Treatment of Congestive Heart Failure

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WHEN I accepted the request of your president to present a paper at the Society meetings this summer, I immediately thought of the treatment of congestive heart failure. It was not without some trepidation, however, when I recalled that this subject was covered at the Refresher Course last autumn, by such an able authority as Dr. Brow. Nevertheless I have gained so much personal satisfaction in the handling of these cases that I am persuaded to touch again on this aging subject. It is my desire to bring to you some of my own impressions of a method of treatment used perhaps particularly by our friends South of the Border.

In the past years we have all witnessed the unhappy, distressing events during the latter days of the smothering, oedematous cardiac. To-day it is possible to prolong the life, to increase the activity, and to improve the comfort of many of these people. It is true that most of them will eventually die a cardiac death, but in the inimitable words of Dr. Hairy Gold, they die "dry." In many cases it is possible to remove, more or less completely, their oedema, and with it, many of their distressing symptoms. The appetite improves, dyspnoea is relieved, sleep returns, and the psychotic mind again becomes normal.

The clinical syndrome, known as congestive heart failure occurs when the output of the heart fails to meet the metabolic requirements of the body. Signs and symptoms are largely due to an increase in the extracellular fluids. Therapeutic measures fall mainly into two groups:[1]

1. Those that effect the cardiac output, namely, rest and digitalis. Both of these measures cause a decrease in the extracellular fluid, and
2. Those that cause a decrease in the extracellular fluid without affecting the cardiac output, to any extent. These result in the output of sodium chloride which exceeds the intake. This is effected by high protein and low salt diet, and by the use of diuretics.

To discuss these measures in more detail: rest decreases the metabolic requirements of the body, lowers the blood pressure, slows, and so rests the heart. The cardiac should be placed at rest. First we think of strict confinement to bed, but this is not necessary. A patient who has been ambulatory may have marked swelling of the legs but with little oedema of the lungs, liver, and essential organs. To have him lie in bed will cause a shift of this fluid to the upper parts of his body with aggravation of his symptoms and increased cardiac embarrassment. The sitting position or cardiac bed or chair, for the first few days, until you have been able to drain off at least some of this excess fluid, by digitalis, mercury, Southey's tubes, etc., may be more desirable. Then you may place him in bed.

Nor must he remain in bed too long (average 2 to 3 weeks). As soon as reasonably possible, he should become ambulatory, within the limits of his cardiac reserve. As his condition improves, he is permitted to move about on one floor, to have bathroom privileges, to go for short walks, and finally,

in many cases, to return to work. He is advised to avoid all excesses—those exertions that cause undue dyspnoea. He should always obtain adequate rest and sleep. An afternoon nap is very helpful. He must not overeat. During assimilation of food, cardiac output may increase 30%, and this increase may last 2 to 4 hours.* Obesity should be guarded against. It is better that his weight be maintained 5 to 10 pounds below normal for his height and age. Master and his associates have shown that 12 to 15% loss of weight is accompanied by 35% reduction of cardiac work.

In speaking of diets, it is well to bear in mind the possibility of a vitaminosis and in particular a vitamin B deficiency, with its effect on the blood vessels, gastro-intestinal tract, and nervous system. A vitamin B deficiency is frequent in alcoholic addicts, pregnant women, in persons with gastro-intestinal disorders, and those whose diet is deficient. When cardio-vascular disease is secondary to thiamine deficiency, the response to large doses of this vitamin (100 mgm. daily) is often very striking.[2] Bradycardia is relieved and diuresis is established. Minor degrees of thiamine deficiency in cardiacs apparently occur more often than generally realized. Dr. L. Wolff of Boston, gives his cardiacs daily intramuscular injections of the B-Complex to guard against this eventuality.

At this point I wish to speak about the role of protein deficiency in congestive failure. In the March issue of the C.M.J., Dr. Shane[3] has written a very fine article on the effect of hypoproteinemia as a factor in the production of oedema in congestive heart failure. When the plasma proteins fall below the critical level of 5.5%, there is a disturbance of the osmotic pressure ratio between plasma and tissue fluids with a resultant positive force aiding filtration of water from the blood stream, at the arterial end of the capillary. The increased venous pressure, associated with failure, retards re-absorption of fluid at the venous end of the capillary. This results in an increase in extracellular fluids—oedema. Cardiac patients who are suffering from anorexia or who may be given a diet deficient in protein, may in some degree be subjects of hypoproteinemia. Dr. Shane's recommendation for a high protein diet appears to be well grounded.

Two years ago I heard a lecture given by a surgeon-commander of the U. S. Navy. He, and one hundred and twenty-five marines had been captured by the Japanese and remained prisoners of war for two and a half years. They were given a diet which was exceedingly low in protein. All of these men became oedematous, though the striking feature was the dramatic increase in the amount of oedema when these men were able to obtain (usually by stealing) even a small amount of salt.

Low Salt Diet

I now come to the question of the low salt diet. A normal individual can excrete the amount of salt contained in a normal diet (6 to 15 gms.). The body fluids are primarily salt and water, and in health or disease the body is extremely sensitive to any change in their tonicity. An increase in these fluids can only occur with water and electrolytes together. In health, the body is able to keep the amount of its fluids and electrolytes within certain narrow bounds, and rid itself promptly of an excess of either, through the kidneys. Water reaches the kidneys only after the other demands of the body have been met. If the available water is too little, then the kidneys do not excrete

metabolites as they should and these products accumulate in the blood and other tissues. Such a process occurs in the untreated cardiac, who is developing congestive failure, not because he is drinking less water, he may be drinking more, but because the water he is taking is diffusing into the tissue spaces along with the sodium he is ingesting. His body has lost the ability to control the *quantities* of its interstitial fluids. As a result too little water is left over to make urine. What urine is excreted is as concentrated as the kidneys can make it, thus indicating that they are doing the best they can. Water will not be released until the body begins to unload the electrolytes into the urine, in the process of diuresis. Limiting water will not reduce oedema, but rather promote dehydration and oliguria.

With the aid of a low salt diet, it is possible to withdraw from the tissues sodium chloride and, with it, quantities of water, thus providing an effective measure in the removal of cardiac oedema. An average low salt diet without the addition of salt in cooking and at the table provides 3-4 gms. of sodium chloride. The prepared lists such as I have here, provide 1.5 to 2 gms. per day.[1]

The advantages of a low salt diet are:[1]

1. It enables one to control oedema that may be resisting the usual measures namely, rest, digitalis, and mercurials.
2. It diminishes the necessity for frequent use of mercurials or eliminates entirely the need for their use.
3. It enables these patients to take more fluid and so aleviates troublesome thirst and insures an adequate intake of fluid to meet the body demands.

The disadvantages of low salt diet are:

1. It is difficult to obtain in a boarding house.
2. Unpalatable diet.
3. Sodium depletion with symptoms of same.
   (*Wheeler, Bridges & White, J.A.M.A., Jan.* 4, 1947).

Diet in the early stages of congestive heart failure may consist of 200 cc. of skimmed milk four times a day; or milk flavoured with lime juice, gruels, whites of six to ten eggs flavoured with lemon, cream soups. (Milk contains 1 gm. of sodium chloride per litre). Dry biscuits, Zwieback, and toast may be added if the patient wants more.[4] While considering the question of body fluids, it is well to bear in mind the paradoxical possibility of the dehydration in the oedematous cardiac. This condition does occur not infrequently, and symptoms and signs of the same should be carefully watched for. Ingestion of water is not the cause of cardiac oedema. Water per se acts as a diuretic. In fact some authorities, notably Schemm, have advocated forced fluids together with an acid ash, low salt diet.

Cardiologists are generally agreed on the advisability of the administration of at least an average amount of fluid—3 to 4 litres a day. In large hospitals, one frequently sees dehydrated, oedematous cardiac being given (slowly) glucose in distilled water intravenously.

Digitalis

Our universally most effective drug is still digitalis. You will forgive me if I digress here for a moment or two to mention some indications and contra-indications to the use of this valuable drug.

Indications:

Treatment of:

1. Congestive heart failure.
2. Auricular fibrillation.
3. Auricular flutter.
4. Paroxysmal auricular tachycardia.

Contra-indications:

1. Acute rheumatic carditis.
2. Paroxymal ventricular tachycardia.
3. Changing AV Block and high degrees of AV Block with Adam Stokes attacks.
4. Pericardial effusions with cor tamponade.
5. Constrictive pericarditis.

Doubtful value:

1. Hypertensive heart disease.
2. Acute pulmonary oedema.
3. Vascular collapse.

Methods of Administration:

"Digitalis saturation or digitalization is, as far as we know, the only satisfactory method of dosage of digitalis when the drug is much needed, digitalization, slow or fast, of the patient's system with the drug until the therapeutic effect is secured or until toxic symptoms develop."

The symptoms of digitalis intoxication are anorexia, nausea, vomiting, diarrhoea, cortical changes, viz., yellow or diminished vision, confusion, depression, inability to concentrate, syncope, convulsions, psychoses. The objective effects are premature heats, bradycardia, block, fibrillation, paroxysmal ventricular tachycardia, together with other electrocardiographical changes.

When nausea and vomiting appear, be sure that it is not due to ammonium chloride or one of the purine compounds you are administering, or mercury if you are giving the latter orally.

