*The New Knowledge of Tuberculosis

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Mr. Chairman and Gentlemen:

Since a 'refresher' course is not, essentially, something you get for the first time, but rather, something that renews old interests and stimulates latent or tired powers, you will not expect me to have any surprises for you. Most of you have kept in touch with the developments in our knowledge of tuberculosis, and you are all keenly aware of the difficulty and complexity of the problem this scourge presents.

It is not spectacular—except, perhaps, in a few surgical cases. It is, both for patients and physicians, a slow, tiresome thing to treat, especially when diagnosis has been delayed. It may not be stimulating to physicians who are, after all, just human men. But we at the Sanatorium, who are in the thick of it and see the tragedy of it, so to speak, in concentration, even we are not without hope and encouragement. These, and also the desperate urgency of the matter, I wish to bring to you as well as I can. I hope at least that it will be interesting and refreshing enough to keep you awake. Even though, with a few necessary figures, it may be a bit dry in spots.

For the hope, we shall first take a look backward and count our gains,—looking back, not like Lot's wife, with any longing for the bad old days, but to learn, and to draw conclusions; to recognize former mistakes and failures and get a finger on the causes of these. Then we must set the goal at which we are definitely to aim, and keep our eyes and minds upon it. Especially must we understand, grasp and use faithfully all the methods known. Here is where the "new knowledge" comes in.

The national system of vital statistics was not established in Canada until 1921 when the Dominion Bureau reports the death rate from tuberculosis to be 87.6 per 100,000 of the population. Twenty-one years earlier,that is 1900, in Ontario and Quebec, the provincial rates were above 200 per 100,000, and, as these provinces contained the greater part of the Dominion's population we can accept these figures as the average Canadian death rate from tuberculosis at that time. It is relevant to note that in the Dominion in 1900 there were hardly any facilities for the diagnosis and treatment of tuberculosis, and apart from a few tuberculosis dispensaries there was only one small sanatorium for the care of consumptives in Ontario. By 1940, a network of diagnostic clinics had developed in every province in Canada. Sanatorium beds have increased almost to 11,000, the capital outlay in building amounting to $30,000,000 and an annual expenditure for upkeep of some $8,000,000. The death rate from tuberculosis in 1941 had fallen to 50.6, a reduction of some 75 per cent in forty years.

But some 6,000 persons still die each year in Canada from tuberculosis, and at least 30,000 new cases crop up annually to cost the country some $8,000,000 yearly, this in spite of the fact that we have today facilities for diagnosis and treatment such as were unheard of twenty years ago. It must be either that these facilities are not properly used, or that they are still inadequate. Have you, gentlemen, thought out which it is?

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Tuberculosis Among Civilians During World Wars I and II: It is within the memory of many in this audience that there was an appalling increase in tuberculosis in Europe during and immediately following the first World War. Published reports show that the death rate from tuberculosis tripled within two or three years of the commencement of the war in a number of the mid-European countries. In England, the mortality from tuberculosis also had risen, especially among young women employed in war industries, and in 1918 it was 25 per cent higher than in 1913. An even greater rise had taken place in Germany among young women engaged in heavy war industries, and in 1917, it was 75 per cent higher than in 1913.

Public health studies have revealed that the causes of this terrific increase in tuberculosis were, malnutrition; crowded, unsanitary housing; exposure to infection; unaccustomed labour for long hours, both in the battle line and on the home front. The world is again facing war on a scale which has already led to conditions even worse than those in 1914-'18. In just the first two war years, 1939 to 1941, the tuberculosis death rate rose in England and Wales, 12 per cent; in Scotland, 18 per cent; in France and Germany, while the precise rates are not available, it is known that there has been a marked increase in tuberculosis. In Canada*, there was a rise of 5 per cent between 1940 and 1941. In the United States, there has been no increase and the rate for 1942, 43.6, is slightly lower than that in 1941. On this continent, we have been fortunate enough so far to escape the devastation that is sweeping over Europe, but even here there are strains and stresses that tend to lower the physical resistance.

Thus, while it is true that there was a steady decline in our death rate from tuberculosis over several decades, we may yet suffer a serious set-back, and the gains of recent years may be lost unless we fully realize the danger early enough and put forth every effort to avoid it, but, instead, turn all our war-time knowledge toward increasing the former gains. We must make good use of what was learned by mistakes in the former World War, and of the accumulating experiences of the one still going on—which, so far as Canadian fighting men are concerned, may be said to be just starting. The hardest physical test for them, and indeed for all of us, may be yet to come. What we can—and must—do about it, I shall come to in a few moments.

Tuberculosis Among Service Men: It will be recalled that, during the World War I, 1914-'18, for diagnosis, the physical findings of the chest, percussion and auscultation, were rated of greater worth than the roentgenological examination of the lungs. We were later to find out the fallacy of this view. In a study of Deaths Among Canadian Pensioners from the first World War, published by the Department of Pensions and National Health in 1939, we find that, of the 600,000 men who enlisted in the service, eventually 8,500 were pensioned for tuberculosis, and that 3000 had died from this disease. In other words for every hundred men killed in action, six have died from tuberculosis, and for each hundred pensioned for wounds, twenty-five have been pensioned for tuberculosis. The cost of tuberculosis, to Canada, as a result of the first World War has been computed at one hundred and fifty million dollars. In the United States, the total cost of the care of tuberculous veterans for the twenty years, 1921-1940, has been computed to be well over $300,000,000. Many of these recruits undoubtedly had tuberculosis at the time of enlistment, but

1. In the preliminary report recently issued by the Vital Statistics Branch of the Bureau of Statistics, Ottawa, 1942, there has been a slight reduction in the death rate from tuberculosis, from 53.1 to 51.5 per 100,000 of the population.

physical examination, alone, carefully as it was given, frequently failed to reveal latent as well as active lesions in the lungs. The lesson learned has been well taken to heart. At the beginning of the present World War, the Department of Militia and Defence, following the advice of specialists in diseases of the chest, wisely decided that all recruits enlisting in the Canadian Army should have an X-ray examination of the lungs before they were admitted to the service. Those found with significant tuberculosis were to be rejected. The official report states that up to March, 1942, of the 400,000 men on whom X-ray films were taken, 3,969 or 1 per cent were rejected on account of past or present pulmonary tuberculosis.

It is further instructive to note in the same report that, among a group of men discovered with minimal tuberculosis, only 270 cases out of 1334, that is, about one in five, could be diagnosed from the clinical findings alone, when the X-ray film clearly demonstrated significant tuberculosis in the lung. In the moderately advanced cases, only some 357 out of 759, that is, about one-half, could be diagnosed correctly from the clinical examination; in the far advanced group, 117 out of 136. Here it seems worth mentioning that, among all the troops in Canada and overseas, only 114 cases of clinical tuberculosis have developed between September, 1939, and March, 1942. This must be taken as evidence of the value of X-ray examination in the detection of early or latent tuberculosis in the lungs.

While we must by no means set aside the physical examination of the chest, for there are various non-tuberculous diseases in the lungs which cannot be clearly demonstrated from radiological findings alone, we may as well accept the fact, as far as tuberculosis is concerned, that the stethescope is not to be compared in accuracy to a well-taken X-ray film in bringing to light early active or silent, quiescent lesions in the lungs, which may be the precursors of later disabling disease.

