The Annual Meeting

Doctor Wilfred Caron, Surgeon, Quebec City and Doctor Jean-Marie Delage, F.R.C.P. (C.O. Quebec City) will accompany Doctor and Mrs. Renaud Lemieux on their visit to Nova Scotia.

The Programme Committee are very busy arranging an interesting programme.

The Ladies Programme Committee are also very active in their preparations for the entertainment of the ladies.

Proposals and Developments for Government Health Insurance in Canada

Presented at the annual conference of Blue Cross and Blue Shield Plans in Hollywood, Florida, April 12, 1956

Joseph A. McMillan, M.D.,
Executive Medical Director
Maritime Hospital Service Association

IN June of last year the Honorable Paul Martin, Minister of Health and Welfare for Canada, addressing a conjoined meeting of the British Medical Association and the Canadian Medical Association in Toronto spoke as follows:

"Down through the ages, to maintain the common health has been recognized as one of the great tasks of society. Institutions have been evolved to serve each of the basic needs of life, whether it be the establishment of a system of law, the preservation of spiritual and moral values, the education of the young, or the warding off of a plague. The health of the people is among the most important of these tasks, and the provision of adequate medical care is at once one of the most difficult. Because medicine is an art as well as a science, economic, social and cultural factors must be set alongside purely technical considerations. And this brings me to the important distinction that must be made between the technology of medicine and its organization. In technology we can include all the arts and skills of diagnosis and treatment that constitute the practice of the profession of medicine. Organization, on the other hand, embraces all of the arrangements, social and economic, by which medical care is brought to the individual."

In summing up this philosophy, and in pointing out that the organization of medical skills and the application of medical service to the people has lagged behind the brilliant technological progress of the past half century, Mr. Martin goes on as follows:

"You will all agree, I am sure, that the doctor is not alone in possessing the right to determine the nation's medical welfare — particularly when this involves, in addition to medical skill, questions of social organization that are, quite understandably, usually outside the province of his professional experience In attempting to work out this problem intelligently and responsibly, we must have the active co-operation and participation of the medical profession.....What is sought is not socialized medicine, but socially sound medicine — satisfactory medical care for every member of our society."

At this meeting, the Canadian Medical Association published a statement which said in part as follows:

"The Canadian Medical Association stated that it (1) reaffirms its long established policy of giving consideration to co-operating in proposals, official or unofficial, that are in the public interest and genuinely aimed at the improvement of the health of the people. (2) Will gladly participate in the formulation of programmes designed to make high quality medical services more readily available and which respect the essential principles of medical practice. (3) Approves of the adoption of the principle of contributory health

insurance and favors a plan or plans which will ensure the development and provision of the highest standards of health services, preventive, curative, and rehabilitative, provided the plan be fair both to the insured and all those rendering the services. (4) Having seen demonstrated the successful application of the insurance principle in the establishment of the voluntary prepaid medical care plans recommends the extension of these plans to cover all residents of Canada, with financial assistance from public funds where this is required. (5) Recommends, where it becomes evident that the voluntary medical care plans cannot achieve adequate coverage that provincial governments collaborate in the administrative and financial task of extending health insurance to all through the medium of the voluntary prepayment plans."

In October of 1955 at a meeting of the repre sentatives of our Federal Government and our Provincial Premiers, it was announced that in January of this year a full scale Government proposal would be made at a special meeting called for this specific purpose. In Canada, where two of the four major political parties are socialistic in objective, these are ominous and significant facts. All political parties in Canada have gone on record as favoring and supporting comprehensive Government sponsored compulsory health insurance with the widest coverage for all Canada, and this — despite the fact that Mr. Martin in the speech which I have just quoted admitted that "no less than fifty-nine percent of the Canadian people now have some type of prepaid protection against the cost of hospital care, while 36% carry medical care insurance of one kind or another." These figures do not include certain special groups which are the responsibility of federal government in whole or in part, such as our native population of Indians and Eskimos, members of the armed forces, war veterans, sick mariners and others.

Since you and I and all of us at this Blue Cross — Blue Shield conference fall into the second category of Mr. Martin's organization grouping, even though some of us may be in practice and therefore belong in the technological group also, I would offer for your consideration this morning, therefore, a short picture of the present situation in Canada.

Even though our two countries are traditionally exponents of our private enterprise system, they are already embarking on a large scale social service experiments. We have been exposed to such government operated services as the Canadian National Railways, radio and television. We have already accepted such government social security programs as unemployment insurance, family allowances, old age pensions and the like, and we may therefore be more prepared than you are for this new venture, despite the fact that our own constitution is so arranged that education and health remain matters of provincial concern and not primarily federal.