A dosage schedu.e that I have found to be satisfactory in the average case is .3 gms. the powdered leaf, three times a day for the first day, then .1 gms. t.i.d. until, with fibrillation the rate is reduced to approximately 70 per minute. Without fibrillation the drug is administered until there is satisfactory clinical improvement, or until signs of intoxication appear. (One should always be on the look-out for these early manifestations of over-dosage).

Digitoxin may be used, bearing in mind that it is just 1000 times stronger than the leaf, therefore the dose is .3 mgm. t.i.d. for the first day, then, .1 mgm. t.i.d. until the desired therapeutic result is obtained.

It is absorbed completely when given orally but may be administered intravenously. A single full digitalizing dose of 1.2 mgms. may be givn orally or intravenously[7] (*Dr. H. Gold, J.A.M.S., April* 17, 1948). With 1.2 mgm. 2% will show signs of digitalis intoxication and with 1.6 mgm. 12% will have toxic symptoms (L. Wolfe[5]). The average maintenance dose is .1 mgm. with a range of .05-.3 mgm. With a maintenance dose of .2 mgm. 37.5% show signs of toxicity and with .3 mgm. 61% have toxic effects.[8] (*R. Batterman, A. C. DeGraff, N. Y. American Heart Journal, Nov.*, 1947).

When a single full digitalizing dose is given its maximum effect will be evident in 6 to 10 hours.

In patients who have marked gastro-intestinal disturbances, it may be that the purified glucoside is the drug of choice, though experimental evidence has shown that the nausea associated with digitalis intoxication is of central origin.

In certain cases one may desire a more rapidly acting glucoside. .5 mgm. ouabain intravenously will show some effect in a few minutes and its maximum effect in two hours and is fully excreted in twenty-four hours.[9] Digoxin and Lanatocide C also are excreted fairly rapidly. All of these three are poorly absorbed from the gastro-intestinal tract.

It is worthy of note that some authorities, notably Dr. Altchule, have reminded us that patients may require a redigitalizing dose from time to time to offset the gradual loss in excretion.

Diuretics

Recently the value of diuretics has been more appreciated. Old ones—urea, xanthines, and ammonium chloride have been rejuvenated, new ones have been added—organic mercurial compounds with theophylline—salyrgan with theophylline, mercurpurin and others.

The theophylline molecule in combination with mercury reduces the pain from the intramuscular injection, prevents necrosis of tissues, increases the rate of absorption, prevents the storage of mercury and increases the concentration of the mercurial within the kidney, thus contributing to the greater diuretic response.[8] (*A. C. DeGraff, J.A.M.A., April* 17, 1948.

Ammonium chloride and xanthines may be satisfactory in the milder cases, bearing in mind the possibility of gastro-intestinal disturbances from these; but in the advanced cardiacs with much oedema, the mercurials with the aid of ammonium chloride are necessary.

It would appear that the mercurials damage, slightly, the tubules of the kidneys, and so interfere with the reabsorption of sodium chloride, with the result that this excess sodium is withdrawn from the body and with it amazing amounts of water. One injection may produce a diuresis of 10 litres or more. The initial dose of Salyrgan should be small, ½ cc. If the patient is not mercury sensitive, it may be increased to 1 or 2 cc.'s. 1 cc. may be given daily for a few doses, then bi-weekly, weekly, or as the weight increase may indicate. 1 cc. bi-weekly will produce a greater diuresis than 2 cc.'s once a week. Signs of dehydration should be watched for and promptly and adequately treated. If there is any oedema fluid at all a diuresis may be expected in 90% of patients when the drug is given intravenously or intramuscularly.[8] (*DeGraff J.A.M.A., April*, 1948).

Oral administration in the form of tablets is quite satisfactory in about

60% of patients who have a moderate degree of congestive heart failure. These may cause nausea and diarrhoea and are preferably given after a meal to avoid gastric irritation.

Enhancement of mercurial diuresis can be produced by administration of ammonium chloride in doses of 3 gms. a day for two to three days preceding the mercurial injection. It would appear that after a period of diuresis the body refuses to further deplete its chloride store, and, therefore, to release sodium. Chlorides must be provided in the form of ammonium chloride, hydrochloric acid, or sodium chloride. If the latter is used, the odema may temporarily increase, but with the discontinuance of the salt and reinstitution of the mercury injection, a further and more effective diuresis may be expected.

Mercurials are not free from danger however. Among the reactions that may be noted are:[8]

1. Sensitization to one of the mercurials, manifested by urticaria, rash, chills, fever, and a sense of tightness in the chest.
2. Digitalis intoxication. Diuretics may, by mobilization of oedema fluid cause a redigitalization even to the point of toxicity.
3. Depletion of sodium with concomitant symptoms—cramps, abdominal colic, nausea, vomiting, especially if the patient is on a low sodium diet.
4. Sudden death. This is relatively rare, and can be prevented if the initial dose is small, and with signs of sensitivity another mercurial is substituted. (*J.A.M.A., April*, 1948).

Dr. Harry Derow of Boston, has reported one case of mercury poisoning. He advises repeated urinalysis during treatment. Warning signs are the initial appearance of albumin and red blood cells, or the increase in the amount of pre-existing albumin and the number of red blood cells. Dr. S. T. Laufer of Halifax feels that mercury should not be given if the specific gravity of the urine is 1015 or less.

In the spring of 1947 I attended a lecture given by Dr. Harry Gold of New York, when he was asked his opinion concerning the possibility of toxic effects of mercury. He felt that there was little, if any, danger of kidney damage, since it was an organic form of mercury. They had given a dog a lethal dose of mercury, and post mortem showed that the dog had not died from kidney damage, in fact the kidneys appeared to be quite normal.

Charting of the weight is one of our most valuable aids in following the progress of patients with congestive heart failure. If he is following an appropriate diet, any appreciable gain in weight is usually an indication for Salyrgan. These changes will be remarkably clear if the weight is charted daily.

Sedatives or hypnotics[10]

In the presence of congestive failure it is often exceedingly difficult to obtain that much needed rest and sleep.

Morphine gr. 1/6-1/3 or codeine gr. ¼-1 is frequently most urgently required for relief of cough, dyspnoea, and orthopnoea.

All the metabolic processes are slowed and with this change anoxemia may be temporarily increased but the relaxation and rest obtained more than compensate for the oxygen loss.

Atropine may be of some benefit for relief of bronchospasm but it is better omitted due to the suppression of secretions and excretions.

Barbiturates gr. ¼ to 1½ may be tried, though some authorities advise chloral hydrate 3-8 gr. 2-4 times a day and up to 24 grs. at bedtime.

Paraldehyde 1-4 drams in a 25% elixir is the most effective hypnotic, though the odour and taste are unfortunate. The rectal dose is the same as the oral and 4-8 cc. may be injected intramuscularly.

Oxygen

50% of oxygen by nasal catheter or a close fitting mask, preferably with positive pressure, may give considerable relief. 10-15% oxygen unsaturation frequently occurs, with heart failure, especially in the presence of pulmonary lesions—congestion, consolidation, infarction, oedema, and the like. With the haemoglobin completely oxygenated one cannot expect any appreciable benefit from oxygen administration, any increase of oxygen in solution in the blood is negligible. It will not relieve cyanosis of congenital heart disease, arterio-venous aneurysm, nor the dyspnoea of anemia.

Mechanical Removal of Fluid

Thoracentesis and abdominal paracentesis may be required for the mechanical removal of fluid. Rarely, with massive oedema of the lower extremities, Southey's tubes or an incision three inches long on the dorsum of each foot will be effective in removing large quantities of fluid. With sterile precautions, sepsis does not usually occur. The cardiac bed or chair, of course, promotes the accumulation of fluid in the legs. These mechanical aids are frequently followed by a significant increase in the action of diuretic drugs.

Cardiac Asthma or Pulmonary Oedema

Acute cardiac asthma or pulmonary oedema may occur and requires emergency treatment. Morphia gr. 1/8-1/4 intravenously or gr. ¼-½ subcutaneously is the drug par excellence.

Phlebotomy has been largely replaced by the use of tourniquets, to reduce the venous return to the right side of the heart. They should be applied to all four extremities, 15 minutes on, and 15 minutes off.

¼-⅛ gram aminophyllin by intramuscular or slow intravenous injection frequently gives dramatic relief, especially in the presence of bronchospasm and Cheyne-Stokes respiration.

Barbiturates gr. 3-3½ intravenously may be as, or even more, effective than morphia.

Oxygen, administered as mentioned above, is a valuable aid in relieving pulmonary oedema.

Theories for those nocturnal emergencies have been advanced. The prone position increases pulmonary congestion: this, together with slower breathing and pulse rate results in lower blood oxygen, and an increase in carbon dioxide also. The circulatory aid derived from muscular massage of the blood vessels is lost.

Complications Retarding Recovery[5]

In cases of congestive heart failure that do not respond to these measures as outlined, one must always consider again the possibility of complicating factors, namely, urinary retention, abdominal distention, infection, haemor-

rhage, uremia, diabetic acidosis, pleural effusion, thyrotoxicosis, avitaminosis, and arterio-venous aneurysm.

The treatment of congestive heart failure requires meticulous guidance of all the patient's activities—mental and physical, rest weight, salt restriction, diet, digitalis and diuretics. In the words of Eggleston (Cecil's Text) "One should always remember that it is the patient who is being treated—not his disease."

