An Evaluation of Group Practice*

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WE are living to-day in a state of universal economic confusion and organized medicine is reeling from the impact of startling social reforms. In the midst of this maelstrom it is not surprising that our professional way of life is blown hither and yon with harassing disquietude. Already the full sweep of these reforms has hit the profession in England with terrific force. In the United States a battle over health insurance is being waged between Congress and the American Medical Association; while in our own country all three political parties have agreed to provide us with some suitable form of health insurance, and for some time this principle has had the approval of our parent body, the Canadian Medical Association.

In this tumult, those of us with a desire for a sane philosophy of living for both our patients and ourselves, must of necessity give serious consideration to ALL medical health plans, and be willing to accept nothing less than the one which provides the most widespread distribution of the best medical care that modern science can provide, at the lowest possible cost. We want this to result from a gradual evolutionary process, and not from a revolutionary one. To-day, medicine and economics walk hand in hand. Poor living conditions and insufficient food contribute not only to ill health and consequent loss of production, but also to social unrest. Our whole economic system is vitally dependent upon our national health.

Nowhere perhaps in the Commonwealth, is rugged individualism maintained to a greater degree than in these Maritime Provinces, and this applies particularly to the practice of medicine. A long line of illustrious men have elevated medicine to the height it at present occupies in Nova Scotia. They were responsible for your fine Society, almost one hundred years old, and the excellent Medical Faculty of Dalhousie University. The success of these early physicians was in no small measure due to their sterling individual efforts as medical practitioners.

In such a country, then, with such a heritage, one must approach the subject of group practice circumspectly.

I should like to recall briefly in passing, the glorious harvest of achievements that has been reaped during the professional lives of most of us here to-day. And what a harvest! Sepsis, typhoid, diphtheria, malaria, gonorrhea and syphilis, pneumonia, tuberculosis, diabetes, and pernicious anemia; all these used to be the stubborn and defiant foes we met and battled to the death, along the highway we travelled with suffering and distress. *Now our fear is no longer hopeless*!

The science of medicine has come a long way since our graduation, and I hope that we, as individuals, have come as far! It is not only a science but a fine art as well. We must therefore combine these to give our patients the best medical care. Sometimes in the rush of daily practice this is a rather difficult procedure, but whether we like it or not, patients to-day, even simple

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unlettered patients, have a way of expecting and demanding the very best care that medical science is capable of providing.

Medical progress depends, in no small measure, on medical research, and the maintenance of the highest qualities in our medical and post-graduation education. Someone wisely said that doctors either go forward or backward professionally with the years, they *never stand still*!

In evaluating group practice I propose to point out some of the advantages and disadvantages, and leave the conclusions to your own judgement.

In order to reach any conclusion, you will want to ask yourself if you are satisfactorily keeping abreast of current medical advances, taking adequate holidays, keeping physically and mentally fit, and providing properly for your retirement; and then set this down against the factual information I will present.

Let us look at the whole question of group practice objectively in the light of first, its value to the patient, and second, its value to the physician.

Definition of Group Practice

Group practice may best be defined as three or more doctors associated together with joint use of equipment and technical personnel, and possessing a centralized administrative and financial organization, and pooling and redistributing their earnings according to a pre-arranged plan.

Growth of Groups

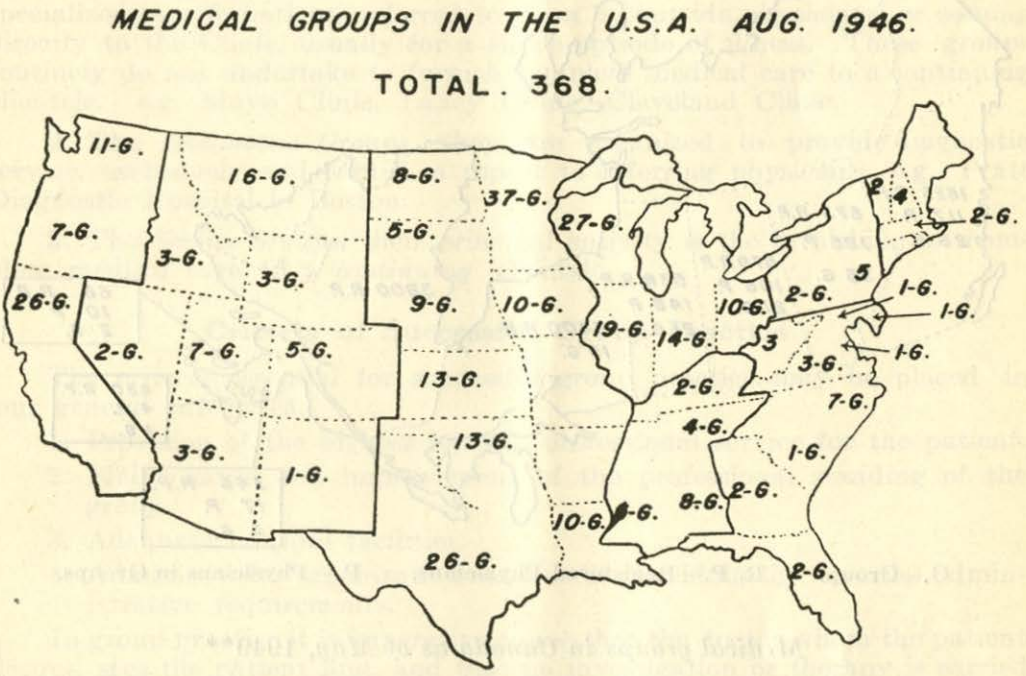
The formation of a medical group that shall be successful and desirable from the point of view of physicians and patients alike, requires an extremely rare combination of personal, professional and material qualities.

The formal organization of private medical groups is a North American phenomenon, either entirely unknown, or at least unimportant, in other countries. In a survey conducted by the American Medical Association in 1940[1] three reasons were advanced for the growth of medical groups:

1. As a result of their experience in practising war medicine, many physicians, on discharge, desired to practise medicine as a group.

2. There have been great advances in standards of medical education and in diagnostic and therapeutic facilities. Many doctors in small or medium sized cities or rural areas found laboratory, hospital and specialist services inadequate, so they formed groups to get these facilities. Seventy-three per cent of all groups in the United States were formed in cities of less than 50,000 population.

3. The influence of the Mayo Cinic on formation of groups is indicated by the many "Mayo graduates" who are members of groups. The Mayo Clinic was organized to supply medical care in an emergency, (a tornado which destroyed much of Rochester at a time when the town lacked hospitals and most other essentials of good medical care). Its amazing growth and reputation have been important factors in stimulating formation of other medical groups.

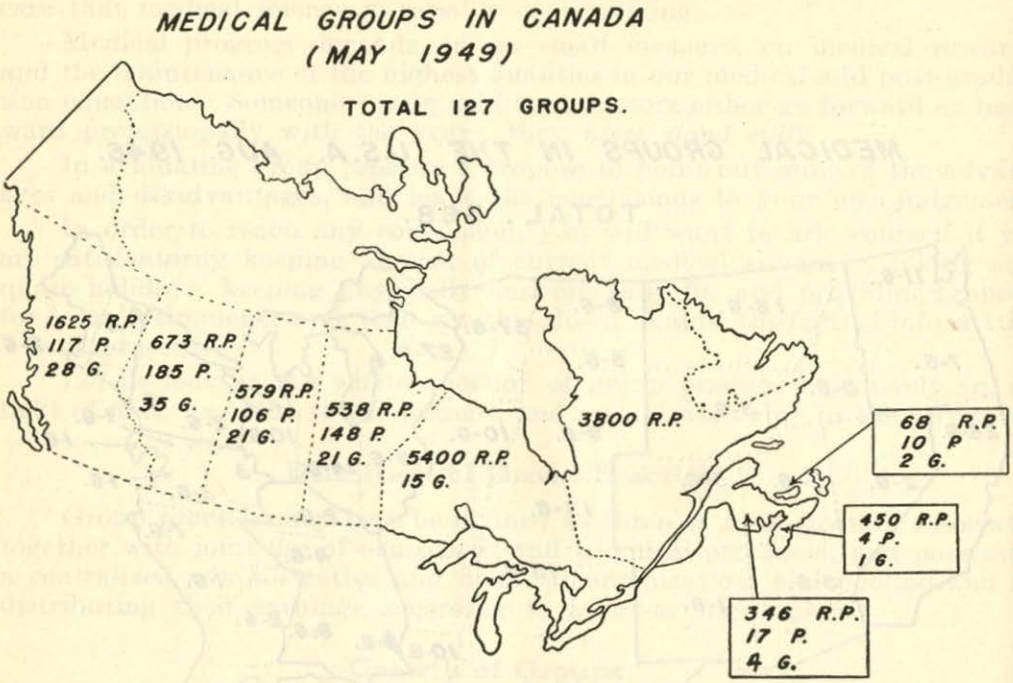


G.—Group.

