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JOHN STEWART MEMORIAL LECTURE—1958

A Teacher's Eye View of the Future of Medicine

H. B. Atlee

You will find my text in Ecclesiastes where it says: "Wherefore I perceive that there is nothing better than that a man should rejoice in his works. . . . for who shall bring him to see what shall be after him?" But since the writer of Ecclesiastes was a disillusioned old cynic, and since I have always been one who preferred to light a fire under the pot rather than merely stirring what's in it, I am going to take my text in an inverted way. There comes a time when a man can no longer rejoice in his works—a time when he must ask himself seriously what shall be after him. Let me therefore try to light a fire—or at least a few hotfoots—under some of the situations that face us as a profession. Let me ask you, as I have asked myself, certain questions about the hazardous and perturbing future towards which we are moving so rapidly.

If the past 150 years show anything they show that while the tempo of our advance as a race is increasing at a dizzying pace, the advance itself is most uneven. In scientific achievement and technological development we are away out in front of our capacity to safely manipulate our gains; in psychology we have far outstripped our morals—and the pace of this outstripping is so disturbing that we are suffering increasingly serious tensions. It is possible that, if we do not soon increase the speed with which our insight and our morals catch up with the other advances, we may one way or another destroy ourselves. We in the western world—even if we survive the threat of the atom bomb—may become so afraid and so neurotic that we will not only lose faith in our present way of life, but—as the speed of our disillusionment and the Russian economic advance continues—lose faith in our capacity to amend and develop our way of life to meet our needs, give in to the tremendous pressure to accept communism or some other absolute, and follow some phoney Fuehrer into some phoney promised land.

I raise this somewhat dismal bogey not because I believe that it is inevitable, but because it constitutes a very real menace unless we decide to live more dangerously and experimentally in the realm of ideas. At present I see no clear sign that we have so decided. In science we have allowed governments through fear to prevent the free exchange of knowledge, in politics we are intensely afraid of novelty, morally we have made little advance since the first century, A.D. Our institutions—guided too often by old men and young men who were born old—are amazingly unreceptive to suggestion and tragically stick-in-the-muddish. Doesn't our own profession as an organized body fall dangerously into this category? We strive above all things to be known as a group that is safe and sane, that has its feet firmly planted on the ground. We doctors, by and large, dress conservatively, drive conservative cars, live in conservative houses, marry conservative wives, and think conservative thoughts.

Having painted this social background, let me now pose against it certain questions concerning our future as a profession. Naturally, in the short time at my disposal I must limit the number of such questions to those that seem to me the more urgent.

Three disturbing major trends have been moving in on medicine in the last half century (1) The relative income and relative number of doctors has fallen. There has at the same time been an increase in the scope of insurance schemes which unquestionably foreshadow some form of government intervention. This, in the face of continuing inflation, will result in a further fall in the relative number of doctors and their relative income. (2) Attempts to improve medical education have resulted too often in an increase in the length rather than the quality of the discipline. (3) The tremendous expansion of psychiatry into hitherto unsuspected fields of medicine and sociology is forcing grave problems not only on the psychiatrist but on the rest of the profession—and society in general.

Let us examine those one by one:

(1) **Lowered Income and Socialization:** The most superficial study of the history of such other groups in the community as our public school teachers makes it plain that, if the relative income of doctors is lowered, and their relative prestige and freedom within society curtailed, the adventurous, the independent and the resourceful young men will look to less trammelled and more remunerative and prestigious fields. Fewer will undertake the long, hard and expensive discipline of medicine, and these will consist—beside the dedicated few—of an increasingly unadventurous and mediocre lot. Indeed, there is already strong evidence that we are getting less of the cream than we once did. Here is a table recently discussed at a meeting of the Association of American Medical Colleges:

Undergraduate Grade Averages of
First-Year Medical Students

Year	%with grade average of		
	A	B	C
1950-51	40	43	17
1951-52	30	55	15
1952-53	18	68	14
1953-54	21	69	10
1954-55	17	69	14
1955-56	16	71	14

It shows that those admitted to the study of medicine with Grade A qualifications have dropped in 6 years to one third, and those with Grade B or mediocre, qualifications have doubled. Of 61 students admitted to first year medicine at Dalhousie last year 6 were thrown out and 4 had to repeat their year. These are not reassuring figures.

For some years after the war, Canadian doctors earned the highest professional income. It has already fallen to third place. While this may have been due partly to a hesitancy on our part to raise our fees to meet the effects of inflation, it has perhaps to a greater degree been the result of accepting the rigid fees provided by our various insurance schemes—fees which may have been reasonable in 1945 but which inflation has put seriously out of line with the monetary realities of 1958.

If we continue to accept the fees of these insurance schemes as our standard can we expect governments—when and if they take us over—to pay more? Governments may be foolish, but not that foolish. Some form of socialization

certainly faces us. We have already accepted a form of government hospitalization, and if this is not the head of the camel in the tent I don't know camels. Large groups of the public want socialized medicine. Political parties would not be averse to baiting their platforms with it. By accepting various insurance schemes such as Blue Cross and our own Maritime Medical Care, we have more or less agreed—if not to the philosophy at least to the form—of socialization.

None of the forms of socialization set up elsewhere—including that in Britain—has attempted, as some trades unions have, to tie fees to the cost of living index to defeat inflation. Nor do we seem as a group to be concerned about the dangers of inflation. It would appear clear then that we are going to suffer the same fate as our brothers in Britain who are battling—without much success—against the grinding effect of the upper millstone of inflation and the lower millstone of socialization. Or like our public school teachers who, as a result of socialization a few generations ago, have become a depressed profession. These are the facts of life and history which we must face. Some of us are already feeling the tightening claws of inflation at our throats. The salaries of the fulltime heads of clinical departments which looked so fine a few years ago are now proving so inadequate that recently one of the most outstanding of our Canadian clinical teachers has abandoned his professorate in order to pick up a few chestnuts before the leaves fall.

It is possible, however, that the greatest danger from insurance schemes and socialization is not that these will lower our fees and—this being a materialistic age—our prestige also. The danger lies in the rigidity and standardization that seem inevitably to result from socialization and bureaucratization. Of all those things that menace the future of the freedom-loving and heaven-aspiring spirit of modern man, perhaps the most dangerous is bureaucracy—bureaucracy, whose mother was compromise and whose child is conformity. Will Durant has written that civilization, like life, is a perpetual struggle with death. The greatest cause of death in all previous civilizations and nations was that increasing rigidity of thought that strangles those ideological variants by which alone further evolution can take place.

The proposition I therefore put to you is this: Will we be able to maintain within the rigidity and standardization of further socialization and bureaucratization that freedom and initiative with which to continue into the future the advances we have made in the past? Will we exert the requisite wisdom, courage and cooperation? It won't be easy. Sir Francis Walshe, late president of the Royal College of Physicians, said recently:

“Thrice within my own professional life has our profession vigorously, even vociferously, stood out for a while against certain Government proposals designed to bring us within a narrower framework and one more subordinate to the State. Yet each time we have fallen back, disunited, disgruntled, defeated and acquiescent.”

Has some intimation of their possible future under an increasingly rigid and socialized status, already had its effect on the number of students applying to enter medicine? I have already suggested that it may have some effect on their quality. Here is an excerpt from a fairly recent issue of the *Toronto Globe and Mail*, which I have since seen echoed in some American journals of opinion:

“It is evident by the slump in medical school enrolment, that young men are becoming more aware of the struggle and difficulties of medical practice and, with the inherent shadow of a national health scheme ever present,

they are definitely looking to other fields."