Modern Concepts of Cardiovascular Disease[11]

(American Heart Association)

Low Sodium Diet

Foods Allowed

1. Meat, boiled fish, or poultry prepared and served without salt.
2. Egg—one daily.
3. Milk—limited to 2 glasses (1 pint).
4. Vegetables—(as desired) any fresh or frozen vegetables except lima beans, prepared and served without salt.
5. Fruits—(as desired) fresh, canned, stewed.
6. Breads—only yeast bread prepared without salt.
7. Cereals—any cooked cereal prepared without salt. The only dry prepared cereals allowed are: puffed rice, puffed wheat, shredded wheat and "Muffets."
8. Potatoes and rice, prepared without salt. Macaroni, spaghetti and noodles contain salt and are not to be used.
9. Butter—unsalted or "washed" butter.
10. Desserts—custards, junkets, and plain puddings made with milk allowance and with no added salt; jello; pies with no salt added to the crust and filling prepared with fresh or canned fruit (no meringues).
11. Beverages—tea, coffee, carbonated drinks or fruit juices.
12. Flavorings—cocoa, chocolate, caramel, maple, peppermint, lemon, orange, vanilla, maraschino cherries, cloves, cinnamon, allspice, nutmeg, ginger and coffee.
13. Seasonings—pepper (black or red), curry, dry mustard, mint, dill, vinegar, parsley, paprika, sage, thyme, onion, garlic, pimiento, rosemary.
14. Sweets—white or brown sugar, honey, molasses, jellies, jams, marmalade, or preserves which do not contain sodium benzoate.

Special Instructions

1. No salt is to be used in preparation of food or in cooking or to be added to the food after it comes to the table.
2. Avoid all canned foods which have salt added, such as canned meats and fish, vegetables, soups, tomato juice and V-8 cocktail.
3. Avoid all brine-cured and smoked foods, such as bacon, ham, pickles, or smoked fish, meat or sausages, and olives.

4. Omit all salty foods, such as salted nuts, potato chips, and buttered or salted popcorn.
5. The following food accessories are also to be omitted because of their salt content: meat extracts and sauces, chili sauce, catsup, mustard, and relishes.
6. Do not use any cheese, clams, oysters, lobsters.
7. Use only yeast breads prepared without salt.
8. Use no foods prepared with baking soda or baking powder, such as soda crackers, biscuits, muffins, cakes and cookies.
9. Use only unsalted or "washed" butter. Sweet butter may have salt added, so be sure to read the label before using it.
10. Home-made mayonnaise may be used, if prepared without salt.
11. Avoid dried fruits, such as figs, dates, raisins, apricots, and prunes.
12. Avoid lima beans, fresh or dried.
13. Sodium-containing medicines, such as soda bicarbonate, soda mints, tums, alka-seltzer, and various indigestion powders should not be used. Salt gargles and toothpastes containing sodium likewise are forbidden.

Recipe for Salt Free Bread

6½ lbs. bread flour
10 oz. sugar
8 oz shortening (Primox)
4 oz. yeast
2 qt. water

This makes six loaves. Apparently this bread takes a little longer to rise than ordinary bread.

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References

The references to points made by Dr. Laufer, Dr. Wolff and Dr. Derowe were all obtained from personal contact with the respective Doctors.

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Prepaid Medical Care

An Open Letter to the Doctors of Nova Scotia

BY an Act of the Medical Society of Nova Scotia at its annual meeting in September, the charter granted by this province to your representatives last April was made effective. You are now sponsoring a corporation—*Maritime Medical Care Incorporated*—whose main business it is to sell prepaid medical care in Nova Scotia. In effect, you are now in the business of selling medical services on a voluntary, non-profit prepayment basis, and actually your business will begin as soon as suitable personnel can be employed.

It has been suggested to this writer that some of our doctors have not had much opportunity to study this matter as fully as they would have liked, and they should be given a review of our position with respect to it, showing what our aims and objects are, and thereby crystallize for the record the thinking that led us to take this very important step.

Let it first be said that the profession of medicine in Canada, several years ago, officially subscribed to the principle of Health Insurance. By the very nature of our profession, we were obliged to do so, for it is our concern and indeed our obligation, insofar as in us lies, to further any movement which has for its object the supplying of good medical care to our people at a cost that is not crippling—at a cost that is not a deterrent to their seeking the care they need.

It is now recognized that the cost of medical care can to a great extent, be spread over whole communities and so kept low to the individual, as, in some respects, the cost of fire losses is spread over and kept from crippling those that are insured; and we have seen this principle being applied and developed in most of the provinces of Canada for several years now, to spread the cost of medical care.

We change more slowly in these Maritimes, and so have thus far expeirenced little urge to apply the same thing here, or to have it applied, until quite recently. Because of this we have heard the question "Why, when there is no demand for any form of Health Insurance (Prepaid Medical Care), should we disturb the present happy arrangement?" In answer to that, we would like to say that if its premise were true, we would personally be sympathetic with the position, but it is not quite true. The growth of prepaid *hospital* care in these provinces is very clear and strong evidence that people welcome the opportunity to provide for themselves by some form of insurance in time of health for the time when they become sick. Especially in these times, people are coming to look for the feeling of security which enables them to say "No matter what happens, I am protected."

The movement to be insured against hospital costs has extended very rapidly on this continent, and we acclaim it as a great movement—a fine thing. It is a natural step from that to a demand to be covered for illness costs as well, and that movement too has grown, until now, it has covered every state in the United States, and most of the provinces of Canada, and the demand for it is spreading and will continue to spread.

The question naturally arises then, whose job is it to meet this demand? Over the years, Medicine has made contributions to science, to the advance of civilization, to the improvement of the social order, and to the sum total

of human happiness, in the aggregate, second to no other group in Social Service in the world. We are proud of our heritage and of those accomplishments. Shall we just forget them now or surrender them to politicians who know nothing of their inspiration and who care less, or it it our job, with our background and knowledge and corporate ideals to assume responsibility for meeting these demands in a changing social order? Consideration of this matter at our annual meeting last month clearly shows that it *is* the concept of organized medicine that it *is* our job, and we are now moving toward the expression of that concept. That means change—quite considerable change—in our thinking and practice, and the question is, how can we effect such change and still retain for our people the benefits of Medicine as an ever-developing social and scientific movement?

Consideration of this problem for Nova Scotia brought three suggestions:

(1) Let governments bring on a system of compulsory health insurance, in which or under which everyone would be covered and taxed, and under which for a short time many would be happy, because they would have the feeling of getting something cheaply; others would not, because the cost would be high in proportion to their income.

(2) Let some commercial or quasi-philanthropic body sell our services.

(3) Set up a system by which we deal with the public as we have always done, except that the cost will be covered by voluntary prepayment on an insurance basis.

These were the things which had to be considered; and if, as we believe, we are the real custodians of the quality of medical service (and who should be but the only group that has nurtured the urge to improve the quality of Medicine over the years?) then, it was felt, it is our obligation to determine which of these things will assure to us that that quality will be maintained, and its improvement continued. Having determined which is the best it is then our obligation to support it, and to render neither aid nor comfort to any other organization or movement which does not, in the view of organized Medicine, meet our high standards of medical service.

One does not need to be much of a student of this subject these days, to know what has gone on under the Socialized Medical Care system of New Zealand—how the quality of and prospects for Medicine in that country have so soon and so sadly deteriorated; nor yet to appreciate what has recently happened in England. There is ample proof that the laws which have spread Medical Services over so thin a layer so that a doctor, to maintain his standard of living, may have to take on 4,000 patients, while most of us work on a basis of about a quarter of that, are laws which have reduced the quality of medical service to a point where the great advances of Medicine are prevented from reaching the people. After all, if there has to pass through one's office in any given hour as many as 60 patients, of what value is scientific training? There is accumulating a great mass of evidence which proves that by these measures, operating as they do in these several countries, the clock of Medicine has been put back by many years, and that because of the nature of the controls now exercised upon it, the prospects for improvement are very gloomy.

It would not call for much exercise of the imagination to foresee in those circumstances with the reduction in scientific thought and effort which is a part of such socialization of Medicine, a return of the magic and demonology

of early times. Helped out by a bureaucratic pamphlet or two and a nice dose of magical medicine, we would be well on the way to the prehistoric. It would remain to eliminate the few intellectuals according to well-known patterns, and the rest would be easy. Then throw in an I-em-hotep or some similar deity—the priest-physicians would require very little apprenticeship—and the system would be complete.

Perhaps we would not go back quite to the Egyptians before something would stop the deterioration, but after all, if so many patients have to be handled in so short a time, what kind of medicine is being practiced? Would an incantation over the crowd not be as effective?

That however, is only one side of the picture of state systems in Medicine. On the obverse side is the effect upon our own profession. The effect is to lose all semblance of independence, and with it the initiative and spirit of adventure that have made Medicine what it has become under our system of free enterprise.

This effect upon our profession and upon ourselves as individuals could be be enlarged upon, but to-day there is none among us so dull or so indifferent as to be unappreciative of the significance of these things, as they affect not only the true interests of Medicine, but the interests of our people, and our own personal and professional lives as well.