Medical groups in the United States as of August, 1946*

A survey of medical group practice by the United States Public Health Service, published this year[2] states that the mean age of functioning medical groups, is 20 years, and nearly half of the total were organized 30 or more years ago. The percentage of practising physicians engaged in group practice in the United States in 1946 was 2 per cent; approximately the same as in 1940.[3]

*These groups all conform to the definition of group practice. Chart I, Hunt, G.H., Goldstein, M.S., Medical Group Practice in the United States, American Medical Association reprint, 1947.



G.—Group. R. P.—Registered Physicians. P.—Physicians in Groups.

Medical groups in Canada as of May, 1949**

The situation with regard to medical group practice in Canada has never been studied and there is no accurate information available. According to the Bibliography of Group Practice for 1927-47, published by the Bureau of Medical Economic Research of the American Medical Association,[4] only three articles about group practice have been published in Canada in 20 years.

Historically the oldest type of medical group is the Out-Patient's Clinic, in the teaching hospitals, staffed by physicians serving on a voluntary basis.

The formation of groups under strictly private auspices as service institutions for paying patients, has been chiefly a development of the last thirty years.

**Prepared from information received from Registrars of the College of Physicians and Surgeons in each Province. Although the medical groups are composed of 3 or more doctors it is not known whether or not they conform in other respects to the definition of group practice previously mentioned.

Types of Groups

The United States Public Health Service in their survey classified medical groups, according to scope and type of service provided into three types:[5]

1. The *Reference Groups* whose principal activity is the furnishing of specialized care to patients referred to them by outside physicians, or coming directly to the Clinic, usually for a single episode of illness. These groups routinely do not undertake to furnish complete medical care to a continuing clientele. e.g. Mayo Clinic, Lahey Clinic, Cleveland Clinic.

2. The *Diagnostic Groups*, they are organized to provide diagnostic service, exclusively and furnish a report to referring physicians, e.g. Pratt Diagnostic Hospital in Boston.

3. The *Service Groups*, their principal activity is the furnishing of complete medical care to a *continuing* clientele.

Criteria of Successful Group Practice

The criteria essential for successful group practice may be placed in four general categories:

1. Provision of the highest form of professional service for the patient.
2. Maintenance and improvement of the professional standing of the group.
3. Adequate hospital facilities.
4. Administrative organization capable of providing the essential administrative requirements.

In group practice it is imperative to see that the doctor whom the patient desires, sees the patient first, and that no investigation or therapy is carried on without his authority. In other words the patients who ask for a specific doctor should always be treated by that doctor in the same way as if he were practising outside the group. If the patient is referred by the original doctor to other specialists in the group, then it is essential to see that the patient returns to his personal physician for the final consultation.

This is an essential part of good management in group practice and successfully maintains the "patient-doctor" relationship which is so important. As Lord Horder recently said, "One must not impair the spirit and quality of a service which is so essentially individual and personal."

If specialists are available in the group, then they should have the highest qualifications, and merit the complete confidence of all their colleagues. These are principles of ethics and good judgment which must be considered in organizing and developing a successful group practice.

In order to maintain and improve the professional standing of the group, doctors should be allowed to assume only those professional responsibilities for which they have demonstrated ability and possess experience. Senior members of the staff should accept responsibility for the training of junior colleagues and be competent to give such education. Wherever Medical Colleges and teaching hospitals are available, specialists in the group should make a substantial contribution to them.

Group doctors should be provided with opportunities for professional study without loss of income. Regular Staff Meetings must be held for the

discussion of cases, and arrangements made for clinical investigation and laboratory research.

Satisfactory hospital connections are a necessity as an excellent group may be seriously handicapped by insufficient or low grade hospital facilities.

Important points in establishing a workable financial arrangement for doctors in a group

A most successful method of group administration is by an elected Executive Committee, composed of doctors who handle all the professional affairs of the group. If there are more than six physicians in the group, there may be a business manager too, with responsibilities limited to non-professional activities. He should be under a Medical Director, who in turn, is appointed by the Executive Committee, and his authority stems from this policy-making level.

Surveys in the United States have shown that financial disagreement was the major cause of dissolution in a large number of groups.[6]

The first requisite in establishing a workable financial arrangement is that the doctors be categorized; for example, assistants, associates, senior consultants, partners, etc. (or they can range from fellows to members) depending on the type of ownership of the group. These categories are based on the individual doctor's—

training,
experience
qualifications
competence
length of time with the group, etc.

The second essential is that basic salaries should be allotted for each of these categories.

And thirdly, from the net earnings of the group, an annual bonus, evenly distributed, in addition to the salary, should be paid to all permanent members of the group.

No financial plan will work without establishing acceptable categories. These vary from group to group; basically however, the distribution of income should never be left to rough and ready reckoning. It must be worked out well in advance and the plan selected must be acceptable to the entire permanent staff, and provide for the perpetuation of the organization. Usually 75-80 per cent of the income comes from professional fees, and the balance from X-ray, laboratory and therapeutic charges.

Winnipeg Clinic Plan

Apropos of this, I feel you might be interested in the Winnipeg Clinic Group Practice Plan, particularly as it possesses factors both unique and original.

In this Plan—

1. The properties, buildings and equipment, which represent a substantial and increasing physical asset, do not become the property of the members of the Clinic. These substantial assets, without reservation, have been deeded to the Manitoba Institute for the Advancement of Medical Education and Research, so that in perpetuity the revenue will support medical research

and post-graduate studies in the Medical Faculty of the University of Manitoba.

2. The individual doctor's income is derived from the combined professional earnings, the same as an individual doctor in private practice. No doctor derives any financial benefit from the accumulated assets represented by properties, buildings or equipment, all of which have been deeded to the Manitoba Institute for the Advancement of Medical Education and Research.

3. In an address to the members, Dr. P. H. T. Thorlakson the senior Founder pointed out that the present Founders (4) wished to provide some means whereby, on a co-operative basis, all members of the group could assume personal responsibility for Clinic management and ownership. To this end an Act of Incorporation was drawn up as a private bill and submitted to the Manitoba Legislature. It was passed in March, 1949.

4. This Act of Incorporation places the entire responsibility and authority for the Clinic on the members named in the Act (20) and any others who may be added later; and ensures that by his vote, every member will have a right to determine the policy of the Clinic, and no individual or small group of individuals can in future, take over complete control or ownership of the Clinic.

5. Membership is given only to qualified medical practitioners, and it may not be assigned, and shall terminate on the death, resignation or expulsion of the member. The number and qualifications of members, their voting and other rights, are all determined by an Executive Council, elected annually by the members and consisting of not less than five and not more than nine. This Council has complete control of all the affairs of the Clinic.

6. No doctor has any special privileges other than what pertains to all members of the organization. On the death or retirement of a member he is not entitled to any income except what is provided by the Pension and Retirement Plan, or by special agreement.

7. In the event of the Clinic ceasing to operate, all the properties and assets remaining after payment of debts and liabilities, would be paid to the Manitoba Institute for the Advancement of Medical Education and Research.

In other words, this means that a doctor, elected to membership in the Winnipeg Clinic, enjoys all the privileges of full membership, equal to the Founders, without assuming heavy financial responsibilities early in his professional career and at no time does he put up any money. So much for what is called the "Winnipeg Clinic Plan" of group practice.

Operating Costs

You are no doubt interested in what it costs to practise in a group, compared with private practice. At the last regular meeting of the business managers representing 102 of the largest medical groups in Canada and the United States, the average operating cost per group was estimated to be 50 per cent. However a 5-10 man group could probably keep operating costs at about 40 per cent because these costs increase with the size of the group. The extreme ranges were from 36-60 per cent. By comparison, a survey by the Bureau of Medical Economics of the American Medical Association[7] showed the average ratio of net to gross income for general practitioners to be 60.5 per cent, and for specialists 61.1 per cent. Which means their operat-

ing expenses were from 30-40 per cent. This is about the same range as a 5-10 man group, and about 10 per cent less than the larger groups.

With regard to financing yearly post-graduate courses, this should come out of group earnings. In our group, time away for specialists is allowed according to a pre-arranged plan. Ours is a 10-10½ months' working basis; the entire income must come from 10-10½ months' work. We have 3-4 weeks' holiday, 2 weeks for a post-graduate clinical trip, and 2 weeks for the odd week-end holiday, or for sickness.

Additional time is always allowed to present papers at medical meetings.

In the case of trainees working towards certification, post-graduate arrangements have to be made to conform to the standards of the Royal College, and in many cases this means leave of absence, with or without pay, to accept an accredited hospital residency.

Advantages of Group Practice to the Patient

Modern medicine is so complex to-day that one doctor cannot comprehend all the intricacies of diagnosis and treatment, and, as a result, if patients are to get the best medical care they must be seen, in many instances, by more than one doctor. If this is true, then group practice provides one way whereby this can be done economically and efficiently. The presence of associates in adjoining offices, with mutual interest in each other's cases, makes for easy consultations with full documentation on hand. This is important, for seeing a patient in consultation, with a completed history and reports of all recent investigations, means avoiding long periods of questioning, and conserves the time of the patient and doctor. This ready availability of specialist services, plus special and more complete diagnostic equipment, gives the patient a distinct advantage. Instead of travelling, sometimes a considerable distance, from one specialist to another, at the cost of time and money, he is immediately made the focus of attention of a number of men, readily available.

