance

The Editors,

The Nova Scotia Medical Bulletin:

The attached copy of an address delivered last month in Chicago before the Fourth Annual Meeting of Presidents of State Medical Societies has just been sent to me from Chicago. It is by Dr. Paul R. Hawley, Joint Director of Blue Cross and Blue Shield Plans, and is reproduced here by kind permission of Associated Medical Care Plans ("Blue Shield"), Chicago.

In the world-wide tendency towards the Socialization of Medicine by governments, the position of our profession in U.S.A. is very similar to that in Canada and therefore much of Dr. Hawley's address could well have been directed to us. His views are those which, in many instances, we have heard expressed by some of our own members who have taken enough time to consider where we stand. Such members will appreciate seeing their views so well expressed by one who is in a position to know. Other members of our Society will be glad by this means, to have the facts of our position made clear to them, so that they may be the better able to appreciate the importance of the decision which, very soon, they will be asked to make.

It would appear that the only connection between "Blue Cross" and "Blue Shield" is in the person of the Director. "Blue Shield" is the trade name of the medical care plans generally sponsored by Medical Societies, as this address implies.

It is expected that direct communication will be made very soon to the members of our profession in this province with respect to a plan of prepaid medical care for Nova Scotia.

Norman H. Gosse
Chairman, Committee on Economics

A speech delivered at the Conference of Presidents and other Officers of State Medical Associations, 20 June, 1948, by

Paul R. Hawley, M.D.
Chief Executive Officer
Blue Cross—Blue Shield Commissions

The dangers that threaten the free practice of medicine in this country are fast becoming critical, and still we delay in uniting in decisive action to meet them.

We waste precious time in quarreling among ourselves over petty questions of local sovereignty. We amuse ourselves by setting up fantastic straw men, and dissipate our energies in knocking them down, while our enemies have been uniting against us in one national effort. We have thus far done no more than fight a series of rear-guard actions with small unorganized and uncoordinated groups. I know of no more certain road to disastrous defeat.

Our national leaders seem to be purposefully blind to the social changes that are taking place. It is impossible to halt a movement by merely refusing to recognize its existence; and this movement toward extending the benefits of adequate medical care to all of our citizens has already gained too much momentum to be halted by any means. The last hope of American medicine

lies in abandoning our present position in the rear of the column, where we have been holding back, and establishing ourselves firmly in the forefront, where we can guide and direct the movement into paths that are the best for our people as well as best for our profession. I emphasize that the welfare of our people must be given at least as much consideration as the welfare of the health professions. Too many physicians regard medical care as their exclusive prerogative. We must recognize that the consumer of medical care also has a great stake in it; and, if there has existed any doubt as to this, it should have been dispelled by the deliberations of the National Health Assembly, held in Washington early in May.

I shall offer no defense of the motives that prompted the organization of this Assembly. They may have been, as has been charged, largely political. But, however impure the motives, only a very stupid person could have listened to the discussions in the Section on Medical Care and come away unimpressed both by the strength and the determination of the groups committed to an *effective* program for prepayment of medical care. I emphasize "effective," because the preponderant opinion there expressed was that existing plans are acceptable only so far as they go, that they do not go far enough, and that, if they are to be fully acceptable as a substitute for compulsory Government health insurance, the coverage they offer must be extended considerably, and must be uniform throughout the country. In fact, a resolution to the effect that *only* a compulsory Government insurance plan could satisfy these criteria was proposed, and vigorously supported by the American Federation of Labor, the Congress of Industrial Organizations, the Cooperative League of America, the National Cooperative Health Federation, the National Federation of Settlement Workers, the Committee for the Nation's Health, the American Association of Social Workers, the Physicians' Forum, the National Consumers' League, the National Women's Trade League, the United Mine Workers, the American Veterans' Committee, the National Farmer's Union, the Physicians' Committee for Improvement of Medical Care, the League for Industrial Democracy, and the Association for the Advancement of Colored People. This conclusion was not adopted, for the reason that adoption of any conclusion required the unanimous approval of the Steering Committee; and a single dissent was sufficient to defeat a proposal. But the array of strength behind this conclusion should convince even the die-hard tories in the health professions that the threat of nationalization of medical care in this country is real, is acute, and soon will be, if it is not already, sufficiently great to precipitate action by the Congress. The press carried yesterday the news that the Wagner-Murray-Dingell Bill would not be reported out of Committee during this session of the Congress; but it also stated that hearings upon this Bill would be resumed in March, 1949. So the Bill is far from dead. The representatives of the people, in Congress assembled, are swayed by numbers of voters rather than by principles. Even discounting the smaller and the more radical groups demanding national health insurance, we still have the A.F. of L., the C.I.O., the National Women's Trade League, the United Mine Workers, and the Association for the Advancement of Colored People demanding national health insurance. These represent a lot of votes. I am sure they represent more votes than have yet been mustered in favor of equal rights for Negroes, and look what has been accomplished in this direction within a very short time! If this array of political strength is not

enough to shock the medical profession out of its lethargy, then we are hopelessly lost and there is no use continuing the struggle.

What, then, will be the future of the voluntary prepayment plans for medical care—both commercial and non-profit? Those demanding national health insurance were generous enough to state that the voluntary plans should continue in operation after the inauguration of national health insurance. This, of course, was but a courteous gesture since it would be impossible for voluntary plans to compete with a government plan. The handicap would not be one of cost, because the voluntary plans can do the job cheaper than the Government can. But the fact that the government plan would be supported by at least one-third by tax money, and that everyone would have to pay this tax, whether or not he subscribed to a voluntary plan, would dissuade the taxpayer from supporting two plans at the same time.