Now because such a system would affect our personal and professional lives very profoundly, there are those who say that we are prejudiced and that therefore our evidence is not reliable. To this we object strenuously. A degree of self-interest there must be, but they will have great difficulty, who attempt to show that it colours our judgment in this matter, to any significant degree. No one among us will deny that we would not want to live under any such system, but the greater and more pertinent facts are all beyond and above this. There was recently published by the Brookings Institution of Washington, D. C.—an organization that specializes in the Social Sciences—results of a study on "The Issue of Compulsory Health Insurance." This study was made at the request of the United States Senate Health Committee. It finds that:— *Under the present system great progress has been made in the application of Medical and Sanitary science, and that there is every reason to believe that progress in lowering mortality rates and increasing life expectancy will continue unabated under the present system of medical care . . . that compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and agencies engaged in providing medical care, regulation and control which does not encourage initiative and development. The Problems of politics in administration of government medical care plans, of government control over the relationship between the physician and patient, of increased costs and civil servant staffs were also pointed to as reasons why very careful consideration should be given to the question before any medical change is made in the existing system.*

No one can charge "prejudice" against so important a non-medical body. There speaks reason, and with its decision we could rest, were it not that there is accumulating so much evidence that politicians at times become so puffed up as to think themselves above reason, and act accordingly.

But there should be recorded here the view that governments too have obligations in this matter. The obligation to take care of those who because of their *res angusta domi* are unable to take care of themselves. Up to now

the doctor has taken care of them, out of the fullness of his charity, and it is a well recognized fact that throughout this country to-day, the people who may have the very best of medical service are the poor. It has been recognized that the doctor has been able to do this because he has been able to get a reasonably substantial living from those of the more affluent, who have been able to pay his fees. Up to now that has not worked out too badly for either the poor or for the affluent, but there remains the great in-between group that constitutes the backbone of any country, who have been called upon at times to contribute more than their proportionate share according to their means. It is recognized that plans for prepayment of medical costs benefit this class more than any other, but it is the experience of all plans that under payment from insurance schemes the doctor receives less. If this is so, and if he is expected to make this contribution to the better distribution of medical care to this class, can he be expected to do as well for the welfare groups and for the indigent? In plain words, if he must scurry around a bit more to secure a living income from those from whom his income is derived, will he have what it will require of time and energy to give adequate care to those other groups that make call upon his charity? With all the generous impulses imaginable, we must yet be realistic. This writer deplores the changes that require that this be discussed in this manner, and must register regrets at the imminent passing of those opportunities for the expression of his charity which have been so long peculiarly the doctor's. Being realistic, however, we must recognize that there is this change, and in the realm of practical economics must raise the question, who will take care of those less privilged groups? For this, there is obviously one answer: the cost of caring for them must now be spread over the whole community, and there is only one kind of body that can make that effective and it is governmental—whether municipal, provincial, or whatnot. Here the same general principles apply, and we are glad to see that in some provinces the government has assumed its obligation to those groups and through organized medical channels have secured their medical care in a manner satisfactory to the people and to the government and reasonably satisfactory to our profession. This has been done too at a cost more satisfactory to the taxpayer, for medical administration through medical organization is effected at a much lower cost than is possible through any governmental department.

It is clear then, that there is place in this business of medical care for both Medical Organization and Government, if the best in medical service is to be assured, and despite the fact that government in medicine is so generally feared, it is our view that it may make and should make a very efficient and satisfactory partnership in the manner herin suggested, if it be kept free from party politics and governmental bureaucracy. Indeed, it would have to be, regardless of the government's political stripe.

Our second suggestion for consideration was: *Let some commercial or quasi-phialnthropic body sell our services.* This suggestion elicited a lot of discussion among us for some of the quasi-philanthropic schemes had friends among our doctors, in this province. No one blames them for that. They were doubtless honest in their belief that such a scheme was the answer to our problem. But information to hand to-day definitely and clearly shows that it can never be the answer and that if they apply the same degree of honesty to the facts which their own scheme provides, they will have no difficulty in

changing their minds—as most of them have done—indeed, they will feel impelled to do so.

Now what is there against our allowing non-medical bodies to do this job for us? But first let no one have any doubt that this writer and others, would have welcomed any scheme which would have removed this headache from the Medical Society (and in particular from those members now called upon to do a job for it), if it could be shown, or if there were any reason to hope, that the job would be satisfactorily done (1) in the discharge of our obligations to the public in the matter of a satisfactory coverage, and (2) in the matter of the protection of ourselves, (a) with respect to the proper distribution of the subscribers' money, and (b) in the acquiring of that knowledge and experience for ourselves which will enable us to speak as having authority—when Medicine's place in a newer order is being challenged.

It was concluded that we could not in this day and age lend our countenance to any plan that we felt to be inadequate. If we are to be in any way connected with Prepaid Medical Care, it should not be very different from that which we ordinarily render to our people. Therefore these partial schemes are out.

"If we may not subscribe to their schemes then," it is asked "Why may we not set up our own plan, and let them run it for us at a definite cost? They have the set-up and equipment and could do it more expeditiously than we could, and more economically." A good question indeed, but again unfortunately, carrying with it a suggestion that is at wide variance from the facts of experience. Let us consider the province of Manitoba where originally this practice was adopted and in which exactly similar groups were involved. For several years the doctors worked under such a system, and it will be remembered that some time last year, even the newspapers carried an account of the terrible situation in which their medical care plan found itself. It seemed that the whole question of prepaid medical care—*medically sponsored, but managed by the Hospital group*—was regarded as a failure. Financially it was. It was terribly heavily in debt to the doctors, and the question of folding up was entertained. The decision of the doctors, however, was that a plan of prepaid medical care must be continued, but that they must terminate their management arrangement, and set up a system by which they would manage the plan themselves. Now, a year or so later, their plan is working smoothly and satisfactorily, taking its place among the successful medically sponsored, medically managed non-profit plans of Canada, with operating costs much less than that paid to the managing corporation, and with a subscribers' list that is now showing satisfactory growth.

In the light of this knowledge could your Committee on Economics have recommended that our plan be directed and managed by such a group? You will be quick to agree that it would have been sabotaging the interests of the doctors of this province before the plan had ever started. Mistakes we shall all make but to do foolish things with our eyes open would be unpardonable.

We were left then with our third suggestion—To set up our own plan—and to that there was no alternative.

The medical men of this province with clear and positive voice have said that was the correct thing to do, and the plan submitted to them was accepted.

The Society, through its executive, which represents the whole province, made its sixteen nominations to the first house of delegates of the new Cor-

poration, picking with considerable care the men whom they felt would well serve the interests of the new Corporation and so the interests and the prestige of Nova Scotia Medicine. No doubt other 16's would have done as well, but we are sure that an effort was made to select men who would give more than lip-service, and it is reasonable to expect that others of our members will come to enlarge the "House" as the months go by.

That body has since met and elected the Board of Directors, and done such other things as were requisite to the legal setting of the new body. The Board of Directors also met and elected its officers and executive and delegated to its executive necessary powers for the securing of funds, the employing of personnel and so on. It is understood that the several steps are being taken with necessary care, and in the meantime there requires to be taken one very necessary step, viz., the securing of the agreements of the vast majority of our professional brethren as participating physicians.

When the new Corporation approaches employees and other groups—very shortly, we hope—to enroll them in the doctors' plan, one of the questions is going to be "How many doctors are behind you?" Our answer must be good. *Indeed, unless it is good—it will not be effective.*

This is a time of crisis in our medical lives. Some of us are recognizing it as such a year too late; some of us have not recognized it as such at all. Five years from now, with the present trend continuing, there will be no doubt about the significance of this hour. It is time for the strongest allegiance to our medical organization, and a time for a show of strength. Immediate execution and return of participating physicians' agreements will be the evidence of our degree of unity.

It may well be that doctors in more remote sections of the country may not come in contact with the plan for some time, although as subscribers move about the province one never knows when one might be called on to work under it. But regardless of whether a man may work under it this year or next, as a member of the body sponsoring the plan he should indicate his interest and support and promptly return the agreement sent to him.

There is a rule, in at least one of the Western provinces, that to become a participating physician a man who is not a member of the Medical Society must pay $35.00—which is there the combined fee of the provincial and Canadian Medical associations—which amount is then passed on to these bodies. To become members of the plan they are readily accepting the condition and paying this sum. In other places there is a registration fee, apparently on the principle that that which costs something is more highly appreciated. In this province there is no such rule, though in these times it is difficult to understand how intelligent men can keep themselves out of their medical organizations which now, more than ever, can do so much to protect the interests of Medicine in general and their own medical lives in particular.

There remains, for the record, one further fact—the movement for a national plan of prepaid medical care grows apace. A meeting of representatives of the medically sponsored plans of Canada, with the Special Committee of the C.M.A., in Toronto recently, indicated that the application for a charter would probably be made, with the various provincial plans as signatories. It would sell to national groups looking for uniform coverage for their employees, and would administer its care through the constituent provincial plans. It would help to correlate the different plans. Full details

have not been worked out, as there is consderable difference in the type of plan offered in the different provinces. The tendency is towards unification but it will be slow in coming.

Further information respecting your plan will be recorded as events occur. By next month we hope to record that 100% Physicians' Agreements are in hand, and further reports will depend on that. The men that our Society has asked to do this job for us must have, just now, the solid moral backing of our members, and as they must be influenced in their effort and in their decisions by the evidence of support which we give, let us sign and return our agreement to them at once.

This contribution is set out to give information to those interested in such a review. It is realized that nothing of this kind can be complete, but your Committee on Economics will be glad to make it more so by considering any request for fuller information on specific points which you may care to make. Any suggestions also which you may offer, looking to the improvement of the medical economics picture in this province, will be dealt with to the best of our knowledge and ability.