Advance in Diagnosis: The technical side of radiology has been immensely improved since the time of the first World War, and it has been conclusively demonstrated again and again in mass surveys as well as by the hundreds of thousands of examinations conducted on inductees into the army, that the X-ray is the surest, in fact, the only means to rule out the presence of tuberculosis in the lungs.

Now, we have a new advantage in what is called the miniature film. The standard celluloid film, 14 by 17 inches, has been employed in Canada by the Department of National Defence in the examination of the chests of some 500,000 men prior to admission to the army. On the other hand, in the United States, the War Department plans to examine practically all men by means of the photo-roentgenogram, a miniature 4 by 5 inch celluloid film, on account of its speed, exactness, economy and the fact that it will reduce storage space by over 75 per cent. As many hundreds of thousands of X-ray examinations are still to be taken on Canadian Service men both at admission as well as at discharge, the 4 by 5 inch photo-roentgenogram will be used more and more as a means of diagnosis as well as a graphic legal record in case of future pension claims.

The cost of these miniature films is about one-eighth that of the standard size and their use for detection of early tuberculosis opens up new possibilities in public health work. There is little doubt from now on it will be the accepted practice to have whole communities, sick and well, examined by means of the

X-ray, for there is where prevention as well as cure has its first and greatest point of attack. This has been the dream of public health officials for years, and now that a way has been opened up, the radiographic film will be a permanent record of the chest condition.

The Tuberculin Test: Our knowledge of the epidemiology of tuberculosis has been gained chiefly through the diagnostic use of tuberculin. The test is of undoubted value in public health, industrial, university and school surveys. Reactors to the tuberculin test are advised to have an X-ray examination of the chest. Non-reactors, with few exceptions, are considered to be free from tuberculosis. Research studies continue to be carried out in America to improve and standardize tuberculin and remove such elements as may cause a non-specific reaction. This new knowledge may become highly valuable, but it is possible, that as time goes by, the miniature X-ray film, on account of its low cost and universal employment, may make the need of tuberculin testing unnecessary in mass surveys.

Sputum Examinations: Examination of the sputum is still of great importance in the diagnosis of tuberculosis. The presence of tubercle bacilli in the sputum undoubtedly points to pulmonary tuberculosis. In cases of suspected tuberculosis with a negative sputum it is well to examine the gastric contents for acid-fast bacilli. Sputum should not be considered negative from one examination alone; several specimens should be analyzed by the concentration method. If the reports are negative and you still suspect tuberculosis request the Public Health Laboratory to carry out the 'cultural' test on a specially prepared medium, with further specimens. The test is almost equal in accuracy to guinea pig innoculation. Unfortunately, it requires several weeks for the results of the test to be determined.

Bronchoscopy: Examination of the bronchial tree by means of the bronchoscope has become a common practice in many sanatoria and chest clinics throughout Canada. The examination by the bronchoscope is of undoubted value in determining the presence or absence of tuberculous trachea-bronchial ulceration. Also, for the differential diagnosis of such conditions as bronchiectasis, unexplained haemoptysis, malignancy, pulmonary abscess, bronchial stenosis. The use of the bronchoscope has been of great help, not only as an aid to diagnosis, but in planning treatment to follow, particularly in thoracoplasty. The procedure is a simple and safe one in the hands of an experienced bronchoscopist.

Treatment; There is as yet no specific cure for tuberculosis. Until one is found, we must continue with the accepted lines of treatment which have been found to be of benefit in the past, that is, rest, careful regulation of life, good food, fresh air, combined, in suitable cases, with one or other of the various compression aides to enforce complete or partial rest of a diseased lung. Unfortunately, collapse therapy is available for but a comparatively small proportion of tuberculosis sufferers, as the majority of them, when first discovered are already in an advanced stage of the disease. This is a matter of deep concern to us all and one which can be remedied if we will only profit from the lessons learned in World Wars I and II. The new knowledge gained from service examinations, as well as from mass surveys among apparently healthy people, shows that approximately one per cent of the population have active or healed tuberculous lesions in the lungs. As I have said, many of these lesions are early and minimal in extent and can be brought to light only by

means of the X-ray. The truth of this is beyond dispute. Patients with minimal tuberculosis generally respond readily to the customary sanatorium regimen and the great majority of them may be completely restored to health when treatment is given at the right time and in the right way. The slogan used in diagnosis campaigns is most appropriate here—early discovery—early recovery.

As to patients who are found to be in a moderately to far advanced stage of tuberculosis, while the outlook for recovery is somewhat gloomy for many of them, much can yet be done in these days, to lengthen out life as well as to enable a considerable proportion of them to take up again some gainful occupation. We have at our disposal the various forms of collapse therapy, as well as a number of surgical procedures, so successfully employed in the leading sanatoria in America—artificial pneumothorax, combined with intrapleural pneumolysis when required, phrenic nerve paralysis, thoracoplasty and its various modifications. These as well as many other procedures are notable advances in comparatively recent years in the treatment of tuberculosis.

Chemotherapy: There is no chemical agent that has proven of real value in the treatment of tuberculosis. In recent years, the remarkable results obtained in other infections, notably pneumonia and streptococcus infections, from the use of sulfonamid compounds has again aroused the hopes of research workers that the cure of tuberculosis may lie along chemical paths. Recently, several investigators have called attention to one of the sulfa-derivatives 'Promin'. Animal experiments, while encouraging, do not yet warrant the general use of this remedy among patients.

Tuberculosis Control: The eradication of tuberculosis while still a serious public health problem is by no means impossible of achievement. Unless the present war continues for some years to come,—and Heaven forbid it—we have every reason to feel that, with the gains obtained in the past, and the goal in sight, it is not too much to hope that, during the next two decades, tuberculosis may be reduced to a comparatively minor cause of death in Canada. This can be accomplished through a Dominion-wide scheme of health education and prevention, that is, case findings by means of Public Health Clinics, periodic examination of people, including the common use of X-ray films, treatment facilities for open cases of tuberculosis, and this means free treatment for those who can ill afford the benefit of sanatorium care. The cost of the undertaking is not beyond our resources, and it is hoped, that, when the coming Federal Health Insurance Scheme is finalized it will embrace a comprehensive and effective plan for the prevention and control of tuberculosis in every province of the Dominion.

A new strictness, a new determination in preventative measures is afoot, aroused, perhaps, by this war and by the years of education, but more is needed, and must be kept going. The problem is a social and economic one, a challenge to all the people, but the medical profession must be prepared to lead and direct the movement and to provide the inspiration—"say not the struggle naught availeth."

The best I can wish for you is that you may all play a strong, wise, and successful part in this great work, and live to rejoice in the hoped-for results.

Dr. Miller's address was followed by an interesting and instructive demonstration of X-ray films.

C.C.F. Health Plan

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IN answer to a request from the Editor of the Nova Scotia Medical Bulletin for information regarding the C.C.F. Health Plan, I am submitting a copy of an address given in September before the London, Ontario Academy of Medicine. Since a number of interesting points were brought out in the subsequent discussion, many of the questions and answers will perhaps anticipate those that would present themselves to members of the medical profession in Nova Scotia.

Since that time the Ontario C.C.F. Health Plan has been discussed with representatives of the C.C.F. from all provinces of Canada at a conference held in Regina over the New Year, and there was general agreement by all provinces on the essential principles.

