—"A Baneful Practice"—

From a committee report, House of Delegates, American Medical Association, June 8, 1942, referring to the issuance of "certificates" of freedom from V.D. to prostitutes:

> This is a baneful practice which encourages the maintenance of vice and may do incalculable damage by giving false assurance of safety and lead to an appreciable increase in venereal disease.

An Absolute Essential

No case of syphilis has been completely assessed without a *C.S.F. examination.*

Neurosyphilis (asymptomatic) cannot be detected without *C.S.F. examination.*

When Is the Patient Cured?

"A small percentage of both male and female patients harbor the gonococcus for some weeks after symptoms have disappeared. In the absence of cultural studies, all patients should be regarded as potentially infectious for a period of three months after all symptoms disappear. If such patients have sexual intercourse during this period, a condom should be used to protect the partner. Cultural studies are of great value in the recognition of carriers and offer the most dependable criteria of cure.

"As scientific evidence of cure four consecutive negative cultures taken at intervals of 2 weeks may be accepted. In women one such culture should be taken immediately after menstruation. The first of these cultures should be taken a week after apparent clinical cure is affected. In addition to yielding negative cultures, the patient should show no clinical evidence of gonococcal infection before 'cure' can be pronounced. Even after 3 months of such 'established cures,' recurrence may be found, but this is rare."

"Venereal Disease Information," May, 1943

"Find V.D. Contacts—Report V.D. Cases"

Gonorrhoea

To-day, penicillin is the drug of choice for the treatment of gonorrhoea. The recommended dosage for male patients is 100,000 units and given intramuscularly in divided doses over a period of 8 to 15 hours, and for female patients 300,000 units given intramuscularly in divided doses over 36 hours.

Syphilis

The treatment of syphilis with penicillin is still in the experimental stage. Preliminary results indicate that the amount of penicillin required for the treatment of early-acquired syphilis, in the primary and secondary stages, will not be less than 2,400,000 units.

Little is known yet of the value of penicillin for the treatment of latent syphilis and of the various forms of late syphilis.

Masking of Syphilis

The amount of penicillin required for the treatment of gonorrhoea (much smaller than amount required for treatment of syphilis) can delay or even, possibly, prevent the appearance of the primary lesion of syphilis in the event that the patient may have contracted both gonorrhoea and syphilis at the same time. This amount of penicillin may also delay the occurrence of the positive serologic test for syphilis in such a case. Therefore, it is of extreme importance to perform a serologic test for syphilis three months after the completion of treatment of every gonorrhoea patient treated with penicillin.

Canadian Physicians' Camera Salon

The announcement of the "Canadian Physicians' Camera Salon" under the auspices of the Montreal Camera Club is of wide interest to physicians who are photographic enthusiasts. The Salon is to be an exhibition of prints taken by Canadian physicians and is to be displayed in the Eaton Art Galleries in conjunction with the C.M.A. Annual Convention in Montreal in June.

Entries are being solicited by means of a contest in which cash prizes are offered for monochrome prints and color slides. There are no restrictions as to the subjects or as to the time when the photographs were taken. Complete information is being mailed to all physicians by Frank W. Horner Limited who have undertaken the organization work on behalf of the Montreal Camera Club.

In order to secure additional entries for the Salon, there is besides the closed class for Canadian physicians only, a class open to all Canadian amateur photographers who are members of local photographic organizations.

*A Spot on the Lung

MAX PINNER, M.D.

IT is futile to search in dictionaries or medical text-books for a definition of the term "a spot on the lung." But the term is being used with great frequency by physicians nurses and laymen alike. If this term is subjected to scrutiny it is found that it may mean anything and everything that produces either a shadow or an area of decreased density in a chest roentgenogram or anything and everything that causes abnormal physical signs over the lungs. If then, this expression has no meaning that cannot be stated more precisely in other terms, it remains to be found out why it is being used. If this is one of the terms that does not express a definite meaning, does it possibly obscure a meaning?

Nobody who has searchingly studied the histories of patients with pulmonary disease can doubt that the real function of the phrase, "a spot on the lung," is to cloud the facts. It is a cloak for a great variety of pulmonary diseases, a protective screen for the inability or unwillingness of the physician to arrive at a diagnosis acceptable to himself, a disguise for a bitter truth that the physician hesitates to tell the patient, an escape for the patient who tries to elude further diagnostic work and necessary treatment. After all, one does not die of "a spot on the lung," but one can die of bronchial carcinoma and one might die of pulmonary tuberculosis. Along with much other evasive, medical double-talk, "a spot on the lung" is a verbal mechanism of escape from reality. In the same category belongs the term "a touch of tuberculosis" and improperly applied, "nothing but a little thickened pleura."

No physician needs to be told that "a spot on the lung" is no diagnosis. He realizes that it is evidence, on the one hand, of healed disease which calls neither for treatment nor for alarming its bearer, or, on the other, of active disease in need of treatment. The physician sometimes uses the term in patients in whom he has failed to establish with a certainty that carries conviction for himself, the difference between active disease and obsolete scar. "A spot on the lung" has a pleasantly innocent sound. It lulls into inertia and indifference whatever doubts or curiosity the patient, and, even in some cases, the doctor may have. But still it is, for the physician, a mental reservation. It seems to beckon as a safe place to stand if "a spot on the lung" later turns out to be carcinoma, tuberculosis or bronchiectasis.

Admittedly, this judgment may be harsh. But I dare say that it will be resented only by those who, with the instrumentality of this ambiguous term, neglect their obligation of persevering until "a spot on the lung" has been accurately diagnosed. No person need be told that he has "a spot on the lung." If the condition is as clinically insignificant as the term suggests, the patient should be told that he has a scar from a previous tuberculous infection —one that needs an occasional check-up or one that needs no further observation. Or when the diagnosis is certain, the patient should be told that his lungs are normal. For, while "a spot on the lung" is often the obscured beginnings of destructive disease, it is, in other cases, the starting point for tuber-

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*Reprinted from *Tuberculosis Abstracts*, April, 1945.

culophobia and anxiety neuroses, conditions that are no less crippling and hardly more easily curable than tuberculosis itself.

But, though every reflecting physician knows that "a spot on the lung" is a meaningless and dangerous term, the utter convenience of the expression —and others like it—militates against their prompt extinction. Past experience justifies a pessimistic outlook. No amount and intensity of medical education are likely to eliminate entirely the term from medical parlance. Medical education however is being overtaken by the information that the public, including the prospective patient, is acquiring. People are learning to realize fully the confusing ambiguity of the term, they are beginning to refuse its acceptance just as an enlightened consumer protests against ambiguous and misleading labels on packaged goods. And the comparison is eminently proper: for all intents and purposes, "a spot on the lung" *is* ambiguous and misleading labeling. It may well be that through the protest of the consumer, by the refusal of every layman to be satisfied with the pseudo-diagnosis of "a spot on the lung" the term will eventually disappear.

It is high time for the medical and nursing professions and everyone engaged in tuberculosis work to bury a medical term that has quite literally buried so many patients.

Medical Service Plan*

RUTH C. WILSON

Executive Director, Maritime Hospital Service Association

MR. PRESIDENT, Officers and members of the Halifax Medical Society, as Executive Director of the Blue Cross Plan in the Maritime Provinces, I wish to thank you for inviting me, although a layman, to appear before you to discuss a subject which is currently very close to the heart of our national economic system. I realize fully that it is a privilege to be given the opportunity to speak before a group of very busy physicians, especially at this time when every moment is so preciously conserved, and I shall endeavour to utilize the time at my disposal to tell you as simply and as clearly as possible something of what is being done in the field of the voluntary prepayment of health services.

Most of my adult life has been spent in close association with the problems of the health field and especially of the problems which beset our doctors in meeting the demand of the general public in the course of their professional work.

The literature at the disposal of the Medical Society of Halifax is sufficiently comprehensive to guarantee that everyone of the members here this evening has a more or less comprehensive knowledge of the current discussions concerning the proposed National Health Act and its allied subjects. Mentioning just a few, we would refer to several articles by Dr. L. Richter, Director of the Institute of Public Affairs at your own Dalhousie University, a very important article written by him on the facts of Health Insurance and the demand for health services dealing particularly with two of your Nova Scotia communities, Glace Bay and Yarmouth, which appears in the *Canadian Journal of Economics and Political Sciences* in May, 1944, a digest of which was published in the October, 1944, issue of the *Canadian Hospital*. The studies and publications of the Canadian Medical Association are most extensive. The matter has been discussed under the heading of "Problem in Medical Economics" by J. Harris McPhedran, M.D., President of the Canadian Medical Association, while a particularly valuable series of discussions have been published by the Canadian Medical Association by Hugh A. Wolfenden with a foreword by Dr. Wallace Wilson, Chairman of your committee on Medical Economics of the Canadian Medical Association.