Since it is impossible for voluntary plans to survive if and when national compulsory health insurance comes, we are going to have one or the other type of prepayment health insurance—not both. So, the future of the voluntary plans depends entirely upon the prevention of the enactment of national compulsory health insurance legislation.

This cannot be prevented through political manipulation. It is my considered opinion that, if left to popular vote, this legislation might pass to-day. Certainly the strength mustered in its support at the National Health Assembly surprised even its protagonists—and was something of a shock to me.

But this disastrous legislation *can* be prevented if the voluntary plans meet every *reasonable* demand for health insurance. I specify "reasonable demand" because, as all of us know who are familiar with the problems involved, some of the demands expressed at the National Health Assembly are impossible of fulfillment at the present time, and for some years to come.

There were unanimously adopted by the Medical Care Section seven criteria for measuring the effectiveness of prepayment plans in meeting the medical care needs of the people. I shall discuss only the more important of these as they point the goals which must be reached by voluntary prepayment plans if they are to be considered adequate to the peoples' needs.

The first criterion is "The extent to which a prepayment plan makes available to those it serves the whole range of scientific medicine for prevention of disease and for treatment of all types of illness or injury." To meet this criterion, voluntary plans must be in a position to offer as comprehensive a coverage as the public demands, regardless of cost. Since many people neither desire so complete a coverage, and are unwilling or unable to pay its cost, this means that plans will have to offer more than one type of contract. This will not be at all difficult once a competent actuarial service is established. I can think of no good reason for limiting the offering of a prepaid medical care plan to a single type of contract. We must always, of course, offer a contract that is within the economic reach of the low-income groups who must bear all or part of its costs. But these large union groups are demanding a much more comprehensive service, and are willing and able to pay for it. We simply *must* be in a position to offer them a contract that meets their requirements, or we shall not only be forced out of business but also we shall have compulsory Government health insurance as a reality instead of as a threat.

The fact that the fee schedules for the low-income group contracts are inadequate for the higher-income contracts need give no physician any concern. It is quite easy to arrange a separate fee schedule for each type of contract. For the higher-income groups, the fees should be higher, and should correspond to the fees normally charged such groups. The wealthier groups expect that —in fact, I am sure that they would demand it, because they do not want to be regarded as charity patients—and they are willing to pay the additional premium for their coverage.

What can it matter to the participating physician whether the patient pays the bill from his private income, or whether the bill is paid by the medical care plans, so long as the amount paid corresponds with the fee customarily charged in that income level? Even if there is some objection to such a procedure, the alternative is to lose millions of potential patients to employee-benefit associations and medical cooperatives operating their own clinics and hospitals. I cannot stress too strongly the fact that this movement has already reached the point where the medical profession has the choice only of making a reasonable effort to meet the requirements of these large groups of consumers of medical care, or of watching the private practice of medicine in this country being rapidly strangled by either cooperative or Government medicine. No other alternatives are left. All other alternatives have been lost in the ten or fifteen wasted years in which organized medicine has pursued an entirely negative course in dealing with this social problem.

The next point of the greatest importance is that these large groups will not be satisfied with anything short of uniform coverage for their members regardless of their place of residence. They simply will not deal with 51 separate Blue Shield plans. Already the United Mine Workers, with 400,00 members, have a 10-cent per ton levy solely for health and welfare. As we assemble here, a union with more than 1,000,000 members is negotiating with a large industrial corporation for a 10-cent per hour increase in wages, to be devoted exclusively to a health and welfare program. Another union, with more than 1,000,000 members, has already appointed a medical advisory council to formulate a prepaid health program for its members, to be paid for by a similar 10-cent per hour raise in pay.

Is organized medicine guiding and directing these programs? It is NOT! I happen to know some of the members of this medical advisory council of this gigantic union. I can tell you that they are openly committed to Government compulsory health insurance. Let me give you the names of some of them—Fred Mott, who is directing the Government medicine program in Saskatchewan; Dean Clark, who is director of H.I.P. in New York; Jack Peters, who is Secretary of the Committee of Physicians for the Improvement of Medical Care. I can tell you further that the plan for the medical care of this large union, which was proposed at the first meeting of this medical advisory council, was similar to that of the Health Insurance Plan of New York—the establishment of clinics in every centre of this union population, and these clinics to be operated by salaried physicians. This Association is on record as opposing such a plan for medical care.

Why was not organized medicine approached for advice and counsel in the establishment of these huge programs for prepayment of medical care? I'll let *you* answer *that* question. But doesn't it shock you, doesn't it give you a feeling of insecurity that the leadership of these great movements,

which will exert the most profound effect upon medical practice in this country—that the leadership in these movements has slipped from the grasp of organized medicine? . . . I can tell you that it disturbs me deeply, and that I am convinced that the cause is lost unless you take prompt and effective action to regain control of medical practice in this country. I say "regain" because I am afraid you have already lost it, whether you realize it or not. And you are not going to regain it through the methods you have followed during the past ten years.

Some three weeks ago I had a conference with one of the most powerful, if not the most powerful, labor leaders in the United States. This organization, of which he is the President, controls many labor unions with millions and millions of members. He has already started this movement for a prepaid medical care program in two of his largest unions, and he assured me that it would be carried on throughout the labor empire that he controls. I am violating no confidence when I tell you that he exhibited a strong bias against the attitude that organized medicine has displayed up to the present moment. His closest welfare advisers made it very clear to me that they would deal with the voluntary nonprofit prepayment medical care plans *only* if these plans met their requirements to a reasonable degree. They did not display an adamant insistence upon 100 per cent performance at once but they set forth a few principles upon which they would not compromise.