I may say that I recognize, I think, more clearly than most people in public life the importance of health services, and the importance of your profession. I believe that the reason I recognize the importance of the medical profession is the fact that I was born, and spent some years of my life in China; and, those of you who have read anything about living conditions and medical services in China, will understand what I mean when I say that I came at a very early age to appreciate the importance of adequate medical service, and of adequate hospital services.

You may be interested to know that in the city where I was born, a city of 100,000 people, in the centre of two or three counties in which dwelt more than 1,000,000 people, there was exactly one doctor, and he an Englishman who was in the habit of seeing at his little mission dispensary approximately 30,000 out-patients per annum; and you may not be surprised to learn that he died of heart failure at the age of fifty. In that country I learned, as I say, at an early age how serious it can be for the great majority of the people to have no access whatever to the modern medical sciences.

It has been unfortunately true that, while the standards of the medical profession in this country are high, and while some excellent facilities exist in the larger cities for providing services to the public, a very large proportion of the Canadian people do not have adequate access to that service, and that, of course, is the starting point of the whole discussion.

Now, before I go any further may I say what may not be necessary, that I disclaim any special knowledge of this subject. I am a spokesman of the Ontario C.C.F., and there are those with the necessary qualifications in my organization who do have special knowledge of the question. What I am going to say to you tonight, attempt to say in a short space of time, is the policy that has been worked out by our technically qualified people, and endorsed in principle in a democratic way by the Ontario convention of the C.C.F. I am going to attempt to give you an outline;—an outline of the C.C.F. plans for the Province of Ontario with respect to health insurance and health services. That does not mean that I pretend to be an authority on the subject—I do not; and I rely on the advice of our advisers in these matters, which, as I say, has been accepted and endorsed by the C.C.F. as a political party.

I should, therefore, explain that we have in the C.C.F., and particularly in the Province of Ontario, a research committee, with a number of sub-committees doing research work on such subjects as the conservation of our natural resources, welfare servies or provincial financing and so forth; but we regard the subject of health planning as so important that our health planning committee is a full-fledged committee of its own. It does work in close co-operation with our research committees, but it is a full-fledged committee in the Ontario C.C.F. and its advice is taken most seriously by the leadership of the party. The majority of our committee are duly qualified medical men, fully qualified and licensed to practise in Ontario. The chairman of the committee, whose name I think I may be permitted to mention, is Dr. Nicholson, of the Banting Institute. Any member of that committee would be better qualified than I to discuss the technical details while, as I say, I am going to give you an outline.

There has been a great deal of discussion about the subject of health insurance, and like so many terms, that term has been used very loosely and generally. I will attempt not to use it loosely and generally; and, I say now it is necessary to recognize the distinction between a system of pure health insurance as already exists in a number of countries, and a system of state medicine which implies a unified and controlled system, controlled from the top,and a system of socialized medicine, which is different from the other two. In general what the C.C.F. is aiming at is a system of socialized medicine, which, I suppose, as far as the general public is concerned, could be referred to as a system of health insurance.

It is inevitable that there are going to be some changes in the basis of medical practice. The Dominion scheme which, as you know, is in the process of being born. . .the Dominion scheme, on almost any footing, will change to some degree the basis of medical practice; and I think you can take it, no matter what government is in power you will see, sooner or later, changes in the organization of the medical practice. The question of interest to you, as members of the profession, is what change or changes will bring the greatest benefits to all citizens and under what system will the status of the physician be the highest. When I refer to the status of the physician, I refer both to income, to opportunities and to working conditions.

Now we start with the premise, that it would be absurd and unfair to socialize the medical profession, while refusing to socialize anything else. That probably wouldn't work, and that is a symptom of the desire on the part of certain governments to throw a sop to public demands for social security at the expense of the medical profession. However, I do not intend to suggest that we don't believe in socialized medicine—we do; and I shall endeavour to explain what we mean. But in order to understand what we mean, I must make reference to the C.C.F. program as a whole, because C.C.F. proposals with respect to health insurance, or socialized medicine, cannot be fully understood unless there is some understanding of the C.C.F. program as a whole, and that program calls for collectivist organization of society on a democratic basis; and it is very clearly to be distinguished from a capitalist society, which is partially collectivist and partially democratic. It is also to be distinguished from totalitarian society, which is very much collectivist, but not in the least democratic.

We believe, therefore, in the social ownership of the means of production, and at the same time we believe in the democratic control of industry from the top to the bottom, and so in the democratic organization of the professional

services. Therefore, it is true,—and I will not do any beating about the bush of any kind—it is true as some people often say in an attempt to frighten you. It is true that the C.C.F. is a socialist party; but it is also a democratic socialist party! It is not advocating socialized medicine as a sop to the general public when they get radical-minded, but as a part of a general scheme of the socialization, as a part of the integration of other services and industries which we believe will be of benefit to the vast majority of the people.

Now the question is, "Under which system is the status of the doctor more likely to be maintained, and, if possible, improved?" As long ago as 1932 Dr. R. S. Pentecost, who died only the other day, in his presidential address to the Academy of Medicine in Toronto made this comparison, and I quote from Dr. Pentecost; "Those familiar with the 'Krankenkassen' in Germany tell us of the deplorable position in which the medical profession of that country finds itself today. In the pages of history you will read of the heroic struggle in the past 20 years to maintain the status of the doctor and the administration of that National Health Insurance Act. It is illuminating to compare the position of the doctor in a state having complete nationalization such as Russia, with his position in a state having nationalization of medicine alone. Information given us by lay and medical investigators, without political bias, would lead us to believe that the doctor in Russia today occupies a much more privileged position in relation to his fellow worker than in other countries. We are told, for instance, that the Chief of the Medical Clinic has the same privileges and receives approximately the same salary as the General Manager of the Trans-Siberian Railway."

This favourable position applies today as well in Russia, for, according to Dr. Henry Sigerist, the author of the book "Socialized Medicine in the Soviet Union", which is one of the most enlightening books on the subject I have ever seen,—according to Dr. Sigerist, the doctors receive salaries equalled only by the professional engineers, and surpassed by none. They have charge of the technical aspects of all health work, and supervise every phase of community life which affects the health of the people.

It is our intention that the medical practitioner's position in this Province, and if possible in this country, shall likewise be on a par with the highest. The medical profession is one requiring a high degree of training and skill, and is entitled to that remuneration. In the Province of Ontario of course we shall never be in the position to establish a completely socialized provincial economy; that must await national development, and a national process of socialization. However, it is true that the Province can go a long way on the road towards socialization, and we do intend in the Province to go as far as is economically feasible in the direct socialization of medicine including within the scope of that term whatever measures of health insurance may be feasible in the light of the Dominion Health scheme.

In these circumstances, within the limits of the Provincial jurisdiction we do not propose to completely socialize the medical profession, but as with other things, to bring a reformation to remedy as far as is possible, with our limitations, the difficulty imposed by existing health services at the present time.