In most cases individual general practitioners and specialists working together can do anything a group can do. But the fact remains that general practitioners and specialists do NOT routinely work together. The average general practitioner, making a diagnosis, is seldom able to have, within a matter of minutes, the co-operation of one or more specialists. Thus the elements of time and space, have an important bearing on the care of the patient. So does the matter of cost. Economies effected by the joint use of personnel and equipment in group practice can be passed on to the patient, and one result might be the carrying out of a more complete investigation for the same expenditure.

Advantages of Group Practice to the Doctor

Some of the advantages of group practice to the doctor are:

1. Continuation of pay during sickness, vacations, and post-graduate courses.
2. Group insurance, at a lower rate than the individual practitioner can obtain.
3. Group pension and retirement plan, which provides security for old age.

4. A medical library and services of a librarian, and record librarian, together with complete record room facilities.

Items such as medical society dues, car allowance, medical books and journals, and travel expenses for attending scientific meetings, are all charged up to expenses by a group, the same as they are by the doctor practicing individually.

When compared to the individual practitioner, the broad income curve of the physician in group practice shows that he has a narrower range of income, earning proportionately *more* during his first ten years of practice, *less* during his middle years, and again *more* during his late years.

Then too, a group doctor usually has complete diagnostic and therapeutic equipment readily at his disposal, which he could not always afford were he practising singly.

He is relieved of bookkeeping and collection worries, and there is sufficient auxiliary staff employed to deal expeditiously with the prepayment and other insurance forms constantly increasing in number.

Younger specialists can concentrate from the beginning on their specialty when practising in groups, without doing general practice in order to earn a living, as they are so often forced to do. They find a select practice within their own specialty awaiting them.

Taken on the whole, I would say group practice provides the patients with efficient and economical medical care; and the doctor with an adequate and permanent income, allowing him to practise his profession under exceedingly favourable conditions.

Criticisms of Group Practice

With regard to criticisms of group practice, one often hears that "patient-doctor" relationship is disrupted. As I mentioned previously, when dealing with the criteria of a successful group, "patient-doctor" relationship can be maintained quite intimately in a properly conducted group. In our group senior physicians and surgeons take turns acting as Co-ordinator, each day, and in this way a senior specialist takes a direct personal interest in the patient. The Co-ordinator interprets the final results to the patient, and if further consultation is necessary he arranges this, and in many instances sees the patient, with the other specialist. If the patient asks for a particular doctor, the relations are exactly similar to those of private practitioners. If, on the other hand, the patient asks for an examination but does not request a specific doctor in the group, the Co-ordinator assumes complete responsibility for the patient's investigation, diagnosis and treatment.

It has been argued by way of criticism that doctors in group practice, are deprived to some extent, of independence of judgment and action, and their professional growth is stunted by constant supervision. This, I think, is drawing a rather long bow.

We all know that there are many physicians who would be most unhappy in a group because they are not entirely independent. They cannot come and go as freely as they would in private practice because of the necessity for co-operation and control among group members. This would not be irksome if the physician had succeeded in adapting himself to the needs of his patients and associates.

Group doctors must be compatible with their colleagues and possess good judgment, common sense, and technical skill. In addition to this the group itself must have a policy of perpetuation. Members of such groups must be subject to certain discipline and restrictions; in other words, they must realize that a good ball team gets nowhere if everybody is Captain, and wants to call the plays. Somebody must be in authority! Authority in a group is no better or worse than the individual who exercises it, and if he knows how to deal with professional associates he should have very little trouble. If proper care is exercised in the selection of the permanent members of the group, very few personality conflicts result. Taken on the average all of us possess fairly good manners, and certain virtues, and we are not, I hope, too emotionally unstable. Add to this the qualifications which I mentioned a moment ago, plus the common love for one's profession, and you have the basic necessities for making professional life in a group pleasant and profitable. Failure to observe these essential requisites is bound to produce disharmony and difficulties.

Membership in a group should never result in the loss of one's individuality. We all admire and secretly enjoy the quiet philosophical type of physician, who adds to a profound knowledge of medicine, the courage of being a sturdy rebel against order and precedent; perhaps after all, he does not want to keep pace with modern civilization because he knows that modern civilization is going the wrong way!

Another criticism of group practice is that it makes for an impersonal medical service by depriving the physician of his responsibility and by emphasizing unduly the technical side of medicine at the expense of its human side. Experience shows that group practice in itself need not make medical care impersonal or too rarefied. Membership in a group can neither make an incompetent doctor competent; nor a well-trained, properly motivated specialist impersonal, inefficient, or lacking in human understanding. These are individual qualities which must be carefully assessed when selecting permanent members for a group.

It has been argued that 70-80 per cent of patients have illnesses sufficiently common to be successfully treated by a general practitioner with the ordinary equipment every doctor has in his office, and it is unnecessary for these patients to be sent "through the mill" of referrals and laboratory work in a group.

As I mentioned previously there are three types of medical groups: Reference, Diagnostic, and General Service. Very few patients with common illnesses go to either of the first two groups, and in the majority of Service groups there are general practitioners, who successfully treat these patients, just as an individual practitioner does, without unnecessary referrals or investigation; however, if laboratory or X-ray studies are desirable, group general practitioners have immediate access to these facilities, plus the assistance of qualified radiologists.

In group practice life can be pleasant or unpleasant, depending in no small measure, on the desires and temperaments of the group family. It is a very poor place for a prima donna!

It has been said that no generalization is ever wholly true, and this is applicable to generalizations about group practice. Many criticisms of group practice are based on theories and impressions, or isolated experiences, and

it is impossible to answer these because, up to the present time, there have been no complete factual studies done which might provide satisfactory answers.

What Then is the Future of Group Practice in Canada?

Frankly! I do not know!

It may possibly eventuate that group practice is better fitted for adaptation to voluntary prepayment plans than individual practice, and that in communities of certain sizes where the work of the physicians is inadequately distributed, organization of a properly planned and conducted group may be the answer to a great many local professional problems. These however, are only possibilities; the very contrary may prevail. No matter then, how personally hostile to group practice one may be, we must all admit, as a fact, that group practice in the United States, has made great contributions to medicine and surgery, and a fact is not disproved by screaming violently against it or calling it names!

When the last word is said, it depends absolutely, on just how one individual physician desires to practise his or her profession. This psychological factor will determine whether or not a doctor joins a group. Many doctors prefer to practise alone. To those, group practice might be anathema.

Many minds, however, are often needed to solve perplexing medical problems, and whether this can be accomplished best for the patient and doctor, in a group, or by the individual practitioner, plus individual specialists, is, in the final analysis, a matter of *purely personal opinion.*

References

1. Bureau of Medical Economics, American Medical Assoc., Group Medical Practice, 1940, Chicago, p. 5, 9, 1 , 13, 14.

2. Goldstein, Marcus S., Medical Group Practice in the United States; V Growth of Groups, The Journal-Lancet LXIX: 46, Feb., 1949.

3. Dickinson, Frank G., Medical Groups in the United States, 1946, J.A.M.A., 133; 1222, April 19, 1947.

4. Bureau of Medical Economic Research, An Annotated Bibliography of Group Practice 1927-1947, Chicago, American Medical Assoc., 1948, p. 8, 10, 14.

5. Gregg, A., Boehr, G., and Rorem, C. R., Benefits of Group Practice, New York, Med. Admin. Service Inc., May, 1949, p. 29.

6. Mackenzie, G. M., Garfield, S., Angrist, A., Group Medicine, a Discussion of Economics of Medical Care, The Modern Hospital, p. 2, November, 1945.

7. Bureau of Medical Economics, American Medical Association, cited by Stern, B. J., American Medical Practice, New York, The Commonwealth Fund, 1945, p. 94.

96th Annual Meeting of The Medical Society of Nova Scotia, 1949

First Business Meeting

THE first general business session of the 96th Annual Meeting of The Medical Society of Nova Scotia was held at White Point Beach Lodge ,White Point Beach, N. S., on Tuesday, September 6, 1949, at 8.30 p.m.

The President, Doctor H. A. Fraser, presided and welcomed Doctor J. F. C. Anderson, President, Canadian Medical Association, who extended greetings to the Society from the Canadian Medical Association.

The President then welcomed Doctor T. C. Routley, General Secretary, Canadian Medical Association.

Doctor T. C. Routley: "It has been four years since I was here. You did me a great honour of electing me an honorary member of your Society. I appreciate that most highly and want to thank you for it. Thank you very much for your welcome."

The President next welcomed Doctor G. E. Chalmers, Immediate Past President of the New Brunswick Medical Society. Doctor Chalmers stated that he was very pleased to be present as a delegate from the New Brunswick Division, and he thought that the Maritime Provinces should have delegates at their meetings to keep in touch a little more closely.

It was agreed that the minutes of last year's meeting as published in the NOVA SCOTIA MEDICAL BULLETIN of October and November, 1948, be accepted as read.

Doctor H. G. Grant read the letter from the Department of Public Welfare; published in the executive minutes. Doctor Grant stated that this matter had been brought before the executive, and they approved of it in principle. As it stands now the Government are willing to pay 75c. The Maritime Medical Care Incorporated had been contacted and they are willing to do the work.