The two most important principles upon which they would insist in full were uniform coverage in every area in which their members reside, and a single contract with one labor-management board regardless of the number of individual medical care plans which would be involved in providing the service. There would be no negotiation with reference to these two principles —we would have to accept them or reject them as they stand.

These gentlemen also made it clear that they were opposed to indemnity insurance and would accept this type of contract only as a temporary expedient. They are committed to the principle of the service contract.

These requirements can be met, and met easily. But they cannot be met so long as our vision is limited by the boundaries of the small areas in which we live and practise medicine. The problem is one of national scope, and it cannot be solved by State and County Medical Societies acting independently. I can assure you that you will not even be listened to, much less dealt with, upon any such basis.

Neither one of these requirements can be met, however, without the necessary machinery at the national level of Blue Shield Plans. You know full well that it would be impossible for 51 separate Blue Shield Plans to get together around a table and agree upon a uniform contract. Even if this were possible in one case, you must remember that different groups may demand different degrees of coverage, and this painful process would have to be repeated each time we were approached by a national group. The time required to effect such agreements would defeat us. These prospective clients demand an answer within days—not months.

For these reasons, only a National Service Agency, controlled by all the participating Blue Shield Plans, can possibly meet this urgent need. My own concept of such an agency is this:

1. It would be controlled by a board of directors elected by the participating Blue Shield Plans.
2. It would underwrite medical care programs of national scope; and, in turn, would pass on to each local plan concerned the share of the business that lay within the area of that plan.
3. If any local plan desired to accept the entire risk of additional coverage offered in any contract, it would be free to do so. If, on the other hand, any local plan declined to carry the additional coverage demanded, the National Service Agency would carry the added risk, and pay the local plan for all such service rendered.
4. The National Service Agency would work *only* through local plans. It would write no contracts in any area covered by a plan that did not involve two or more plans, and it would offer no contract of itself except in areas not covered by any Blue Shield Plan.
5. The National Service Agency would have no control over any local plan other than to see that agreements entered into with subscribers were carried out.
6. The existing organization of Associated Medical Care Plans would not be disturbed. The National Service Agency would be an underwriting organization, and *not* one of control.

As a physician, who is intensely interested in the future of medicine in this country, I cannot see the slightest danger in such a project. Each local Blue Shield Plan would preserve its present degree of autonomy, and the national agency would be one that *served* all the plans rather than one that *controlled* all the plans. And, don't forget one thing—it is either some such arrangement or be forced out of business. If we are not going to be in a position to serve these new millions of organized consumers of medical care, we had better announce that fact right now and liquidate our Blue Shield Plans. Sudden death is much preferable to a lingering, painful death; and slow death for us is certain—and maybe not so slow at that—unless we get in step with the rest of the country.

I mentioned earlier that straw men were being set up so that they could be knocked down. Perhaps the largest of these straw men is that this is just a scheme for Blue Cross to gain control of medical practice in this country. This is not only the largest of the straw men, it is also the most fragile. I work just as closely with the Blue Cross Commission as I do with the Blue Shield Commission. I have not seen the slightest evidence of any desire—much less, intent—on the part of the Blue Cross Commission to exert even the slightest control of the practice of medicine. The cry of "No Merger" has been raised against the two Commissions. I have been instructed by the Joint Executive Committee of the two Commissions to state that merger of Blue Cross and Blue Shield has never been considered. All that has ever been seriously proposed is a federation of the two groups for the single purpose of promoting the success of both. The leaders in Blue Cross believe, just as do the majority of leaders in Blue Shield, that we must effect enough cooperation between these two great organizations for us to offer prepaid medical and hospital care in one package. The public cannot understand

why they should be forced to join two different organizations to protect themselves against the cost of illness—and, when you think of it, it is hard to explain. But joining hands solely for the purpose of offering prepaid health protection in one unit is a far cry from merging the two organizations under single control.

I beg of you not to be misled by any such vicious propaganda. So long as I remain in this position I shall defend medical practice just as zealously as I uphold the principles of Blue Cross. If there were any real areas of conflict between these two organizations, I would certainly discover them at once; and I can find none.

You did me the great honor last year of inviting me to address you at Atlantic City. I spoke to you very frankly at that time, pointing out the dangers to American medicine from within. That the majority of you approved my remarks, and believed in my complete devotion to our medical profession, is indicated by the fact that you have again invited me. I doubly appreciate this present honor; and I am again forcibly reminded of my great responsibility to the medical profession. I shall not, in the slightest, shirk this responsibility nor shall I ever compromise with my obligation to American medicine.

But my heart grows heavy as I see the indifference of many physicians to the threat to freedom in medicine that is becoming more menacing each day; and as I encounter the petty, selfish greed of a few physicians who had rather seen the entire structure of American medicine wrecked than to concede one small personal advantage in the general interest.

If we get socialized medicine in this country, it will be organized medicine, and only organized medicine, that has brought this curse upon us. We, as physicians, will have only ourselves to blame. If I were among the group that wants socialized medicine in this country—if I were Channing Frothingham, or Ernst Boaz, or Jack Peters, or Michael Davis, or Isidor Falk—I would not exhaust much energy in making a great personal effort—I would relax and let organized medicine do the job for me. All that is necessary to bring socialized medicine to this country within a very short time is for organized medicine to pursue the same course that it has pursued for the past ten years.

The demand for more comprehensive medical care, and for an effective means of budgeting its costs, has grown, within ten years, from a whisper to a roar. Our people will not be denied much longer. If the medical profession does not at once assume the leadership, if it does not at once cease its double talk and double dealing with the voluntary non-profit prepayment plans, and throw its influence squarely and honestly behind these plans, we are going to have compulsory government health insurance in this country within three years.