If, on a continent where the population is increasing at a tremendous rate, not only the relative number but the actual quality of medical graduates is diminishing, you don't have to be an Isaiah to ask: Watchman, what of the night? Our sister profession, nursing, has recently found itself—largely because of lowered relative income and an insufficient modification of the rigidity of its Florence Nightingaleism—with fewer available graduates and a greater demand for them. Their answer to the problem was to introduce an inferior type of nurse—the nursing aide—into their setup. Will we be forced to do likewise who have looked with such scorn on the chiropractor and osteopath?

Perhaps you are asking yourselves: "Why on a lofty occasion like this does our lecturer descend to such mundane talk of income?—man does not live by bread alone." But this is a materialistic age, perhaps the most materialistic man has known. Income has become the magic wand that makes possible most of those freedoms, satisfactions and prestiges without which we seem to be able to feel no complete sense of achievement. I did not create this deplorable materialistic situation: I am merely saying that we should either fight against it or come to the best possible terms with it. We should do this not only to prevent deterioration in ourselves, but—and this should be our ultimate aim—to prevent a consequent deterioration in the service we give the public.

What can we do about it? We can certainly try to offset the deteriorating effects of inflation by tying our fees in some sensible way to the cost of living index. We can start giving serious thought to the behaviour necessary to maintain freedom of thought and action under the standardizing effect of further socialization. And we can try to make our medical course more attractive to the really able prospective student, and shape it to produce a better qualified doctor from the steadily deteriorating type of man who now seems to be entering it. Which brings me to the second issue I would like to raise.

(2) **Length and Quality of Medical Courses:** The medical course is a long hard discipline of approximately nine years from high school to earning, and consists, by and large, of four years in arts and science, four years in purely medical studies, and the required interne year. Very few are likely to get through it for less than from \$12,000.00 to \$15,000.00 if they remain single, and college fees and board are going higher every year. In addition to the long lean years there is the ardour of the high standards of scholarship that we expect. Nor is there any indication that medical schools have reached the limit of the number of years they intend appointing to the discipline. Only last year Dalhousie raised its premedical requirements by a year.

But in view of the financial future that seems likely to be our lot, should we not be giving serious thought to shortening rather than lengthening an already grievously long pilgrimage? Come socialization or not, hasn't the time arrived to call a halt to a situation where a man is practically a grandfather before he begins to earn a real income, and can afford to get married before his teeth fall out only if he has rich relatives, or can marry some love-hungry nurse or stenographer who will help pay the rent with her wages?

In examining our curriculum with this thought in mind, it would seem that three major criticisms might be leveled against it. (a) The purely medical part of it is far too comprehensive in the ground it covers, including too much of the fine print and emphasizing too little the big. (b) It is cluttered peda-

gogically with too many relics of its medieval past which consume unnecessary time. (c) There is grave doubt that the sudden divorcement between general and medical education that occurs on matriculation into medicine, does not militate seriously against the fullest possible cultural development of the student.

(a) Is it not possible that we might actually improve the quality of our product if we eliminated a large amount of the minutiae that now encumbers our course, and instead concentrated on a better teaching of the essentials and fundamentals? It would be interesting—if possible—to learn how much of the matter committed blindly to memory for examination purposes is actually integrated to the student's future needs, or ever after utilized by him because of the rarity of its applicability. Would 30% be an unreasonable figure? I have many times asked myself wonderingly what possible virtue the other 70% could contain to offset the clutter it created in my own mind.

At present it is a most temerarious student who refuses to encompass the whole 100%, because he knows he may be faced with an examination question so recondite that even some of the specialists in the field concerned would be hard put to answer it correctly. I think it is a fair statement that, on the day the final year student faces his inquisitors, he knows more facts about medicine than he will ever know again, or than any single one of his examiners knows. Some of the more brilliant students probably know more facts in the actual field in which they are being tested than their examiner. Is this a sensible state of affairs?

If, as medical educators, we grappled with this matter intelligently couldn't we—with actual benefit to its quality—concentrate on that common body of knowledge that every student should know and is likely to use throughout his working life, and merely indicate to him how to approach those sources of reading and methods of investigation whereby he could deal with the uncommon and the esoteric? Or leave these to be learned as part of a post-graduate effort? In doing so might we not set free from the curriculum a considerable modicum of time?

Furthermore, is it not possible that we might in this way turn out a better-oriented product? The student brain—less strained by the terrific burden of fact—might be more receptive to philosophy and method, those twin energizers that must work on facts to bring them to their highest use? All his life the doctor dealing with patients must be a philosopher using the methods of integration and induction in order to reach those diagnoses that are the basis of therapy. The tendency of the fact-crammed mind is to fit symptoms to memorized facts without the intervention of either integration or induction—a sort of thing that brings the technique of diagnosis perilously close to reading the future from tea leaves.

Yet where is there time for the student to develop a philosophy when all his days are filled with classes and his nights with memorizing? What teacher of clinical medicine has not suffered the frustration of seeing the fact become more important than the patient? On many occasions some of my student groups have failed to turn up to watch the investigation of a difficult obstetrical problem because they had to study for a test the next day. Was that their fault—or ours?

(b) That our methods of pedagogy are still cluttered with medieval relics, the continued widespread use of the systematic, or didactic, lecture attests. This type of lecture, which is in effect a digest of one or more textbooks, buttered with a minimum of personal experience, is droned at the students

hour after hour. Entering through his two ears, it travels down his arm and through his pen to the pages of a notebook—very little, if any, remaining between the two ears that in it went. There was a time several centuries ago when this had some validity. There were no textbooks. All the information was in the heads of a few men in Salerno, Paris and Oxford. Students had to take notes to carry the torch to the rest of darkest Europe. But today there is no field of medicine that is not covered by several excellent, well-illustrated and dependable textbooks, from which the student can read in twenty minutes what it takes the lecturer an hour to deliver.

And of what value are the notes so laboriously taken? A good many years ago two of my students asked if they could mimeograph for sale didactic lectures which I had foolishly given in my unregenerate past. I agreed—asking only the privilege of first looking them over. I found, to my surprise, on almost every page serious mistakes in fact, and every here and there statements I had never made in my wildest moments. Realizing from this incident the folly of the didactic lecture—and its bastard child the student's notebook,—as proper pedagogic tools in a modern world, I promptly gave up all systematic lecturing, and from that day onward taught only on a patient. I recommended what I hoped was the best student textbook, and in addition prepared mimeographed notes embodying our practice at Dalhousie. But here is an ironic fact: some of the time I thus set free from the curriculum was promptly snatched for lectures in—of all subjects—medical jurisprudence!

I herewith nominate for oblivion the didactic lecture. With this much medieval clutter out of the way, I am not sure that, by applying ourselves intelligently to getting rid of other outworn pedagogical techniques, we could not eliminate still more hours—not only from clinical but preclinical instruction. Nor is there any good reason why we could not use this free time to make the medical discipline a fitter instrument for the student's needs and a developer of other of his intellectual processes than memory.