Doctor H. C. Reardon: "I think we should be careful that we don't sell ourselves too short. We have a fair sample of that in dealing with the C.N.R. in treating all of their employees."

Doctor W. G. Colwell moved that the meeting accept the action of the executive taken in the afternoon on matters regarding the care of the indigent of Nova Scotia, which was seconded and carried.

Doctor Eric W. Macdonald stated that this was a matter to be settled to-night, and thought that the offer should be accepted graciously. He moved as an amendment that the Society inform the Government they would assume charge of this amount of money and distribute it to the best of their ability. This was seconded by Doctor V. O. Mader and carried.

Doctor W. A. Curry: "Last summer a committee was appointed to draw up a scale of fees. The committee consisted of Doctors L. M. Morton, H. A. Creighton, M. J. Macaulay, W. G. Colwell, H. W. Schwartz, H. F. MacKay and myself. We drew up a scale which was referred to the different branch societies, and we have received several lists of alterations."

Doctor W. K. House stated that this was to be considered a minimum scale of fees.

Doctor W. G. Colwell did not consider it a minimum scale of fees, but a scale of fees for the Maritime Medical Care Incorporated.

Doctor F. J. Granville moved that this be the minimum scale of fees, which was seconded and carried.

Doctor R. M. Rowter moved that the "and up" be removed all the way through the scale of fees, which was seconded by Doctor R. O. Jones, and carried.

It was moved by Doctor D. F. Macdonald and seconded by Doctor J. W. Reid that the fee for night calls be $5.00. Carried.

Doctor D. F. Macdonald moved that night calls be from 9.00 p.m. to 8.00 a.m., which was seconded.

Doctor J. W. Reid moved an amendment that the evening hour be changed from 9.00 p.m. to 6.00 p.m.

It was moved by Doctor H. F. Sutherland and seconded by Doctor E. I. Glenister that the evening hour be changed from 9.00 to 8.00 p.m. Carried.

It was moved by Doctor W. G. Colwell and seconded by Doctor J. W. Reid that the certification clause be accepted as is. Carried.

It was moved by Doctor W. G. Colwell and seconded that the consultation fee be $10.00. Carried.

It was moved by Doctor J. W. Reid and seconded that $1.00 mileage be established the year round. Carried.

It was moved by Doctor J. W. Reid and seconded that the diagnostic skin tests be $2.00. Carried.

It was moved by Doctor J. E. LeBlanc that Haemorrhoids Injecting be $5.00. This was seconded by Doctor W. A. Curry and carried.

It was moved by Doctor W. G. Colwell that Haemoglobin Estimation fee be $2.00. This was seconded and carried.

It was moved by Doctor J. W. Reid that the phrase "after 42nd day, $15.00 and up per month" be deleted, which was seconded by Doctor S. Marcus and carried.

It was moved by Doctor W. G. Colwell that the Society accept page one as altered, which was seconded and carried.

It was moved by Doctor J. E. LeBlanc that on page two Electrocardiograms, repeat, be $10.00 instead of $5.00. This was seconded by Doctor H. R. Corbett and carried.

It was moved by Doctor C. H. Reardon that on page one under Special Procedures be added that the fee to a General Practitioner for an electrocardiogram be $10.00, which was seconded and carried.

It was moved, seconded and carried that under the section Obstetrics on page two be added the item Caesarean Section, fee $100.00.

It was moved by Doctor W. G. Colwell that under Obstetrics, Specialists' fees be $100.00. This was seconded by Doctor G. R. Forbes, but the motion was defeated.

It was moved, seconded and carried that under Obstetrics be added "Incomplete Abortion, fee $35.00."

It was moved by Doctor W. A. Curry, seconded and carried, that the Society accept page two as altered.

It was moved by Doctor V. O. Mader that on page three under Skin Grafting, Nerve Suture and Tendon Suture that the original fees be deleted, and that the phrase "according to circumstances" be added. This was seconded by Doctor J. F. L. Woodbury and carried.

Under Surgery it was moved, seconded and carried that the words "fee to include post-operative care for thirty days" be added.

It was moved by Doctor R. O. Jones that under Surgery "Electro encephalogram" be deleted and be added under Neuro-Psychiatry on page two, and that the fee be $15.00. This was seconded by Doctor F. J. Granville and carried.

It was moved by Doctor W. A. Curry, seconded and carried that the Society accept page three as altered.

It was moved by Doctor W. G. Colwell that on page four the fee for Perineorrhaphy be left at $75.00. This was seconded and carried.

It was moved by Doctor W. A. Curry that the Society accept page four as altered. This was seconded by Doctor W. G. Colwell and carried.

It was moved by Doctor Eric W. Macdonald that the fee for Appendectomy on page four be $75.00, and for acute or ruptured appendicitis $100.00. This was seconded. Motion defeated.

Doctor W. K. House: "This schedule of fees is not binding; many of us will charge more or less as we see fit."

It was moved by Doctor F. J. Granville that on page five the fee for Cystoscopy, $15.00, be retained.

It was moved by Doctor W. G. Colwell that on page five the fee for cystoscopy be raised to $25.00, this to include catheterization of the ureters. This was seconded and carried.

It was moved by Doctor W. A. Curry that the Society accept page five as altered. This was seconded and carried.

It was moved by Doctor S. Marcus that on page six the fee for Cauterization of cervix, without anaesthesia, at office, $10.00 be added. This was seconded by Doctor W. G. Colwell and carried.

It was moved by Doctor G. W. Turner that on page six "Pelvic examination, $10.00," he deleted. This was seconded by Doctor W. G. Colwell and carried.

It was moved by Doctor W. A. Curry that the Society accept page six as altered. This was seconded and carried.

It was moved by Doctor V. O. Mader that on page seven under Fractures, "Coccyx (non-operative)" the fee be $25.00 instead of $5.00, and that "Coccyx (operative)" the fee be $75.00 instead of $100.00. This was seconded and carried.

It was moved that the fee for "Malar bone (operative)" be $50.00, and for "Malar bone (non-operative)" be $10.00. This was seconded and carried.

It was moved that the fee for "Fibula (operative)" be $50.00, and for "Fibula (non-operative)" be $25.00. This was seconded and carried.

It was moved that the fee for "Nasal bones (operative)" be $25.00, and for "Nasal bones (non-operative)" be $10.00. This was seconded and carried.

It was moved by Doctor W. A. Curry that the fee for "Pott's fracture (operative)" be $100.00, and for "Pott's fracture (non-operative)" be $50.00. This was seconded and carried.

It was moved by Doctor W. A. Curry that the Society accept page seven as altered. This was seconded and carried.

It was moved by Doctor H. W. Schwartz that on page nine that the fee for "Cataract, needling" be $50.00, and for "Cataract, senile" be $150.00. This was seconded and carried.

It was moved by Doctor H. W. Schwartz that on page nine "Orbital tumour" be changed to "Exenteration of the orbit." This was seconded and carried.

It was moved that under Ear, Nose and Throat there be added "Laryngeal fissure, fee $15.00." This was seconded and carried.

It was moved that the fee for Larynx, removal of benign growths be $75.00 instead of $100.00. This was seconded and carried.

It was moved that under Mastoidectomy (radical) the words "Including post-operative treatment" be added. This was seconded and carried.

It was moved by Doctor W. A. Curry that the Society accept page nine as altered. This was seconded and carried.

It was moved by Doctor J. E. LeBlanc that on page ten under "Blood counts, Red," be added, "at office, fee $2.00," and under "Blood counts, White", be added, "at office, fee $2.00." This was seconded and carried.

It was moved that under "Coagulation Time" be added "at office, fee $2.00". This was seconded and carried.

It was moved that under "Bleeding Time" be added "at office, fee $2.00." This was seconded and carried.

It was moved that under "Sedimentation test (Westergren)" be added "at office." This was seconded and carried.

It was moved by Doctor W. A. Curry that the Society accept page ten as altered. This was seconded and carried.

It was moved that on page eleven under "Faeces for Occult Blood" be added "if done at office, fee $2.00." This was seconded and carried.

It was moved by Doctor W. A. Curry that the Society accept page eleven as altered. This was seconded and carried.

It was moved by Doctor W. H. Eagar that the fees for Radiology be submitted to the Radiological Association for their consideration, to report back to the general meeting. This was seconded by Doctor H. R. Corbett and carried.

Doctor F. J. Granville moved that Doctor W. A. Curry deserved a vote of thanks for all his patience in connection with the schedule of fees. This was seconded and carried.

Doctor H. G. Grant read the letter from The New Brunswick Medical Society regarding a full-time executive secretary for the three Maritime Provinces, as published in the Executive minutes. Doctor G. E. Chalmers, Doctor T. C. Routley, and Doctor J. F. C. Anderson all spoke briefly regarding this matter.

Doctor W. H. Eagar thought this matter was very essential and necessary but something the Society should be very careful about, and that a committee should be appointed to look into the matter.

It was moved by Doctor N. H. Gosse that a committee be named by the President to go into the matter and report back to the Society. This was seconded by Doctor W. G. Colwell and carried.