The voluntary prepayment plan for hospitalization stems from many schemes, including a small plan in operation in Great Britain. It is interesting to observe that there were small local plans in the Maritime Provinces in the 19th century, one of which I know was operated by the Sisters' Hospital at Chatham, N. B. While acknowledging freely that these plans are not new insofar as they pertain to tackling of local problems in one area or another we may assert with a certain degree of confidence that the application of their principles on a broad and actuarially sound basis is comparatively a new venture in the health field. No doubt there are some members of the Society who have often wondered of the origin of Blue Cross. It dates back to 1929 when a few school teachers in Dallas, Texas, solicited the Board of the Baylor University Hospital in that city to prepay small sums during their school year

* Address delivered before Halifax Medical Society, April 25, 1945.

to protect them against illness, especially during the vacation season. With considerable misgivings, the hospital agreed to the plan and it eventually spread throughout the city until other professions and industry sought the same privilege. Now, this was all very well up to a point, but it had a very weak spot in it. It was a sort of a combination between one community hospital and the population of the city. This meant that there was no free choice of hospital. The inevitable happened, groups of one religious denomination preferred to go to hospitals administered by members of their own faith, and that the arrangement in force thus was not possible if they wished to take advantage of the group method of prepayment of their hospital bills. Now there was in the city of Newark, New Jersey, a gentleman named Mr. Frank Van Dyck, who is now one of the Vice-Presidents of a New York Blue Cross Plan which also operates United Medical Services for the Medical Society of the City of New York. At that time, Mr. Van Dyck was in Newark and he travelled down to Texas to learn all he could about this new fangled experiment he had heard of. He was very much interested but he was also very curious about the solving of the problem of the prepayment association members who wanted to go to hospitals of their own choice. He returned to Newark and he worked on a plan which he submitted to all of the hospitals in his city and in Essex County which served the suburban population of Newark. In this plan he incorporated the principles which started voluntary hospital plans on their road to their present success. By having all of the hospitals or at least as many as cared to participate sign agreements to serve subscribers, he was in a position to promise his subscribers that they would also be assured of a free choice of hospital just as they were guaranteed non-interference with their free choice of physician. The general idea was that physicians sent their patients to the hospitals where they liked to work and by having all hospitals participate to accept subscribers, there could be no complaint of interference between doctor-patient relationship. Based on Mr. Van Dyck's success in the Newark experiment, the idea spread to other parts of the country and in 1933, it came to the attention of the American Hospital Association. After a thorough investigation of the possibilities inherent in such plans, the American Hospital Association endorsed them in principle in 1933. In 1934, they were endorsed by the Board of Regents of the American College of Surgeons. In 1937, the American Hospital Association created a committee on hospital service to watch and control the plans and, in 1937, the American Medical Association established a group of principles similar to those established by the American Hospital Association in 1933. The Catholic Hospital Association in 1937 encouraged its members to join such plans "as conform to certain standards." The Standards of Approval as set out for Blue Cross Plans by American Hospital Association are as follows:

1. There should be adequate representation in the governing body of all important groups in the community concerned with the provision of hospital care, particularly hospital administrators and trustees, the medical profession, and employers and employee groups.
2. Emphasis should be placed upon the welfare of subscriber rather than the financial value of the Blue Cross Plan to the member-hospitals.
3. The organization should be non-profit, in fact as well as in legal theory. Private investors should not be permitted to make a profit from the activities of the organization.

4. Benefits should be available in "service" rather than cash, and should be guaranteed to the subscriber through contracts with member-hospitals in the areas where enrolment occurs.
5. There should be free choice of hospital and physician and all hospitals of standing should be permitted to participate in the activities of the community plan.
6. Blue Cross Plans should be financially solvent and should maintain adequate statistics of receipts, payments, and services.
7. Enrolment and public education procedures should be maintained on a dignified basis consistent with the relation of the member-hospitals to the communities which are served.

Only such plans as follow the strict principles laid down by the American Hospital Association are given the privilege of using the name Blue Cross, the symbol itself being a large Blue Cross on which is superimposed the official seal of the American Hospital Association. At the present time, there are 81 Blue Cross Plans operating on the North American continent and in Puerto Rico. There are five plans operating in Canada covering seven provinces. The oldest Canadian plan, the Manitoba Hospital Service Association, has been in existence seven years and the youngest, the Blue Cross Plan in British Columbia, has been in existence a little over one year. The Maritime plan will close its second year of operation in May of this year, and is unique in that it is the first plan to cross Provincial and State boundaries. It does, as you know, cover the three Maritime Provinces under the sponsorship of the Maritime Hospital Association. Over 17,000,000 enjoy the protection of Blue Cross on the North American Continent, and between one-and-a-half and two million people are protected in Canada; over 90,000 of these are in the Maritime Provinces and the Maritime plan expects to protect at least 100,000, or approximately 10% of the Maritime population at the end of the second year of its operation. I know that you are not particularly concerned with the operation of Blue Cross except as it affects the medical profession. It will be of interest to you to know that one of the latest recommendations of the American Hospital Association is that representation on the Boards of Directors of Blue Cross Plans be made up of one-third trustees, one-third doctors, and one-third subscriber representation. Another factor in which I know you are vitally interested is that of serving Blue Cross subscribers. We wish to make it clear that a Blue Cross subscriber as such is not entitled, because he is a Blue Cross subscriber, to the free services of a physician or surgeon. None other than Dr. George Stephens, Medical Director of the Royal Victoria Hospital, and a gentleman well and most favourably known to all of you, has very simply and clearly identified the status of Blue Cross in the matter of the hospitalization of subscribers. All discussions pertaining to Blue Cross and hospitals are summed up in his words: "Blue Cross does not sell hospital service, it pays hospital bills." This deals with the matter of sending a Blue Cross subscriber to the hospital and the classification given to the subscriber is a matter strictly between the doctor and the hospital. Every subscriber is subject to the rules and regulations of the particular hospital to which he is sent, and must be subject to the rules and regulations of the attending staff. It would be futile to state that because a family is a Blue Cross subscriber, it might not be entitled to every consideration so far as health services are

available. Out of the 9,121 wage earning families in the city of Halifax, the average earnings amount to only $1,644 (male) and $829 (female) with only 13% with an income of over $2,950; 16% with an income of between $1,950 and $2,949; 46% with an income of between $950 and $1,949; and 25% with an income of less than $950. If we may believe the reports of the Dominion Bureau of Statistics and the survey of the Medical Procurement and Assignment Board, and assuming that the head of each family is a wage earner, the average number of members per family would be 6.6. No doubt this would be reduced closer to the average of five if there were a careful analysis of the indigent and unemployed. Nevertheless, five is regarded as an average Canadian family and it is not difficult to realize the difficulty experienced by at least 71% of the population in Halifax in maintaining such a family on incomes less than $1,949 and to pay full costs for health services without going deeply into debt or failing to meet the obligation entirely or in part.

Time does not permit tabulation of the earnings for all of Nova Scotia both rural and urban, or Prince Edward Island and New Brunswick, but the figures are easily available and are in line with those discussed herein. Subscribers who have saved a certain amount of money because Blue Cross has paid their hospital bill, should take this money and give it to his attending doctor who, in the past, has had to wait until the hospital claim was settled. It is doubtful if this practice is followed. It is extremely unlikely that money thus saved actually reaches the medical profession. Most of the members here tonight would acknowledge without hesitation that their hope of collecting 100% of their accounts is somewhat remote. What position then do our doctors face? Let us discuss known possibilities.

In the United States, the trend in the health field is to continually work against Government. This was emphasized particularly during a recent meeting of Canadian Blue Cross Plans in Toronto when a prominent American Official expressed surprise at the amiable relations existing between Canadian health services and the Government. It was a distinct compliment to Canadian Government, and we are able to affirm that in all of our working relationships the policy of our health field has been to work consistently *with* Government in Canada.

Which brings us to the point of Social Security plans in Canada. Our Canadian Blue Cross Plans are doing a job in the very best way they know to serve our people right here and now. Blue Cross carries on with the realization that it may be superseded by an all-embracing national health act. It has no illusions, nor is it lessening its efforts to produce a healthier society while Government plans are being discussed. Canadian Blue Cross Plans are using about 85% out of every subscriber's dollar to pay the hospital costs for this subscriber. They are able to build reserves and investments as a backlog against emergency and epidemic. In addition to that, they are accumulating vital statistics of inestimable value for the future guidance of any health agency which otherwise would have to work from minus zero. All of us are familiar with the Marsh Report and the details of the proposed Health Insurance legislation. Perhaps the following quotation will be of interest to my listeners and will require no comment on the part of the speaker.

In May, 1944, the Canadian Medical Association approved through its General Council, 18 principles relating to Health Insurance. The 14th principle reads: The

method, or methods, of remuneration of the medical practitioners and the rate thereof should be as agreed upon by the medical profession and the Commission of the province.