(c) For a long time our present system of teaching the student the arts and sciences for three or four years to develop him as a human being, and then suddenly stop so developing him in order to turn out a fact-stuffed medical technician, has struck me as highly ridiculous. What are we aiming at in this nine years' discipline—or do we know? As I understand it from listening to various discussions of the matter at faculty and other meetings, two motivations have been at work.

First of all there is the genuine desire to turn out something more than a medical ignoramus—a man who knows too much about medicine and too little about anything else. We would like our graduate to be literate enough to appreciate the odd allusion to the Bible or Shakespeare, and articulate enough to express himself in clear and reasonably grammatical English. At the same time we would like him to combine the supposedly humane and gentlemanly qualities of a doctor of the old school with the scientific methodology of the new. This concept, which is neither clear nor free from a nostalgic sentimentality, probably comes as close to representing what is in our minds, as the bearded and benevolent old gentleman of the colored Sunday School card does to representing God. Not that this is an ignoble ideal. The trouble is that it is not good enough for our modern needs. If we are to recover that moral grandeur that we have somehow lost in the last fifty years, a moral grandeur integrated to the problems and perplexities of modern medicine and modern society, we surely need to cultivate a more austere and less sentimental ideal.

If any man will look about him at the world today, he must agree that the two qualities most lacking everywhere, from Quemoy to Halifax, are wisdom and moral courage. Is there any calling more in need of these than our own? Shouldn't we then heighten our efforts to turn out not merely medical technicians, but at the same time men of wisdom and courage? This being our aim, how can we integrate to our purely medical studies the wisdom of the ages and the courageous example of our ancestors as revealed in history, literature, philosophy and science, in order that they may make the greatest impact and cause the most sparks to fly upward?

Surely not by confining their teaching to those first four most immature years of the student's life, and then neglecting them entirely for the next five. Few things can have a more maturing effect on a man's mind and emotions than that contact with human woes and suffering that comes during the later years of his purely medical studies. Isn't this the time when he should also be exposed to literature, history and philosophy, so that his rapidly maturing mind may feed on a richer diet than mere human pathology? Would not our aim in developing the student as a human being as well as a doctor be better served thus than by the present absurd divorcement of culture from medicine that occurs at the time of matriculation from arts and science into medicine? Nor can we refuse the challenge this implies by crying that our business is to teach men to become doctors and nothing else. It was we who insisted on the four years of premedical study. We are stuck with it and we should make the best of it.

We have two serious strikes against us in anything we try to do in this regard. We live on a continent where—at least on the emotional plane—culture is held in some contempt. Even university presidents, orating before business men, have been known to deny their culture as abjectly as Peter did his Lord, performing an intellectual striptease whose main object seemed the revelation of the amount of hair matted on their chests. Haven't we all sinned in this matter? And isn't that why we suffer the disillusionment of hearing our best students speak scornfully of those sciences and premedical humanities on which their clinical studies are based, speak of them as a hurdle to be overcome rather than as a key to life?

The second strike against us is the rigid frame of requirements which, through our qualifying boards, we have clamped on ourselves. Let us suppose that a well known medical school decides to add a year to its course, or to its premedical requirements. Other schools, jealous of their place in the sun, follow suit blindly. Presently the bandwagon is crowded and then the licensing boards step in to make the extra year a rigid requirement. But once that extra year is added, an implacable yoke has been lowered on our necks that not even Archimedes' lever can lift. Let even the most prestigious school decide to remove one of those added years and, no matter how it may have improved its total course in doing so, its graduates find themselves in jeopardy before licensing boards, and have to walk in the rear of all military processions.

So from Atlantic to Pacific in a hundred medical schools, the student is taught precisely the same subjects in precisely the same way. If the Dean of medicine at the University of California gets a pain in his right side, the Dean of Dalhousie has his appendix out. In a field where we should be experimenting wildly in order to further that evolution which alone will give us continued life, we are caught in this rigid frame of ideology that means certain death. Nevertheless, despite all the difficulties that would beset any effort to change radically our methods of teaching and the length of our course, it would seem

that the time is arriving when we must give it some thought. Would the following suggestions light a fire under the pot?

- (1) Admit to the medical course itself those who have finished two years in the Arts and Sciences.
- (2) Tear out ruthlessly all our outworn methods of pedagogy and teach the subjects of the medical curriculum in such a way that the student is thoroughly grounded in the basic necessities, but taught a good deal less intensively the unusual and esoteric.
- (3) Into the many hours thus set free from the purely medical five years introduce the remainder of the humanities equivalent *at least* to an Arts or Science degree, spreading these over *all* the years of the purely medical course, *but not increase the present number of those years.*

This would shorten the entire discipline of medicine from nine to seven years, but is there any reason why the policy of shortening the time required to turn out a better product should be confined to the industrial world? If it is possible, using better modern technological methods, to build a better automobile in a shorter time, is it impossible, using better pedagogical methods to turn out a better doctor in a shorter time? Such a scheme as I have outlined—altogether apart from the fact that it would save the student time and money—might have one highly salutary effect, it might drive home to him in a very real way—perhaps even down to the emotional level—the realization that knowledge is one and indivisible, and that for the modern doctor a knowledge of Man is as important as the knowledge of Man's diseases.

(3) **The Problems and Potentialities of Psychiatry.** No one looking at the future of medicine can disregard either the problems or the potentialities of psychiatry. I am not so sure but that psychiatry, more than any other medical specialty, does not offer by far the most exciting vista into our future as a profession. Somatic medicine tends to become more and more a cut and dried science and less and less an art. Its methods, like those of religion must be based on persuasion—and persuasion will always be an art.

The possibilities facing psychiatry are tremendous, and the decisions that will have to be made concerning it are fraught with the gravest consequences. In the matter of possibilities, may I illustrate from my own specialty those fields within it which psychiatry will probably have to enter before any really great further advances are likely to be made. Here are just a few of those conditions in which our present treatment is highly ineffective or too surgically slanted, and in which there is some evidence of an emotional cause: spontaneous and habitual abortion, the toxemias of pregnancy, the various benign uterine bleedings, dysmenorrhea, sterility, frigidity—and so on.

Already considerable of a psychiatric invasion has occurred. These days most obstetricians treat hyperemesis gravidarum psychologically. Natural Childbirth—which those of us more afraid of good plain English than gobbledygook are now calling the Psychoprophylaxis of Labor—is unadulterated psychiatry. It is the psychological conditioning of a woman to face pregnancy and labor in the same way that military training and patriotic propaganda condition the soldier to face death. Hypnotism likewise—which has been waiting around the corner for over a century, and which has neither the dangers nor the disadvantages of any other form of pain relief—is being timidly essayed by some of my brothers. I can see the possibility that it may make our present methods of analgesia—certainly in labor—as anachronistic as the crossbow.

But how is this psychiatric invasion of the non-psychiatric clinical specialties to be handled? Are we simply going to dump these problems into the lap of the already overworked and understaffed departments of psychiatry, in the same way that we turn a sprained back over to the orthopedist? I do not see the biggest dividends in such a method. It seems to me that a wiser and more enlightening way would be for psychiatry to send men into each clinical department to work more or less as missionaries among the heathen. Not only would these missionaries help us to solve our joint problems, but we would learn from them, they would learn from us, and the medical student would learn in a better way than at present from us both. However, the achievement of this much to be desired cooperation will not be easy. We tend to burrow deeper and deeper into the watertight compartments of our individual specialties, and the deeper we burrow the more we lose sight of the bright sky of possibilities above—and the more we tend to stare at our own navels.