However, the federal government, as controller of the purse-strings of the nation has already concluded wide-spread and far-reaching arrangements with the provinces on grants of various kinds, some matching and some outright. A wide field of health service including venereal disease control, mental health and tuberculosis, poliomyelitis, cancer detection and treatment, construction of hospital beds, both for acute and chronic cases, as well as nurses' homes in conjunction with nursing schools, all these are already subsidized from federal funds. Even the provision of such equipment as X-Ray and laboratory

facilities and grants of money for the training of the professional personnel connected with these endeavours, including both medical, nursing, technical and auxiliary health personnel, have already been established for over five years in the preliminary provision of health services from public funds. During these years it has been the expressed purpose of our government to provide sufficient trained persons for the implementation of health insurance.

We now have over 16,000 doctors in Canada with a ratio of one physician for every nine hundred and forty-eight persons. Excluding federal, tuberculosis and mental hospital beds we have on recent estimate — 95,348 beds for the care of the acute and chronic ill with an over-all ratio of 6 beds per thousand of population. The latest statistics I can find indicate an over-all percentage occupancy of public general hospital — 76.4%. We have therefore been gradually prepared for recent developments.

In 1953 the Federal government offered to any province up to a maximum of $0.50 per person of provincial population per year, for the provision of diagnostic laboratory and radiological services at cost, and already this has been initiated in some areas.

In January of this year, the following developments occurred. I will just summarize them:

(1) The Federal government expressed its willingness to assist with technical support and financial assistance any province wishing to embark upon agreed phases of provincially administered health insurance schemes.

(2) Concensus of opinion on the part of the provincial authorities and the Prime Minister indicates that priority of intention should be given to the development of Plans to cover diagnostic, laboratory and radiological services and hospital care, and that only after the establishment of some form of hospital insurance, should further consideration be given to what additional steps should be taken.

(3) Such Insurance Plans should —

(a) make coverage universally available to all persons,

(b) include diagnostic services,

(c) provide that a limit be placed on any co-insurance or deterrent charges included in such programs.

(4) The Federal Government will pay to each Province which operates a recognized Plan a sharable cost amounting to 25% of the average per capita cost in the Province involved, multiplied by the population coverage. Such is the proposal made by the Federal government to the ten provincial governments only a few weeks ago. Since many of you are not familiar with this program, I should explain the following:

(1) We will not have a federally operated health insurance Plan in Canada, nor is it likely that we will have one over-all program. It appears most likely that we would have to have ten provincial plans, each one geared to the particular locality concerned. Six of the ten provinces must signify their intention to operate an acceptable plan before any will be initiated, and these six provinces must represent at least 50% of the total population of the country.

(2) If such approval of six provinces and 50% of the population takes place, the federal government will then develop the appropriate legislation which does not now exist. Mr. Martin, speaking in Calgary the other day, indicated that only one province has as yet expressed its willingness. However, since two other provinces have already provincially operated hospital

schemes of one type or another, it is presumed that at least these two also might be willing. Within the past month several of the provinces have initiated legislation which could be used for such an operation at a later date, and three others have appointed special committees to study these federal proposals.

(3) Much concern was expressed by most of the provinces, especially those now operating hospital plans, over the federal government's refusal to include costs of caring for mental and tuberculosis patients in the health insurance programs. In other words, no extension of money would be forthcoming to the provinces in these two specific fields. It has been recently stated that psychiatric care in general hospitals will not be covered.

(4) It is worth bringing to your attention that the federal government's contribution to the costs of hospitalization would be a specified proportion of sharable costs. Sharable costs would be determined on the basis of normal operating and maintenance costs, insofar as these related to standard-ward care only. Thus, sharable costs would not include capital costs, such as depreciation, interest, amortization of debentures, or to any extra costs that could properly be attributed to the provision of semi-private or private care. Any amount paid directly by patients through co-insurance, deterrent charges, per diem levies or any such arrangements could not be included under the formula for sharable costs. Costs of care provided under Veterans' administration, Workmen's Compensation insurance claims or any similar arrangement would also have to be deducted in determining sharable costs. The total cost of operation and administration would have to be borne by the Provincial government and could not be included for sharable costs by the federal government.