The existing deficiencies are perhaps something about which I shall speak with some criticism; and I, therefore, turn to a different authority, speaking of a different country, which has, I think put in the right words a statement of the present difficulty. This statement was made by conditions in

Britain, not in Canada, but we believe it is, generally speaking, applicable to conditions here, and is therefore a good analysis, or a good diagnosis, if I may be permitted to use that word. I am referring to paragraphs 17, 18, 19, and 20 of the Draft Interim Report, Medical Planning Commission of the British Medical Association, which appears in their Journal of June 20, 1942. I am quoting—

"The general public find many grounds for criticism in the provision and distribution of medical services. The benefits of National Health Insurance are restricted to wage-earners, though the needs of the dependants of insured persons and other persons of similar economic status are no less. The benefits of this scheme are also severely limited in that they do not include as statutory benefits consultant, specialist, and institutional services. Another complaint is that economic status rather than medical need is felt to be too often the criterion of eligibility for medical service. The distribution of doctors, both general practitioners and specialists, is said to be governed more by the economics of the medical profession than by the medical needs of the various types of area. Consultant and specialist services are not always conveniently available, partly because practitioners engaged in them tend to concentrate in university centres and the large towns. The absence of co-ordination in medical services is a general ground of criticism by the public. The patient who requires treatment that cannot be given by his own doctor expects that his doctor should be able to secure that service for him. In fact, the general practitioner is not always provided with the means of securing for his patients all the treatment they may require.

"The sense of isolation is one of the chief grievances of the general practitioner. Many statutory authorities charged with personal health functions well within the scope of the general practitioner have preferred to exclude him from their organization. Hospital authorities, both statutory and voluntary, have often failed to foster his good will and to create the machinery necessary for full co-operation and consultation with him. In some directions his sphere of professional activity has been limited to such an extent as to endanger his general efficiency. Though verbal tribute is often paid to the important place of the general practitioner in the pattern of the country's health services, in practice statutory bodies do not generally admit him to partnership with them, and even tend to widen the gap between official medical services and the general practice.

"There is another form of isolation which the general practitioner experiences. The days when the doctor armed only with his stethoscope and his drugs could offer a fairly complete medical service are gone. He cannot now be all-sufficient. For efficient work he must have at his disposal modern facilities for diagnosis and treatment, and often these cannot be provided by a private individual or installed in a private surgery. He must also have easy and convenient access to consultant and specialist opinion, whether at hospital or elsewhere, and he must have opportunities for real collaboration with consultants. Facilities such as these are inadequate at the present time. There must also be close collaboration among local general practitioners themselves, for their different interests and experience can be of value to each other. Although this need is recognized by practitioners collaboration has not been developed as it should be.

"Other criticisms offered by general practitioners relate to the conditions in which they work. There are insufficient facilities for regular postgraduate study and the development of special scientific and clinical interest. The pressure of work, which may be ascribed in part to bad distribution, often leads to excessive hours of duty and insufficient holidays. Some criticisms of the present system concern finance. A considerable capital outlay is required before a doctor can establish himself in general practice. Those who have to borrow the whole part of the necessary money find the strain very great, and the proportion of practitioners who carry a heavy financial burden in their early years is growing. Various arrangements have been made by insurance companies and others to aid practitioners, but some of them have financially crippled the borrower. The absence of any compulsory or universal financial provisions for retirement and pension is the subject of complaint. Although such arrangements can be made privately by any practitioner who desires them and can afford them, it is felt that there should be some organized scheme which would give the general practitioner advantages in this respect similar to those enjoyed by practitioners in the public services.

"Other defects result from the existence side by side of two essentially different hospital systems—the individualistic voluntary hospital depending for its continuance on voluntary enterprise and staffed by medical practitioners who in most cases receive no direct remuneration for their services, and the municipal hospitals administered by local government authorities and staffed by practitioners who are paid officers of the local authorities."

The last sentence applies more to conditions in Great Britain than to conditions in this country. Now whether that be a correct description of conditions in Canada, at least it has a familiar ring, and in drawing up our whole scheme for health services we have endeavoured to devise a system which would remedy those deficiencies, which would, as far as possible in the present economic system, fulfil the criterion for satisfactory health services, which is laid down in the resolution on health services passed at the last provincial convention of the Ontario C.C.F.

I might quote, I think, from the preliminary words of that resolution—"Satisfactory health service should provide all citizens with complete preventative as well as remedial services to all ages, and should be so designed that the major emphasis is the achievement of positive health rather than the simple absence of obvious disease; further, it should insure to all personnel of health services opportunity and facilities for maximum improvement of their knowledge and skill under conditions of practice which allow sufficient leisure for recreation and study, and adequate remuneration and security."

That is the starting point of a rather long resolution on the subject passed at our last provincial convention. We are also looking further to the future, and trying to lay our plans in Ontario so that when the time comes the reformed health services of Ontario may be so defined as to administration and organization that they will, when a C.C.F. government comes into power in the Dominion, be transformed with the least possible confusion and delay into a thoroughly socialized medical system, which is a natural part of a socialized society.

In drawing up the broad outline of our whole provincial scheme, and I say again "broad outline" because the actual details can only be worked out with the Government in power, capable of commanding the services of adequate staff able to devote all their time and energy to perfecting the details; we, there-

fore, do not pretend to have a blue-print of the detailed plan, but an outline of the principles to be applied; and in preparing that outline we have examined the majority of existing schemes for health insurance, state medicine and reforms of medical services—those which are already in operation, and some of those which are proposed.

We hope that our scheme will be such that it will open many advantages to the average medical practitioner, and that under our scheme the status and influence of the medical profession will be improved, or increased rather than diminished. We intend to avoid the mistakes made in many health insurance schemes, of simply instituting a system of payment for physicians, which in most instances was inadequate, and whose administration burdened the physician with many irritating restrictions.

Those difficulties are inherent in a system that is no more than an insurance system, and as far as the insurance system goes it may do some good, but I am skeptical about its value. Health insurance alone is not much more than a statistical or actuarial operation. It may be sound in dollars and cents; it may be statistically and actuarially sound, but it will not necessarily enable everybody to obtain the necessary medical services, and it will not necessarily enable any better or any more medical service to be supplied. For example, to give you an obvious example, health insurance of itself does nothing to provide better facilities or more facilities for training doctors, or providing the country with more doctors if more doctors are needed.

Our scheme in general is a modified combination of an organization of health services as found in Russia, and that recommended by the Medical Planning Commission of the B.M.A. We intend to establish centres of group practice, called health centres, in accordance with the B.M.A. Scheme's dispensaries. In these centres would be housed the general practitioners for a given area with all necessary diagnostic and therapeutic equipment, secretarial assistance and desirable ancillary services. The offices of some of the consultants and specialists might also be in these centres, depending on the type of district and the proximity to a general hospital.

In urban areas each health centre would have offices for twelve general practitioners. and would serve approximately 10,000 people. That is calculated, the proportion of general practitioners to the number of the population which corresponds to the recommendations of the American Committee on Costs of Medical Care. Each group of ten to fifteen health centres would be affiliated with a general hospital staffed by consultants, some of whom would naturally be senior members of the group having offices in the health centre, and specialists who would be in regular contact with the members of the health centres. A similar definite affiliation would be maintained with the local public health departments.

The personnel of the Health Centres with the assistance of the staff of the affiliated hospitals, and public health departments, would be in charge of the preventative and curative work for their district—pre-natal and post-natal care, immunization and periodical health examinations, and of course the attendance on all cases of illness. They would also arrange for such regular special examinations, for instance, the periodical X-ray of chests of all individuals under their care for the early detection of Tb., as may be necessary for the public health program. They would also be in general charge of the program of health education for their district.

The staff of the centre would be assured of reasonable hours of work,

security against sickness and accident, pensions on retirement and definite times off for holidays and post-graduate work. All unnecessary house calls will have to be eliminated, and arrangements for office consultations will have to be encouraged to as great an extent as possible.