(May I add here in parenthesis that I believe the time has come when every major clinical department should be staffed in part by men trained in other specialties. Offhand I can say of my own department that it would benefit enormously by the immediate attachment to it of a psychiatrist, an internist, a urologist, an endocrinologist (or physiologist) and a pathologist. And that represents only a beginning. To put it in naval parlance: we have been tending to divide ourselves into groups of destroyers, groups of cruisers, groups of submarines, groups of flat-tops. Isn't what we need a combination of all the essential units in a series of comprehensive clinical task forces?)

But this is perhaps not the gravest problem that besets both us and the psychiatrist. If the future of medicine, as I have hinted, is to lie increasingly in the manipulation of emotions and behaviour, we will soon find ourselves seriously concerned with the problem of morality. I know of no system of philosophy that would exclude from morality the expression of those emotions and behaviours which result in sickness, criminality, or simply an inability to face up to the challenge of life. If hypertension, migraine and gastric ulcers are the expression of improperly controlled emotions and behaviour in what way do such emotions and behaviour differ from sin?

Could this mean that our profession—at least the psychiatric part of it—has now come the full circle, and that the priest-physician, who was the first physician, must return again? While it may not be fully apparent here, it is a fact in those larger centres that set the pace and fashion of our behaviour, that more and more of the most intelligent and useful leaders in business and professional life are turning their back on the church as their confessor and comforter in favor of the psychiatrist. It may be deplorable that they prefer to lie supine on his couch to callousing their knees before their God, but it is a rapidly growing phenomenon which we cannot evade. If it is the wave of the future we are all going to be splashed by it.

But as I see it—and I am ready to be corrected in this—the psychiatrist has fought desperately against accepting the ancient priestly function. He permits the patient to talk to him in the hope that, by such verbosity, a catharsis may result in the sick one seeing through his emotional haze the heights of Pisgah. But he does not then say categorically to the sick man as the religious teachers have done through the ages: "There is the path to Pisgah—girt up your loins and take it!" He does not even say: "Go and sin no more." In fact, he tends to leave the patient with the idea that he—the patient—is more sinned against than sinning, that the initial transgression lies rather with his parents and with society than with himself, and out of this almost Buddhistic

fatalism he must work his salvation. But do we best enhance the quality of our social morality by regarding his transgressions as sicknesses to be excused rather than as sins to be atoned for?

How much longer can the psychiatrist continue in this method? If, in the face of the ever-increasing numbers of those seeking his help to overcome emotional sin, he persists in refusing the priestly role, there is not the slightest doubt that some other species of guide, counsellor and healer will rush into the vacuum being created. Out of this overlapping of worlds all sorts of frictions, rivalries and antagonisms will arise until eventually some sort of unity of effort is arrived at. But if eventually, why not now?

But if the psychiatrist is faced with difficult decisions anent the future of his specialty, so are the rest of us with regard to psychiatry. If what I hear about the place is any indication, our present attitude towards psychiatry is so positively antipathetic and irrational that it can only be the expression of a serious degree of emotional immaturity. Are we internists, pediatricians, obstetricians—and especially we surgeons—prepared not only to admit the coming invasion of psychiatry into our fields, but to make those changes in our attitudes and practice which must inevitably be required? In the end, of course, we will have to—but it will only be after a struggle in which our consciences will have undergone a hellish battering.

This matter touches very acutely on medical education. If the picture I have just drawn has any validity it must give us concern as to the type of student we admit to the study of medicine. If some similitude of the priest-physician must be revived, should we not search more avidly for the dedicated man, rather than just the career seeker who happens to have the requisite knowledge of reading, 'riting and 'rithmetic. And once we have got him does it not become absolutely essential that we fill him as full as we can, and in the best way that we can, with the wisdom of the ages? Can we do this by divorcing stupidly, as we now do, the teaching of culture and medicine? Can we do this by setting him no greater example in moral courage than we are now showing in the face of so many of our problems?

Medicine has reached, or is reaching, a sort of zenith. With his entry into the heart, the surgeon has explored the last of the vital organs. With his entry into the soul, the psychiatrist may well, as I have hinted, be on the point of seriously influencing human belief and behaviour. But long before a human system reaches its zenith that rigidity of thought and timidity of experiment which caused the downfall of every empire from Babylon to Britain have fastened their death grip. With our present attitudes can we escape?

I believe we can. While the trends may be running against us, nothing is inevitable in human destiny. And because, as I said in the beginning, I prefer lighting a fire under the pot rather than just stirring what's in it—because I agree with Thomas Wolfe that "the essence of faith is the knowledge that all flows, that everything changes"—I make my plea here for a greater flexibility in our thinking, a greater courage in our philosophy, and a greater adaptability in our policies. As someone has wisely said: "There are many roads to Rome, but we shall never find the best so long as every pilgrim is forced to take the same path." In view of the impending future hasn't the time come for us to throw off our present smugness and lethargy, face the hard facts of our medical tomorrows, and make a really courageous and intelligent effort not only to save what is worthwhile from our not ignoble past, but mix with its stones the mortar of a greater intellectual adventurousness and so build a better medical world than ever was?

Eneuresis

Presented to the Dalhousie Refresher Course
October 20, 1958

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Definition: (Bakwin) "The repeated involuntary discharge of urine after the third year of life."

Incidence: In a survey of 1,000 unselected children between 4 and 12 inclusive, in the Children's Out-Patient Department of Bellevue Hospital, it was found that 26 per cent wet themselves during the night or day or both. In some the basis was grossly organic, but such children constitute only a small proportion of the cases. It was the custom for some years in the Out-Patient Department at Bellevue Hospital to inquire about this symptom routinely and, therefore, its presence or absence was regularly noted, even when the parent might otherwise neglect to mention it.

Michaels and Goodman found the same incidence in their group of 475 children. Their comprehensive summary of the literature on the frequency of Eneuresis indicates that about 1 out of 4 children wet the bed after the age of 7 years.

This high incidence may not be representative of the general population. Presumably the data were based on clinic populations where special socio-economic conditions exist. The figures nevertheless give some measure of the frequency of this condition and indicate that it is one of the most common disorders of childhood. Thorne found, in a group of 1,000 selectees for the draft, that 16 per cent wet the bed after the age of 5 years.

WHAT DOES THE PROBLEM LOOK LIKE TO SOMEONE IN PRIVATE AND CLINIC PSYCHIATRIC PRACTICE AND THE FATHER OF A LARGE FAMILY?

- (1) It is extremely common to find involuntary urination in taking the history of a child.
- (2) Frequently eneuresis is not the primary complaint.
- (3) It is extremely common in boys—so much so that if it is the *only* complaint in a boy under 7 I do not consider it is too serious.
- (4) In most cases "girls seem to train themselves, boys usually need help." "Getting children up to toilet at night" is almost invariably found necessary only with boys.
- (5) If a girl is seen with eneuresis almost always the main etiology is psychogenic.
- (6) Eneuresis is rarely a *solitary complaint if the psychological factors are of greatest importance.*

My Own Feelings About Eneuresis are:

- (1) Most children, especially boys do NOT toilet train for urinary control as early as the older text books stated. Probably older stricter methods of training gave earlier control—but I feel potentiated a greater likelihood to relapse.
- (2) Before the diagnosis is made a *complete evaluation* for each individual case is required. I am against the statement that a child who hasn't

achieved urinary control after 24 months is an eneuretic!