I give free medicine a lease on life of three years solely because other heavy financial commitments of the Government will preclude the assumption of the additional burden of compulsory health insurance. The Marshall Plan and the rearmament program will keep the Government, and the taxpayers, strapped for the next few years. But, within three to five years—and I think it will be nearer three—either these measures to restore peace will have been successful, or we shall again be in a war. I believe we shall have peace; and just as soon as the taxpayer is relieved from this terrific burden

of his investment in peace, you may be sure the politicians will be ready to impose upon him the burden of a compulsory health insurance program—that is, unless by that time we have demonstrated that voluntary health insurance is a completely satisfactory answer to the problem. And I would emphasize further that, if we start right now, it will take at least two years to effect an organization that can do this job. We cannot afford to waste any more time in fruitless discussions that lead us nowhere. We must decide right now whether we are going to unite in this effort; and, if we are, we must cease all delaying and obstructive tactics.

Don't be lulled into a sense of security by such able studies on socialized medicine as have been made by the Brookings Institution, and the National Industrial Conference Board, and other capable agencies such as these. Of course, every thinking person is convinced that socialized medicine would be a great mistake—a costly mistake both in money and in health. But this issue will not be decided by wisdom. It will be decided entirely by emotion. Like President Coolidge's preacher, who was "agin sin," everyone is against sickness and death. Only a small minority of our people can understand the dangers of socialized medicine—all they know is that they want everyone to have good medical care, and they are not capable of choosing between the various ways in which medical care can be better distributed. Only a "*fait accompli*" will convince them—and so we have only a short time in which to show them an accomplished fact.

It is useless for the medical profession to undertake the education of our people to the dangers of socialized medicine. Our public relations have been so miserable in the past few years that a majority of our people suspect us of having only a selfish, personal interest in this question. I honestly believe that the medical profession does more harm than good when it attempts to decry socialized medicine—our motives are too suspect.

Don't be misled with such absurdities as the assurance that the Government cannot make you practise medicine if you do not want to. You see what has happened in England. The members of the British Medical Association voted at first to have nothing to do with government medicine. The majority was heavy—80 per cent pledging themselves to remain outside the Government plan. But, as the deadline for participation approached, British physicians by a small majority, voted to accept the Government plan.

How long can you hold out in a strike against the Government? How many of you could stick it a year with no income? And how many of you would stick it if you saw a minority group collecting all the gravy? You are trained in medicine. How many of you would be willing to forsake medicine and embark upon another career?

Don't let anyone fool you! If Government medicine comes, 90 per cent of you will be forced by circumstances to accept it, no matter how bitter a pill it will be for you to swallow. So, the only way to prevent this tragedy is to stop it before it arrives—there is little you can do about it after it comes. The medical profession *can* prevent this tragedy but only by positive action that will meet the reasonable demands of these large groups. Consistently negative action has brought us to this critical juncture and has played directly into the hands of the enemies of free medicine. Time is running against us. We cannot longer delay.

This convention, which is about to open, promises to be the most important in the hundred years of existence of the American Medical Association. The great work of the past hundred years can be undone over night by unwise action during this week. I beg of you to weigh carefully the issues that will be presented. I ask you to weigh them in the light of the events of the past few weeks. I am as certain as I am that I stand here that, if this convention fails to encourage and support the expansion of the Blue Shield movement, the death knell of free medicine in this country will have been sounded.

The Annual Meeting

"Keltic Lodge"

Ingonish, Cape Breton

September 13th, 14th, 15th and 16th

Plans are now about completed for the annual meeting which will be held at "Keltic Lodge," Ingonish, in September. The executive will meet on the afternoon of Monday, September 13th. The scientific and business sessions will be conducted on the 14th, 15th and the morning of the 16th. The Cape Breton Medical Society are hosts and no effort has been spared to make the 95th annual meeting an unqualified success.

The scientific programme includes papers by outstanding medical authorities. Doctor William Magner, the newly elected President of the Canadian Medical Association, not only will address the executive and the general business session, but has kindly consented to give a scientific paper and will speak on the important subject of "Jaundice." Doctor Adrian Anglin of Toronto has chosen the excellent topics—"The Management of Bronchial Asthma" and "The Management of Rheumatic Heart Disease." Doctor W. J. McNally of Montreal, one of the illustrious graduates of the Dalhousie Medical School, will speak on "Some Remarks about Dizziness," and "The Significance of Persistent Hoarseness." Doctor Daniel Blain, the secretary of the American Psychiatric Association, will give an address on some aspect of psychiatry. From our own Society papers will be given by Doctor C. W. Holland, Doctor C. E. Kinley, Doctor A. R. Morton and Doctor J. C. Wickwire. The scientific programme should appeal especially to those doing general practice.

The business sessions should be the most important in the history of the Society. The Committee on Economics under the chairmanship of Doctor N. H. Gosse have worked faithfully during the year on the question of Prepaid Medical Care. This report should be heard and voted on by every member of the Society. The future of medicine in Nova Scotia will depend largely on the action taken in September on Prepaid Medical Care.

We are pleased to know that Doctor William Magner, the President of the Canadian Medical Association, will be with us, and also Doctor Art Kelly, the Assistant General Secretary. We regret that the General Secretary, Doctor T. C. Routley, will not be with us as at that time he will be engaged in important matters in connection with the World Medical Association.

The lighter side of the meeting has not been overlooked. The annual dinner will be held on Wednesday, September 15th, and will be preceded by a reception.

If you have not booked your reservations, do so now with Doctor Eric W. Macdonald, Reserve, Cape Breton. The accommodation at "Keltic Lodge" is limited.