In a notice of these principles, the following comment appears on Page 28 of a pamphlet entitled *Health on the March*, issued by the Canadian Federation of Agriculture:

> Principle No. 14 advocates that Health Insurance shall be based on the Schedule of Fees as laid down by the medical profession of each province. The average citizen is amazed that any one group should assert such a principle. Nobody proposes to turn over medical *services* to the control of politicians. Nobody contends, for instance, that a board of aldermen should decide when to operate for appendicitis. The practice of medicine, nursing or dentistry is the responsibility of the professions concerned. But the question of how these services shall be paid for is very much the concern and responsibility of the public.

I repeat the last sentence of this paragraph: "But the question of how these services shall be paid for is very much the concern and *responsibility* of the public." This statement justifies serious consideration.

In any type of Government Health Insurance scheme, the rights of the doctors and patients must be honestly respected. Any scheme or set-up is only as good, no matter what its ideals, as its administration.

No doubt most of the members of this Medical Society have read the April 1945, issue of the *Readers' Digest* which contains "The Road to Serfdom," by Friedrich A. Hayek of the University of London. If you have not, we recommend it. I doubt if you will sleep for several hours after receiving the impact of its portent.

I know that you will not care to listen to an exhaustive discussion on medical plans. I have brought with me some material which may enlighten you in the quiet of your offices. If any of you have read the February 10th issue of the *Journal of the Americon Medical Association*, your attention has no doubt been drawn to an article by Lester H. Perry on the co-ordination of Medical and Blue Cross Plans. I read this article with a great deal of interest, in fact sufficiently so to discuss it with the President of the Hospital Service Plan Commission, who told me that Dr. Lewis Reed, the Senior Economic Analyst of the U. S. Public Health Service, had prepared a commentary to rebut conclusions arrived at by Mr. Perry. Dr. Reed very generously sent me a copy of his manuscript which is to appear in the *Journal of the American Medical Association* at an early date; in fact, it may have already appeared. Dr. Reed conducted an independent survey for the U. S. Public Health Service on prepayment hospital and prepayment medical plans. He surveyed 38 of the Blue Cross Plans and all but two of the Medical Plans. According to his findings, and I quote "at the present time, there are in operation 19 Medical Service Plans sponsored by Local and State Medical Societies." (NOTE: Since this manuscript was prepared, two other plans have been developed for, at the present time, there are 21 sponsored plans.) These plans have a total enrolment of over 1,800,000 and no doubt when they allow for the two other plans developed since, we may say that they cover over 2,000,000 people. New plans are rapidly being organized in every section of the country and enrolment in already existing plans is beginning to increase rapidly. The proper actuarial basis for these services has been established. The workable operation of administrative techniques seems to be in process of crystallizing. In short,

it looks as if Medical Service Plans are at about the same stage of development as Hospital Plans were in 1936 or 1937, and that a rapid growth of these plans paralleling the rapid growth of Hospital Plans is to be expected."

Dr. Reed goes on to say that one of the most important problems which must be solved if Medical and Hospital Plans are to achieve their full potentialities, is that of their proper co-ordination with each other. He proceeds to make a detailed analysis of four types of relationships to be found between the Medical and Hospital Plans. He goes into the problems and difficulties which always had been a development of magnitude, but his conclusions which I believe we should value inasmuch as they represent the conclusions of a Federal Security Agency of the U. S. Public Health Service, are of great interest and I quote them here:

> Co-operation between medical and hospital plans is essential. This co-operation can be achieved under various arrangements, any one of which can function at least temporarily with success, depending upon the stage of thinking of those who do the co-operating. Complete unification of hospital and medical plans into Blue Cross Health Service Plans seems to provide the final and best solution. It represents the end of the road. But less forthright arrangements may not be without their temporary value.

Incidentally, I would like to say that the material in my possession is at the disposal of this Society if this Society is sufficiently interested to appoint a committee to investigate a voluntary non-profit prepayment medical plan.

At a meeting of the Medical Relations Committee of the Blue Cross Plans which the speaker had the privilege of attending in New York City in March, 1945, the following recommendation was made:

> *Recommendation of the committee*: That the Hospital Service Plan Commission consider the possibility of seeking to co-operate with the Medical Service Plans Council of America and the American Medical Association and the American Hospital Association in the organization of a single Health Service Plan Commission on the national level with equitable representation from all four groups and the public; such Commission to co-ordinate the present functions of the Hospital Service Plan Commission and the proposed functions of the Medical Service Plans Council of America with a view toward developing maximum effectiveness in promoting the voluntary health service movement in America.

A review of most of the literature dealing with Blue Shield Medical Service Plans—Blue Shield being the medical partner of the Blue Cross Hospital Services Plans, will indicate that very few of the Blue Shield rates exceed $2.00 per month for an entire family, with lower rates applicable to single or two-member families. National Health Insurance would provide for, "complete medical and nursing services, hospitalization on a general ward basis, medicines within an approved list of standard remedies, and dental care to the extent that existing dental facilities would allow." All persons (in the Provinces going under the scheme) sixteen years of age and over unless they could show inability to pay, would pay an annual flat contribution of $12.00 and, in addition, single persons would pay 3% of income over $660 per year up to a maximum of $30.00, and married persons 5% of income over $1,200 per year up to a maximum of $50.00. The Manitoba Medical Service Plan offers a surgical plan as follows:

Yearly Subscription Rates

	Plan A (Surgical)	Plan B (Medical and Surgical)
Individual	$ 7.20	$18.00
Family (Applicant, wife and all unmarried children under 19)	21.00	30.00
Sponsored dependent	13.80	24.00
Military Service Contract	13.80	24.00

The Medical Services Association of Vancouver, B. C., offers a service with the following rates:

Yearly Subscription Rates

Employee	$13.80
Dependents—wife and all children over 3 months and under 18 years	28.20

Initial registration fee of $1.50 per employee.

In a recent health broadcast, the Premier of the Province of Manitoba, the Hon. S. S. Garson, K.C., set out the position of certain provinces in a very convincing way. On January 3rd, the Hon. Brooke Claxton, the newly appointed Federal Minister of Health, said in a broadcast that the Dominion would have a Dominion-wide scheme as soon as they could come to an agreement with the provinces concerning it. The form this help of the Dominion to the Provinces will take is important, for example, if it is a grant made by the Dominion which must be met with an equal provincial expenditure. In this way, it is easy to see that the province's ability to pay its half share of the expenditure is limited by its own financial standing. The point the Premier of Manitoba makes is that the province whose financial standing is poor and who, on the basis of need, would require the largest grant from the Dominion, would be the least able to financially provide the matching grant under which such a scheme would entitle it to Dominion assistance.

Manitoba is one of the three Canadian Provinces which has a prepayment Medical Plan. The Manitoba Medical Service is tied in with Blue Cross and serves a population of about 700,000. British Columbia also has a Medical Service Plan which operates with Blue Cross and serves a population of over 800,000. Before quoting from the Province of Manitoba Medical Service I would like to refer to a report prepared by the Committee on Economics of the College of Physicians and Surgeons of British Columbia, in which it states: "150 groups of employees are now enrolled with the Medical Services Association with a total membership of over 18,000 and it is growing rapidly, having spread widely over the province. The Medical Services Association is popular not only with the member groups but with the profession. The Board of Directors has two employee members and one each from the employers and doctors. In many instances the employer contributes part of the assessments. The Medical Services Association is now providing medical services only, but works very closely with the Blue Cross Hospital Plan." It enumerates a set of principles which we would be very happy to give to this meeting upon request.

Reverting now to the work in Manitoba, the development has been vigorously aggressive. Like all voluntary prepayment plans established for

the Medical Societies, the fees are set by the doctors themselves through their Medical Society and the plans retain all ethical and economic ideals which are cherished by the medical profession. I am going to read you an extract from the Sixth Annual Report of the Blue Cross Plan of Manitoba and this I am going to follow at once with a description of the Manitoba Medical Service, which is the Blue Shield Plan for Manitoba, as prepared by Dr. A. Hollenberg, Chairman of the Committee on Economics of the Manitoba Medical Association.

"The negotiations which have been in progress with the medical profession of Winnipeg for the establishment of a plan for the prepayment of medical and surgical fees resulted in an agreement being reached late in the year by which the Association has been enabled to offer medical service to its members on satisfactory terms. The Manitoba Medical Service is incorporated by Act of the Legislature and possesses its own Board of Trustees and Medical Director. While the Association acts as agent for the sale of contracts and collection and distribution of the dues, the contracts with the medical profession and the settlement of their accounts are the function of the Medical Director. This Association is compensated upon a commission basis. Ninety per cent of the medical profession of Winnipeg have accepted the fee schedule which has been adopted. Subscribers to the Hospital Plan are responding to the opportunity of similar protection against medical costs and it is believed that this service will have a steady growth as its value is better understood.

"Until Medical Service is more generally available throughout the province, enrolment will be restricted to the City of Winnipeg and territory adjacent thereto."

Dr. Hollenberg describes in the following paragraphs the Manitoba Medical Service, its origin, purpose, development, progress and prospects.