- (3) Since eneuresis is basically only a symptom or one of a group of symptoms we should *not* treat it in isolation. If a successful "symptomatic cure" is achieved (which is rare) the underlying condition still remains and usually appears in some other guise, e.g. a child treated with the Wee Alert (a bell that rings with 1st moisture) stopped bed wetting but developed fairly marked facial ties.

In What Psychological Conditions Does Eneuresis Appear?

- A. Eneuresis as a symptom of a Habit Disorder.
- B. Eneuresis as a symptom of an Anxiety State.
- C. Eneuresis as the main complaint

Habit Disorder (more commonly boys)

Symptoms in child: He is younger than his years, is more dependent and babyish. He only asserts himself in order to remain a baby and be cared for. He often shows other symptoms like thumbsucking and temper tantrums when he doesn't get his own way.

Symptoms in mother: She is usually immature and inconsistent. At times she is very overprotective, other times disgusted and angry with her child's babyishness. She often asks her doctor for rules in handling but rarely follows them. She has never used a consistent pattern for *any* type of training.

Usual History: The youngster, often the first or only child, was "never trained." Mother states at times she put him on the toilet, but other times "forgot" or "was busy." In taking the history, sometimes we find with warm but consistent handling from some other person the habit often improved temporarily.

Treatment:

- (1) Work with the parents. Get the father to help too (especially if he is more mature).
- (2) Help the mother become more mature and thus she will help her youngster become more mature.
- (3) In some cases the physician should get the mother interested in something else and the child out with other normal children. (i.e. break the emotional umbilical cord). Progress is usually good but it varies with the parents.
- (4) Symptomatic treatment is well listed in Spock and the Dept. of Health and Welfare Booklet on Bed Wetting.
- (5) In some cases the mother can't be worked with, you should then consider referral.

B. Anxiety Reaction:

1. Acute and usually transient (boys sl. more frequent than girls.)

History: The child, previously trained and moderately well adjusted (rarely *well adjusted*), develops childish habits under stress, e.g. birth of sibling, and illness either of child or mother, a separation, starting school, etc.

Treatment: As long as previous adjustment was fairly good and the present situation is understood as a reaction to stress and the handling is based on encouragement and love the relapse usually resolves itself. At times the parents must revert to earlier training methods—e.g. get youngster to void four times daily and the child should get up at night again for a while.

This reaction is nearly completely preventable and the family physician can help the parents in this regard. Children are smart so parents should not try to fool them. They should be told the truth with the level of explanation proportionate to their understanding. Children should be prepared therefore for the birth of a sibling, a period of hospitalization, a separation, etc. It is the sudden, the unexpected and the unknown that produces anxiety.

2. Chronic anxiety producing enuresis

(Boys and girls equally effected)

This type may have started as an acute reaction but either it wasn't treated well, or stresses continued. It is partially based on the child's temperament—i.e., the more tense the child, the more chance of this occurring, but **ESPECIALLY BASED ON HIS ENVIRONMENT (ESPECIALLY HIS MOTHER'S PERSONALITY)**.

The findings vary but the history is often a child (male or female) who *was* trained but when exposed to an upsetting situation (acute or chronic) developed, among other symptoms, enuresis.

The additional symptoms add up to a beginning anxiety neurosis. They may include numerous fears (of dark, of strangers, of school, of illness) general tension, night terrors, irritability or shyness, changes in appetite, even nausea and vomiting. The logical step is to investigate the cause. Too often too much attention is paid to physical factors. Often following a negative physical examination the parent is told there is "nothing wrong." This is patently absurd! Granted there is nothing *physically* wrong—say just that and go on (if you haven't done it already like you should have) to evaluate the psychological factor.

Case Presentation

Patricia is a very slight, eight-year old girl, who was referred to me by a genito-urinary specialist with a history of bed-wetting for the past four years. She wets nearly nightly, but not during the day, and though she has been fully investigated medically—twice with special genito-urinary treatments—her symptoms have persisted. Certain other typical signs were obvious. As mentioned, she is very small for her age. She, also, is very tense and fearful. She seemed to anticipate blame and punishment, and shows little spontaneity. The mother, too, proved to be tense, but after I obtained the full history, the contributing factors were obvious.

(As a routine, I attempt to obtain from the parents certain factual data, and usually, after twenty minutes a fairly clear picture can be obtained.)

This mother, for example, felt the emotional problems were of greater significance than the bed-wetting. In other cases you may find an over-emphasis on enuresis alone, but I would warn you again to find out *all* the youngster's symptoms. In brief, this youngster was toilet trained at two, but at four—with 1. a sudden infection (pyelitis and cystitis) and, 2. the family breaking up,—she developed wetting that has continued ever since.

At times, it has improved. (This is significant and you should always carefully go into these periods of improvement.) In Pat's case, she improved when there were visitors staying in the house, because then father was on his best behaviour. In summary, the family history was full of turmoil. The parents married young. Father, a spoiled child, always fought and drank to excess. He has beaten his wife, resents her superior education, but, most significantly, has utterly rejected Pat. He never wanted a girl and never paid

any attention to her except to criticize. Apparently, nothing Pat does ever satisfies him.

The family broke up when Pat was four, due to father's behaviour. Mother had an affair, father remarried. After two years his second marriage broke up, and now the parents have remarried, but his behaviour towards Pat has not changed.

Pat is unhappy everywhere. At school, to catch up to the Nova Scotia curriculum, she was under a lot of pressure. She is small for her age, and thus can't keep up with her age group in play, and the home situation has already been mentioned.

Thus, her bed-wetting is only a symptom of an unhappy girl. She shows many other symptoms of anxiety, such as night terrors, chewing her fingers, etc. She also soils herself at times. Psychological testing at the Child Guidance Clinic reveals a girl of average intelligence, who acts very passively. Underneath, however, she is very aggressive, but is so afraid of expressing these feelings that she is now almost incapable of spontaneous activity.

Treatment in such a case is obvious. Not only must we help the child, we must work with the home situation. Repeated patient interviews with both parents by our social worker, and co-operation by the teacher must supplement our approach to the child. The whole technique is too long to present at this time. It is sufficient to say that this is a serious, deep-rooted problem—best treated by the special facilities of a Child Guidance Clinic. Sympathetic therapy is useless!

Many physicians feel very incompetent to take a look at the psychological factors. They flounder by asking leading questions, especially those that can be answered by "No." and then they have to conclude in the "absence" of definite psychological findings that they are stumped.

May I suggest the following simple steps.

1. If any child (or an adult too) turns up with symptoms that may be psychogenic give yourself enough time to get a good history, especially on the first visit. It will save time in the long run as well as being more scientifically sound.
2. Make your questions specific *only for facts* (e.g., what is the problem, when did it seem to start, what steps were taken to correct, what makes the problem worse, what improves, etc.) but when you want to hear attitudes and feelings make your questions *indirect* e.g. How did you *feel* about—the child wetting—or being afraid—or sucking thumb, etc.
3. Be careful when you're asked *what exactly to do*. If you do you're committed yourself—if you're correct and it works you're the best doctor in Canada—but if your exact rules fail. . . .

Don't forget rules or advice are only of value if the person can accept them and integrate them into their functioning.