It was moved by Doctor R. O. Jones that the general business meeting be continued on Wednesday evening, September 7th, at 9.30 p.m. This was seconded by Doctor J. E. LeBlanc and carried.

It was agreed that the Soicety sell entertainment tickets at $2.00 per person to help defray expenses.

Doctor H. A. Fraser presented the names of the Nominating Committee

as follows: Doctors Eric W. Macdonald, V. O. Mader, D. F. Macdonald, W. A. Hewat and W. F. MacDonald.

Doctor W. G. Colwell stated that he had been given the job of chairman of the Finance Committee in connection with the 1950 meeting of the Canadian Medical Association in Halifax, and he would like some suggestions as to how to raise funds. He suggested that each member of The Medical Society pay $15.00, which might be added to their annual fees and collected by the Secretary, or that each Branch Society collect $15.00 from each of their members. The Canadian Medical Association contributes a certain amount of money, but nothing for the entertainment with the exception of a grant towards the President's reception. He read the following quota according to the 1949 membership of the Branch Societies, at $15.00 per member.

Halifax Medical Society	163	members	$2,445
Cumberland Medical Society	23	"	345
Colchester-East Hants Medical Society	31	"	465
Valley Medical Society	44	"	660
Pictou County Medical Society	31	"	465
Cape Breton Medical Society	64	"	960
Lunenburg Queens Medical Society	28	"	420
Western Nova Scotia Medical Society	25	"	375
Antigonish-Guysborough Medical Society	18	"	270
Members living outside of Nova Scotia	15	"	
Total members	442		

Doctor Eric W. Macdonald moved that each member of the Society be assessed $20.00 towards the entertainment of the Canadian Medical Association in 1950. This was seconded by Doctor W. J. MacDonald.

Doctor J. A. Noble suggested that a quota be allotted to each local Branch and that the local treasurer be responsible for collecting that quota.

Doctor J. S. Robertson moved that a subscription list be opened immediately in the various Branch Societies, that it be open for three months, and that the remaining sum be raised by a levy based on the figures given by Doctor Colwell. This was seconded by Doctor S. Marcus.

Doctor W. G. Colwell advised that he would prefer not to have a ruling by the Society, but suggestions.

The original motions were withdrawn.

It was moved that the meeting adjourn at 11.30 p.m.

The adjourned meeting of the first business session was called to order by the President at 9.45 p.m. Wednesday, September 7, 1949.

The financial statement was read by Doctor R. O. Jones, as published in the Executive minutes, who moved the adoption of the report, and this was seconded by Doctor W. H. Eagar, and carried.

Report of the Medical Economics Committee

Your Committee, during the past year, has not had a very heavy load to carry and only one subject to deal with which might have been called contentious.

It will be remembered that when the situation at New Waterford was presented to our Executive last year it was the decision of the Executive that the Society should do everything in its power to help our members in that district to resist the efforts being made there to saddle them with a system of medical practice distasteful to them and violating many of the principles of sound medical practice as we see them.

New Waterford and the Co-operatives

Not many months had passed before a call came from New Waterford, and our Secretary and your Chairman flew to Sydney to see what we could do. There, on Saturday, December 18th, we met the President of the Cape Breton Medical Society and other members of our Society, and on Sunday afternoon with a group of Cape Breton doctors we met at New Waterford the forces of the U. M. W., and the representative of the Co-operative scheme, (one, Mr. MacIntyre) in an interesting session lasting some three and a half hours.

Your Chairman, in response to a question from the union, was obliged to state that he did not consider the system of medical practice as found among them to-day to be at all adequate or satisfactory. We felt, however, and our New Waterford confreres were generous in saying so, that we gave strong support to the New Waterford men in their effort to prevent such action on the part of the miners as would throw them from the present frying-pan into the fire of a co-operative scheme. An interesting commentary upon that incident is that the U. M. W. in Cape Breton must have been strongly influenced by the co-operative group against their best interests; for a review of events in several Commonwealth countries will show that where Labor Governments have attempted to put over a system of State Medicine, under which of course there would be no free choice of doctor, *it was the Trades Union in every case that kicked and* prevented the government from enacting such a measure. In contra-distinction to that the Cape Breton union was asking for it, of course under Co-operative direction.

It is to be hoped that in the time that has since elapsed our union friends in Cape Breton have come to see the extent to which their real medical interests would have been compromised by such a scheme, and that in due course they will realize that the improved medical service which they seek, and to which it is conceded they are entitled, cannot be secured at a lower cost than their present system but at a higher cost—to them or to anyone who will pay it—and that it is available to them any time they seek it.

Since our last meeting, there has been much for thoughtful men to observe as to the effect of the impact of government upon the practice of medicine in other countries, especially in our sister countries within the Commonwealth. There has also been need to consider the extent to which experience in those countries may soon become our experience.

Health Insurance in England

Outstanding among them is England where failure to prepare against the day that they knew would come—failure of organized medicine to stand solidly in support of the trust that was theirs—had resulted in the imposition of a system of Medical Care upon the people of Britain that in our judgment is bad for the people—though as yet they do not all think so—and bad for the

doctors. It is bad for the people in that, since any doctor may have 4,000 patients, it spreads medical care over too thin a layer to be effectual; and it imposed such a load upon the doctor to secure for himself a bare existence, that opportunity for that amount of study which is necessary to keep him mentally alive is precluded or greatly reduced. Thus is the clock of medicine set back many years. All this is so bad for the doctor, so devastating to those ideals that have seen medicine develop and flower so beautifully during recent decades, that many doctors have left the country, and reports coming frequently to us indicate that many others are anxious to leave, that they may, like their pilgrim forefathers of old, find that freedom and opportunity which the Old Land again would seem to be failing to give.

And not only is this bad Medical Economics, it is in its effect, bad National Economics. Instead of proving a boon to the people, it is a definite element in the encompassing of an impending national disaster. For the great burden which this service imposes upon the state is held to constitute no small factor in the cost of production of goods for export; and their high cost is the biggest single element in the reduction of trade with those countries with which trading would seem to be imperative, if the equilibrium of the world is to be restored.

A very interesting sidelight on this situation should probably be recorded. Mrs. Aneurin Bevin, M.P.—wife of Britain's Health Minister—acknowledging the plight of England in this regard the other day, stated that the reason for her plight was that the United States is not a Welfare State! This attitude has also been expounded recently by the "New Statesman & Nation", and we have no doubt but that Russia feels the same way. It is to be hoped that our movement to the left in this country will stop short of such folly.

The Situation in Australia

In Australia, whether due to the greater virility that is to be expected in a younger nation, or to some other cause, the efforts of their government at the complete socialization of medicine have not been so successful.

The first principle which was violated by them was the "free choice of doctor." On this the profession won out, largely because labor itself did not want the present doctor-patient relationship disturbed.

There have been many other bones of contention in that country. Recently the government dropped their state-medicine idea and stated that they were prepared to accept the suggestion of the profession that the doctor be paid on a fee for service basis. They, however, laid down certain restrictive conditions, one being that *the doctor must look to the state for the part of the payment which the state would make, which was to be* 50%; and another being that *a history of the case or at least a diagnosis of the case would have to be submitted.* These conditions were not acceptable. The doctors were determined not to accept payment from the state, and they refused to divulge to any third party the patients' confidential secrets. Doctor Hunter of Australia speaking in Saskatoon, stated that their great desire was to preserve complete professional freedom. Their great fear was bureaucratic control; but they had no objection to the government's arranging with the community to extend medical service. Some efforts, it seems, were made to coerce the doctors into subscribing to the very severe limitations imposed by a Pharmacy Benefits Act—and when the screws were applied, the profession in Australia found it necessary to appeal to the courts and had the measure declared null and

void, as being ultra vires the constitution of their country. It is our understanding that a further appeal to the courts on another phase of government-doctor relations is now pending, or has just been heard. (Incidentally the hospitals there are state supported to the extent of about 75%).

New Zealand

In New Zealand, a Labor Government undertook to bring in a complete medical service, and it was going to be free to the people regardless of the size of their incomes. This was introduced by a series of isolated measures or benefits, for definite services—Radiology, e.g.—a bit at a time. Then came legislation compelling the doctor to practise their (the government's) way. This was to do away entirely with private practice and have the whole profession controlled by the Department of Health.

The first legislation there provided that the doctor must enter a capitation scheme—for a fixed fee. This the doctors refused. To them the capitation system differed in no important essential from a salaried scheme. It was a fine system for the government because they could budget so accurately for it. But when the deadline was reached for taking up contracts with the government some 36 out of their 1,800 doctors had done so, and according to Doctor Mercer—New Zealand's representative at the Saskatoon meeting, from whom most of this was obtained—when he left there this summer that number was reduced to six.

Now Sir, we come to a very important part of this report. It is a quotation from Doctor Mercer: "When our government realized that the profession were deadly in earnest in fighting this scheme and that it was unlikely to satisfy the needs of the people, they moved to the fee for service system by direct claim. But they limited the fee for the doctor's ordinary service to 7s. 6d. and specifically prevented him by the same legislation from recovering any more than that, if that were inadequate." This denial of a right that belongs to all citizens apparently made the doctors pretty sore, and by resolution they placed themselves on record as refusing to co-operate in any way with the government—advisory, disciplinary or in any other way—as long as that legislation remained.