"The prepayment plan of the Manitoba Medical Association was incorporated by Act of Parliament in 1942 for the purpose of supplying either surgical and obstetrical medical attention (Plan A) or total medical service (Plan B) on a prepayment basis. This service began to operate September 1, 1944. The Board consists of fourteen medical practitioners and seven laymen with Dr. E. S. Moorhead as Medical Director. This service is run on a non-profit basis and is using the set-up of the Manitoba Hospital Service Association (M.H.S.A.) for the enrolment of members, the collection of dues and the disbursement of the funds to the practitioners and other non-medical parties, such as advertising, printing and so on. It is required that only members of the M.H.S.A. can enrol as members of the M M.S. A monthly fee of $500.00 at present is paid to the M.H.S.A. by the M.M.S. for acting as its agent in the duties aforementioned.

"The M.M.S. has received no government grant or guarantee. It was wholly brought into being by the Manitoba Medical Association with a view to **demonstrating to our people that medical coverage can be obtained at a satisfactory premium without government interference and regulation.** The financial cost of setting up this service was borne by a joint contribution of the Manitoba College of Physicians and Surgeons, the Manitoba Medical Association and the Winnipeg Medical Society; and as a final act of good faith nearly all participating practitioners have signed a demand note for $100.00 in favor of the M.M.S. to cover any contingency in the formative stage of the scheme.

"In the beginning, as was the case in the formation of the M.H.S.A., membership was temporarily restricted to residents of Winnipeg. It is hoped that when the plan succeeds in Winnipeg the population of the province as a whole may then be allowed to enrol.

"A schedule of fees for the general practitioners has been formulated and passed by the Manitoba Medical Association which forms the basis of fees to be paid by the M.M.S. This scale of fees is built upon the principle of equitable distribution of funds available from the M.M.S., having regard to the relative value of the work done. This schedule of fees was distributed to every member of the profession in the province and it was generally very favorably regarded. As it is felt that for the first few years there will not be enough money available from the M.M.S. to pay full fees, according to the schedule, these objections seem rather theoretical. Some predict that for the initial period the members of the profession will probably receive 50% to 60% of the schedule of fees for any major work. There is a provision that any one service of $10.00 or less will be paid in full while any service whose charge is greater than $10.00 will be pro-rated at the end of each month according to the amount of money available for distribution after operating expenses have been deducted.

"*Regarding specialists*: This has caused a great deal of concern to the Board. As there is now no complete panel of specialists, the Board has taken the view that, for the purpose of this scheme, a practitioner shall be a specialist in any field in which he designates. In such a field he will be entitled to a premium (25%) on the G.P.'s fee for the same procedure. A practitioner may name a second field in which he will practise (e.g. major specialty, orthopedics, minor specialty, X-ray) but for the minor specialty he shall receive only those fees paid to the G.P. A guiding principle of the M.M.S. is to maintain the practice of medicine as it has been carried on up to now, namely, that as many G.P.'s have always done surgery, X-ray, etc., that they shall continue to practise as heretofore and receive payment on the G.P. scale of fees for these procedures. It must be stated that the arrangement with the specialists (i.e. 25% bonus on G.P. fees) is now in the process of negotiation. The principle that will govern in these negotiations is that, as there is only a limited amount of money available for all the practitioners in the scheme, the share of each group or specialty shall bear a fair proportion to the total work done. With tolerance, understanding and reason being shown by all concerned, it will not be long before an amicable agreement is reached on this issue.

"At the moment of writing, February 19, 1945, there are on the books of the M.M.S.

1,080 Contracts of Plan A (surgical and obstetrical).
3,660 Contracts of Plan B (complete medical coverage).

The services to be rendered by the profession in the fulfilment of its obligation to the people who have taken out contracts, there are no reservations as to previous illness. The aim is to provide an adequate, first-class service to our people without exceptions and reservations, except where there are existing agencies for treatment set up in our province, i.e., tuberculosis and mental disease. Even in these exceptions payment will be made for the services necessary to diagnose and allocate the case to the proper authority.

"No drugs, dental service or nursing service is included in the benefits of the M.M.S. No fees are paid outside the province except in the case of an accident or an emergency condition or operation.

"The panel of doctors of the M.M.S. is open to any qualified medical practitioner of our province, provided he is a member of the Canadian Medical Association (Manitoba Division) or upon the payment of an annual fee of $15.00 to the M.M.S. where the practitioner refuses to become a member of the M.M.A. This plan is further commendable in that it allows free choice of doctor by the subscriber and no practitioner is bound to accept a patient whom he does not want. There is no pre-arranged designation of physician to patient or vice versa.

"The premiums per month for the two plans are:

	Plan A (Surgical and Obstetrics)	Plan B (Total Medical Coverage)
Single	$ .60	$1.50
Married (whole family)	1.75	2.50
Sponsored Dependent	1.15	2.00

"As the M.M.S. was primarily set up to cover those people upon whom the financial burden of a major illness would be catastrophic, the profession at large has insisted and the Board has adopted the rule that where the annual income of a single individual is $1,800 or more and of a married individual is $2,400 or more, then the fee for any operation or major medical illness may be arranged between the practitioner and the subscriber before the service is rendered, and the payment received by the medical member from the M.M.S. shall be credited to the personal account of such a subscriber.

"It is felt by many that the premiums above mentioned are inadequate to pay for such a service as we offer. The premiums were arrived at by a consideration of our experience in Winnipeg with the Firefighters' Club, which has had a prepayment scheme for the past five years, and the premiums charged by an organization similar to the M.M.S., which has been operating in Detroit, Michigan, for the past several years. Time will tell and the medical profession in Manitoba, without any outside assistance, is to stand the cost of obtaining the experience necessary to arrive at a proper and just premium scale."

I believe that by giving you the actual working papers of an active medical service in Canada it will be of more information than by referring in general to several similar plans.

The general public and many agencies are prone to believe that doctors care little about the dollar value of their services, due no doubt, to the natural modesty and reticence of the doctors themselves to discuss such practical subjects as payment of fees for services rendered. This is readily established by examining the average schedule of fees prepared by groups responsible for the welfare of certain segments of our population who would fare very badly if deprived of the services of a physician. Shall I mention, e.g., the fees thrust upon our doctors and hospitals by Workmen's Compensation Boards, by various Federal Government agencies and by certain groups which a prominent surgeon friend of mine, long since passed to his reward, spoke of as vicarious philanthropists. As a matter of fact, who among us have not been approached at one time or another by a civic-minded committee whose hearts were pulsing with benevolent love for their fellow creatures while soliciting the gratuitous services of the doctor or surgeon who usually bear all the responsibility while the patrons of the object of their solicitude took all the glory?

Blue Cross in its brief life proves that if given sufficient opportunity, it will be able to take our hospitals out of the red and leave more money in the family budget to pay for the ordinary day-by-day expenses. It is possible for physicians to work out a similar plan to take their accounts receivable out of the red and to make a similar contribution toward their patients' family budget.

We believe that Blue Shield, or call it what you may, a voluntary prepayment, non-profit plan for medical care, will salvage many a potential medically indigent from the charity lists of the doctors of Halifax and permit them to retain their essential self-respect through the knowledge that by small, regular, prepayments through salary deduction at their place of employment, or by some similar method, their beloved family physician will be assured of a just return for his professional services on a scale and at a rate which is determined by the doctor and his colleagues through their own medical society. The speaker does not pretend to any profound knowledge in the realm of medical economics. In fact, she has found that kind of reading which she has attempted, is rather heavy going. What she has attempted to show, is based upon simple common sense and experience. The establishment of a Blue Shield Medical Plan can be achieved by the Medical Society of Halifax, or by the combined medical societies of the Maritime Provinces, if not all Canada as a whole. As a matter of fact, the suggestion has been made and often discussed that a continental Blue Cross Plan working in close co-operation with continental Blue Shield Medical Plans, is not impossible of achievement if ethically sponsored by the official organizations set up by the doctors and the hospitals themselves. We may state without equivocation that such a national plan need not be limited in its scope of service but that its mechanics could be applied from the lowliest indigent to our heaviest taxpayers. As proof of that we could mention that the J. P. Morgan Company of New York is the first company to subscribe to the so-called "Doctors' Plan" of the United Medical Services of New York City under a service contract by which it will pay the entire cost of the service for 681 employees and their families, including 80 now in the armed forces. This medical protection supplements the Blue Cross protection it already gives to its employees.

In closing, the speaker wishes to express to the Medical Society of Halifax on behalf of the Blue Cross Plan and the Maritime Hospital Association, most sincere thanks for the privilege of appearing before this distinguished gathering present tonight.