4. The best approach is to help the parents work out the problem with your co-operation. If the parents can accept the child, praise his good points but consistently work to alter his less acceptable behaviour and habits the child will respond. The emphasis must be on working with the parents!

5. After you're tried to help without much result do not hesitate to consider a psychiatric consultation. In the past the phrase "will grow out of it" has been used. This should not be used unless we are sure. Certainly the anxious youngster, exposed to a chronically unhappy stress situation will not "grow out of it." On the contrary unless a miracle occurs the child will get worse and could go on to a deep seated emotional disturbance.

C. Eneuresis as a Principal Symptom.

It is my impression that there are at least some children whose *main* symptom is eneuresis. (However many have some or both of the previous two groups symptoms)

There is much argument in the literature if these conditions actually occur but my personal and clinic experience leads me to add three different types where Eneuresis seems the major complaint.

1. The child with a hypersensitive bladder
2. The child who sleeps too deeply
3. The child who wets in revenge

1. **Hypersensitive Bladder:** These children usually wet day and night. They have small urinary capacity and when they "gotta go they gotta go." If they are far from a toilet by day, then they frequently wet. The stimulus level is low, laughter, excitement, activity, emotion, or temperature change often precipitate. At night they frequently void, especially when stimulated a lot during day, or too much excitement at bedtime, or getting chilled, etc. The physician should help cut down too much stress and suggest *in this group*.

1. Restriction of fluids after supper
2. Cut out excitement and pushing
3. Get to toilet *every* bedtime
4. Getting up to toilet every parents bedtime (in the older child an alarm clock helps)
5. Getting the child up as soon as he awakens

I feel this is the only group where atropine will help. I have found Donnatal extantabs helpful both by day and night but the previously listed steps must be taken too, i.e., don't rely on atropine to cure!

2. The child who sleeps too deeply is sometimes quite a problem. No. 1 group has too irritable a bladder, this group's bladders are not sensitive enough! It is not enough to call or shake him. Get him up! If you get him as far as the toilet he still is sometimes asleep (this time on his feet). But if you don't make sure he voids the bed will be wet next morning!

I would suggest in this group

- (1) Fluid restriction after supper and void at bedtime
- (2) Get child up every parents bedtime and if necessary during night
- (3) Try dexedrine in doses enough to lighten sleep, but not to keep awake

3. We have seen a few cases where the child hit back by bed-wetting. This is related to both the habit and neurotic type but is not exactly the same.

Frequently the mother in this type is a compulsively obsessed with cleanliness, criticizing type who happened to produce a somewhat aggressive child who figuratively says "pee on you and your ideas."

All the drugs and fluid restrictions in the world won't change this type. If the home physician can't modify the mother's attitudes (and the chances are he can't) he will probably have to refer for consultation and treatment.

In summary then, my aims in this paper have been:

1. To attempt to destroy the concept that eneuresis is a disease entity.

2. To illustrate that it is actually a common symptom of many psychological conditions
 3. That we can break it down into certain broad categories
 4. That each case must be separately evaluated and classified
 5. That there should be a logical treatment approach depending on the findings of each individual case.
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SURGICAL TREATMENT OF INGUINAL HERNIA IN FEMALE INFANTS AND CHILDREN*

During the past ten years 211 congenital inguinal hernias in female infants and children have been operated upon at the Children's Memorial Hospital. Approximately 15 per cent of these children had a sliding hernia of the tube and ovary. Not uncommonly, an ovary was incarcerated in the inguinal canal. Such children had symptoms, such as irritability, colic, excessive crying, constipation, etc.

The operation in simple cases consists merely of high ligation of the sac. A transverse incision of the inguinal region in the suprapubic fold of skin gives a far neater scar than the conventional oblique incision. In case of a sliding hernia it has been necessary to use a plastic operation on the sac which is fully illustrated. Operation is advised when the diagnosis is made and at any age, provided the child is otherwise normal.

There has been no mortality. There was one recurrence.

Goldstein, J. R., and Potts, W. J., Proceedings of the Institute of Medicine of Chicago. 21: 304, 1957.

*From Medical Abstracts, December, 1957.

The Practical Value of the Tuberculin Test*

By Floyd M. Feldmann, M.D., Pediatrics,

The tuberculin test has long been accepted as a simple and highly specific test for the presence of tuberculous infection, but its possibilities and its limitations tend to be overlooked. Studies done in recent years by the World Health Organization in connection with BCG vaccination programs, and observations made by the U.S. Public Health Service and others have provided valuable information, but there is still much to be learned.

Significance of Dose of Tuberculin. There is a tendency to think of the tuberculin reaction as an "all or none" phenomenon, although every pediatrician has learned that there is a wide range of tuberculin sensitivity in any group tested. Usually a tuberculin test is called positive or negative on the basis of size of reaction. If a Mantoux test is done, the indurations larger than five or six millimeters in diameter are arbitrarily called positive, but there are many smaller than this which represent some degree of sensitivity. Are these people with just a little sensitivity infected with tubercle bacilli? Undoubtedly some are but there is now good evidence that many represent a cross sensitization with other antigens. Studies now in progress may reveal the nature of the antigen or antigens able to produce some tuberculin sensitivity.

These findings give additional emphasis to an earlier study with graduated dosage of PPD which showed that in tuberculosis patients extremely small doses produce no reactors but with a gradual stepping up of the PPD strength an increasing percentage was positive until the dose of 0.0001 mg. was reached. At this point practically all persons with tuberculosis had a reaction of five millimeters or more. If the dose was further increased reactions were obtained in large numbers of children who were probably not infected. This with other studies indicates that a standard dose of 0.0001 mg. of PPD is satisfactory for most purposes.

The size of the tuberculin reaction may also be of diagnostic and prognostic significance. Recent preliminary studies (unpublished) at the Phipps Institute in Philadelphia indicate that the size of the tuberculin reaction is correlated with the probability of active tuberculosis; the bigger the reaction, the more likely it is that active disease is present.

Many observations point up the increasing usefulness of the tuberculin test to the pediatrician. The interpretations of various degrees of tuberculin sensitivity may be summarized as follows:

1. If a child has no reaction to 0.0001 mg. of PPD there is little possibility that he has a tuberculosis infection. Periodic testing, at least annually would establish the approximate time of a tuberculous infection.

2. A low degree of sensitivity with induration under five millimeters (5mm) in diameter could be the result of some other infection, or an insignificant tuberculous infection. The chance of active disease being present is extremely small.

3. With a reaction over five millimeters in size, the chances increase that active tuberculosis is now present, or will develop. Each child with such a reaction should have a thorough examination to confirm or exclude the presence of an active lesion. Most of such children will not have active lesions but will have an increased risk as they go through the ages 15 to 30, so long-term follow-ups and periodic examinations are important.

Effect of BCG on Tuberculin Test. If a child has a positive test when first seen by the pediatrician, it will be important to know whether BCG has been given or not. The reaction may be a result of the BCG inoculation. A positive test should lead to a search for tubercle bacilli if there is reason to suspect a virulent infection. Some children do acquire serious tuberculosis disease in spite of a BCG vaccination.