NORMAN H. GOSSE
Chairman, Committee on Economics

95th Annual Meeting of Medical Society of Nova Scotia, 1948

First Business Meeting

The first general business meeting of the 95th Annual Meeting of The Medical Society of Nova Scotia was held at "Keltic Lodge," Ingonish, N. S., on Tuesday, September 14th, at 10.00 a.m.

The President, Doctor Eric W. Macdonald, presided, and stated that the Secretary, Doctor H. G. Grant, could not possibly attend the meeting and had sent his regrets.

It was moved by Doctor R. O. Jones, seconded and carried, that Doctor F. J. Barton act as secretary for this session.

Doctor Eric W. Macdonald said that the hosts were the Cape Breton Medical Society and he would like to call on Doctor M. J. Macaulay, the president of the Society.

Doctor M. J. Macaulay stated that the Cape Breton Medical Society wished to extend a welcome to the President and Secretary of the Canadian Medical Association and the other speakers and members of the society and that they were very glad to have them all there.

The letter from Doctor A. D. Kelly re representation on the Committee appointed by the Provincial Government to make a health survey of the Province, as printed in the Executive minutes, was the first item on the agenda.

Doctor A. D. Kelly advised that at their last annual meeting this matter had been the most important topic, and he hoped that it had been possible for the Nova Scotia Division to be officially represented on the committee doing the work on these health survey grants. Any federal grants that remain for the fiscal year unexpended do not revert to the province at the end of

Doctor Eric W. Macdonald: "When this matter came to our attention the Minister of Health was approached and the Minister was sympathetic to the suggestion and assured us that when and if this commission was set up that our Society would have representation. Yesterday it was moved and seconded that a medical advisory committee be set up to offer advice to the Government on our behalf, it was further suggested that this matter be discussed at the meeting this morning. As you know, this grant is an allotment of about $35,000 to this province to conduct a survey of the requirements of the province that would be necessary under a form of health insurance. From Doctor Kelly we have a very detailed memorandum on just what phase this survey will likely take."

Doctor William Magner stated that these grants were something new, and were announced by the Prime Minister and later by the Honourable Paul Martin in May of this year, looking to the setting up of a scheme of health insurance, but a survey has to be made pointing out the deficiencies of the present system. They feel in the Canadian Medical Association that is of extreme importance that every Division should be closely related to the powers which will have the authority to spend this money. It is of the greatest importance that the profession in this province would appoint one man who will be commonly interested in it and not be slow in offering advice to the Government.

Doctor R. O. Jones stated that in spending the mental health grant a

group had met and drawn up a plan which has been offered to the Government. He presumed that other fields would want to organize themselves in the same way.

Doctor N. H. Gosse stated that most of the things we are concerned about have to do with the study of health matters in the province. The Minister of National Health has said that this is the first step toward paving the way to national health insurance.

Doctor William Magner asked if the Government had approached the Society to nominate any man.

Doctor A. E. Blackett: "At the time the meeting was held with the Premier he asked us if we would name a small committee, preferably living in Halifax, that he would call upon for advice on these matters, and we promtply then and there named the committee, the members of our Medical Economics Committee who resided in Halifax."

Doctor N. H. Gosse moved the adoption of the following resolution which was seconded by Doctor J. W. Reid and carried.

Whereas matters of Public Health and those that effect the general practice of medicine in this province are of concern to The Medical Society of Nova Scotia, and

Whereas it is proposed that a Health Survey of the province shall be made and that various phases of the practise of medicine shall be modified by the newly announced Federal grants, which are said by the Minister of National Health to pave theway for Compulsory National Health Insurance, and

Whereas it is the view of this Medical Society of Nova Scotia now in Annual Meeting assembled that the knowledge held by us of both general and special medical character should be availed of by the Government of this province in the administration of the several funds now made available.

Be it now resolved that a committee of this Society be elected to advise the Government respecting these several matters.

It was suggested that a special nominating committee be appointed by the President to meet in the next half hour.

The letter from Doctor C. M. Bethune with the drawing of an emblem for cars of the doctors was next considered.

Doctor Eric W. Macdonald: "Last year Doctor Bethune was instructed to get a design and price for an emblem for motor vehicles and if it is your wish a supply of these can be purchased by the Secretary and sold to the members. The only modification in that design suggested by the executive as that the name of this society be printed in the correct form. The supply will be in the hands of the secretary and purchased from him."

On motion the recommendation of the executive was approved.

The adoption of the Treasurer's report, as printed in the executive minutes, was moved by Doctor R. O. Jones and seconded by Doctor E. I. Glenister, and carried.

The next item was the letter from Doctor A. D. Kelly re the annual meeting of the Canadian Medical Association in Halifax in 1950, also printed in the executive minutes.

Doctor Eric W. Macdonald: "There was no doubt in the minds of the executive that this meeting in Halifax in 1950 was a Nova Scotia meeting,

and that this Society will be hosts to the Canadian Medical Association at that time."

Doctor N. H. Gosse: "It is customary in the place where the Canadian Medical Association holds its annual meeting for the Provincial Division to hold its annual meeting at the same time. I think it would be a nice gesture if the local Society offered the suggestion to New Brunswick and Prince Edward Island that they hold their annual meeting in Halifax at the time of the Canadian Medical Association meeting, and that the local committee make provision for them.

Doctor J. C. Wickwire asked if the hotels in Halifax would accommodate them.

The action of the executive in this matter was agreed upon, and Doctor Gosse's suggestion was referred to the Committee on Arrangements.

The letter from Doctor A. D. Kelly re fees, as printed in the executive minutes, was next considered.

Doctor Eric W. Macdonald: "This is a very important letter in that it will mean a reduction in fees payable to this Society, and personally I do not believe, in spite of Doctor Jones' excellent report, that we will be able to carry on with a $5.00 fee."

It was moved by Doctor E. F. Ross and seconded by Doctor H. S. O'Brien that the combined fee for the Canadian Medical Association and The Medical Society of Nova Scotia be $20.00 in 1950. That motion was withdrawn and Doctor E. F. Ross moved that beginning in 1950 that the overal fee for membership in the Canadian Medical Association be $20.00, $10.00 for membership in the Canadian Medical Association and $10.00 for membership in The Medical Society of Nova Scotia. This was seconded by Doctor H. D. O'Brien and carried.

The adoption of the Workmen's Compensation Board Committee report, as printed in the executive minutes, was moved by Doctor E. F. Ross and seconded by Doctor C. C. Stoddard.

Doctor R. A. MacLellan: "Without in any way criticizing the committee, I would say that in my opinion that schedule of fees is a schedule of fees for medical or special qualifications rather than a schedule of fees for the general practitioner. One subject is apparently in doubt, that of mileage. The present rate of mileage is 50c per mile after the first two miles. I have been practising medicine for forty years and the only similar type of business services was in connection with the Marine Department. I could get a better fee forty years ago than I can now. At that time I received one dollar for the first mile, fifty cents per mile thereafter. I was allowed to take a consultant and to charge for any remedies I supplied; there was no criticism for the consultant's fee or the charge for medicine. It hardly seems reasonable that medical men should be serving for less than that at forty years ago. My second objection is the brief period for rendering a medical account, but again I am not casting any reflection upon our committee. I wonder if we could not solicit the aid of the U. M. W."

Doctor Eric W. Macdonald: "I would like to commend Doctor MacLellan for his excellent remarks. The fifty cent item per mile is an eye sore. The arguments we submitted to the Committee of the Workmen's Compensation Board I feel left nothing unsaid."

Doctor J. W. Reid: "I think we should not accept that as a working day,

that is from 8 a.m. to 10 p.m. Another thing the Medical Society should do is to demand certain mileage."

Doctor Eric W. Macdonald: "I think this committee should be commended for their negotiations with the Board."

Doctor J. C. Wickwire: "I am in full accord with Doctor Reid. I think our fees require a bit of adjustment. When you think of the prepaid medical scale that is being set up, there is no mileage in it at all. This mileage has been abused by many of the doctors in the province, and that is why Mr. Rowe has kept to the fifty cents rather than raising it higher."

Doctor J. W. Reid: "We accepted a reduction, fifty cents mileage from one dollar. If we have a scale of fees below which we will not work they have got to meet it and it is a question of standing together."

Doctor N. H. Gosse: "It has been pointed out by Doctor MacLellan that some of the fees benefit the man who is doing special work. I do not think we can do very much about their schedule. We should put a rider to it for the benefit of the Workmen's Compensation Board that we are not satisfied as a body with the recognition of the general practitioner's claim as shown in that report. The motion is that this report of the Workmen's Compensation Committee be adopted."

It was moved by Doctor J. W. Reid that this Society pass a resolution and send it to the Workmen's Compensation Board regretting their unwillingness to meet our request in a higher mileage fee and office consultations and higher schedule of fees to the general practitioner and requesting them to reconsider the matter. This was seconded by Doctor H. J. Martin and carried.

Doctor E. F. Ross: "I would recommend a complete changeover of the Workmen's Compensation Board Committee."

The original motion to accept the report was carried.

Doctor A. W. Curry: "The Executive appointed a committee to draw up a minimum scale of fees for The Medical Society of Nova Scotia. We studied several different schedules and the Ontario Medical scheme seems to us the most comprehensive, so we modified it. I think it should be referred to the incoming executive to study and modify. I move that it be referred to the incoming executive for their study and modification before being adopted." This was seonded by Doctor J. C. Wickwire and carried.