Notes on the Banff Convention

H. L. Scammell

THE Association of Workmen's Compensation Boards of Canada held a Convention at Banff, Alberta, from May 21st to May 23rd, 1945. The eight Canadian provinces having Compensation Acts were represented. This convention is usually held every two years and is for the purpose of reviewing and consolidating the activities of these organizations. The Medical Section, in which the Medical officers of seven provinces participated, held its meeting at the same time but separate from the above meeting. It was unfortunate that Dr. Curran of New Brunswick was unable to be present. The guest speakers, who also participated in round table discussions with the medical officers, were: Dr. Stafford L. Osborne, M.S.,Ph.D., Assistant Professor, Department of Physical Medicine, Northwestern University, Chicago, Illinois; Dr. W. D. Robson, Medical Director, McIntyre Research Limited, Shumacher, Ontario; Dr. A. R. Riddell, Division of Industrial Hygiene, Department of Public Health, Toronto, Ontario; Dr. R. R. MacLean, General Medical Superintendent of Provincial Mental Institutions, Ponoka, Alberta; and Dr. Mark R. Levey, Professor of Ophthalmology, University of Alberta.

Perhaps at the beginning a word about Banff might be proper. One always hesitates to write anything descriptive about a place in one's own country, no matter how remote, from a feeling that he is more or less "bringing coals to Newcastle," although he would write quite cheerfully about London or Edinburgh, the same distance from home in an easterly direction. Those who read this and who are well acquainted with Banff and its surroundings may at this juncture turn over the page.

The Bow River, which takes its origin in the Bow Glacier and the Bow Lakes in the Rockies, winds its way among the mountains through a comparatively narrow valley until it reaches Banff. Here the valley widens for a space and the river traverses a level plain before emerging finally into the foothills.

In Banff, a small town of something over two thousand people, the mountains surround you and almost seem to hem you in. The elevation is about 4500 feet above sea level. The ascent by either rail or road is so gradual that a feeling of discomfort at this elevation is rare.

On our arrival on May 19th we found four inches of snow which disappeared rapidly a day or two later under the influence of a warm wind from the Pacific.

Situated as it is in a National Park, the animals of the forest and the mountains wander freely about the town and even in the town itself. It was a common sight to see a deer on the main street at noon day, paying little attention to either people or automobiles. Moose and elk grazed in herds in the evenings on front lawns. Mountain sheep, often considered very timid, could be approached even by automobiles and it was very easy to get good pictures of them on the nearby highways. The buffalo were enclosed, but the bears were at large and made the fullest use of it to plunder garbage cans or outside storehouses. We were told that campers, having automobiles without steel tops, had to cover them, if parked outside at night, with a canvas mat studded with roofing nails to prevent curious bears from invading the interior through the roof.

As one of the interesting sights of the town, we were taken one evening to the local "dump," by courtesy, the nuisance ground. On arriving there we found one large, black bear busily engaged in exploring for food or mischief. He was working his way into a large mound of empty tin cans, which he threw to right and left, seeming to enjoy the noise and clatter as much as the doubtful forage results. At our approach he merely lifted his head, sniffed loudly, and continued his activities. A companion, working a short distance away, turned and walked into the woods at our approach.

Many years ago hot springs were discovered at Banff. These are now under control. At the level of the town and a short distance from it is a spring known as The Cave and Basin. Here there are two swimming pools, the temperature of the water remaining constantly in the eighties. Visitors are permitted to enter a cavern near the pools showing the origin of the water which bubbles up through the limestone. In this cave the odor of hydrogen sulphide is strong enough to be decidedly unpleasant, particularly to those who have only remote memories of analytical chemistry. Swimming in water of this temperature, if carried out leisurely, is a comfortable procedure.

Further up the mountain is another pool, The Upper Hot Spring. Here the temperature of the water is over 100° F., and swimming, while possible, is not at all a procedure to be recommended. There is a drinking fountain at this spring and, apart from the odor, the taste of the water is not unpleasant. It is slightly cathartic. An analysis shows, besides sulphur, a very high calcium content. There are also present traces of radioactive compounds.

Attention has been taken of these springs from a therapeutic standpoint. At the Upper Hot Spring there are facilities for indoor baths and massage. The water is also available in a small pool at the Banff Health Clinic, of which more later.

The chief group to seek relief at the hot springs are arthritics. It is difficult to size up its value in such cases. Undoubtedly the heat has a beneficial effect so far as relieving pain is concerned, but the element of faith, strengthened by the unusually beautiful surroundings and complete freedom from worry (financial excepted) no doubt accounts for the values claimed. At any rate we were told that setbacks were common when the treatment was discontinued.

The Banff Health Resort is now operated by the Sisters of St. Martha of Antigonish. It has about 50 beds and is equipped to take care of general hospital cases, although the greater number of its inmates were cases referred by the Workmen's Compensation Board of Alberta. This group is under the direct supervision of Dr. "Terry" McGuffin of Calgary, specialist in physical medicine. He spends about one-half of his time in Banff, supervising treatment. Cases referred are chiefly post traumatic orthopedic problems although many cases of traumatic psychosis are greatly benefitted by the change of air, surroundings and food, to say nothing of dips in the hospital's sulphuretted hot spring. This clinic has been in operation for several years and the Board is satisfied with the beneficial results revealed.

The Meetings

The meetings of the Medical Section were held in a fine community hall. As the number in attendance was small, the gathering was most intimate and, while a definite program was followed, there were opportunities for close and detailed discussion impossible to secure in a large group. The many problems

dealt with would be of little interest to our readers in general, but three outstanding features should be noted.

The first of these is the increasing necessity for the employment of physical medicine in the treatment of injuries. By this is meant intelligent use of physiotherapy by qualified medical practitioners with such assistance as may be necessary by trained technicians. Where so employed the results have been amazingly gratifying. The point of most importance is that treatment must be instituted early in the patient who has met with an injury, properly and intelligently carried through to a finality. In the past we have suffered from the idea that physiotherapy must be a late procedure. On this assumption its many failures may be explained. Another cause for its discredit in the past has been the indiscriminate use, and one may add the unskilled use, of its various branches without any particular study as to the exact requirements of the case. The interest newly aroused is likely to make this an important and fruitful field for physicians willing to give the time to secure the necessary training.

Of prime importance was the information gained regarding the use of aluminum in the prevention and treatment of silicosis. We were singularly favored by having present Dr. W. D. Robson, Medical Director of the McIntyre Research Limited, and Dr. A. R. Riddell of the Division of Industrial Hygiene, Department of Public Health of Ontario. Dr. Robson outlined the theory on which he made his original approach to the use of aluminum. The idea that silicosis is caused by mechanical irritation of the lung parenchyma by particles of silica, thereby causing fibrosis, has been abandoned. It has been shown that in order to cause silicosis, particles of silica inhaled must be extremely small and must go into solution in the lung juices, thereby creating silica hydroxide and possibly other silica compounds. Whether or not silica goes into solution is apparently an individual matter. Some persons long exposed, do not develop silicosis. Others develop it after a comparatively brief exposure. Compounds of silica so formed in the alveolar spaces set up the irritation which causes the fibrosis. This process goes on even in those removed from the inhalation of silica until all available silica in the lungs has been so utilized. There is evidence to show that the so-called "dust cells" and the lymphatics remove appreciable amounts of free silica from the lungs and this, no doubt, explains how ordinary persons breathing on dusty roads many months of the year do not develop silicosis as miners and others constantly exposed often do.

In the test tube finely divided aluminum is attracted by a difference in electrical charges to the particles of silica causing a firmly adherent mechanical coating of the silica particle. This coating prevents it from going into solution in ordinary solvents. In animal experimental work, carried on at the Banting Institute, the results of laboratory experimentation appear to be fully borne out, not only in prevnetion, but also in the treatment of silicosis. Applied to humans the results are not so clear. It would appear that an insufficient number of controls have been studied to evaluate either of these phases. From the standpoint of treatment psychic factors often mask or influence symptoms. The patient put under rest, good food and the use of aluminum inhalations gets a sense of benefit, not always borne out by the radiological findings and not always possible to attribute to the use of aluminum alone. More study is definitely needed before it can be said that this form of treatment, either preventive or curative, may be generally employed with beneficial results.

It is interesting to note the method so far in use by way of prevention. The mine employees are passed into a room hermetically sealed, into which, by means of compressed air, is injected one gram of finely divided aluminum per one thousand cubic feet. This is inhaled for a period of ten minutes. There is no consciousness on the part of the individual that such inhalation is taking place. During the ten minutes he is exposed, the worker is employing himself in changing his clothing.

Along with Dr. Riddell a very extensive study was made of X-ray films made in cases of silicosis and those cases resembling silicosis.

The third feature of interest was a discussion of eye injuries. The marked industrial activity in Canada during the present war has resulted in a very large number of these. Emphasis cannot be placed too strongly on early treatment of eye injuries by those skilled in that particular branch of medicine. Even where this may not be feasible or possible, a definite effort should be made by the general practitioner to rule out the presence of an intraocular foreign body. This is easily done by the instillation into the eye of one or two drops of fluorescin solution. Injury or ulceration of the cornea with the use of this drug shows up as a green-stained area. No harm can follow the use of fluorescin. If injury or ulceration of the cornea is discovered and the workman's employment is of such a nature that a foreign body could have caused the injury, reference to a specialist, even though many miles away, is justified. A large series of intraocular foreign bodies were shown that were only discovered when they had caused serious damage to the eye: their removal was impossible and loss of vision invariably resulted.