Chemoprophylaxis in Tuberculin Positive Children. Isoniazid prophylactic treatment of tuberculin reactors to prevent the subsequent development of active disease has been advocated frequently in recent years. Perhaps studies now in progress will provide more precise indications for chemoprophylaxis. At this time, however, opinion is divided and the physician will have to use his best judgment based on such things as recency of infection, the age of the child, the size of the tuberculin reaction, the presence of any lesions on X-ray, the presence of predisposing conditions such as diabetes, and the future exposure to infection. Current investigations have confirmed the considerable risk of future disease in tuberculin reactors.

Tuberculin Testing in Community Case Finding. Tuberculin testing in private practice will pay an extra dividend in community tuberculosis control by providing leads to active cases which might escape detection otherwise. If the test is positive in a young child, the infection must be recent and its source is likely to be an active case among his close associates. In older children the source of infection may be more remote. The size of the reaction is important here too. Not only are those with larger reactions much more likely to have active tuberculosis, but higher rates of tuberculosis are found among their contacts. The physician can be of help to public health authorities by insisting that all associates of tuberculin reactors receive adequate examination.

Tuberculosis Testing as an Index to Tuberculosis Prevalence. The tuberculin test is a relatively simple and inexpensive procedure for determining infection rates in groups of children and adults. If these groups are retested at intervals, trends in the rates of new infection can be detected. It is quite clear from the evidence now available that infection rates have dropped markedly in the last few years in the United States. The need for more accurate measurement of tuberculin sensitivity is increasingly apparent. The only quantitative procedure now available is the Mantoux or intradermal test. The method and material used in the test has been described often and need not be repeated.

The patch test has been used extensively because of its convenience and the fact that no needle is necessary. However, it does have serious basic limitations and is not recommended. Many attempts have been made to improve patch test results but the dose of tuberculin cannot be controlled, because of the many factors which affect absorption of tuberculin through the skin.

Tuberculin Testing Schedule. A practical age schedule for tuberculin testing must always be a compromise. It seems to be common practice to test at least once each year as long as there is no reaction, substituting annual X-ray examination if the test becomes positive. Finding even an occasional new infection should be worth the little effort it takes in view of the risk to the child of future serious complication and the effectiveness of therapy.

If school children are being tested, the grades tested will depend somewhat on the number of new infections expected per year. In a low rate area it may be sufficient to test beginning students in kindergarten or the first grade,

children about to leave elementary school and the last year in high school. In a high rate area it may be worthwhile to test all grades every year. Such group tuberculin testing programs must be carefully planned so the essential followup of contacts will not be neglected and to provide for a critical evaluation at the end.

Tuberculin testing of children cannot take the place of the established public health program for tuberculosis control. Isolation and treatment of infectious patients, supervision of inactive cases, examination of contacts of active cases, X-ray screening of high rate groups, and programs to improve general public health are basic to any organized attack on the disease. However, routine tuberculin testing by all physicians coupled with well planned group testing of school children and others in a community can provide additional information useful for a more direct attack on the disease with the present effective therapeutic tools.

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MITRAL COMMISSUROTOMY*

The author's experience in 100 cases in which mitral commissurotomy was performed, the patients ranging in age from 10 to 44 years and followed up for periods varying from four months to three years. Statistics on the series are tabulated and compared with those published by other investigators. It is pointed out that pregnancy does not necessarily contraindicate this procedure; assuming that the anaesthetist is thoroughly competent, pregnancy adds nothing to the mother's danger and increases the hazard to the foetus only slightly.

In the author's opinion the symptoms, not the age of the patient, should receive first consideration in deciding whether or not mitral commissurotomy should be performed, although it is undeniable that with the advance of age the number of good results decreases. There is great difficulty in obtaining subjective evidence of improvement, because of the wide variation among the patients as to what is expected. Nor is objective evidence, beyond reduction of the cardiothoracic ratio, easy to obtain. The most reliable criterion of clinical improvement is the patient's ability to cope with the ordinary problems of daily life.

Sen, S. K., *Journal of the International College of Surgeons*. 28: 563-574, 1957.

*From Medical Abstracts, December, 1957.

Hospital Insurance — A Review and Preview

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On the eve of a new venture in Hospital Insurance for Nova Scotia, I am thinking back 10 years to 1949 when as a country practitioner I experienced a similar venture unfolding in British Columbia. This was something new in Canada and neither the doctors nor the general populace were agreed as to its merits nor the rightness, philosophically, of the concept itself. This scheme was launched precipitately indeed, by a Liberal administration amid howls that the socialist platform had been stolen. A high-priced firm of consultants from the U.S.A. had drawn up a master plan but no one had any exact idea of how it work or what it would cost. Since it was to be an Insurance plan, premiums were collected individually or by payroll deduction. Administration was so cumbersome and losses through default so substantial that before long the premium principle was dropped and a retail sales tax of 2% was levied. This worked, and it was rumoured at the time that 400 employees were released from the administrative offices in the consequent simplification. The scheme is now accepted by and large just as public highways and postal services are accepted and it is unthinkable that the scheme could be dropped.

What of the hospitals themselves and their managing Boards? The principle of local management has been retained, but inevitably he who pays the Piper calls the tune and major decisions must be approved by the Hospital Insurance Commission. A fixed daily rate for public ward service is struck for each hospital and reviewed from time to time in the light of experience. This scheme is necessarily rigid, but there are some advantages. The rate is a truly all-inclusive cost with regard to current operations and accurately reflects these expenses. Budgeting and planning from year to year becomes a fairly accurate procedure and no longer is there the spectacle of a hospital unable to pay its current obligations.

In the area of new construction, expansion and renovation the problems are more serious. These items are not the direct concern of the Commission as yet and only nominal charges for capital expenses are allowed. Therefore it remains the responsibility of the local Board to meet these requirements. Here there is unlimited scope for community initiative. A new development in this field is that of the Hospital District. Such a District can be formed if an application and plans are approved by plebiscite in the area concerned. Local funds may then be raised by taxation, bonds sold, and matching provincial and federal grants sought. The remarkable growth in new hospital construction in this Western province indicates what can be done when local interest is sufficient and these hospital Boards can look with pride at what they have accomplished despite the gloomy prediction that they would have no further role when the government went into the hospital business.

How did all these developments affect the physician and his patients? Basically the relationship among patient, doctor and hospital remained, of course, unchanged. Initially, and to some extent still, the principal problem was lack of sufficient beds to meet the demand. During the first few months of operation there was undoubtedly a backlog of elective work which had been deliberately delayed. This however, was of only temporary importance and had to work itself out through time. There still remained the matter of the

best utilization of available beds. Tiresome financial 'deterrents' did little to relieve this problem. Let me say clearly that no government commission or hospital Board under the sun can regulate this, and the responsibility rests squarely on the doctors to act with honesty and without fear. In the interest of all, he must firmly insist that his patient leave hospital as soon as reasonable, to make way for others. When the cost incentive to vacate a hospital refuge is removed, we must be firm, and when the appeal is put in an honest way real difficulties rarely arise. Of lesser importance, but none the less relevant, is the matter of drug costs. All hospital pharmacies moan about constantly rising costs. None of us enjoys taxes, and a watchful eye kept on prescribing costs makes good sense.