Doctor J. W. Reid: "An attempt should be made to review and study it before the prepaid medical scale is adopted."

Doctor Eric W. Macdonald: "I do not see how this can be finalized before we put on a voluntary health scheme."

Doctor D. M. MacRae: "Would it not be worth while to refer this scale of fees to each individual society?"

It was moved by Doctor D. M. MacRae and seconded by Doctor J. J. Carroll that it be suggested to the executive that they send out this scale of fees to each Branch Society before they finalize it. Carried.

Doctor J. W. Reid: "I would suggest also that it be sent to the Astronomical Association."

Doctor N. H. Gosse: "As you know this matter of prepaid medical care is one that has been giving the whole profession of Canada a very real concern for some years past. Last year at the annual meeting of the Society we started preparing our thinking along these lines. With the help of very able and representative group of men we got busy and sent a report to all practising

physicians in the province. Following consideration by the executive the following resolution was sent out together with a ballot, and a fair number of replies have been received:

Whereas the principle of Health Insurance has been accepted by organized medicine in Canada, and

Whereas Medically Sponsored Prepaid Medical Plans offer a means by which that principle may be applied and is being applied in most of the other provinces of Canada, and

Whereas such plans may properly be expected to develop so as to include different groups and strata of society that now require a high type of medical service without the fear of prohibitive or crippling cost, and

Whereas it is widely held that medically directed plans are best calculated to effect this result while preserving the highest standards of medicine and the present desirable doctor-patient relationship, and

Whereas under instructions from our Medical Society of Nova Scotia our Committee on Economics has produced a plan of Voluntary Non-profit Prepaid Medical Care which, in their judgment and in the judgment of this Society, offers reasonable hope of the fulfilling of these requirements and the realizing of these ideals, now be it

Resolved that the actions of the Committee on Economics be confirmed, that the plan prepared and submitted by the Committee be adopted, and that necessary steps be taken forthwith for its implementation.

The Ballot.

In giving that report, Mr. President, I would like to say that we have coming upon us the very definite trend to compulsory health insurance, indeed the promise of it. We already have taken action to-day with a view to influencing Governments with respect to the thinking that obtains in our profession. We in this province must have some knowledge, some experience, as to how prepaid medical care should be administered. I believe that this plan provides opportunity for that, and at the same time that it has great potentialities for good for the people of this province. I, therefore, have much pleasure in moving the adoption of this report."

Doctor J. G. B. Lynch: "It gives me great pleasure in seconding that report and to commend Doctor Gosse for his ability in preparing it."

Doctor W. J. MacDonald stated that he had been requested by the Colchester-East Hants Medical Society to say that they were unanimous in asking that there should be further study and consideration of the various necessary details at this meeting. They believe that further study should be given to it.

Doctor W. O. Coates felt that the time had come when refusal to adopt a scheme was not sufficient unless one was prepared to counteract with some definite proposal. "Some of us will remember an address by Doctor Coady to an representative body of the United Mine Workers. One of his proposals was for them to get busy on a prepaid medical scheme. He also referred to several organizations which had fostered a prepaid medical scheme. I think it behooves us a body, unless we have a definite better plan than this prepaid medical care scheme, to accept it. I take great pleasure in commending Doctor Gosseupon his excellent work and I hope we will get behind this proposal."

Doctor H. A. Fraser stated that a report had been sent in from the Lunenburg-Queens Medical Society.

Doctor J. W. Reid: 'That plan should be accepted; we should do everything we can to put it in operation at the earliest possible date. I feel certain that there are not enough people in Nova Scotia to-day to pay $100 a year. I do think that this meeting should here and now adopt it and try and put it into operation. It is purely a waste of time to mull over it. I think that this meeting should adopt that report."

Doctor J. P. McGrath stated that Doctor Gosse had outlined the scheme at a meeting of the Valley Medical Society and he did not think there was any really objection to it. "We are going to have some sort of socialized medicine, and it is up to us to try and forestall it by introducing our own plan. We are inclined to put things off to the next meeting. This matter is coming ahead very rapidly. We will be forced more or less to accept a lot of conditions that are very distasteful to us. I am very much in favour of the scheme and I shall vote that way."

Doctor W. J. MacDonald asked that a short period of thirty days be given to consider adopting the report and that a further meeting be held in Halifax. He was prepared to present a motion that it be delayed for one month to strengthen the Society.

Doctor J. A. MacDougall stated that they had had a meeting in Antigonish and as a group they approved of the report, although as a group they were not prepared to sanction the Blue Cross Medical Plan, but they thought it would be a good buffer.

Doctor Eric W. Macdonald: "This Society has definitely gone on record as being opposed to the Blue Cross running our affairs. Shall we implement the report of the Committee on Economics or step aside and let lay people run our affairs? We, the Executive, considered that it would not be fair to the majority of the members, therefore it was decided that every member should get a vote, and hence your ballot, and the ballots received have been greatly in favour of implementation, so that when the final count is made, we will have an expression of the whole profession of the province to allow us to know which is the opinion of our Society."

Other contributions to the discussion—in response to questions:

Doctor N. H. Gosse: "In some instances as in British Columbia they have sold no group insurance under the prepaid plan that has not been on the 50-50 basis, employee half and employer half. The possibilities in some of these schemes is just about limitless. When your committee considered the various things that the Blue Cross had to offer, it was found that they did not sell medical care, but rather an indemnity against certain illness costs. They do not provide medical service in the home."

Doctor A. D. Kelly: "During the year in which the policies have been sold in Ontario progress has been made. There are now approximately 20,000 persons covered by Physicians' Services Incorporated, all of them, in groups. Of the medical profession of about 4,000 practising physicians approximately 2,500 more or less are participating physicians. Progress is being made in Ontario. The possibilities for expansion of these plans is enormous. The great National Railways are interested. We would be very happy to see some plan in the Maritimes."

Doctor Eric W. Macdonald: "Gentlemen, it is getting late and I can't

possibly see how this important question can be shelved at this time or finished, and I would suggest, if you are agreeable, that we hold a meeting and try and finalize something about this scheme, say at eight o'clock. We have not finished our other business."

It was moved by Doctor M. J. Macaulay that the meeting adjourn and meet again at 7.30 p.m.

Meeting adjourned at 12.50 p.m.

The adjourned meeting of the first business session was called to order by the President at 8.10 p.m., Tuesday, September 14, 1948.

The President advised that the report of the Economics Committee which had been under discussion in the morning was still open for further discussion.

The resolution which had been sent out with the ballot was read by Doctor A. E. Blackett who stated that it was the resolution on which the Society is voting.

Doctor R. A. MacLellan: "I would like to know how we can get a better expression of opinion in this Society than by each man casting a ballot."

Doctor Eric W. Macdonald: "It is necessary legally for this meeting to take action one way or the other. The ballot count so far received is: For the resolution 189, against the resolution 3."

Doctor N. H. Gosse: "I would like to move that the ballot as counted and announced by you, Mr. President, be taken as the ballot upon this resolution, and that the results of that ballot be declared by you to finalize the matter."

This was seconded by Doctor R. A. MacLellan and carried.

Doctor Eric W. Macdonald: "By a vote of the members of this Society this resolution that Doctor Blackett has read, has been passed by a majority of this meeting, and by an overwhelming majority of all others voting, thus approving the setting up of a system or an organization to supply health insurance in the Province of Nova Scotia."

Doctor W. O. Coates asked that the steps necessary to carrying out this resolution be outlined.

Doctor N. H. Gosse stated "that the Society should make its nominations to the House of Delegates. The regulations provide that The Medical Society of Nova Scotia shall nominate sixteen members to the House of Delegates. It is the prerogative of The Medical Society to say how these sixteen members shall be nominated. The committee that brought in the report is now dead, but as chairman of that old committee, I feel that I have some moral obligation to speak a word or two with respect to this plan which has just been adopted. The first is that it is now a scheme of The Medical Society of Nova Scotia. It is every doctor's scheme and it will rise or fall by the support that it gets from each and every physician practising in this country. If it suffers, the Medical Society must suffer in reputation. A scheme of this kind cannot be put over unless various members of The Medical Society are ready to make a very real contribution in effort and personal service—service for the people of this country and service for the medical profession. It is provided that you elect sixteen nominees from this Society. They should be sixteen persons who are ready to take off their coats and go to work without any thought of remuneration in this world. We, too, must be ready to do a

job, not only the sixteen men, but every other one of us is called upon now as never before to take an important step. We are passing through a time of crisis. Ten years from now the profession of medicine of that day will look back to this time to us and will say, 'these people did a pretty good job' or 'what a slow, stupid bunch they were' "

Doctor Eric W. Macdonald: "It is not provided in the articles just how these sixteen should be selected, or is that a matter for the meeting to decide."

Doctor H. F. Sutherland: "At a recent meeting of the Cape Breton Medical Society we passed a resolution that the appointment of those delegates be made from the individual branches."