A word should also be said on the experience of the Canadian Compensation Boards in dealing with extruded intervertebral discs. In general it may be said that operative results have not been encouraging. It must be remembered that industrial cases are usually men who earn their living by hard physical effort and that this form of employment is that to which many of them must return. One province could only point to one such case in a large number treated surgically where the workman had resumed his former employment without symptoms of an unfavorable nature. Most of those operated had partial permanent disability. Some that appeared at first to have a good outlook were developing a recurrence of symptoms. A considerable number were regarded as totally disabled and likely to remain so. The universal experience again emphasized what we have been led to believe, that operative procedures should only be undertaken where there is a definite indication therefor, where the clinical signs are clear, and there is no other alternative to restore the individual to a situation where he may earn his livelihood. It is noteworthy that individuals engaged in sedentary occupations give more favorable results after operative treatment, no doubt due to the very nature of their occupations.

In closing it may be said that the Chairman of the Workmen's Compensation Board of Nova Scotia was elected President of the Association, and that the next meeting as a result will be held in Halifax. Whether this will be in 1946 or 1947 will depend on circumstances.

One of the problems of industry will always be accidents. Another of its problems will be the employment or denial of employment of those suffering from some physical disability. The care of the injured will remain an increasing responsibility of the medical profession in Canada as years go by. It behooves all of us to take an active interest in this side of our professional work.

Correspondence

The Editor of the Bulletin,
Dear Sir:

"Health Insurance" as seen by a General Practitioner

WITHIN the last six months the MEDICAL BULLETIN has given us many previous articles of a high scientific value. Those who published them, as well as the authors, deserve our highest commendation. We are sometimes led to minimize the publication of some issues because of scarcity of material, but as a rule our BULLETIN makes a good "Showing" and is a great factor in propagating sound medical thought throughout the Maritime Provinces and Canada generally.

To-day, we are faced with a tremendous national problem, that of health insurance, and few of us have had the time and the leisure to study it very thoroughly. Consequently, with the lack of knowledge at our command we hesitate to express an opinion. Still the problem is ours and we must face it with a proper approach because it is being discussed in the public press, in our public meetings, in our Journals, everywhere.

On the 5th of February, 1942, the Governor in Council nominated a Consulting Committee with the express purpose of formulating a federal law of Health Insurance. This Committee was composed of Specialists (Physicians and Statisticians) presided over by Dr. J. J. Heagerty, director of Nationa: Health, who went to work and studied the four following aspects of the probleml

(1) Legislation in vogue in other countries.

(2) Official Organization of Health in Canada.

(3) Our vital statistics.

(4) Probable cost of Health Insurance in Canada.

In attempting to formulate a law of Health Insurance the above body of men drafted a tentative plan composed of two parts:

(a) A Federal Law composed of eighteen clauses,

(b) A Provincial Law made up of forty-eight clauses incorporated in the Federal Law.

It is clearly seen in part I that our Federal Government wants to establish in Canada a Compulsory Health Insurance Scheme by creating an organization which will give benefits to all the assured. The Government will determine the amount of money voted for services. The Provinces will be submitted to certain conditions, one in particular will be to vote a provincial type of law similar to the Federal. The Government at Ottawa will determine the relations which must exist between the Provinces for the good administration of the law. Moreover, the draft as aforesaid, suggests the creation of a Ministry of Health at Ottawa, a Service of Health Insurance and an important Consulting Council composed of officials from the various professional organizations—physicians, surgeons, hospitals, nursing and the assured public itself.

This document, as we can already infer, does not include only the working class as it happened in some countries, but all residents in Canada under

sixteen years of age. New Zealand may serve us as an example. We quote from the draft itself:

> Every adult in whose case the requirements of the Act are complied with by him or on his behalf and every juvenile of whom he has for the time being the care and control shall be qualified to receive the benefits of Health Insurance conferred by the Act.

Not only the adults but also the juveniles are entitled to benefits provided they register and comply with the law, in other words, all the population of Canada.

This is worthy of note because in some countries only the indigent class is eligible to membership in the Health Insurance Scheme; not so in Canada should we wake up one morning with a "New Order" in medicine.

To be more precise, we quote again from the draft:

> Every adult shall on or before the prescribed date file with the Commission a return in prescribed form and manner and containing such information as may be prescribed for the purpose of enabling the Commission to establish and maintain a register of qualified persons and for other purposes of this Act.

With regard to the financing of the Act, a fund is supposed to be raised by means of contributions from the assured, from the employer from grants from the Federal and Provincial Governments.

The text of the draft does not determine the amount of annual tax but the Consulting Committee has suggested the sum of $26.00 a year.

For a laborer with a salary less than $866.00 a year, the employer will assist and pay part of the contribution, hence with a yearly revenue of $840.00 the laborer will pay 3% of his salary, i.e., $25.20, and the employer 80c. If the salary is above $866.00, the employer pays nothing.

For those who have dependents, the Province will assist considerably. Every assured must pay proportionate to his revenue. To state the case more simply, an employee who earns $866.00 or more must pay, in addition to his tax 0.7% of his salary, i.e., $5.88 in favor of his dependent and the Provincial Government pays the difference, i.e., $20.12.

Such are some of the most salient features of the Draft Bill. Are we prepared to accept or reject it? That is the question.

We, medical men, feel that if a reform in medicine is to take place, it must be based on a co-operative plan. In other words, let the people pay for services rendered. We are opposed to State Medicine because we are opposed to dictatorship; to a totalitarian state as we shall see further.

The above draft deserves commendation. It was given time, study, and the work required for the drafting of a Bill involved serious social implications. The health problem of our country is a very important one. Our Departments of Health throughout Canada each year emphasize the fact that they cannot cope with the situation; that much work is left undone. Hence the alarming need for more adequate measures to promote public health. In 1944, thirty-three countries had a compulsory system of Health Insurance and nine had a voluntary system. The health situation in Canada following the critical years of depression will require a vigorous effort for betterment.

We, as general practitioners, are prepared to state our views regarding the above scheme. The project has much merit because it respects the fundamental principle of freedom both for the insured population and the professional bodies. The patient has free choice of doctors, of hospitals, of nurses. The medical practitioner has freedom in the choice of his patients, the methods of treatment and the relations with the hospital. The Professional Associations have the privilege of representation on the Provincial Commission. Section 19 (paragraph 4) states that hospitals shall be represented. This recognition is a previous guarantee for the Provinces.

Another excellent point is to be noticed. Every Province shall administer its own Health Insurance Act. This is in conformity with the spirit of its constitution and the Sirois Report. The extent of the services allowed is noteworthy as well as the preventive and social aspect of the Bill.

Interesting as it may be, the project is not perfect. In this regard, certain phases of the bill should be emphasized, and studied clause by clause, paragraph by paragraph.

The first weak point seems to be the known interference of the Federal Government in the Social Field. Certain sections of the Federal bill tend to paralyze the Provinces in their administration of the Law. The Federal Government does expect the Provinces to legislate but the Act is drawn (section 3-6) precluding any possibility of social initiative. Furthermore, the Governor-in-Council may make regulations for the application, the amount to be expended by the Province, the control of benefits, the nature of services and the class of beneficiaries. The activities and services with respect to the general public health of the Provinces must be approved (Section 5). They are subject to the Minister who may reduce the grant. The Minister may ask for any report deemed necessary (Section 11), have investigations made in all the provinces and give the person appointed for such investigations the powers of a Commissioner. Briefly speaking, why should the Federal assume so much control of the Provinces in a field exclusively their own?

We shall go no further as the subject of our letter implies simply the candid expression of our own views regarding "Health Insurance." The need of the hour is for us, therefore, to be on the alert. Dr. Routley made a very important declaration on the 7th of February, 1945, (Medical Bulletin, page 62):e

> The introduction of the Bill is conditional upon suitable agreements with the Provinces.

and, furthermore, we quote the words delivered on February 14th, ultimo by Mr. Justice Graham at the opening of the Nova Scotia Legislature:

> Believing in the very great importance of all matters pertaining to social security and in order that there may be no duplication of the effort and no infringement of the Province's prerogatives, my Government considers in the light of present developments that the time has now come when a definite understanding must be reached with the Federal Government respecting the character and scope of all such affairs to be undertaken by each jurisdiction.

J. E. LeBlanc, M.D.

Abstracts from Current Literature

Effect of "Nitrite" Drugs on Blood Pressure. Weaver, J. C., Wills, J. H. and Hodge, H. C.: Amer. Heart Jour., 1944, 28: 601.