I might say in passing that I understand it has been found that under the municipal doctor system in Manitoba the proportion of house calls decreased decidedly—people learned to go and see their doctor at his office before it was too late. In rural areas the scheme of health centres would have to be modified to suit the density of the population. I am sure you will all appreciate that the problems of rural areas are very different from the problems of urban areas. The rural centres would vary in form of establishment, through a simpler organization based on small general hospitals, which are to be found in many country towns. The extremely remote, the municipal doctor areas in sparsely populated districts could be provided with consultant and specialists services by a travelling clinic with a salaried staff. And before reaching the specific suggestion of health centres, I might say that I have seen a good many hospitals, as a layman of course, very much as a layman, in China, and in the United States and in Canada, and in Great Britain, and also in Russia. I saw a health centre in Moscow, which I would think was in charge of too many people by our standards. It was responsible for the health of 40,000 people, but it was a most impressive institution, with apparently an active and aggressive and able staff, many of whom were doing entirely preventative work among the people of their district.

Now I come to the question of the choice of the general practitioner, with one reservation, and one reservation only, namely that no practitioner should have more patients than the number that the consensus of professional opinion decides is the maximum which can be handled efficiently in a work-day of reasonable length. Subject to that one reservation, each family should have a free choice of any general practitioner located in any health centre within a reasonable distance of his home. For densely populated urban areas it has been suggested that a reasonable distance should be about a mile. I don't know whether that is a little too short; it may be.

With regard to specialist and consultant services, consultants and specialists would be members of the staffs of the hospitals serving the district. Some would be full-time members of the hospital staff, some be part-time members of the centres as would family practitioners whose special interest, experience, and ability are such that they could qualify as members of the hospital staff. The consultants for specific cases would be chosen by the general practitioners and patients jointly.

Now we come to the general hospitals—all hospitals should be under the control of the professional health commission, in the Provincial Department of Health, and would naturally have to conform to the highest standard as to the staff, building and equipment. Because all who require hospitalization should receive the benefits of specialist care, the patient would be in charge of a specialist, a member of the hospital staff, but he would be expected to act in close consultation with the family practitioner as being the man with the knowledge of the background of the case. So there is no intention to exclude or dismiss the general practitioner upon admission to hospital. Although for the present and for some time to come, it may be necessary to keep the different types of hospital wards with their divisional scales of charges, all patients,

regardless of rate paid, would receive the same status, attention, privileges and duties, the only difference being in their actual physical surroundings.

We would hope ultimately to differentiate, if necessary, between patients on the basis of the nature of the case rather than the financial means of the patient. Convalescent hospitals, which appears to have been rather a neglected subject in this country, are we think, important; and a sufficient number should be established to take all convalescent and clinical cases as soon as the staff of the general hospital decides they are ready for that type of treatment, and get them away from the general hospital atmosphere. In addition, rest homes and camps, and sanatoria would be established for the cases requiring such treatment but not requiring ordinary hospitalization. And it is perhaps necessary for me to point out again that in Soviet Russia the establishment of convalescent hospitals and rest-cure institutions has been carried to an extraordinary length with great success.

Now, there is the little matter, which is perhaps of no interest whatever, but I think important enough to mention—the little matter of the method of payment, or what should be the methods of payment. There would be no direct payment by the patient himself to the professional personnel or to the hospitals. All the patient's expenses would be met preferably by taxation. We think the best place for them to come from is the consolidated revenue fund, without wasting any time about the trouble involved in collecting weekly or daily, or monthly or annual contributions from people. We have already the machinery for collecting taxes, and it would seem logical and efficient to use that machinery rather than set up one more machine in order to collect contributions for the support of the scheme. Where extra special hospital accommodation is desired, or desirable, the extra amount would be collected by the hospital as it is at present.

Regarding payment of professional personnel, in a socialized society there is no doubt about it, that all payments would be by salary, but we don't expect that that will be feasible for some time to come, probably for a long time to come. Certainly in a provincial scheme at the present the payment of general practitioners would be by combination of capitation fee and basic salary. The practitioner would receive a basic salary on which he could, if necessary, get along, and also payment computed on the basis of his work. The basic salary would vary with the experience and ability of the practitioner.

You may well ask, "Who is going to decide the experience and ability?" We believe that the practitioner's ability must be judged by the members of his own profession, by a board set up for the purpose (by the medical association) who would be asked to take into consideration, (1) His knowledge and skill as judged by the colleagues on the board, (2) The general public assessment of his ability as indicated by the number who elected him as their first choice for their family physician—it being, of course, quite possible that some doctors would get first choice of more people than they could take, so that t ey would have to ask people to indicate a first and second choice, and so on; the board would be asked to take into account in deciding the basic salary . . . eventually, not until after a period of time with adequate records—but eventually they should also consider, (3) The health record of the families under the practitioner's care. This basic salary would be continued after the practitioners were incapacitated for any length of time to give a measure of security equal to the loss in practice due to circumstances beyond his control. A system of retirement pensions would be inaugurated.

Payment of specialists and consultants who are full-time members of the hospital staffs, as distinguished from the general practitioner, preferably would be by salary; but it might be necessary for some time to allow a certain amount of payment by fees for services. And I might say that that is recognized in Russia. The individual's salary, again in the case of hospital specialists or consultants, would be determined by members of his own profession—a board, which would take into consideration, (1) The specialists's training and experience, (2) The number of requests made for his services by the general practitioner and, (3) (eventually) The health record of the cases under his care.

Coming to the question of administration, I understand there has been a good deal of controversy over the administration of the proposed Dominion Health Insurance Scheme—a number of groups in particular representing labour, agriculture and some others object to the predominance of the medical nature of the proposed commission, which gives the majority control to those in charge of providing services, with little voice to those receiving and paying for such services. These groups, labour and agriculture, claim that administration should be primarily in the hands of laymen, or lay groups; on the other hand, the representatives of the Advisory Committee on Health Insurance, and of course the medical profession claim that the general public has not sufficient understanding or knowledge of health matters to be able to administer a system of health services efficiently.

I think both of these views are in part correct; they are both right up to a point, but they both fail to take cognizance of the fact that there are two aspects of administration, (1) The general aspect, and (2) The technical aspect.

The general administration, which would deal with such matters as the amount the community are willing to spend on health services, the amount that they are willing to sacrifice in order to have the best possible health service, and all that kind of consideration; the general administration, and the general objective that you wish to reach in a given period of time, and the speed at which you wish to proceed, the amount of authority to be given to health personnel enforcing health measures, the determination of the best ways to prosecute health educational measures throughout the community, and all other matters of general concern should be administered by a democratic representative body on which the professional personnel of the health services would be represented, and members appointed by the various representative groups.

The government should take no part in naming these individuals other than this, the government must reserve the right to veto the appointment of men known to be antagonistic or hostile to the whole concept of the scheme of health service in the unlikely event that such individual should be nominated to be representative of an organization such as a farmers' organization or a workers' organization. In some cases municipal councils and also the professional organizations. . . these professional representatives would form a minority of the general administrative bodies, and would present the view of the professional health workers in the same manner as representatives of other groups, and would uphold the interest of other parts of the community which they represent.