Doctor N. H. Gosse: "I am very sorry to be in error: Appendix II, Section 2, reads in part—'The Board of Directors shall . . . admit nominees of the Executive Committee of The Medical Society of Nova Scotia to a number not exceeding sixteen, such membership to be for terms of one year.' There should be a special meeting of the Executive. The sixteen nominees having been named by the executive committee would then meet with the old Board of Directors still operating. That Board would accept the nominees and then call for the election of a Board of Directors which would be from the House of Delegates. That Board of Directors must then meet and elect their President, then look into the question of setting up the organization. They would first endeavour to find a person for their general manager, and the Board of Directors must take the responsibiliy of finding the right person. The first duty is to raise the question of where the funds are going to come from to set this thing up. The Ontario Medical Association said we have some money, will advance you $25,000; that is how they got started. The Windsor scheme got the doctors to chip in, and after a time they were paid back. Where is it going to come from in Nova Scotia? I would like to report that the manager of one of the banks phoned me, and said you are setting up a scheme of prepaid medical care. If it is set up, we would like to have your business. I asked him if he would advance us $25,000. There would seem to be no difficulty in securing finances from such a source. It is a pity that we are not in better funds ourselves, but the Nova Scotia Medical Board is said to have $45,000 set aside, and in some provinces such funds have been made available financing their medically sponsored plan."

Doctor Eric W. Macdonald: "Would the members of the Executive be willing to spend half an hour after this meeting and consider this matter?" Agreed.

Doctor F. J. Barton then read the letter from the Store Managers' Conference, as printed in the executive minutes.

Doctor Eric W. Macdonald: "This matter came up before the Executive yesterday and Doctor Kelly had some very good advice to offer on the matter."

Doctor A. D. Kelly stated that a similar letter had been received by the Canadian Medical Association, that it would be discussed at the forthcoming meeting of the executive and a special answer be made.

Doctor Eric W. Macdonald advised that there were several letters along the same lines and suggested that Doctor Kelly's advice be taken and replies be deferred.

It was moved by Doctor A. W. Ormiston and seconded by Doctor H. R. Corbett that the recommendation of the executive be accepted regarding any replies to the Co-operative Unions. Carried.

The next item was the letter, as printed in the minutes, regarding certification of members attending medical meetings.

Doctor A. D. Kelly: "I would like to point out that three types of meetings are recognized now; annual meeting of the Canadian Medical Association, one per year; annual meeting of the Provincial Association, one per year; and one meeting of specialists, either in the United States or Canada. We may look forward to further concessions concerning post-graduate education. I think if we do not abuse the privilege that the prospects for further concessions are very good indeed."

It was felt that the Canadian Medical Association should be congratulated on the steps they had taken, but that the concessions did not apply to doctors on salaries.

Doctor A. D. Kelly stated that the salaried doctor could have an understanding with his employees for an allowance to attend meetings.

Doctor N. H. Gosse: "You named a committee to-day to consider the advisory committee with respect to Government matters. We would like to ask for some discussion as to the type of a committee which this Society would like, whether we should have a very large representation or whether we should have a small compact committee that the Government could call upon for advice."

Doctor A. D. Kelly: "In other provinces, and in every instance, the idea has been that we should have a very small group. Two representatives were named by the Ontario Medical Association, in the Province of New Brunswick the same, and in Prince Edward Island two representatives. I believe that it is more efficient to have a small committee."

Doctor H. J. Martin: "That would be the answer to Doctor Gosse's question. That this committee should select a small active and aggressive committee to advise the Government on any medical matters that might arise."

Doctor A. L. Sutherland: "I would like to move that we receive applications from the Branch Societies to make up the House of Delegates."

Doctor Eric W. Macdonald: "Any Branch could make application to the Board of Directors and have any clause changed. Each Branch Society of The Medical Society is to have one nominee in the House of Delegates until such time as a branch of the corporation is set up in that district."

It was moved by Doctor N. H. Gosse and seconded by Doctor H. W. Schwartz that a resolution should be spread on our minutes expressing a very sincere and real regret of the illness of the Honourable F. R. Davis, and a copy sent to Mrs. Davis. Carried. The following is the resolution:

"*Resolved* that The Medical Society of Nova Scotia in Annual Meeting assembled records its sincere regret that Honourable F. R. Davis who came here to attend the meeting was so suddenly taken ill and unable to attend its sessions, an, extends to the doctor an expression of its profound sorrow and its best wishes and prayers for his speedy recovery:

"*And it is further resolved* that this resolution be spread on the minutes and a copy sent to Mrs. Davis."

It was moved at 9.10 p.m. that the meeting adjourn and that a special meeting of the executive be held in Cabin "D" immediately following this meeting.

A special meeting of the Executive of The Medical Society of Nova Scotia was held at Cabin "D" Keltic Lodge, Ingonish, N. S., on Tuesday, September 14, 1948, at 9.20 p.m.

Present: Doctor Eric W. Macdonald, President; Doctors N. H. Gosse, W. J. MacDonald, H. A. Fraser, J. E. Park, J. J. Carroll, R. O. Jones, E. F. Ross, H. D. O'Brien, D. J. Mackenzie, H. B. Havey, R. M. Zwicker, A. E. Blackett, D. K. Murray and F. J. Barton.

Doctor Eric W. Macdonald: "As you know we are here to pick sixteen men to act as our House of Delegates on this Prepaid Medical Scheme."

It was felt by the meeting that the personnel should be carefully selected:

(a) For ability to make a real contribution;

(b) For willingness and industry to make some personal sacrifice to get the scheme going;

(c) For representation by districts and by departments of medicine.

The following were named and in some cases where certain men were the unanimous choice yet some question was entertained as to that person s ability to serve, an alternate was named so that the Society's representation would not be lessened:

Doctor N. H. Gosse of Halifax.

Doctor J. C. Wickwire of Liverpool.

Doctor L. P. Churchill of Shelburne.

Doctor J. P. McGrath of Kentville, and if he cannot act, Doctor G. R. Forbes.

Doctor David Drury of Amherst, and if he cannot act, Doctor E. J. Gordon.

Doctor D. S. McCurdy of Truro.

Doctor A. E. Blackett of New Glasgow.

Doctor J. J. Carroll of Antigonish.

Doctor H. J. Martin of North Sydney.

Doctor D. F. Macdonald of Yarmouth, and if he cannot act, Doctor P. E. Belliveau of Meteghan.

Doctor Eric W. Macdonald of Reserve.

Doctor H. A. Fraser of Bridgewater.

Doctor D. M. MacRae, Doctor J. R. Corston, Doctor H. L. Scammell, Doctor J. V. Graham of Halifax, and as alternates, if they are unable to act, Doctor A. G. MacLeod of Dartmouth and Doctor E. T. Granville of Halifax.

Doctor Eric W. Macdonald: "That is all we can do tonight, except wish them well."

Meeting adjourned at 10.20 p.m.

The second business meeting of The Medical Society of Nova Scotia was held at "Keltic Lodge," Ingonish, N. S., Wednesday, September 15, 1948, at 12.05 p.m.

The President called the meeting to order.

The first item was the report of the Editorial Board Committee, printed in the Executive Minutes, which was read by Doctor Margaret E. B. Gosse, who moved the adoption of the report, which was seconded by Doctor R. H. Sutherland. Doctor H. R. Corbett referred to a communication which he

had addressed to the President, who stated that it had been dealt with and that it was the opinion of the meeting that the members of the Editorial Board had carried on their duties as they should have and were commended on their policies in selecting articles for the Bulletin. Doctor Corbett stated that he quite appreciated the policy of the Editorial Board.

Doctor Eric W. Macdonald: "The editors or the editorial committee of any publication have always the leeway that they may select articles edit them or reject them as they see fit, and this Society went on record as commending the present editors of the Journal for the manner in which the Journal has been conducted during the past year."

Motion carried.

Doctor A. E. Blackett said that the first important step was the matter of money to carry on the work of Maritime Medical Care Incorporated. A grant had been made to carry on the study of the work of the Economics Committee, and only $400 expended by the Committee, and that this unexpended balance and a further sum of $1,000 be made available for the Corporation to carry on its work of organization until it has made arrangements along the lines suggested by Doctor Gosse last night to carry on its work. Because the Committee of Economics went out of business last night he suggested that this unexpended money be used up

Doctor Eric W. Macdonald: "It would keep the bookkeeping and the legal end of it better if the balance of that money was returned to the treasury and a new sum of money voted."

It was moved by Doctor A. E. Blackett and seconded by Doctor H. R. Corbett that The Medical Society of Nova Scotia make available to the newly formed Corporation of Maritime Medical Care a sum of $2,000.00.

Doctor R. A. MacLellan said he would like to have the particular point made clear whether that sum would be regarded as a loan or an outright gift, before the vote was made.

Doctor A. E. Blackett said he would submit the word "grant" instead of "money available."

After some further discussion Doctor A. E. Blackett said he would change his motion, that this Society make available to the new Corporation the sum of $2,000 as a loan, interest free, which was seconded by Doctor H. R. Corbett and carried.

Doctor Eric W. Macdonald: "I would ask Doctor Barton to read the list of those who made application for membership during the past year." After the list was read, as published in the Executive minutes, it was moved by Doctor R. H. Sutherland and seconded by Doctor R. O. Jones that these men be taken into the Society. Carried.

The names of members who had passed away during 1947, as published in the Secretary's report in the Executive minutes, was then read, while the members stood.

The report of the Nominating Committee was as follows:

Place and date of 1949 meeting: White Point Beach Lodge.

President—Doctor Hugh A. Fraser, Bridgewater.

First Vice-President—Doctor E. F. Ross, Halifax.