Coming down to the dollar and cents arrangement that such a program would provide the government statisticians indicated that because of the widespread differential in hospital costs across Canada from coast to coast, some provinces would get amounts of money that would equal more than 50% of their costs. This would result when the in-area costs were less than the national average. On the other hand, on the West coast for example, the percentage of over-all costs to be contributed by the Federal Government would be less than 50%. To make everybody happy the formula worked out in such a way that those provinces that got the least money percentage-wise have the highest per capita contribution. Percentages varied from 45 to 71 percent of cost contributed by the federal government and the per capita values varied from $8.77 to $12.84.

	Percentage of Case	Per Capta
Newfoundland	71	$ 8.77
Prince Edward Island	65	9.27
Nova Scotia	59	9.89
New Brunswick	57	10.21
Quebec	53	10.91
Manitoba	51	11.21
Ontario	49	11.77
Saskatchewan	47	12.22
Alberta	46	12.36
British Columbia	45	12.84

This obvious challenge to the very existence of voluntary plans, both Blue Cross and Blue Shield, cannot be passed over lightly. Although no specific mention has been made of medical care insurance there is every indication it would follow as the next step in such a program. The specific inclusion of wide coverage for diagnostic, laboratory and radio-logical services is a challenge which Blue Shield Plans and Blue Cross Plans should study with great care. In Canada it is estimated that the over-all cost for a complete service of this type would be provided for $3 per person. This would include both out-patient and in-hospital X-ray and laboratory services. It is a rather wide-spread feeling in Canada that this might well be the first step that will be instituted in the provision of health insurance. The federal government insists on this particular phase of operation and the belief is that it will prevent a great deal of the over-utilization so prevalent in hospital care plans at the present time. Most of the comprehensive medical care Plans in Canada provide such services when done under medical sponsorship, but do not make coverage available for this type of service for out-patient hospital care or when the service is provided by hospitals.

At the present time only three provinces have introduced any type of government medical care program. These are limited to Newfoundland, Manitoba and Saskatchewan and they involve only about 400,000 persons. In other words, although compulsory government hospital care Plans cover something close to 3,000,000 or about 19% of the population, medical care plans of a similar nature only involve about 2.7% of the population. Without burdening you too much about details of these Plans, I might simply say that in all cases where government has attempted medical care programs, the range of services instead of being widened with time has been narrowed, and it has been found that deterrent charges and other safe-guards had to be introduced. In contrast to this, the voluntary medical care programs have prospered, grown and enlarged their services all throughout Canada, and with private insurance at the present time offer services for almost 4,000,000 Canadians representing almost 25% of the total population. More than half of these Plans have extended their services into home and office care, diagnostic services in and out of hospital and medical care on a complete service basis without income limit. The co-operation and backing of the medical profession on the whole has been a highlight of this phenomenal coverage, under the leadership of Trans-Canada Medical Plans, initiated and supported by the Canadian Medical Association. In Canada it would appear that public demand and medical opinion both have indicated that diagnostic services should be prepaid. That some of these services may not fulfill the provisions for insurability of risks is not adequate reason for not including them in care plans. Pre-payment, not necessarily insurance, is demanded and must be provided. Trans-Canada Medical Plans have already gone a long way in this field.

Canadian medicine has gone on record as indicating that it feels that the Government should provide some contribution, at least, for the medical care of the indigent. Following along this line of thinking, five provincial medical societies have entered into agreements with their local governments to provide varying limited forms of medical care for groups which we categorize and speak of as the welfare group. These would include such people as receive pensions

or allowances from Government. So called catastrophic insurance has not received either attention or demand in Canada. Medical and hospital care Plans and governments have all unanimously decided that nothing should be done in this field at the present time. Considering such coverage theoretically as about the coverage of all health costs over 3% of income, Mr. Martin categorically declared to the House of Commons only about 10 days ago that such coverage would require constitutional amendment, be almost impracticable to administer and not reach a large body of people requiring protection.

The latest experiment in government sponsored health insurance plans was announced only a couple of weeks ago in Newfoundland. Although no details are as yet available, the Provincial Government in that area has announced that it is prepared to provide a hospital, medical and dental care plan for all residents of Newfoundland of sixteen years and under. I have been unable to get any concrete information about this proposal, nor does the medical profession in that area have anything definite on it at this time.

It would be unfair to close these remarks without some reference being made as to the methods used to finance these rather extensive health insurance Plans.

Although various methods have been proposed — per capita tax, sales tax, etc., I believe it now appears that Government thinking at all levels is that health insurance funds will be derived from consolidated revenue.