That is all right for the general administration of the scheme, but for the purely technical and scientific aspect of health services, the administration should be entirely under the control of the professional staff, which after general direction has been given, would determine the standard of services both preventative and curative, the best distribution of general practitioners, specialists

and ancillary services, the number and distribution of hospitals, the equipment of health services and hospitals, and all such purely technical matters. That administrating body would be composed primarily, or entirely, of representatives of professional personnel of health services, and should be nominated by the professional association, which should themselves be recognized by law as representing the profession. This general scheme of administration would apply to all branches of administration with possible necessary modifications as might be necessary to prevent it from becoming too compulsory an administrative machine.

Now you will see that it is an attempt to provide for the democratic self-government of health services by the medical profession in collaboration with representatives of the community in which they serve. It is not state medicine; that is because it is not completely controlled from the top. The general standards might be prescribed or laid down by a provincial commission, but the manner in which that would be carried out would be a matter for these representatives, both of the profession and of the general public to decide.

I would like, before I conclude, to make reference to the importance of providing more and better facilities for medical education. We have in mind, of course, in keeping with our general educational program, financial assistance to students who deserve it, funds for the expansion of medical schools and research facilities, and more funds for research itself, and may also have what might be termed refresher courses to which I have already referred and for post-graduate work. It will of course be said by those who are critical of schemes such as this that it will cost a great deal of money; but our answer to that is that health, or the lack of health, already costs a great deal of money. It costs a great deal to keep the people of this country supplied with patent nostrums on the advice of a great deal of advertising, which also costs a great deal of money, and is an enormous economic waste. It costs a great deal of money to meet the cost of avoidable or preventable illness, and it is therefore a good investment for any community to spend money on a generous scale in the reorganizing and improving its health services.

Finally, may I point out again that all steps of the kind I have mentioned, with a view to enlarging, extending and improving health services are part of a general effort to reorganize our society so that it will function on a more efficient and more democratic basis, any steps, for example, legislative, social or economic . . . and I am now quoting from Mr. Grauer's report on public health for the Royal Commission for Dominion-Provincial relations—"Any steps, legislative, social or economic that help to do away with poverty are fundamental contributions to the field of public health. Thus minimum wages, and adequate housing may be as potent forces for public health as vaccine."

And it may also be said, as it was in this booklet which you may or may not have seen, Design for State Medicine, by Morden Lazarus, which originally appeared in the Canadian Forum—"Even a noble passage can be deprived of much of its meaning when considered apart from its context. So state medicine loses in flavour and value when considered apart from socialism. Socialized medicine must be considered a major driving force within an organized democratic society, relating the adjustments between economic and social requirements. In the long run the ultimate cannot be done in improving and maintaining national health standards until the serious economic ills to which we are now subject have been adjusted. It is useless to treat a patient only with medicines when he is suffering from malnutrition. It is useless to try to wipe

out Tb. when people are living in slums. It is useless to give the farmer medical care alone when he needs sanitary facilities. It is useless to try to diminish mental diseases when people are living under terrific economic tensions."

If you are interested in understanding the wider scope of the C.C.F. program I can also suggest that there is now available, off the press yesterday, an outline of the C.C.F. policy for this country; it is entitled "Make this your Canada", by David Lewis and Frank R. Scott. Mr. Lewis is the National Secretary of the party; Mr. Scott is Professor of Civil Law at McGill University, and National Chairman of the party. It only costs $1.00; and while it does not deal with the topic of provincial socialized medicine, it does give you a picture of what the C.C.F. is aiming at in broader terms, and on a national scale.

I am very happy to have had this opportunity of speaking to you, and I shall welcome any questions you may care to ask, although I can't guarantee that I will be able to answer all of them.

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1. QUESTION: It was pointed out in Britain that there are vast reformation plans, but there will be no money in the post-war to carry this out. In Canada with the cost of the present war to pay for, where is the money to come from to carry through all the proposed changes, keeping in mind that the money must come from the people?

ANSWER: That is an excellent question, it goes right to the heart of the economic problem, and the answer in one sentence is this, we can afford to do anything which we can afford to do physically. Too many people have been convinced by the financial pages of the newspaper, and they have come to think that what looks financially impossible cannot be afforded by the country. That is a fundamental fallacy. We can afford to do anything we can afford physically to do. The one thing we cannot afford to do is to refuse to make use of our labour power and of our natural resources, and of our great industrial plants which exist. If we refuse to do that, that is if we keep the large masses of our people idle, and a large part of our resources unused, then we shall not be able to afford the services that our people are demanding, such as socialized health services; but if we do make use of our labour, and resources and industrial plants we shall be able to afford the proposed services, and much more.

I know that some people are under the impression that the war effort is made possible by the spending of a lot of money, but that is very superficial. The war effort is not made possible by the spending of money; it is made possible by the application of human labour to our natural resources and to our existing industrial plants. That is the way in which goods and services get produced. They are not produced by money; the money is merely a medium of exchange, that is all. Some people don't believe that, because they say it is necessary for the government to borrow a great deal of money and raise a great deal of money by taxation in order to pay for the war effort, and it is a heavy burden, and many people fear we can't go on carrying a burden such as this, and we will have to stop spending money on this scale when the war ends. I understand and sympathize with their difficulty, but the facts are that the Canadian People must sacrifice at the present time—not for a monetary reason.

Money isn't the explanation at all. The reason is this, that a large part of our labour power, and a large part of our resources are being devoted to the production of the goods of destruction, and to the maintenance of our people in the fighting services who are not producing. A large part of our resources

and a large part of our workers, are now devoted to producing guns and shells, and ships, and planes, which do not add anything to the real wealth of the nation, but are very necessary for the purpose of winning the war. Now the difference between that situation and the post-war situation, is this, that if you have the same workers producing the goods of peace, producing refrigerators, and washing machines, and house furnishings, and new houses, and clothing and so forth, and hospital equipment, for that matter . . . if you have them producing those things, and if you have the people who are now serving in the Services producing real goods and services, then you do what: you add to the real wealth of the nation. If you double the production of useful goods and services, you make it possible to double the standards of the living of all your people. It is just as simple as that; and if you double your production of useful goods and services, you can afford to carry the cost of free service, such as socialized health services, wider educational facilities, and so forth.

2. QUESTION: Do you plan to stop the manufacture and sale of all useless patent medicines?

ANSWER: I can answer that in one word—the answer is "yes".

3. QUESTION: If the medical profession is to carry out the application of health insurance, how long do you expect a medical man to work in twenty-four hours, and for how many years?

ANSWER: We believe that one of the chief advantages of a socialized scheme, such as we propose to the medical men, would be that it would make your living and working conditions much more tolerable, much happier; it would supply you with more recreation, normal family life and more time to study. I used to know a good many doctors, a good many more than I know now, and all the doctors I ever knew were over-worked, and all their friends and everybody else knew they were over-worked; but it was always said . . . there was nothing that could be done about it; it was something that went with the medical profession, absolutely unavoidable. I think you can see with the system we suggest, with group health centres, with the general practitioner who would not be permitted to take on more work than he could handle, and with a guaranteed income, I think you can see that this ridiculous business of working at all hours, on all days, and nights, would come to an end.

4. QUESTION: In what way would doctors be allotted to health centres? Would there be any doctors in practice who did not choose to practise that way?