PROGRAMME

Keltic Lodge, Ingonish, Cape Breton, September 14-16, 1948
Nova Scotia Society of Ophthalmology and Otolarynology

Tuesday, September 14, 1948

2.30 p.m. Business Meeting.

4.30 p.m. Dr. W. J. McNally, Montreal—"Some Remarks About Dizziness."

Wednesday, September 15, 1948

9.30 a.m. Dr. D. M. MacRae, Halifax—"Retinoblastoma."

10.30 a.m. Dr. H. R. McKean, Truro—"Some Nasal Conditions."

2.30 p.m. Business Meeting.

3.30 p.m. Dr. H. F. Davidson, North Sydney—"Contact Lenses—A general review and presentation of two patients—A High Hyperope and Keratoconus successfully treated."

4.30 p.m. Dr. R. S. Shlossberg, New Glasgow—"Some Observations on Refractions."

Thursday, September 16, 1948

9.30 a.m. Dr. W. J. McNally, Montreal—"Significance of Persistent Hoarseness."

Society Meetings

Cape Breton County Medical Society

Minutes of the Annual Meeting of the Cape Breton County Medical Society held June 3, 1948

The annual meeting of the Cape Breton County Medical Society was held on June 3, 1948, at the Royal Cape Breton Yacht Club, Sydney, N. S., with Dr. Joseph A. MacDonald, Glace Bay, in the Chair and Dr. F. J. Barton, New Waterford, as Secretary. The meeting was called to order at 8.40 p.m. Thirty-eight members present.

Guest speakers for the evening were introduced by the President,—Dr. A. D. Kelly, Associate Secretary of the Canadian Medical Association, Toronto, Dr. Norman Gosse, Chairman of the Economics Committee of The Medical Society of Nova Scotia Halifax, and Dr. H. G. Grant, Dean of the Faculty of Medicine of Dalhousie University and Secretary of The Medical Society of Nova Scotia.

The minutes of the last regular meeting, Feb. 23, 1948, were read and approved. Reading of the minutes of the last annual meeting was dispensed with.

A letter from the Cape Breton Regional Hospital Association re Pathologist was read. Moved by Dr. A. W. Ormiston and seconded by Dr. F. J. Barton that this be held over until the next meeting.

The Secretary read the Financial Statement which showed a balance of $202.78. Drs. H. J. Devereaux and M. G. Tompkins were appointed auditors. Financial Statement was duly approved.

A nominating committee was then appointed from the Chair, composed of Dr. J. Fraser Nicholson, Glace Bay, Dr. A. L. Sutherland, Sydney and Dr. Hugh Martin, Sydney Mines. The following slate of officers for the 1948-1949 term was proposed by the Nominating Committee as follows:

President: Dr. M. J. Macaulay, Sydney, N. S.

Vice-President: Dr. Alex C. Gouthro, Little Bras d'Or Bridge.

Secretary-Treasurer: Dr. Bruce C. Archibald, Sydney.

Cape Breton Executive:

Dr. H. F. Sutherland, Sydney.
Dr. F. J. Barton, New Waterford.
Dr. S. Arthur Green, Glace Bay.

Nova Scotia Executive:

Dr. Hugh J. Martin, Sydney Mines.
Dr. Gordon C. Macdonald, Sydney.
Dr. John R. Macneil, Glace Bay.

It was moved by Dr. J. G. B. Lynch and seconded by Dr. M. G. Tompkins that nominatio s cease.

Dr. Macaulay, the new President then took the Chair and expressed his gratitude for the honour bestowed upon him.

New Business:

Dr. J. F. Nicholson brought up the question of fees for certification of mental patients for the Nova Scotia Hospital and the Cape Breton County Hospital. Discussion by Drs. J. G. B. Lynch and M. R. MacDonald. It was moved by Dr. A. W. Ormiston and seconded by Dr. J. F. Nicholson that the Secretary write Dr. J. J. MacRitchie, Halifax, re responsibility of Government for payment of fees in these cases. Suggested by several members that fees be raised to $10.00 instead of $5.00 which has existed since the last century. Carried. Motion spoken on by Dr. J. G. B. Lynch and Dr. M. R. MacDonald.

Dr. Kelly was called upon to outline the procedure followed in Ontario on these cases and he stated the fee was still $5.00 there.

Dr. MacDonald recommended a Committee be appointed to clarify the situation. Moved by Dr. A. L. Sutherland and seconded by Dr. H. R. Ross that the M H.O.'s of Sydney, Glace Bay and North Sydney meet with the Municipal Clerk to discuss the matter. Carried.

It was moved by Dr. J. G. B. Lynch and seconded by Dr. M. G. Tompkins that a letter of condolence be sent to Dr. T. Khattar, Glace Bay, in connection with the recent death of his mother.

Dr. Kelly was then called upon to address the meeting. He spoke upon the proposed Health Plan in British Columbia. It will probably be somewhat similar to that in effect in the Province of Saskatchewan. Health Insurance, as such, is not in effect in Alberta as yet. The Saskatchewan plan of voluntary prepaid medical care is really compulsory, Contributary Health Insurance. At first the doctors received 80% of accounts rendered but last year only received 56%. Rate has now been increased.

Dr. Kelly also spoke on the Swift Current Health Scheme of fee for service financed by personal and property tax. He thought, generally speaking, the doctors were being imposed upon.

In Manitoba Health Insurance is run by the Government but has not yet been given a fair trial, the profession acting in an advisory capacity only.

Ontario: In 1935 a group of doctors was asked by the Government to provide medical service at the rate of 83 cents per month. Many other plans for medical care are in vogue also in this province.