Their medical organization (a branch of the B. M. A.) advised that they carry on and practise medicine as they had always done. They, however, indicated to the government that they hoped they would allow to the patient a refund of the 7s. 6d. on the doctor's usual charge. The government accepted that, and it is known as the "refund system". Most of the work in New Zealand is done under this system but it is very expensive, for every refund of 7s. 6d. to a patient costs 1s. 6d. to make. That has been their main system, but there are three other systems in operation to a lesser degree, which we shall not describe.

It is interesting that the government complained that the system was being abused by the doctors, but the Health Department would never release the figures. When finally they did come out it was shown that the number who consistently abused it was 5%, and good service had been given to the people.

It had long been recognized that such a hodge-podge of systems is not good for anyone, and both government and profession have now come to see that co-operation ought to rule in such affairs. Accordingly on a suggestion from

the government the profession nominated members to a government committee for the purpose of determining the points of agreement as between the profession and the government, looking to the institution of a complete service.

It would seem that many points of agreement were found, and the following measures are now suggested by the joint committee:

(1) The disciplining of the profession and the organization of the profession in relation to the service shall be done by the profession itself, and that all be handed over to their National Medical Organization. To this end the government has suggested that the Medical Association bring in its own legislation.

(2) The replacing of the hodge-podge of systems by one to be known as the "Schedule System," whereby the doctor agrees to accept, on behalf of his patient, a part payment of the fees, and the Government accepts, not each individual voucher, but a schedule of attendance made out by the doctor, including the name of the patient, the date, and the address of the patient, and in the next column the payment he claims from the fund. These will be sent to the Department of Health at stated intervals and the doctor will receive the proper amount.

(3) Introduction of a specialist benefit on a fee for service basis, of some sort.

These are the points of agreement presented by the Committee to both government and profession and their adoption is expected.

This, it is shown, would enable the doctor to practise as he has always done—free from any government interference, although they will be accepting money from the State, and as the patient has to pay part, the system tends to prevent the wild orgy of running after wigs and teeth and spectacles, and unnecessary medical services, and leaves the doctor opportunity to give his services to those who need them.

New Zealand Points of Special Interest

We find the case of New Zealand of great interest and would point to certain facts in her case as being of considerable significance to us, at this juncture in our medical lives.

(1) The Labor Government came to power in that country in 1935, determined to bring in a full measure of Social Security as they had promised it.

(2) At first, unfair coercive legislation would seem to have been the order of the day, as a result of which there were produced years of turmoil; and it is only now, fourteen years later, that there seems to have been regained that mutual appreciation of the rights and prerogatives of government and of profession, which should never have been lost. Out of such appreciation there is likely to come that which does little to inflate anybody's ego but that which is best for all concerned.

(3) A third, and very important fact is that *no government seems to learn from the experience of another.** New Zealand's failure to fully socialize medicine was no deterrent to Australia's Government to try on the same thing; indeed it appears to have spurred her on to more tyrannical action. Then the difficulties in New Zealand and Australia were, in turn, no deterrent to Britain to go to even greater lengths.

(4) There is however, in spite of this similarity of pattern, a great difference between Britain and the overseas Dominions—a difference which sets a great lesson for us. New Zealand has had its equilibrium restored, and Australia will come out of great tribulation, on the road to sanity, because in both instances, a well informed medical profession that knows the truth has had the courage to fight for it, "come hell or high water". Britain, on the other hand has never known the type of cohesion in medicine that it is necessary for it to have if it is to withstand *the enemy from within.* Lloyd George had the weapon in his pocket with which to slaughter the doctors, in his day—the jaw-bones of the asses who "knew not the day of their visitation." Bevin banked (we purposely reject "gambled") on the same defect. He could not lose, if the same conditions obtained, and apparently the same conditions did obtain, for we have seen a high degree of subjugation of Medicine in that country to the whims of a dictator.

Committee's Conclusions as a Result of These Studies

Your Committee feels that it should set down what to them are the obvious conclusions proceeding from these facts:

(I) Medical Economics to the immediately foreseeable future must rank as a "compulsory" subject in our studies.

(II) It is a living — vital — subject susceptible of being shaped and moulded as we go along, not only by us, but by a host of others who from the experience of our sister Dominions may not be either wise or friendly.

(III) The profession of medicine of our day with the knowledge that it has, has a great trust and responsibility, to preserve for the people of our country as well as for our profession, freedom to develop as we have developed and to serve as we have served; and that trust may demand from us, at any time now, the unpleasant and unpopular duty of saving our people from the consequences of their own devices as expressed by their leaders; and,

(IV) It will be only by virtue of an informed and solidly united membership with a wise and devoted leadership, that organized medicine will be able to withstand the impact of those forces of unreason, which are extending themselves throughout the world, alike in Canada and the antipodes.

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*In view of the terrific cost of complete government provided government operated medical services there is increasing evidence that other governments are growing more cautious.

The Canadian Position

But, it may be asked, why should we be disturbed by what other countries do? Why this homily? There are few of us who do not know the answer but for the record and for posterity we believe that it should now be given:

The recent political contest in Canada saw all parties including in their platforms promises to extend the Welfare Service of the country, with Compulsory Health Insurance having high priority. It is my understanding that our Prime Minister has stated that he will fulfil the promises of his predecessor in this connection. What is the attitude of organized medicine in Canada with respect to that? It will be remembered that Canadian Medicine has for a long time been on record as being in favour of Health Insurance. It has, for a long time, seen advantages that might accrue to our people by the extension of medical services that Health Insurance can provide. It requires, however, before it can have the support of organized medicine, that certain principles—fundamental and essential—be duly respected in its operation as, for example, the free choice of doctor; and that no measure, rule or influence will in any way curtail the scientific freedom by which we have developed, it is of the utmost importance that it be properly administered.

In this spirit, and moved by these thoughts, our different divisions have sponsored their own plans of Medical Insurance, on a voluntary basis, all of which are proving successful in the relatively limited field in which up to now they have been working.

The Discussions in Saskatoon

In the meetings in Saskatoon earlier this year, Medical Economics held a very prominent place, and the Council of the Canadian Medical Association, after long and serious deliberation formally adopted a resolution which said, in effect, that the Canadian Medical Association should take steps through its constituent divisions to extend these voluntary plans of Prepaid Medical Care as widely as possible. It was intimated in discussion that insofar as persons are able, they should pay the premiums themselves, and insofar as any are unable to pay, it should be paid for them. It is here suggested that thrift and industry should not be relegated to the limbo of lost virtues, with any governmental agency officiating at their obsequies.

Compulsory Hospital Insurance

It was also agreed by Council that in any extension of Welfare Services, contributory *hospital* insurance should be instituted before any compulsory medical services scheme should be considered. In this connection, several provinces have already seen the importance of this, and have established a compulsory Hospital Insurance service and it is understood that other provinces are considering it also.

In Nova Scotia

In Nova Scotia, while voluntary Hospital Insurance has demonstrated its value, and most doctors we believe will acclaim its worth, there would seem to be no widespread demand as yet, for its wider application under governmental auspices. It is something however for which demand will come.

Maritime Medical Care Incorporated

In the realm of Medical Care Insurance, in Nova Scotia, your plan "Maritime Medical Care Incorporated" is making a noble start to supply a real need. After many difficulties and delays, first in connection with the employment of suitable personnel, then in connection with office space and equipment, it finally got going, on the 7th of March this year. Now, although your Committee understands that there is nothing spectacular to show, the degree of success achieved is greater than that usually seen in so short a time, in similar plans, and that, in the face of competition from various sources.

Communication from the officers of the Corporation expresses the view that that success is largely due to the support which members of this Society have given it, first by becoming Participating Physicians (some three-quarters of our members having signed up) and secondly by being boosters of their Plan and pointing out, as they have done to their people, the very great advantages which their Plan has, over all other Plans of Medical Care Insurance doing business in this province.

Your Committee is strongly of the opinion that such plans of Prepaid Medical Care, properly used and fully backed by our profession may indeed become a great bulwark against the kind of political aggression of which the pattern is recorded herein.

Medical Care of the Welfare Group

The extension of Welfare Services entered a new phase in this province when at last session of the legislature the Premier announced that the government had undertaken to provide medical care—outside hospital—to its Welfare Groups—old age pensioners, mothers' allowance and blind. This came before the Executive of our Society and has since been handled by a special committee of that body, under the chairmanship of our President.

The Schedules

Your Committee would call to your attention again the fact that the By-laws and Regulations of Maritime Medical Care Incorporated to which we subscribed last year require that body to pay doctor's accounts on the basis of the latest approved schedule of fees of The Medical Society of Nova Scotia.

It is our understanding that formal application was made to the Society for such a schedule of fees and that same was duly received. It seems, however, that the schedule supplied is of considerable antiquity, showing rates below those of current usage; but though this is so, the taxing committee of the Corporation has been obliged to be guided by it, to the regret of all concerned. Your Committee recommends that action be taken to bring the schedule up to date.