ANSWER: Obviously as a doctor came into practice there would be vacancies falling open in some places; and there would have to be negotiations between him and the authorities of the centres where there were vacancies. That is largely a matter to be worked out by the medical profession itself. Would there be any doctor in practice who did not choose to practise that way? —We think that it would be necessary for a time to recognize that right; we don't think, however, that many people will want to go on that way after they have seen the system in successful operation. However, if there are those who desire to continue in private practice by themselves, in the hope of making $20,000 or $25,000, we are in favour of letting them try it for a while. I want to point this out to them—let them be under no illusions; as we get a socialized society some people's income will be more than other people's income, that is inevitable and unobjectionable, but very large incomes will not be possible;

incomes such as $25,000 will be unheard of, that is, if we get a socialized society. Some people think if we avoid socialism they will still be able to make large incomes. They are just kidding themselves—there aren't going to be large incomes, even under the present economic system. I will tell you why: unless and until we get socialism there is going to be mass unemployment, and great wars from time to time; and the present government has found it necessary to levy heavy graduated income taxes, and they are not going to end when this war ends. And if people want to kid themselves that they can go ahead and make $25,000 a year, they are kidding themselves, because income taxes on larger incomes are not going to go down; even if Mr. MacKenzie King remains in power they are going to go up.

5. QUESTION: What facilities will be available for general practitioners in rural areas to change from local to urban centres?

ANSWER: Although it is not yet part of our official policy it has been suggested by some of our people, as I believe it has been suggested elsewhere, that the problem of finding enough doctors for the remote communities, for the sparsely settled areas, might be solved in this way: the younger members of the profession might be required to spend a limited time after graduation, and after getting some urban experience, they might be required to spend a limited time in these remote areas. There are undoubtedly hardships in that kind of work and the younger men can take it better than the older men, although exceptions should be made of those who have obvious qualifications for immediate specialization; but, by and large, the younger men would do that for a few years, and then be permitted to bid themselves into the urban centres. That is the suggestion, and I am not saying it is going to be part of our official policy, but it seems to me to have some merit. Certainly if it is true, as I am advised, that 28% of the people of Canada have access to 45% of the doctors in Canada, you can see that we have a rather unbalanced system; and you see also that the system hasn't got a sound economic basis. As a matter of fact no profession and no occupation has a sound economic basis if the members of that profession do not make a decent living unless there is a scarcity. If you can't successfully practise unless there are not enough doctors to go around, there is something wrong with the economic organization of your profession. That appears to have been the experience in Canada. Many doctors, it is true, have been able to make good incomes, but how have they done it? They have done it by working much too hard, and much too long, trying to look after too many people, and also on the footing that there aren't enough doctors available to satisfy the demands, or perhaps I should say the need rather than the demand.

6. QUESTION: (1) What is the C.C.F.'s idea of the personnel of the Health Commission? (2) To put in C.C.F. Health Plan is it your belief that it is only possible if the state as a whole is socialized; (3) In rural areas made up of several towns in close proximity to each other by the C.C.F. plan will one town have the doctors and the surrounding towns none? (4) Has the C.C.F. any idea how much the consolidated revenue will have to be increased by direct taxation?

ANSWER: Now, the first one, personnel of Health Commission. I haven't gone into details of that question, but I understand that what they have in mind is a commission composed of about three-quarters medical people and one-quarter other people with scientific qualifications of some kind. It wouldn't be a political commission—they wouldn't be politicians; they

would be people who have made a special study of the medical services, hospital questions and related problems. The second question—I wouldn't say that; I would say this: that we won't get the best results until we achieve a very large measure of socialism, but the question is one of degree. There will never be such a thing as a perfect socialized society—there never was such a thing as a perfect capitalist society, because there are always exceptions within the general scheme of things, and it is a matter of degree. No. 3—in rural areas would one town have all the doctors and the surrounding towns have none: that surely depends on circumstances. In the first place it depends on the population of those towns. We have in mind, as I said, health centres serving each 10,000 people, approximately, with twelve general practitioners attached to that centre. As you can see, it would depend to some extent on the distance each town was from the other. As I pointed out, we cannot institute the same scheme as we institute in a big city or a large town; you have got to modify it to fit the rural conditions. The final question—"How much it would cost out of the consolidated revenue fund . . ." That is up to the general public—that depends on what standard of service the general public really want. If they are prepared to demand the kind of service I think they ought to demand, it will cost a great deal of money; but it will be money well spent, and will probably cost them much less than it is costing them right now.

7. QUESTION: How will the public demand for twenty-four hour service by each doctor be overcome, granted all governments eventually accede to public demands?

ANSWER: The public will have to stop demanding twenty-four hour service; that is all there is to it. In that connection may I say this, that one of the suggestions I didn't mention in my speech, because we can't refer to everything, was that, as a result of regular examination of everybody, a very useful system of records can be built up in health centres for every individual, and they can be transferred from one health centre to another when that individual moves, and over a period of years you will have a record that is really worth something . . . Not of examination every ten years, but of regular examinations, and that will enable the doctor to follow another doctor, to deal with less difficulty with another when called on for emergency. But the public will have to forget the idea they have got, to have one man for twenty-four hour duty.

8. QUESTION: Does your party propose to nationalize hospitals?

ANSWER: I don't quite know what that means. We do propose to put all hospitals under control of the provincial health commission. They may well be administered by local bodies—bodies locally chosen, on democratic basis, but they must all be socially controlled, that won't be permitting them their own sweet way.

9. QUESTION: How does your party propose to handle such patients as are now to be found in the public wards on a non-contributory basis?

ANSWER: They will continue on a non-contributory basis, in a natural manner.

10. QUESTION: Does your party propose to disturb in any way the present relationship between patient and physician—free choice by either party?

ANSWER: The patient will have a choice of his own physician, if the physician is available within a reasonable distance, but he can't have somebody that lives 50 miles away.

11. QUESTION: Does your party propose to have health insurance cover every person in Canada, if not, whom?

ANSWER: Yes, every person in Canada, that is, when our national scheme is instituted.

12. QUESTION: I would like to ask the speaker where nurses' services and other ancillary services, such as dentists—?

ANSWER: You may wonder why I did not mention that question; it is a very important one. I don't claim to know a great deal about it; although my sister is involved in it, and many of my relatives are involved in it. We consider that the nursing profession is an under-paid and over-worked profession, largely because the whole system of health services in this country is on an unsound economic footing, and that is particularly true of nurses. One of the first things we would do would be to insist on adequate remuneration for those people. We would of course be interested in improved training facilities, although we do not question some training facilities, which are very good indeed.

In regard to dentists, I am informed that the need for more dentists is more acute than the need for more doctors in Canada. Dental students should be subsidized as well as medical students; and I need hardly add, when we subsidize students we propose it should be done on a selective basis; what I mean is that ability should be the test, and we don't admit that anybody who has the money and thinks he wants to be a doctor should be able to get through merely because he may be able to work hard enough to get by.

13. QUESTION: Mr. Speaker, if one doctor were told to go to a certain area, and he refused, or didn't go, what would be his fate?

ANSWER: Well, you see the younger doctors would be entering the profession on this basis—they would be financed through their course, and at the end of that course, a long and arduous one by most standards, they would be receiving authority from the state through the professional authorities to practise medicine. Now that is a privilege conferred not on a person who is going to be irresponsible. People who are so irresponsible as to refuse to comply with the conditions on which they take training and receive assistance, just wouldn't be eligible to be licensed to practise.