Weaver and his associates gave glyceryl trinitrate, sodium nitrite, erythrol tetranitrate, mannitol hexanitrate and a placebo to normal and hypertensive subjects and made blood pressure measurements at brief intervals until the effect of the drug was over. Each of the 38 subjects received one or more of the substances and most received all four nitrite drugs. The patients were led to believe that the blood pressure measurements were a part of their routine management. Fifty-one per cent of the subjects who were given the nitrite drugs had a fall of systolic pressure, and 23 per cent had a lowering of diastolic pressure. The systolic fall was almost always greater than the diastolic. None had a fall in blood pressure after the administration of a placebo. The amount of the fall in blood pressure in hypertensive patients varied greatly, but the averages were as follows: glyceryl trinitrate 16/4 mm. of mercury, sodium nitrite 21/1 mm., erythrol tetranitrate 14/5 mm. and mannitol hexanitrate 12/4 mm. In normal subjects the average fall in blood pressure was as much as 10 mm. less than the corresponding figure for the hypertensive. The period between the administration of the drug and the beginning of the fall in blood pressure was variable. For glyceryl trinitrate this interval averaged 2 minutes, for sodium nitrite 7 minutes, for erythrol tetranitrate 35 minutes and for mannitol hexanitrate 55 minutes after the drug was given. The average duration of blood pressure lowering was as follows: glyceryl trinitrate 20 minutes, sodium nitrite 62 minutes, erythrol tetranitrate and mannitol hexanitrate about the same, 256 and 252 minutes respectively. With the last two drugs there was wide variation in the duration.

Hemolytic Disease of Fetus. Wiener, A. S., Wexler, I. B. and Gamrin, E.: Amer. Jour. of Diseases of Child., 1944, 68: 317.

According to Wiener and his associates, the usual method of demonstrating Rh sensitivity is to test the patient's serum for anti-Rh agglutinins, as was first done by Wiener and Peters. It was soon discovered that there is a high percentage of persons with Rh negative blood who are highly sensitive to the Rh factor whose plasma does not contain demonstrable anti-Rh agglutinins. These puzzling cases have been explained, at least in part, by the discovery that in addition to Rh antibodies that produce hemagglutination there are Rh antibodies able to combine specifically with Rh positive cells without producing a visible reaction. If Rh positive blood is mixed with serum containing antibodies of the latter type, the blood loses its capacity to be agglutitinated by anti-Rh agglutinating serums, presumably because all the combining sites on the erythrocytes have been occupied. Because of this property of blocking the action of anti-Rh agglutinins, the new type of antibody has been named the blocking antibody. The blocking antibody has served to explain the hitherto puzzling lack of correlation between the titer of anti-Rh agglutinins and the severity of hemolytic disease in the infant. A biologic test of detecting Rh sensitivity was described by Wiener in 1942. This test has proved particularly useful for the prevention of hemolytic reactions to intragroup trans-

fusion in the absence of the facilities or the time for carrying out tests for the Rh factor. The biologic test consists of intravenous injection of 50 cc. of blood to which the patient may be sensitive and comparison with the naked eye of the colour of the patient's original citrated plasma with that of a comparable specimen taken one to one and one-half hours after the injection. If sensitivity is present, the second sample of plasma will be distinctly darker, and not infrequently the patient will have a chill fifty to sixty minutes after the test is started, followed by a rise in temperature. In case of doubt an additional 50 cc. of blood may be injected and a third specimen of the patient's plasma obtained for comparison after one more hour. If the reaction to this test is negative, any quantity of blood from the same donor can be given without untoward effect. The authors describe some experiences with the application of the biological test for the detection of sensitivity to the Rh factor caused by pregnancy. In a woman who had previously had repeated miscarriages, a negative biologic reaction proved that these were not caused by Rh sensitivity, even though her blood was Rh negative and her husband's was Rh positive. On the other hand, in a case involving a husband with Rh positive blood and a wife with Rh negative blood, who had had two stillbirths of obscure cause, a positive biologic test proved that isoimmunization was responsible, even though in vitro tests for anti-Rh agglutinins in the woman's serum had previously given negative results. Two cases of hemolytic disease of the newborn are described in which transfusions of Rh negative blood were given. In one case the therapy was dramatically life saving, while in the second, in which the disease was apparently milder, the infant died of cholemia and icterus.

CONGENITAL ABSENCE OF LUNG. Ferguson, C. F. and Neuhauser, E. B. D.: Am. J. Roentgenol. & Rad. Therapy, 1944, 52: 459.

Ferguson and Neuhauser report 5 cases of agenesis of the lung encountered at the Children's Hospital in Boston during the past six years. In all of these the condition was diagnosed during life by bronchoscopy followed by iodized oil roentgenograms of the tracheo-bronchial tree. These 5 cases of agenesis of the lung illustrate the fact that this deformity is not incompatible with a normal existence, since 4 of the 5 patients are living normal lives and are not handicapped by their defect. All 5 cases showed additional congenital anomalies. In the first case the left hand was absent. In the second there were a patent ductus arteriosus, accessory spleen with hypoplasia and hypoplasia of the kidney and liver. In the third case there was a congenital malformation of the external ear. In the fourth there were congenital anomalies of the vertebrae and ribs noted by the roentgenograms. In the fifth there was a harelip and a complete cleft palate. The cases in the literature also have shown frequent associations of other congenital anomalies. The authors feel that an inherent defect in the germ plasm is probably responsible for this as well as the other associated congenital anomalies. The symptoms are so inconstant or lacking that X-ray studies plus bronchoscopy with injection of the tracheobronchial tree with iodized oil are the recommended methods for diagnosis. The prognosis should always be guarded, although the condition is compatible with longevity. In 3 of the cases reported in the literature the age was well over 50 years. Of the 5 patients whose histories are presented, 4 are living normal lives and the oldest is 8 years old. The authors stress

that in cases of persistent emphysema or atelectasis, of supposed unresolved pneumonia or of recurrent pneumonia in the same lobe, congenital anomalies of the tracheobronchial tree must be considered.

PENICILLIN IN PRIMARY ATYPICAL PNEUMONIA. Short, J. J.: U. S. Naval Med. Bull., 1944, 43: 974.

In the first of Short's series of cases of atypical pneumonia the administration of penicillin led to a sudden and sharp temperature decline, disappearance of symptoms and rapid convalescence. Eight additional cases have been treated, all of which responded more or less promptly to the drug. A control series was not observed, but results with penicillin seemed to be much superior to those with the expectant symptomatic treatment formerly used. The average number of days from the institution of penicillin therapy until the temperature became normal and remained so was 3.5. This is decidedly less than the usual expectancy with supportive treatment.

COMPARISON OF INSULINS. MacBryde, C. M. and Reiss, R. S.: Jour. of Clin. Endocrinol., 1944, 4: 469.

Of 350 well controlled diabetic patients treated by MacBryde and Reiss in four years only 186 could be regulated with protamine zinc alone, while 164 required in addition a separate morning injection of regular insulin. The authors show that if the majority of moderate and severe cases of diabetes are to be controlled with one daily injection, some different modification of insulin will prove necessary. The authors investigated several insulin modifications. They give particular attention to a standard modified protamine zinc insulin having the same pH as market protamine zinc insulin (7.2) but containing only half the added protamine and zinc. Approximately 75 per cent of this insulin is in precipitated, slowly absorbed form, while 25 per cent is in solution and is rapidly absorbed. In 16 comparative case studies, modified protamine zinc insulin gave better control in 13 patients than globin zinc insulin. In no case did globin zinc insulin establish better regulation than modified protamine zinc insulin. Globin zinc insulin failed to prevent after-breakfast hyperglycemia in 12 of the 16 cases and caused afternoon hypoglycemia in 9 of the 16. Fasting blood sugars were higher in 13 of the 16 cases when globin zinc insulin was used. Even when special diets were employed, allowing a smaller breakfast and a larger lunch, the same defects in control were observed with globin zinc insulin. In ten direct comparative studies with an extemperaneous mixture made with 2 parts of crystalline insulin and 1 part of protamine zinc insulin, modified protamine zinc insulin gave better control in every one of the 10 cases. Irregular results were obtained with the mixture, with failure to duplicate twenty-four hour curves. The rise in blood sugar after breakfast was poorly controlled with the mixture, and there was a tendency to hypoglycemia at midafternoon or midnight. In a total of 110 case studies conducted over a four year period, good regulation was established in 98 patients with a single injection of modified protamine zinc insulin daily. Severe as well as mild cases were well controlled. The authors think that the use of multiple forms of insulin should be discouraged. They think that two forms of insulin should be sufficient: (a) modified protamine zinc insulin such as that used in these studies, which might well be substituted for standard

protamine zinc insulin since it will control a much larger percentage of patients with uncomplicated diabetes, and (b) regular (or crystalline) insulin for use in diabetic emergencies and whenever supplementary insulin is required.

TESTOSTERONE COMPOUNDS IN THYROTOXICOSIS. Kinsell, L. W., Hertz, S. and Reifenstein, E. C.: Jour. of Clin. Invest., 1944, 23: 880.