Apologia

It has not been customary for our reports of Committees on Economics to take this form, but these are strange times, and at the risk of incurring a charge of prolixity, your Committee has thought fit to present not only an account of our provincial and national affairs but a review of the situation obtaining in the countries named. We do not expect the pattern to be followed

here that was followed in those other countries. We like to think that we are in Canada more reasonable than any of them, and that is our belief. Nevertheless, though that is our trust, the dry powder of their experience cited herein may prove to be of value when the shooting begins.

All of which is respectfully submitted,

F. J. Barton
P. S. Cochrane
W. G. Colwell
J. V. Graham
D. F. Macdonald
D. M. MacRae
N. H. Gosse, Chairman

Note: Since the above was prepared statements purporting to come from government officials at Ottawa indicate that no system of compulsory Health Insurance will be instituted until adequate hospital facilities and adequate medical and nursing personnel is assured.

Doctor N. H. Gosse moved the adoption of this report which was seconded by Doctor J. C. Wickwire.

Doctor V. O. Mader stated that he had read the Economics report of the Canadian Medical Association which includes reports of all the Empire, and he thought it would be wise for each one to read the report of the Canadian Medical Association which is a great volume.

Doctor N. H. Gosse advised that the report of the Canadian Medical Association had been used in making the Committee's report.

Doctor J. W. Merritt: "I would like to ask for clarification. In the radio address of the present Prime Minister I heard him say that he would live up to his pre-election promise, and he made only one, and that was to give this country the best possible Government. The second is a small petty detail. The first is that we have imposed on ourselves the necessity of rendering accounts every month. I think a maximum period of twenty-eight days is a little hard on the average practitioner. We have imposed upon ourselves a penalty of five per cent if these accounts are not rendered in twenty-eight days. The third point; in our accounts it requests that an anatomical and aetiological diagnosis be given. In a great majority of cases this can be only made out by one person, and that is the doctor himself, which involves more work. We are going beyond the rule of professional confidence when we give this information to lay people."

Doctor H. E. LeBlanc: "Doctor Gosse's report denotes a lot of work, and I was glad to see the applause which he received. I hear from another speaker that there is a political issue. We are coming here to be well informed and we would like to have some details before we vote, as we want to go back home with a clear back ground. The Secretary of the Canadian Medical Association is present, and if there are any differences he should be called upon to dispel these grounds before we take action."

Doctor T. C. Routley: "I listened to Doctor Gosse's report with very much interest. I agree with the last two speakers that a meeting of this character should be thoroughly informed. One of the great tragedies of

certain countries is the apathy of their people to the important matters which confront them. The great majority of doctors do not become well informed on these great issues. It is surpassing strange to me why we have so much difficulty in persuading our colleagues in coming to grips with major problems. Sir Lionel Whitby said to-day that participation in some form of medicine by the State faces us. I know something about what the Prime Minister of Canada has said. Mr. King, in announcing these grants in May, 1948, said that they were 'fundamental pre-requisites of a nation-wide system of Health Insurance.' Mr. St. Laurent is reported to have said that he fully intends to implement the promises made by his predecessor, Mr. King, in the great field of welfare and social insurance. It seems to me that in gauging our position to these measures, we should ready ourselves for anything. The Canadian Medical Association has gone on record, you will find it in your September issue, has recommended that we all get behind our plans of voluntary prepaid medical care. Mr. President, that is a very laudable plan. I think we can take a hopeful view that we could go a long way in Canada with these voluntary schemes. Nowhere in the world have these voluntary schemes failed. The voluntary effort of the medical man has the answer to the question. I think we should redouble our effors in the voluntary field. It offers the profession an opportunity to become thoroughly acquainted with the workings of a scheme of a corporate nature. I would also remind this meeting that several of the Divisions have now been recognized by the Provincial Governments as being capable of rendering voluntary complete medical care to old age pensioners. Since 1935 Ontario has had an arrangement with its Government to provide medical care to the welfare group. These are all indications that the responsible Governments in Canada do recognize the necessity of administering medical care. If health insurance comes, with your experience of administering medical services to the poor, why are you not capable of administering medical services to all the people. The biggest question facing medicine is medical economics. We must become thoroughly informed ourselves as to what it is all about. If we drift along what position will we be in if some political party suddenly precipitates something. I trust and hope that the Division will come to grips with the situation and that you will be informed thoroughly on all these problems."

Doctor H. A. Fraser stated that the report of Doctor N. H. Gosse's was merely informative.

Doctor V. O. Mader: "The reason I rose in the first place is exactly the reason that has become so clear by the remarks of Doctor Routley and Doctor LeBlanc. This is a very serious matter. It contains so many important things that have to be carefully considered before they go on the records of this Society."

Doctor J. W. Reid: "There seems to be some difference of opinion as to what Doctor Gosse's report contains. Maritime Medical Care has been mentioned in that report; otherwise Doctor Gosse said nothing in that report except to tell us what is going on in the rest of the world, and I see no reason why it should not be accepted."

Original motion carried.

As Doctor W. A. Curry had to leave the meeting Doctor H. W. Schwartz acted as chairman of the Fees Committee, and read the following changes, in the Radiology section.

Certified Specialists in Radiology—
Consultation, in office, diagnostic or treatment ..... $ 5.00
Angiography 25.00

Chest—Thoracic Viscera
(a) Bronchography, including lipiodol, etc 20.00
(b) Routine Fluoroscopic 10.00
(c) Kymogram 25.00
(d) Tomogram, etc 25.00

Eye—
(a) Establishing presence of foreign body 10.00
(b) Localizing foreign body, additional 15.00
Face—small bones of, and/or nose 15.00
Fluoroscopy, surgical, fracture 10.00
for extraction of foreign bodies 15.00

Gastro Intestinal Tract—
(a) Oesophagus, only 15.00
(b) Stomach and duodenum 20.00
(c) Special small bowel studies 15.00
(d) Colon, only 15.00
(e)f Entire G. I. tract, including barium enema 30.00
(f) Cholecystogram (oral) 15.00
(g) Stomach duodenum and cholecystogram 30.00
(h) Entire G. I. tract and cholecystogram 35.00
(i) Choleangiogram 15.00
(j) Miller-Abbott tube 25.00
(k) Abdomen for free gas or obstruction 10.00

Genito-Urinary Tract
(a) Without contrast media 10.00
(b) Pyelogram—retrograde 12.00
(c) Pyelogram—intravenous 15.00
(d) Cystogram or urethrogam 10.00
(e) Utero-salpinogram, including fluoroscopic control 20.00
(f) Pregnancy 10.00
(g) Placentagram 10.00
(h) Pelvimetry 15.00

Lower Extremity—
Hip 15.00
Surgical (pinning, etc.) 15.00
Femur 10.00
Knee 10.00
Arthrogram 25.00

Leg, Ankle or Foot	10.00
Toes, only	5.00
Mandible, one side	10.00
Mastoids	15.00
Sinuses—para-nasal, routine	10.00
—special basilar or lipiodol studies (additional)	10.00
Shoulder—	
Complete	15.00
Skull	15.00
Ventriculogram or encephalogram (not including surgical fee)	25.00
Spine—	
(a) 1 area	15.00
(b) 2 areas	25.00
(c) Entire spine	30.00
(d) Myelogram (not including surgical fee)	20.00
Teeth—	
(a) Single area (each)	2.00
(b) Upper or lower complete (7 f.)	6.00
(c) Full series	10.00
(d) Additional films (each)	1.00
Therapy—	
Roentgen therapy, per treatment for neoplasms	5.00 and up
Roentgen therapy, per treatment for non-neoplastic	3.00
Radium or radon therapy	$10.00 to $50.00
Pelvis	10.00
Portable; in home (additional)	25.00
Upper Extremity—	
(a) Humerus, elbow or forearm	10.00
(b) Wrist, complete	10.00
(c) Wrist or hand	7.50
(d) Fingers	5.00
Follow-up examinations of same condition	less 25%

Doctor W. H. Eagar moved the adoption of the complete report of the radiologists' fees as submitted, with the exception of the non-specialist radiology fees. This was seconded by Doctor H. R. Corbett and carried.

As the non-specialist radiology fees still had to be disposed of, it was moved by Doctor A. R. Morton that the Chairman appoint a small committee to go into the matter of non-specialist radiology fees. This was seconded by Doctor H. R. Corbett and carried.

Doctor H. G. Grant then read the list of obituaries, when a moment's silence was observed.

Doctor H. A. Fraser named the committee to look into the matter of a full-time secretary for the Maritime Provinces as follows; Doctor C. B. Stewart, R. M. MacDonald, and the incoming President.

Doctor H. A. Fraser made a special plea that the members be on hand the next morning at nine o'clock for the scientific papers.

Doctor A. R. Morton moved that the business meeting scheduled for twelve o'clock on Thursday be postponed until two o'clock, which was seconded and carried.

It was moved that the meeting adjourn at 11.30 p.m.