The Windsor Medical Service has eighty-five to ninety thousand subscribers. The Physician's Services Incorporation sell two types of policies, one for surgical coverage and the other full coverage. The Blue Cross Plan has over a million subscribers (Hospitalization). The doctors are definitely opposed to the plan of the Blue Cross to provide prepaid medical care.

Quebec: Blue Cross has been given authority to sell medical services in this Province. The Services Desante has just recently started up and should be successful.

Maritime Provinces: In Prince Edward Island, the Blue Cross has obtained necessary authority to provide medical care on an indemnity basis.

Nova Scotia and New Brunswick: The Maritime Medical Care Incorporation Act was passed during the last Session of the Nova Scotia Legislature authorizing the selling of prepaid medical care. The profession in Nova Scotia is definitely against working under the Blue Cross plan for medical care.

Dr. Norman Gosse, Chairman of the Economics Committee of The Medical Society of Scotia Nova was the next speaker. He spoke briefly on the Mari-

time Medical Care Incorporation Act, which was passed at the last Session of the Legislature, authorizing The Medical Society of Nova Scotia to sell prepaid medical care. He stated that a committee has already been named and that a copy of the report has been sent out to the different branches of the Medical Society. The Act has been patterned after the Ontario plan. It is anticipated that this Act will be endorsed at the annual meeting in September at Keltic Lodge.

Dr. H. R. Grant, Dean of the Faculty of Medicine of Dalhousie University, gave a brief address on the same subject. He thought that the profession should stand united in not allowing the laity to tell the profession how it should run its own business.

Dr. Eric W. Macdonald, President, The Medical Society of Nova Scotia, stated that there were big changes taking place in the practice of medicine and that it would probably be a short period before state medicine would be established similar to that now in force in the United Kingdom.

Dr. J. G. B. Lynch warned the Society to be on the alert for canvassing by the Blue Cross. He moved that The Medical Society of Nova Scotia write to all employees of labour advising them that in the near future the Society will offer a system of prepaid medical services. Seconded by Dr. M. G. Tompkins. Carried.

A very interesting discussion followed these addresses. Among these taking part were Drs. H. F. Sutherland, A. L. Sutherland, H. J. Devereaux, F. J. Barton, and many others.

It was moved by Dr. J. G. B. Lynch and seconded by Dr. M. G. Tompkins that a committee consisting of Drs. Norman Gosse, Eric Macdonald. H. G. Grant and A. D. Kelly draw up a statement to be published in the local papers within the next few days. Passed.

It was moved by Dr. M. G. Tompkins, seconded by Dr. H. J. Devereaux that a Publicity Committee of five members be formed. Passed. Moved by Dr. J. F. Nicholson, seconded by Dr. H. R. Ross that the meeting adjourn.

B. C. Archibald, M.D.
Secretary

Colchester—East Hants Medical Society

The Colchester-East Hants Medical Society held its annual meeting on June 18, 1948. The following officers were elected for 1948-49:

President—Doctor P. R. Little, 893 Prince Street, Truro.
Vice-President—Doctor S. G. MacKenzie, Sr., 681 Prince Street, Truro.
Secretary-Treasurer—Doctor D. S. McCurdy, 640 Prince Street, Truro.
Representatives on the Executive of The Medical Society of Nova Scotia —Doctor H. B. Havey, Stewiacke and Doctor W. J. MacDonald, 605 Prince Street, Truro.

Doctor D. F. McInnis, retiring President, presided, and after all having enjoyed a good dinner at Pryors Guest House, the business and professional sections of the meeting were carried out.

The Secretary outlined to the medical men the programme being sponsored by the Truro Rotary Club, that of doing something for crippled children.

The Rotary Club offered their co-operation and support to the medical men in whatever way should be necessary as crippled children should be reported. Probably a crippled children's clinic will be held during the year, etc.

The subject of Nova Scotia Workmen's Compensation Fees was discussed and a resolution passed stating that the low rate of compensation fees which has existed for years should be brought to the attention of The Medical Society of Nova Scotia, the Workmen's Compensation Board and the Government with a view to having them changed to a similar basis as that used by the D.V.A. It is hoped that this matter may be seriously considered at this year's meeting of The Medical Society of Nova Scotia.

After other business of local interest the following cases were presented:

Agranulocytosis by Doctor P. R. Little.
Peritonitis by Doctor J. A. Muir.
Fracture of process of spine and odontoma by Doctor W. J. MacDonald.

Giant celled bone tumour by Doctor D. S. McCurdy.

Doctor E. B. Howell was welcomed as a new member as he has recently come to Truro and is devoting his practice to anaesthesia.

D. S. McCurdy
Secretary-Treasurer

The Canadian Medical Association

July 15, 1948.

To the Secretaries of Divisions

Dear Doctor Grant:

Attached for your information please find copy of a directive from the Deputy Minister of Taxation, Department of National Revenue, concerning the deduction of expenses of attending medical meetings for income tax purposes. It is a matter of great satisfaction to be able to report the successful conclusion of negotiations with the Department of National Revenue of this matter, and I am sure that the members of your Division will be interested. You are authorized to give this the widest publicity through the medium of your Provincial bulletin or otherwise.

You will note that the effective date of this memorandum is January 1st, 1948, which will permit members who attended the 79th Annual Meeting of this Association and/or the Annual Meetings of Divisions to claim their expenses. We are preparing a certificate with respect to the annual meeting of the Canadian Medical Association along the following lines:

The Canadian Medical Association

This is to certify that.....

.....

was in attendance at the 79th Annual Meeting held in Toronto, Ontario, June 21st—25th, 1948, for a period of .....days.