From these necessarily rather sketchy outlines of the proposals and programs now existent in Canada covering the various phases of health insurance, certain general conclusions perhaps can be drawn. These are entirely my own and for that reason have no official value. I offer them to you in an attempt to point out the type of challenge which we, in Blue Shield, must necessarily face in the light of such developments. Similar happenings may occur in your country. The fact that as yet no hospital or medical or prepayment Plan personnel have been invited to sit in on these discussions has always meant to me that health insurance in Canada no longer is a medical hospital insurance, or even economic problem, but has passed into the realm of politics as a purely political issue. I have yet to be convinced personally, that there is anything concrete going to come out of this latest development in the very near future. The basis for such an opinion is as follows:

(1) The federal government has so arranged things, that the provincial governments must first set up their scheme as a project before receiving any money whatsoever from the federal government. This means that provincial governments must find revenues which would be out of all proportion to their regular provincial budgets before the federal government would come in.

(2) In all of the preliminary talks it was indicated that the arrangement so favored the federal government that it would get all the credit and pick up only an unreasonably small percentage of the price tag. It was even mooted, for example, and this was not pushed very hard at the latest conference, that as far as hospitalization goes, the sharable cost of the federal government might only be accepted to the utilization of about 1,600 patient days per thousand persons covered. If the province's utilization averaged higher than this for active hospital services, the provincial government would have to pick up the whole remaining price tag. This would be most unacceptable.

(3) Very strong opposition has developed to the failure of the federal government to include tuberculosis and mental disease in the program. Moreover, the use of deterrent charges which have proved so necessary in all of our Canadian experiments have been frowned on by the federal government to such an extent that the total charge for such deterrent features would have to be borne by the provinces' share. No existing plan therefore meets present federal proposals.

(4) Since no further legislation is being enacted this year at Ottawa it must necessarily be one year before any federal enabling legislation might institute health insurance. There was no final agreement a few weeks ago on the federal-provincial arrangement for tax sharing and there is not likely to be any activity in this line this year.

Since the total over-all proposed cost for health insurance in Canada is based on approximately $40 per head of which $16 is for medical care for diagnostic laboratory and radiological services and the remainder for hospitalization, it would appear that certain general trends will have to be followed by medical care plans in the immediate future.

First of all, it is pretty generally accepted that all prepaid medical care plans in Canada will have to beam their services to all the people. There is nothing to indicate to us that income limits are going to be of much permanent value. Although voluntary prepayment plans cannot possibly provide services for those who have no ability to pay, nevertheless it becomes more and more imperative that both group and individual enrolment must be extended so that if income limits are used, that they be high enough to be realistic.

It is my belief that we must explore now — without delay — provision of diagnostic services. Medicine must come up with an answer to the problem of how these must be paid for, but at the same time organized medicine must not be blind to the fact that chemistry, physics, radiology and other technical aids to diagnosis are not professional services as such, and can be provided cheaper in volume without any loss of professional efficiency. Safe, sound and unemotional leadership in our Profession should provide this answer in a manner acceptable to all. If such services cannot be insured in the strict sense, then let us develop this part of our health package on a cost plus basis with the professional end of the deal being a charge to medical care on a service basis.

Blue Shield Medical Care Plans should not be awed by any of the proposals or developments which I have mentioned. Voluntary prepayment plans in Canada and the United States are still away out in front both in theory and in practice, and still offer the only sane, practicable method of prepaying health care according to the dictates of the principles under-lying our national character. We should not be timid about pointing out the dangers and fallacies of much of the political propaganda that confronts us on all sides. Only a few months ago when the Saskatchewan government wanted to extend its medical care coverage to another health region involving almost 200,000 people, the prepaid medical care Plans in the area and the doctors made an all-out commendable and highly successful opposition to the government's proposal, pointing out carefully, accurately and without any emotion whatsoever, the advantages of voluntary prepayment, its adaptability to the changing needs of the population, its more economical method of operation, and the advantages

of its non-political nature. So successful was this effort, even in a Province whose government has been elected time and time again on a socialistic platform, and with people who had ample knowledge of government sponsored hospital and medical care in the next health area, nevertheless, as I say this campaign by organized prepayment plans was so successful that the populace voted against government operation of a medical prepayment plan almost six to one in both rural and urban areas.