14. QUESTION: What if his opinion differed from that of the Board that advised him?

ANSWER: He would have to take it or leave it. He doesn't have any choice in the examinations he is to write.

15. QUESTION: In that case he would go into another position, I suppose?

ANSWER: Well, he has the option. May I point out there is nothing new about that. There are certain standards now he has to comply with; if he does not comply with them he can't practise.

Minutes of Meeting Called by President J. C. Wickwire February 15, 1944

A meeting of the members of the executive of The Medical Society of Nova Scotia resident in Halifax was held at the Dalhousie Public Health Clinic, Halifax on February 15th, 1944, at 8.30 p.m. There were present Dr. J. C. Wickwire, President, Dr. H. K. MacDonald, Dr. W. G. Colwell, Dr. D. M. MacRae, Dr. N. H. Gosse, Dr. M. D. Brennan, Dr. H. W. Schwartz, Dr. W. L. Muir, and Dr. H. G. Grant.

The President, Dr. Wickwire, first called the meeting to order. He announced that the Lunenburg-Queens Medical Society had extended an invitation to The Medical Society to hold their annual meeting at White Point Beach and that the invitation had been accepted. The management have promised that they can accommodate one hundred and fifty and they also have buildings in which the scientific programme can be held.

The executive of The Medical Society of Nova Scotia will meet on Tuesday, July 4th, at 2.30 p.m. at White Point Beach. The general meeting will be held on Wednesday, July 5th, and Thursday morning, July 6th. The annual dinner will be held on Wednesday evening, July 5th. It will be informal with the ladies also attending. It was decided not to hold the golf tournament, although those who wish to play will have the opportunity to do so as there is a golf course quite close to the hotel.

The last part of the meeting was devoted to the scientific programme. The invitation of the Canadian Medical Association to send two speakers to our meeting was accepted and a list of names was sent to Dr. T. C. Routley, indicating our choice of speakers. Invitations were also sent to several members of The Medical Society of Nova Scotia to contribute papers.

The meeting adjourned at 10.30 p.m.

Personal Interest Notes

Dr. W. Alan Curry and Dr. C. E. Kinley of Halifax and Surgeon Captain Donald Webster, R.C.N.V.R. attended a war session of the American College of Surgeons in Montreal on March 17th. Representatives from Quebec, New Brunswick, Prince Edward Island and Newfoundland also attended. The programme included motion pictures depicting activities of the medical corps of the U.S. Army and Navy and discussions of war experiences. Captain Webster spoke on depth charge injuries, wartime medical hazards and problems of venereal disease were also discussed. At the afternoon medical sessions war wounds, decompression sickness, emergency medical service in war time disasters, medical service in industry and navy war service were among the topics discussed. Prior to a dinner forum session surgical problems in the Pacific area were discussed by Vice-Admiral Ross T. McIntire, Surgeon-General of the United States Navy.

Lieutenant John H. Budd, (Dal. '33) of the U.S. Army Medical Clrps, son of Mr. and Mrs. F. W. Budd, Halifax, has been transferred from the base hospital at Maddison, Wisconsin, to Atlanta, Georgia, where he will be connected with a surgical unit.

Dr. D. R. McRae of North Sydney addressed the local Rotary Club in February on "Prevention and Care of Eye Trouble in our Youth." He outlined the different problems which result from defective vision of childhood, stating that 20% of children suffer from defective vision.

The marriage took place in Bridgewater on February 14th of Miss Helen Kaizer, R.N., daughter of Mrs. Ethel Kaizer and the late Parker Kaiser, Bridgewater and Dr. Joseph Anthony Gallant, (Dal. '41) son of Judge and Mrs. Thomas Gallant, Gravelbourg, Saskatchewan. Mrs. Gallant is a graduate of the Children's Hospital. The honeymoon was spent in Cape Breton and they are now residing in Saint John, N.B., where Dr. Gallant is on the staff of the Saint John Provincial Hospital.

Captain A. D. McDonald, R.C.A.M.C., and Captain M. J. Chisholm, R.C.A.M.C., both at present overseas, have been promoted to the rank of Major. Major McDonald was born in Sydney August 5, 1909, graduated in England in 1937, and practised in New Waterford before enlisting. Major Chisholm was born in Margaree June 9, 1906, graduated from Dalhousie Medical School in 1934, and also practised at New Waterford before enlisting. Captain George H. Murphy, R.C.A.M.C. of Halifax, who a few weeks ago was given command of No. 2 Canadian Mobile Bacteriological Laboratory, has also been raised to the rank of Major. Major Murphy was formerly pathologist at Cogswell Street Military Hospital and later on, at Sydney. He went overseas eight months ago.

Dr. D. F. McInnis of Shubenacadie had a painful forty mile drive into Halifax the end of February to admit himself into the Victoria General Hospital. He had gone to Milford around three o'clcok in the morning on an urgent call, and on his return journey his car got stuck in a heavy drift of snow. He found it impossible to move the car under its own power so enlisted the aid of a horse team. As he was connecting a chain to the car one of the horses lurched forward suddenly and the doctor's left thumb was torn away. He applied first aid to his injury immediately and then started his long journey into Halifax.

The BULLETIN extends congratulations to Captain and Mrs. H. Ian MacGregor (Patricia MacLeod) formerly of Halifax on the birth of a daughter on January 27th, at Sydney, and to Dr. and Mrs. M.D. Brennan of Dartmouth on the birth of a son, Daniel George McBriney, on March 10th.

Obituary

Lieutenant-Colonel Joseph Hayes, D.S.O., M.D., C.A.M.C., died suddenly in Wolfville on March 2nd, following a heart attack. Dr. Hayes was born in Wingate, County Durham, England, March 23, 1864, and came to Canada in his early youth, and settled at Springhill. He attended Mount Allison Academy and University as a special student, and graduated in medicine from the University of Pennsylvania in 1888. In December of that year he married Maria Pippy of Springhill who died a year ago. He practised medicine in New York, Springhill and Parrsboro, and at the outbreak of the last war went overseas as medical officer of the 85th Battalion, Nova Scotia Highlanders. He was awarded the D.S.O. at Passchendale and returned to Canada in command of No. 2 Canadian Stationary Hospital.

He was secretary and organizer of the Nova Scotia Liberal-Conservative Association from 1908 to 1915 and Unit Medical Director for the Department of Soldiers' Civil Re-establishment in the Maritime Provinces from 1919 until the change of Government in 1921.

He became well known as the author of various medical publications, among them, "The 85th in France and Flanders," "Nova Scotia Medical Services in the Great War," and numerous public health and general articles published in pamphlet form and in the press.

Dr. Hayes was a man of broad sympathies, well read, cultured and a splendid conversationalist.

Surviving are two sons, J. B. Hayes, manager of the Nova Scotia Light and Power Company, Halifax, and Professor F. R. Hayes of Dalhousie University, and five grandchildren.

A funeral service was held at the home of his son, J. B. Hayes, Dutch Village Road, March 4th, at 10 a.m., and burial took place in the family lot in the United Church cemetery at Parrsboro that afternoon.

The BULLETIN extends sympathy to Lieutenant Colonel Thomas Lebbetter, Headquarters staff, Ottawa, on the death of his father, Mr. Michael Lebbetter, which occurred at North Sydney on February 23rd; and to Dr. G. G. Gandier of Dartmouth on the death of his wife on February 12th.