T. C. Routley,
General Secretary.

Members who registered will be provided with the necessary certificate on application to this office, and such application should indicate the number of days actually in attendance.

I am submitting the above form of certificate for concurrence by the Department of National Revenue, and secretaies of Divisions will doubtless want to provide themselves with supplies of similar documents for the meetings which have been or will be held in the year 1948. If any essential change should be made in the form of the certificate, I will advise you further.

Yours faithfully,
Yours faithfully,
(Sgd.) A. D. Kelly,
Assistant Secretary.

Directive Number 205

DEPARTMENT OF NATIONAL REVENUE TAXATION DIVISION

Directive from the Deputy Minister for Public Circulation.

Date 12th July, 1948.

Subject: Assessments—Convention Expenses of Medical Profession.

Effective 1st January, 1948, the reasonable expenses incurred by members of the medical profession in attending the following Medical Conventions will be submitted for Income Tax purposes against income from professional fees:

1. One Convention per year of the Canadian Medical Association.
2. One Convention per year of either a Provincial Medical Association or a Provincial Division of the Canadian Medical Association.
3. One Convention per year of a Medical Society of Association of Specialists in Canada or the United States of America.

The expenses to be allowed must be reasonable and must be properly substantiated; e.g. the taxpaper should show (1) dates of the Convention, (2) the number of days present, with proof of claim supported by a certificate of attendance issued by the organizations sponsoring the meetings, (3) the expenses incurred, segregating between (a) transportation expenses, (b) meals and (c) hotel expenses, for which vouchers should be obtained and kept available for inspection.

None of the above expenses will be allowed against income received by way of salary since such deductions are expressly disallowed by statute.

(Signed) D. Scully,
Deputy Minister (Taxation).

Personal Interest Notes

Doctor H. W. Wilson, a graduate of Dalhousie in 1937, who formerly practised at Ship Harbour, has recently been appointed in charge of civil aviation medicine by the Department of National Health and Welfare at Ottawa.

Doctor R. Gerald Rice, an assistant in the Halifax City Department of Health, has been awarded a fellowship by the International Health Division of the Rockefeller Foundation. This will entitle him to take further studies in public health at Harvard University, Cambridge, Mass, next winter.

Doctor Hugh MacKinnon and daughter, Catherine, of Halifax, have returned home from a three week's vacation in Quebec and Ontario.

Doctor and Mrs. W. K. House and children of Halifax left the middle of July for England where they will spend several weeks holiday.

Doctor and Mrs., N. Barrie Coward and son of Halifax left in June for several weeks vacation in England.

Doctor G. A. Barss of Rose Bay Lunenburg County, has returned home from a three months' visit to the West Coast.

Doctor and Mrs. S. W., Williamson of Yarmouth have returned home from a four week's visit in Upper Canadian cities.

The Honourable and Mrs. F. R. Davis of Halifax have returned from a trip to the West Coast.

Doctor J. C. Worrell of Halifax has returned from a two weeks' motor trip to Oakville, Ontario, where he visited his parents, Mr. and Mrs. Frank Worrell.

Doctor N. G. Pritchett, Senior President Rhysician at the Halifax Tuberculosis Hospital, has resigned to accept a position in the Kansas State Sanatorium in Norton, Kansas. Doctor G. Ivan Wilson, who has been junior resident physician during the past nine months, has taken over the position vacated by Doctor Pritchett.

Doctor C. S. Marshall of Halifax, head of the recently established Neurosychiatric Division of the Provincial Department of Health, represented Nova Scotia at a special two-day conference of provincial directors of mental health held at Ottawa early in June.

Doctor J. S. Campbell, a member of the medical staff of the Nova Scotia Sanatorium for the past year, resigned recently to accept a position in the Department of Pathology at the Eastern Maine General Hospital in Bangor, Maine.

Doctor R. Clarence Young of Pictou and Dr. F. J. Misener of Glace Bay have recently been appointed to the staff of the Nova Scotia Sanatorium at Kentville.

Doctor R. S. Grant, (Dal. 1948), has joined the clinic of Doctor Charles Gass at Sackville, N. B.

The marriage took place at Dartmouth on June 18th of Miss Inez Joyce Elliot, R.N., daughter of the late Mr. and Mrs. R. K. Elliot of Dartmouth, and Doctor Thomas Harvie Earle, son of Mrs. Earle and the late Rev. C. A. M. Earle of Newcastle, N. B. Doctor Earle graduated from Dalhousie Medical School last May, and will practise in Bridgetown for the summer months.

The marriage took place at Halifax on July 3rd of Miss Fay Catherine Gertrude MacLellan, daughter of Mr. Neil MacLellan and the late Mrs. MacLellan of Moncton, N. B., and Doctor Neil Kenneth MacLennan, son of the Rev. and Mrs. C. R. E. MacLennan of New Glasgow. Doctor MacLennan graduated from Dalhousie Medical School in May and is at present on the X-Ray staff of the Victoria General Hospital.

Doctor J. L. Cock, who has recently retired after twenty years in charge of the Immigration Medical Service, was presented with a radio by the medical staff and an instrument bag and surgical instruments by the immigration staff to mark the occasion.

A total of 452 candidates were successful in examinations held last month by the Medical Council of Canada, Doctor J. F. Argue, Registrar, announced recently. The examinations were held in Halifax, London in Ontario, Winnipeg, Edmonton, Vancouver, Quebec City, Montreal and Toronto.