Thyrotoxicosis is characterized by an increase in the urinary excretion of nitrogen and creatine and by a decrease in body weight. Testosterone propionate has the opposite effect of these three variables. Kinsell and his coworkers investigated the metabolic effect of testosterone propionate and methyl testosterone on 3 patients with thyrotoxicosis. Testosterone propionate induced a positive nitrogen balance in these patients and caused a weight gain; these effects were obtained in patients whose diet was constant and even in individuals whose caloric intake was less than their caloric expenditure. Methyl testosterone had a similar initial effect on the nitrogen balance, but its effect was not sustained. The difference between methyl testosterone and testosterone propionate may possibly be attributed to the calorigenic effect of the former or, more probably, to its different effect on creatine metabolism. Testosterone propionate decreased the hypercreatinuria which characterizes thyrotoxicosis; methyl testosterone increased it. It is suggested that methyl testosterone may increase creatine formation at the expense of protein anabolism. In the one patient with thyrotoxicosis in whom calcium studies were carried out, there was with testosterone propionate therapy a striking reduction in the hypercalciuria characteristic of thyrotoxicosis. The effect of testosterone propionate in reducing the serum potassium level was confirmed in one patient. Testosterone propionate improved the clinical status of thyrotoxic patients; methyl testosterone, on the contrary, aggravated their toxicity. The latter drug is probably contraindicated in this disease. Testosterone propionate may prove to be a useful therapeutic adjunct in preparing for operation thyrotoxic patients who have sustained severe weight loss, with emaciation and muscle wasting. A daily dosage of 12.5 mg. is probably adequate. This should be given in addition to whatever drug is used to reduce the metabolic rate—iodine or thiouracil.

FALSE POSITIVE SEROLOGIC TESTS FOR SYPHILIS. Davis, B. D.: Medicine, 1944, 23: 359.

A positive test in a candidate for induction into the armed forces of the United States may be the basis for rejection. The findings of the Committee on Medical Research of the Office of Scientific Research and Development are discussed by Davis. The incidence of transient positive tests following acute infections depends largely on the frequency of testing during the acute and convalescent stages. Although postinfectious or postvaccinial positive reactions occasionally last as long as three months, most become negative within a few days or weeks. Since it is customary to perform serologic tests on hospital patients only on admission, at which time acute infections have not fully developed their antibodies, it is likely that the ability of many common infections to lead to false positive serologic tests is grossly underestimated. False positive serologic tests are common (more than 10 per cent of cases) in leprosy, malaria in the acute stages, infectious mononucleosis, vaccination against

smallpox, rat bite fever due to Spirillum minus, relapsing fever, lupus erythematosus and possibly certain types of atypical pneumonia. There is no reliable evidence that the serologic tests are significantly affected by pregnancy, menstruation, scarlet fever, jaundice (other than infectious), subacute bacterial endocarditis, tuberculosis or hypoproteinemia. Inadequate data are available on measles, mumps, infectious hepatitis, lymphopathia venereum, chancroid and many other diseases. Transient false positive reactions may occur in apparently normal persons without recent illness. Even persistently positive reactions may occur in nonsyphilitic patients. Since a large proportion of seropositive persons have no syphilitic lesions at necropsy, it is entirely possible that many seropositive persons without a history or signs of the disease have been mistakenly diagnosed and treated for latent syphilis. In large serologic studies the number of innocent victims may be large, and the psychologic, social and legal consequences to the individual may be serious. A positive serologic test is not an emergency. The most important procedure, in the absence of pregnancy, is a probationary period of at least three months before starting treatment. While many false positive tests will be revealed as transient during this period, there is no verification test available to-day to help in the diagnosis of those which remain positive.

E. David Sherman, M.D.
Abstract Editor

Society Meetings

Western Counties Medical Society

At a meeting of the Western Counties Medical Society held in May the following members were elected as representatives of the Executive of The Medical Society of Nova Scotia—Dr. P. E. Belliveau, Meteghan and Dr. A. M. Siddall, Pubnico. The officers for the ensuing year are as follows:—President, Dr. F. J. Melanson, St. Anne du Russieau; Vice-Presidents:—Dr. L. P. Churchill, Shelburne, Dr. H. J. Melanson, Weymouth, Dr. W. C. O'Brien, Yarmouth; Secretary-Treasurer: Dr. D. F. Macdonald, Yarmouth.

We had a very enjoyable dinner meeting at Green Tree Inn and an excellent paper on Anaesthesia by F/L Wearing, R.C.A.F.

D. F. Macdonald, Secretary-Treasurer

Personal Interest Notes

IT was announced at Manila recently that Major Bernard Francis Miller, of Halifax, who spent three years in Britain with the Royal Canadian Army Medical Corps, soon will complete a four-month tour of study of United States Medical Services in the Pacific. Major Miller, who went to Britain in 1941 with No. 7 Canadian General Hospital, has accompanied United States assault forces in operations against Zamboanga and Mindanao to see the medical services in the Pacific at work. He has been able to gather information about diseases common to that theatre and their prevention, the effect of the climate on the efficiency of fighting men and the treatment and evacuation of casualties.

Major Miller was born in New Waterford, where he practised before the war. He graduated from Dalhousie Medical College in 1931.

A former member of the N. P. A., he enlisted in the Canadian Army in August, 1939. His duties in England included the command of all medical personnel in the Northern Command prior to D-Day. After D-Day he returned to Canada, took a course at the Royal Military College, Kingston, and went to the South Pacific for a tour of American medical bases.

Since the war began his home has been at 2 Lilac Street, Halifax, where his wife is residing at present.—(Halifax Chronicle, May 23rd).

Major James A. Muir, R.C.A.M.C., returned to Canada early in May. Major Muir graduated from Dalhousie Medical College in 1936, and formerly practised in Port Hawkesbury. Following his enlistment with the R.C.A.M.C., he served in Canada prior to proceeding overseas in 1941. He served in Italy and was among the Canadians secretly switched to the Western Front prior to the big Allied drive in the west.

Dr. C. B. Trites of Bridgewater enjoyed his annual holiday trip to the United States during April. While away he visited a number of clinics in various American cities.

Dr. and Mrs. S. W. Williamson, of Yarmouth, left the latter part of May for a visit to Providence, R. I., and visited Toronto and other Canadian cities before returning home.

The marriage took place in Halifax on May 5th of Miss Laura Katherine Stanley, only daughter of President and Mrs. Carleton Stanley and Dr. Lewis Benjamin Woolner, son of Mr. and Mrs. Benjamin Woolner, Hunter's River, P. E. I. Following a reception at the home of President and Mrs. Stanley, Dr. and Mrs. Woolner left by plane on a trip to the United States. On their return they will reside in Halifax.

THE BULLETIN extends congratulations to Flight-Lieutenant and Mrs. Ralph W. Ballem (Ruth Graham) on the birth of a daughter, Leslie Margaret, on May 29th, at Halifax. Also to F/O and Mrs. W. Leith on the birth of a daughter on May 22nd, at Halifax.

Obituary

DOCTOR JOHN BARTLEY MARCH, one of Lunenburg County's pioneers in the medical field, died at his home in North Brookfield, Queens County, June first, at the age of eighty-five. Victim of an accident about fifteen years ago, Doctor March suffered a severe injury from which he failed to completely recover. He was born at St. Jerome, N. B., a son of the late Rev. Stephen March and Elizabeth Keating March of Bridgewater. He received his early education in the Bridgewater schools and took his pre-medical studies at Acadia and graduated in medicine from the University of Michigan in 1885. Shortly after graduation he practised at Riverport for three years, went into partnership with his brother, the late Doctor Harry March, at Bridgewater, for a number of years. From Bridgewater he went to Berwick where he practised for over twenty years, and from there to North Brookfield until forced to retire on account of ill health. Doctor March was twice married, his first wife being Miss Ida Whitford, daughter of Mr and Mrs. Joseph Whitford, of Bridgewater, who predeceased him in 1918. Five children from this marriage survive: Cyril March, barrister-at-law, formerly practising in Manitoba, a veteran of the First Great War, now chairman of the Pensions Board at Ottawa; Burdette, Mrs. M. Salis, Cleveland, Ohio; Grace, Mrs. Corey, Cambridge, Mass.; Harold, electrical engineer, Charleston, Mass.; and Earl in the Canadian Army. His second wife, who survives, was Mrs. Ethel Taylor of Aylesford. Of this union there are five children: Joyce, Mrs. Moody Harlowe, North Brookfield; John, Dartmouth; Harry, Elizabeth and Jean at home. There are also two brothers, Arthur and S. Edgar March, LL.B.,C.E., both of Bridgewater. The funeral was held in Bridgewater on June 4th, with interment in Brookside cemetery.

THE BULLETIN extends sympathy to Captain J. Douglas McFetridge, R.C.A.M.C., now stationed in hospital in England, on the death of his mother, Mrs. Harry McFetridge, (the former Elizabeth Henry), of Middle Musquodoboit, which occurred on May 19th, at the home of her daughter at Onslow, Colchester County.