My last remarks concern the standard of patient care. These things are difficult to measure, but actively watching the changes over the ten year experience in British Columbia, one can see certain things. Undoubtedly there has been a vast improvement in physical plant. The doctor-patient relationship has not suffered in any way through hospital insurance. (There are of course grey clouds on the horizon, and it behooves us all to give real leadership in directing the changes which must occur in other areas of health management, but this is another subject). Good technicians with their skills and facilities to assist the physician are found in rapidly growing numbers even in the smaller hospitals. And finally, and of prime importance, the relative numbers of nurses has perhaps not increased, but the very fact that they are still present and being paid something approaching a living wage can be attributed partly at least to hospital insurance. So one can only conclude that patient care has improved.

From the viewpoint of the sick person and his family the benefits of this scheme are obvious. The principle of insurance against financial crisis externally caused, is widely accepted and there should be no quarrel with this extension. The advantages to the patient go far beyond the release from financial worry—in the directions I have enumerated.

Studying the Nova Scotia Act, I find I am on familiar ground. The terminology and most of the regulations are identical to the present scheme in British Columbia as it has evolved after the growing pains of a decade. No scheme devised by man is perfect, but I for one am sure this will be a great boon to Nova Scotia. Let us accept it, use it, and constantly seek to improve it as is our privilege and obligation.

324 Spring Garden Road.

INFECTIOUS DISEASES—NOVA SCOTIA
Reported Summary for the Month of September, 1958

Diseases	NOVA SCOTIA				CANADA	
	1958		1957		1958	1957
	Cases	Deaths	Cases	Deaths	Cases	Cases
Brucellosis	0	0	0	0	0	0
Diarrhoea of Newborn	0	0	0	0	0	0
Diphtheria	0	0	0	0	15	10
Encephalomyelitis— Infectious	1	1	0	0	8	4
Food Poisoning	0	0	0	0	0	0
Gastroenteritis (1) Infectious	133	1	18	1	198	101
Hepatitis—Infectious Including Serum Hepatitis	16	0	1	0	0	0
Impetigo of Newborn	0	0	0	0	0	0
Influenza (if unusual number of cases)	185	1	704	2	338	6597
Meningococcal Meningitis and Meningococemia	2	0	0	0	19	27
Pertussis	14	1	28	0	594	1011
Poliomyelitis (paralytic non-paralytic)	0 0	0 0	0 0	0 0	64 25	33 28
Scarlet Fever and Streptococcal Sore Throat	167	0	208	0	396	510
Tuberculosis (pulmonary non-pulmonary)	20 4	0 0	5 0	0 0	473 36	558 33
Typhoid and Paratyphoid Fever	0	0	0	0	39	44
Venereal Disease (syphilis) (gonorrhoea)	1 30	0 0	2 13	2 0	132 1209	164 1001
Anthrax	0	0	0	0	0	0
Cholera	0	0	0	0	0	0
Psittacosis	0	0	0	0	0	0
Rabies	0	0	0	0	0	0
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	0	0
Trichinosis	0	0	0	0	0	0
Tularemia	0	0	0	0	0	0
Other rare diseases	0	0	0	0	0	0
Other (if unusual number of cases)	0	0	0	0	0	0

(1) amoebic and bacillary dysentery and salmonellosis

REMARKS:

Re: Case of Herpes Encephalitis

During the month of October, Dr. C. E. van Rooyen, Virologist, reported a death from encephalitis. Clinically the case resembled Eastern Equine Encephalitis. No virus was recovered from the spinal fluid. Tissue removed at autopsy from the cortex, brain stem and lung were also studied. From the cortex a transmissible viral agent was recovered on human amnion cells. Four litters of young mice were inoculated during the study. Specimens of mouse brain emulsion and human amnion tissue culture were forwarded to another laboratory for expert assistance in diagnosis. The virus isolated was identified as herpes simplex.

CHLORPROMAZINE IN THE TREATMENT OF BRONCHIAL ASTHMA AND PULMONARY EMPHYSEMA*

Clinical experiences with the use of Thorazine in 35 patients with bronchial asthma and/or chronic pulmonary emphysema are reported. The effect on minute volume of respiration and arterial blood gases and pH, was determined in 21 patients with chronic diffuse obstructive pulmonary emphysema.

It is concluded that the drug may be safely and effectively administered, either singly or in combination with known bronchodilator agents, in the therapy of paroxysms of bronchial asthma. In chronic pulmonary emphysema, chlorpromazine appears to be a useful adjunct, in combination with intensive therapy designed to correct pulmonary ventilation.

Baum, G. I., Schotz, S. A., Gumpel, R. C., and Osgood, C., *Diseases of the Chest*, 32:574-579, 1957.

*From Medical Abstracts, December, 1957.

SURGICAL TREATMENT OF DISSECTING ANEURYSM*

The authors offer a modification of the method devised by DeBakey, Cooley and Creech for dissecting aneurysm. The outer coat of the dissected wall is divided transversely, the posterior wall being left intact. After gentle loosening of the clamps and milking of the aorta, the clot in the outer chamber is removed. The distal split coats are sutured together with No. 4-0 arterial silk. The proximal outer coats of the dissected aortal wall are sutured to the entire distal reconstituted wall, which will then allow blood to flow proximally in both the outer dissected channel and in its true path into the reconstituted distal aorta.

Gilman, R. A., and Bailey, C. P., *Journal of Thoracic Surgery*, 33: 670, 1957.

*From Medical Abstracts, December, 1957.

Maritime Medical Care Reduces Group Requirements

For a number of years past it has been apparent to the Administration of Maritime Medical Care that, due to the fact that this coverage was sold only on a group basis (groups of ten or more, with one employer), Maritime Medical Care was not readily available to a large percentage of Nova Scotians. In order to correct this situation to some extent, the "Individual Plan" was introduced two years ago. This plan has not been particularly well received, due to necessary actuarial restrictions in the contract and waiting periods, and it was obvious that some other course must be adopted in order to make M.M.C. generally available.

A lowering of group requirements appears to be the obvious answer. As of November 1st, 1958, M.M.C. will now be made available to groups of five to nine persons employed by a common employer. Rates will be slightly higher than the standard group contract (covering ten or more employees) in order to offset the greater risks inherent in small groups but the actual contract will be the same. It is felt that this contract will greatly increase enrolment in the smaller provincial centres and eventually prove very beneficial to participating physicians who practise in those areas.

Society Meeting

At the Annual Meeting of the Pictou County Medical Society held May 28, 1958, the following officers were elected.

- President —Dr. V. H. T. Parker, Stellarton.
 Vice-President —Dr. J. A. Fraser Young, Pictou.
 Secretary-Treasurer—Dr. J. H. Fraser, Westville.
 Nominee to Executive Committee of The Medical Society of Nova Scotia
 —Dr. F. J. Granville, Stellarton.
 Nominee to Nominating Committee The Medical Society of Nova Scotia—
 Dr. W. A. MacQuarrie, Trenton; alternate, Dr. S. D. Dunn, Pictou.
 Mediation Committee—
 —Drs. V. H. T. Parker and J. A. F. Young.
 Representative to Maritime Medical Care Inc.—
 —Dr. H. B. Whitman, Stellarton.

At the annual meeting of the Pictou County Medical Society on May 28, 1958, their confreres honoured and congratulated Doctor J. C. Ballem of New Glasgow and Doctor W. A. MacLeod, M.L.A. of Hopewell on having reached fifty years in the practise of medicine. They were presented with a scroll commemorating the occasion and a small memento. Both Doctors responded in a manner that was appreciated by all present and added much to the enjoyment of the meeting.

J. H. Fraser, M.D., Secretary.