Successful candidates included at Halifax:

From Nova Scotia; Eric Joseph Cleveland, Ronald Douglas Drysdale, Robert Silver Grant and Douglas Leonard Roy of Halifax, Nathan Bernie Epstein, New Waterford; Richard Cameron Fraser and Neil Kenneth MacLennan, New Glasgow; John Allan MacCormick, Antigonish; Joseph Irving McGillvary, Amherst; Daniel Lawrence Sutherland, Pictou; James Alfred Scott Wilson, Berwick.

From New Brunswick; Melvin Irving Acker, St. Stephen; Arthur Kevin Carton, Fairville; Thomas Harvie Earle, Dorchester; Roy Wilfred Fanjoy, Young's Cove Road; Lewis Herbert Freedman and Donald Carey Francis Metcalfe, Saint John; Earl Robert Lee, Fredericton; Gordon Lockhart Milton, Sackville.

From Prince Edward Island: Lloyd Sharp Allen, Summerside; Lorne Houston Burdett, Dundas; Lloyd Sutherland Cox, Morell; Marcus Allison Deacon, Freetown; Allison Leeman Saunders, Charlottetown; George Ivan Wilson, New Dominion.

From Newfoundland: Clifton Joseph Joy, Stephenville; Angus James Neary and Lorne John Stevenson, St. John's; Gregory Martin Albert Neiman, Corner Brook; Ian Edwin Lawman Hollands Rusted, Carbonear.

Obituary

Doctor Terence Cochrane Lockwood died suddenly at his home in Lockeport on June 28th. He was in his 91st year. Last October on the occasion of his 90th birthday a celebration was held for him by the local medical men. At the same time he was made an honourary member of The Medical Society of Nova Scotia, and received a congratulatory telegram from the Society.

Doctor Lockwood had practised in Lockeport for more than fifty years, and up to the time of his death still saw old patients in his office, although he was not able to get out to their homes.

A personal reminiscence may be permissible. Some years ago, during the war, the writer was in Lockeport in connection with the Red Cross Blood Donor Service. The Lockeport clinics were always remarkable for the widespread and willing co-operation by all and sundry. On this occasion Doctor Lockwood, who was, of course, not able to assist in the clinic, insisted that he should entertain me as an overnight guest in his house. At a late hour his housekeeper guided me to his home which we entered by the office door. Doctor Lockwood was in the office, stretched out on the old-fashioned and not very comfortable examining table—asleep! I think he belonged to a generation which is passing, the doctor whose profession was not his job, not his bread and butter, but his vocation. His office was his native heath, and the place to which his footsteps turned, even when no task called him there. There he felt at home and there he could pass the long hours of the advancing years. Much has been said of the value of hobbies, so that when working days are over, the mind may be occupied. Who can say which is the better part? I am sure Doctor Lockwood never felt the need of a hobby. He had a wealth of memories and was content with his lot.

M.E.B.G.

Dr. Athol Fraser MacGregor

Doctor Fraser MacGregor died suddenly at his home in New Glasgow on July 3rd. Seven years ago he had received the warning which indicated that his future must be one of limited activity. He accepted this restriction with reluctance but with the philosophical cheerfulness which characterized his outlook on life. As year succeeded year, friends began to hope that with care his brilliant career might be continued indefinitely in a life of modified professional activity. However, during the past three years, he had not been able to practise at all.

He was born at MacLellan's Brook, Pictou County, in 1892, the son of Alexander and Sarah Fraser MacGregor. After completing high school he entered Dalhousie University, where he studied for two years, before entering Medicine at McGill University where he graduated in 1917.

His career had been interrupted by Great War I during which he served with the Royal Canadian Army Medical Corps. Following graduation, he pursued his studies in the field of Surgery notably at the Montreal General Hospital for some four years, before returning to his native town to practise his specialty.

From the very beginning he was successful. This was due to his capacity for friendliness and friendship as well as to the undoubted skill which he brought to bear upon every problem presented. To an unusual degree he inspired confidence, both in his patients and in his fellow physicians with whom he was associated.

He was an enthusiastic fisherman, curler, and golfer, and a member of the New Glasgow Gyro Club.

The funeral was held on July 6th, attended by many members of the Medical and Nursing professions. Interment was in Riverside Cemetery, New Glasgow.

To Mrs. MacGregor, Alexander, his son, and Shirley, his daughter, the BULLETIN extends its sincerest sympathy.

The BULLETIN extends sympathy to Doctor L. P. Churchill of Shelburne on the death of his brother, Robert Dickinson Todd Churchill, which occurred on June 21st following an illness of several months: and to Doctor Harold R. Ratchford of Inverness on the death of his father, John W. Ratchford of North Sydney, on June 10th, in his 75th year.

As the Twig Is Bent

Teaching a child to accept a spoon at a very early age may often save the mother endless trouble later on when she begins to offer the child soldi foods, national health officers say. The age of one month is not too early to accustom a baby to accept such foods as cod liver oil and citrus fruit juices from a spoon.

When the child is accustomed to a measure of spoon feeding, many of the feeding problems that often arise three or four months later may be avoided.

The Wet Habit

Bed wetting in a child is not just a "bad habit." Doctors know that each case of poor bladder control calls for careful study. The cause of the trouble may be one of a large number of factors and it is necessary to isolate the cause before constructive measures may be taken to free the child from his problem.

Understanding and encouragement on the part of the parents are essential. Above all, parents should avoid trying to solve the situation by scolding, beating, shaming or bribing.

Cleanliness First

When travelling in lands where sanitary conditions are primitive, cleanliness is always the first rule of health safety, health officers say. This will present no problem in most countries, at least along regular tourist lanes, but in cases where travellers are forced to "put up" in doubtful places it is best to exercise extreme caution.

It pays to make sure water has been boiled, milk is pasteurized or canned and that food has been handled and prepared in a sanitary way.