Second Vice-President—Doctor J. J. Carroll, Antigonish.

Treasurer—Doctor R. O. Jones, Halifax.

Secretary—Doctor H. G. Grant, Halifax.

Legislative Committee—Doctors J. G. B. Lynch, A. L. Murray and J. W. Reid.

Cancer Committee—Doctors V. O. Mader, S. R. Johnston, C. M. Harlow and chairmen of the Branch Societies Committees on Cancer.

Public Health Committee—Doctor J. S. Robertson and the Executive of the Nova Scotia Medical Health Officers' Association.

Historical Committee—Dr. H. L. Scammell, S. B. Bird and J. A. Webster.

Workmen's Compensation Board Committee—Doctors R. A. MacLellan, J. W. Reid, A. E. Blackett, E. F. Ross, T. B. Acker and C. M. Jones.

Editorial Committee—Doctors Margaet E. B. Gosse, H. L. Scammell and C. W. Bethune.

Medical Museum Committee—Doctor D. J. Mackenzie and Secretaries of the Branch Societies.

Cogswell Library Committee—Doctors A. L. Murphy, H. D. O'Brien and D. J. Tonning.

Medical Economics Committee—Doctors N. H. Gosse, W. G. Colwell, D. M. MacRae, F. J. Barton, H. A. Creighton, P. S. Cochrane, A. E. Blackett, D. F. Macdonald, J. V. Graham, J. R. Corston, H. G. Grant and H. S. O'Brien.

Pharmaceutical Committee—Doctors R. A. Moreash, H. R. Ross and D. M. Cochrane.

Industrial Medicine Committee—Doctors H. J. Martin, D. M. Cochrane and J. C. Murray.

Divisional Representative, Editorial Board of Canadian Medical Association—Doctor H. L. Scammell.

Membership Committee—Doctor H. G. Grant and Secretaries of the Branch Societies.

Members appointed by The Medical Society of Nova Scotia to the Provincial Medical Board, 1949-1951—Doctors R. O. Jones, H. D. O'Brien, H. B. Havey, Eric W. Macdonald, J. P. McGrath and L. M. Morton.

Doctor J. C. Wickwire moved the adoption of this report which was seconded by Doctor M. Jacobson and carried.

Doctor Eric W. Macdonald: "That being the case I declare this slate of officers elected for the coming year."

Doctor A. L. Murphy: "With regard to the time of the meeting next year. The meeting here has been delightful. At the same time it has made us cancel the Dalhousie Refresher Course. It has been going on for a good number of years and we feel it would be a pity if it is postponed again because of a clash of The Medical Society of Nova Scotia. It cannot be held in the summer and we would like to be considered when the time of the meeting is being considered for next year."

Doctor Eric W. Macdonald stated that the executive thought the fall was the most opportune time to hold a meeting, but that the general meeting could override the executive.

Doctor J. P. McGrath thought that as White Point Beach Lodge was a summer resort it would be much more pleasurable to have the meeting in the spring of the year or the early summer.

Doctor Eric W. Macdonald stated that the summer resorts would not give the Society accommodation except before their season opened.

Doctor R. O. Jones stated that with the changes at Dalhousie it would be much harder in the future to hold September meetings.

Doctor H. W. Schwartz stated that the Society met in Halifax the Refresher Course could be held at the same time.

Doctor A. L. Murphy stated that the experience of the Refresher Course was that Courses held in conjunction with The Medical Society were not as successful, and they preferred that they be kept apart.

Doctor R. H. Sutherland: "I would move that the Executive Committee get in touch with White Point Beach Lodge and have our meeting there just before the opening. I would move that the next annual meeting in 1949 be held the first week in July at White Point Beach Lodge, which was seconded by Doctor A. L. Murphy. Carried.

Doctor William Magner suggested that the Society suggest to the other two Provinces, New Brunswick and Prince Edward Island, that they also hold their meetings in July.

Doctor Eric W. Macdonald: "As your President during the year I have enjoyed the work very much. I have tried to attend to the business of the Society and I have certainly enjoyed it. I thank you for your kind co-operation and the interest shown in the interest of the Society. I take pleasure now in turning over this high office to Doctor H. A. Fraser."

Doctor C. H. Reardon hoped a resolution of the Halifax Medical Society had not been deliberately passed over. It had been brought up at the Executive meeting and they took the stand that it was purely a local matter because it was a matter involving one Halifax hospital as far as the resolution was concerned. After further discussion and the reading of the resolution, which was printed in the Executive minutes, it was moved by Doctor C. H. Reardon that The Medical Society of Nova Scotia fully endorse the action taken by the Halifax Branch of The Medical Society of Nova Scotia by their protest against the restrictions placed by the Victoria General Hospital on the general practitioner without certification in surgery and/or anaesthesia;

And that this Society go on record as strongly disapproving any similar move by other institutions which will cause these institutions to lose their former relationship with the general practitioner;

And finally that notice of the endorsation by The Medical Society of Nova Scotia be forwarded with a copy of the original resolution of the Halifax Medical Society to the Department of Health and to all Hospital Boards in Nova Scotia.

This was seconded by Doctor F. J. Barton. Carried.

Doctor Eric W. Macdonald: "I wish that we had some badge of office or some insignia that the out-going President could turn over to the incoming President, and I will endeavour at some future date to present one, but until such time, I will bow to the incoming President, Doctor Fraser."

The chair was then taken by Doctor H. A. Fraser who regretted he could not begin to fill Doctor Eric Macdonald's high standards or those of his predecessors. He thought that the Society should express their appreciation to the Cape Breton Medical Society and to Doctor Macdonald for the enormous work they had done and for one of the most successful meetings ever held.

The Secretary advised that the Committee appointed to name the Advisory Committee with respect to Government matters had appointed Doctor Norman H. Gosse, Doctor A. E. Blackett, Doctor J. W. Reid and Doctor M. J. Macaulay, with the President, Doctor H. A. Fraser, ex officio.

Meeting adjourned at 1.30 p.m.

Correspondence

Camp Hill Hospital
November 16, 1948

Dr. Margaret E. Gosse
240 Spring Garden Road
Halifax, N. S.

Dear Doctor:

Would you please include the following announcement in the next issue of the Medical Bulletin.

"The R.C.A.M.C. Mess has been recently reorganized into the Medical Services Officers' Mess. Membership is extended to all ex-Medical Officers, Active and Reserve, of the three services and to those who served in the ranks and obtained a degree in later life.

"The G.O.C., Eastern Command has graciously given us quarters in the Gymnasium at Garrison Barracks, Windsor Street, Halifax, N. S., and we have obtained the use of the Bowling Alley from nine to eleven on Saturday evenings. The Clubrooms are large, well-furnished, and have the usual facilities of a well-run Club.

"Thursday evening is reserved for meetings, but Saturday is the social evening, when all members are urged to come, bring their wives and any guests they wish, to spend with us a thoroughly informal evening.

"Membership fees are five dollars for residents of Halifax and Dartmouth, and one dollar for others. Dr. Carl Stoddard, 106 Oxford Street, is the Treasurer."

Thanking you

Yours very truly

C. G. MacKinnon, M.D.

Skin Cleanliness

Dermatitis is a potential threat to many industrial workers because chemicals and materials used in manufacturing processes may be irritating and harmful to the human skin. Sometimes the product itself is the offender. Sometimes it may be a solvent or a dye. Some, like acids, may cause trouble immediately on contact with the skin. Others may be troublesome only if they are allowed to remain on the skin or in the clothing for some time. Some people are more susceptible to irritants than others.

It is sometimes difficult for a worker to avoid contact with irritating substances. But it is rare for a worker to get dermatitis if he keeps clean on the job. A good part of the responsibility for cleanliness on the job belongs to the worker himself but his employer must also help in maintaining cleanliness in the whole working environment. Scrupulous personal care is of little avail if tools, machines, floors and walls are covered with grime or dust. Do

What can the employer do? First of all, let him look to his housekeeping. Is his plant in an orderly condition? Are waste materials collected regularly? Are tools and machines cleaned daily? Does he provide effective protective clothing and ointments if the materials his workmen use require them? workers have well ventilated lockers in which to hang their street clothes? Are there adequate washing facilities? Are a sufficient number of shower rooms available if the processes in the plant require showering after work?

All the employer's efforts toward cleanliness can do little good, however, if the worker doesn't help. Good plant housekeeping depends to some degree on his working habits. Does he take pride in his machine and keep it clean? Does he use the protective clothing or ointments his employer provides? Is he scrupulous in his personal habits? Does he change his work clothes—from the inside out—every day if necessary? Does he wash frequently enough during the day and does he shower and change his clothes at night before leaving the plant? Individuals should wash after every trip to the toilet, before eating, at the end of the work period and every time irritant substances are spilled or splashed on the skin.

How a worker washes is also important. Here are a few simple rules he can follow:

1. Rub the cleanser into the skin, using as little water as possible. Use a soft brush or rag if necessary.
2. Wash until all the dirt is gone. Watch the danger spots around the nails and between the fingers.
3. Rinse well until all the cleanser is gone and then inspect for dirt. If there is some left, begin again.
4. Dry carefully, especially between the fingers and around the nails.
5. If the skin has been irritated by the washing process, apply a cream containing lanolin.
6. *Don't* use solvents (gasoline, etc.), strong alkalis, or harsh abrasive cleansers for cleaning.