Society Meeting

Cape Breton Medical Society

The November meeting of the Cape Breton Medical Society was held at the Point Edward Tuberculosis Hospital on the evening of November 10th. Routine business was discussed and Doctor John R. Macneil was appointed to represent the Society on the Central Committee of the Canadian Medical Association Convention Planning Group.

The President, Doctor A. C. Gouthro, introduced the speaker of the evening, Doctor John Laurie, Medical Superintendent Point Edward Hospital, who presented a brief resume of the use of streptomycin therapy in the treatment of tuberculosis.

H. R. Corbett, M.D.
Secretary

Personal Interest Notes

Doctor Arthur W. Titus who has been practising medicine in Halifax with Doctor J. W. Merritt since his graduation from Dalhousie Medical School in 1947, will leave the first of December to take up practice in Liverpool.

The marriage took place in Montreal in September of Miss Ellen Maria Henriette Laurent, daughter of Mr. and Mrs. Hans Christian Hansen, Tatamagouche, formerly of Denmark, and Doctor Ian Edward Lawman Hollands Rusted, son of Rev. Canon and Mrs. E. E. Rusted, Carbonear, Newfoundland. Doctor Rusted graduated from Dalhousie Medical School in 1948, and is at present working as a Fellow in Internal Medicine at the Mayo Clinic in Rochester, Minnesota.

Announcement was made recently of two new appointments to the staff of the Victoria General Hospital in the department of anaesthesia. Those appointed are Doctor Cyril M. Kincaide and Doctor Ralph W. M. Ballem. Doctor Kincaide is a native of Saint John, N. B., and graduated from Dalhousie Medical School in 1945, and for a year was resident in medicine at the Lancaster Hospital in Saint John. Specialized training in anaesthesiology was received at the Lahey Clinic in Boston over a period of two years. Doctor Ballem is a native of Sydney and also graduated from Dalhousie Medical School in 1945. Training in anaesthesiology was received for a year at the Victoria General Hospital and for another year at Hartford General Hospital in Connecticut.

Doctor Kenneth C. Rodger, Dal. 1947, who has been practising at River Hebert left the end of September for London, England, where he will take post-graduate studies at Hammersmith Hospital.

Doctor Kenneth A. MacKenzie of Halifax has been appointed a councillor of the Canadian Heart Association.

Doctor J. H. Buntain, Dal. 1935, who has been practising at Kentville, has left for New York where he will take post-graduate work at the New York Polyclinic Medical School and Hospital in diseases of the eye, ear, nose and throat.

Doctor and Mrs. Smith Henderson of Halifax and Doctor Russell Zinck of Lunenburg were present at the 25th anniversary reunion of the class in medicine, 1924, at McGill University which took place on October 17th in Montreal.

The second group of nurses to graduate from the new Victoria General Hospital received their diplomas at the graduation exercises of the School of Nursing at the Lord Nelson Hotel on September 15th. The diplomas were presented to the thirty-eight graduates by Doctor P. S. Campbell, Deputy Minister of Health, and the address to the graduates was given by Doctor H. L. Scammell.

Doctor Arthur H. Sangster, F.R.C.S., son of Judge and Mrs. H. W. Sangster of Windsor, has been appointed senior surgeon to the hospitals under the control of the Board of Management for Southern Ayrshire, Scotland. Doctor Sangster matriculated from Ashbury College in Ottawa, and graduated from the Dalhousie Medical School in 1930.

The Bulletin extends congratulations to Doctor and Mrs. D. S. MacKeigan (Pat Flynn) of Dartmouth on the birth of a son, Peter John, on September 4th; and to Doctor and Mrs. G. B. Shaw (Marie Burton) on the birth of a daughter, Karen Elizabeth, on August 30th.

Doctor and Mrs. Cyril M. Kincaide, who have been living in Boston for the last two years, moved to Halifax the last of July, and are living at 141½ Coburg Road. Mrs. Kincaide is the daughter of Doctor T. M. Sieniewicz.

The BULLETIN extends congratulations to Doctor and Mrs. H. Ian MacGregor of Halifax on the birth of a son on October 18th; to Doctor and Mrs. G. H. Murphy, Jr., (Frances Martell) of Virginia on the birth of a son on October 25th; and to Doctor and Mrs. J. J. Stanton (Margaret MacLean, R.N.) of Canso on the birth of a son, John Terrence, on October 27th.

Miners Critical of Medical Plan at Glace Bay

A sub-district convention of U. M. W. locals at Glace Bay on November 7th on the proposed co-operative medical set-up instructed delegates to ascertain the stand of their locals and report back to another meeting on November 20th.

This meeting, called by No. 11 Local, heard criticism of the present medical plan and rising cost of drugs. Three directors of the union-sponsored New Waterford Co-operative Medical Services outlined progress to date in that area. Miners in New Waterford and Glace Bay sub-districts voted in favour of the co-operative medical plan. The vote was about 10 to 1 in New Waterford, but was close in Glace Bay.

Obituary

Dr. P. A. Macdonald

ALL of our members of the medical profession of Halifax and Nova Scotia were deeply grieved when we heard of the passing of one of our most esteemed and distinguished colleagues, Dr. P. A. Macdonald, on October 27th, at the Victoria General Hospital, Halifax, N. S., after an illness of three months.

Dr. P. A. Macdonald, familiarly known as Dr. P. A., was born at Alma, N. B., in the year 1879. After he was graduated from McGill, he spent more than a year with Dr. G. A. Armstrong of Montreal, one of the leading surgeons of his day. He then came to reside in Halifax, N. S., where he opened a practice of his own.

Dr. P. A. was a Fellow of the American College of Surgeons, a member of the Masonic Order, of the Halifax Club, and of the Ashburn Golf and Country Club. His chief medical interests were the Children's Hospital and the Grace Maternity Hospital. He was an elected member of the Children's Hospital, and Mr. Corbett, the donor of that Institution, stipulated in the Act of Incorporation that Dr. P. A. Macdonald was to be a member of the staff during his lifetime.

Dr. P. A. Macdonald was one of nature's noblemen; he was kind, friendly, generous and charitable. He will be remembered in his younger days as an outstanding athlete, and even in later years he was our most proficient golfer. He was also a born entertainer—some of his stories were masterpieces. No gathering was complete unless Dr. P. A. was in the party.

He enjoyed an exceptionally large practice, both among the rich and the poor alike. He won the esteem and affection of his patients because his was a service rendered for the love of his profession and not for monetary gain. Many of his patients never received an account from him. Those of us in his own profession esteemed him for his common sense and uncanny judgment. He belonged to the old school, in that he did so many things extremely well. As an obstetrician, he had few equals and certainly no superiors.

Over the many years of our acquaintance, the writer of this brief tribute never heard him utter a harsh or uncharitable word about anyone. Quiet, modest, and unassuming, he had the capacity for making and keeping friends. I, who knew him so well, perhaps better than most, found my admiration for him growing with the years.

The funeral service, which was attended by a large gathering of people from all walks of life, was conducted by his long time friend and patient, the Rev. Dr. Harry B. Clarke, who applied to him the following appropriate lines:

Uncounted Friends

He was a friend
Whose heart was good;
Who walked with men
And understood;
His was a voice
That spoke to cheer,
And fell like music
On the ear.
His was a smile
Men loved to see;
His was a hand
That asked no fee
For friendliness
Or kindness done.
And now that he
Has journeyed on,
His is a fame
That never ends;
He leaves behind
Uncounted friends.

Surviving Dr. P. A. Macdonald are his wife, the former Miss Verna Cross of New York; his sister, Mrs. Charles Dorman of Hantsport, N. S.; and one brother, E. L. Macdonald of Halifax, N. S. To these mourners, the Medical Profession desires to extend its deepest sympathy.

F. R. Little

The BULLETIN extends sympathy to Doctor R. H. Sutherland of Pictou on the death of his wife, Mrs. Gladys Lawrence Sutherland, which occurred on October 24th, after several weeks illness, and to Doctor D. Lawrence Sutherland on the loss of his mother.

Dr. Henry Ernest Kendall, Lieutenant-Governor of Nova Scotia from 1942 to 1947, died at his home in windsor on September 2nd. Dr. Kendall was born at Sydney in April, 1864, son of Rev. Samuel Frederick Kendall of Bristol and Emily Long Kendall of London, England. He was educated at Sydney Academy, received his Arts Degree from Mount Allison University and studied medicine at McGill University, completing his course at Bellevue Hospital Medical College, graduating in 1888. Until the outbreak of the First World War he practised in Sydney, with the exception of a short time spent in practice in St. John's, Newfoundland. For a time he held the post of Provincial Medical Registrar in Halifax. Doctor Kendall was twice married, his first wife being the late Ida Burchell, daughter of George Burchell, Sydney. Of this marriage one daughter, Miss Helen Mary, R.R.C., of Sydney survives. In 1913 he married Margaret McLennan, second daughter of the late Hon. Senator John S. McLennan of Sydney, who survives him. There are two children of this marriage, Hugh McLennan Kendall, M.B.E., now living in England and John Stewart Kendall, now of Windsor. Also surviving are an adopted daughter, Mary Christine, at home, three grandchildren and two great-grandchildren.