Over-all government operated health insurance plans are not inevitable. On the other hand the needs of the people must be satisfied — they want prepaid health care and they will get it on a voluntary basis from Blue Shield Plans just as long as, and only as long as our Plans are courageous enough to stay out in front in the development of ways and means of providing the best form of prepaid medical and hospital care. Developments in Canada should at least stimulate our thinking — remotivate and rededicate our purpose, and particularly should justify our leaders to a strong positive promulgation of the almost sacred principles on which the Blue Shield movement was founded and still operates. In the face of today's political pressures it is useless to decry government health insurance or to use a negative approach in selling Blue Shield. Blue Shield should solve all of the small and probably nuisance problems which engage so much of our time and our attention and courageously come forward with sound widespread uniform and attractive service contracts with which neither private insurance or even governments can compete. We should no longer oppose Health Insurance — we are Health Insurance. Let us tell this to all the people again and again, with better contracts, more widespread coverage and the world's best medical care at reasonable cost.

Haemorrhage in Pregnancy**

B. Tenney, M.D.,*
Boston, Mass.

HAEMORRHAGE in pregnancy is, of course, a fairly broad field, so to-night I will confine my discussion to the subject of haemorrhage in the last trimester. At the present time, we class haemorrhage in the last trimester into three principal groups — the same two old stand-bys — placenta previa and premature separation of the placenta. In recent years, a third factor has been added — so-called rupture of the marginal sinus.

I think we might briefly discuss rupture of the marginal sinus, first, because that is rather an innocuous type of trouble, compared to the other two. It is a fairly indefinite type of lesion and I think it is frequently used to explain a haemorrhage for which no other cause can be found. However, in spite of that there is a definite entity of rupture of the marginal sinus. As you all know, a great deal of the maternal blood or the blood from the placental pool is collected from various veins and returned to the marginal sinus, which is a large venous structure that pretty well surrounds the placenta. In certain types of placentae, particularly the circumvallate type, and also in those with a low implantation of the placenta, the onset of labour or even with rupture of the membrane previous to the onset of labour, may cause rupture of the sinus. The diagnosis is difficult to make, previous to delivery, and somewhat difficult to make after delivery. But, there are a few important points; one is that rupture of the marginal sinus is never a serious type of hameorrhage. The problem is to rule out placenta previa. If you can rule out previa and premature separation you do not have to worry too much about bleeding from the marginal sinus. The clinical picture is one in which the patient bleeds fairly steadily throughout labour and delivery. The haemorrhage is never severe, in my experience, but is just enough to bother the obstetrician and to make him wonder if something else is happening. The actual diagnosis is made following delivery, when you examine the placenta. If you do examine the marginal sinus you will see a definite rupture with a blood clot protruding from it. There is a good deal of argument about this particular entity. Some people deny that it happens often. Others claim it happens quite frequently. But it does explain certain cases of bleeding, which you have all seen for years, during labour and delivery, which apparently had no other explanation.

Once previa and premature separation are ruled out you do not have to worry too much about this particular problem.

Haemorrhage during the last trimester is a very serious complication. It is a problem that is responsible for a certain amount of maternal mortality during any given year and usually we feel that two things are present if there is a disaster involved. One is that the patient does not report the condition to the physician early enough, and the other is that the physician does not recognize the seriousness of the condition in which he is involved. Clinically speaking, we try to divide haemorrhage into three types. If a patient is admitted into the hospital in the last trimester, if she is haemorrhaging severely,

* Director of Obstetrics and Gynaecology, Boston City Hospital.
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if she shows signs of blood loss approaching shock, or if the haemorrhage is uncontrollable at the time, there is only one treatment for that patient and that is to deliver the baby as quickly as possible and deliver the placenta and stop the source of haemorrhage. We try to teach our own residents that this type of case is an acute emergency. . It may be either a premature separation or placenta previa, but the problem is the haemorrhage, an acute and severe haemorrhage that is continuing and endangering the life of the patient. There is no need to make a differential diagnosis. The important thing is to deliver the patient immediately, in the most safe and suitable way. In some cases this is by Caesarian section, which is certainly the quickest way of stopping any type of bleeding involving the placenta. It takes a great deal longer to get hold of that placenta and deliver it from below, than it does from Casearian section. In our experience, however, it is only about five or ten per cent of cases of either abruptio or premature separation or placenta previa in which this severe and dangerous type of haemorrhage takes place.

A more common type of situation is a patient coming in with moderate bleeding. When she has not bled severely enough to endanger her life, and does not show any change in her blood picture there is a very definite importance in making a differential diagnosis. As long as your hand is not forced by profuse haemorrhage, the question of differential diagnosis does become important. Of course, in haemorrhages of any type, immediate replacement of blood is extremely important. That is certainly true, in my experience, and I imagine everybody else's. It is quite difficult to tell the amount of blood loss a given patient has had before you see her. It takes a certain period of time for the blood dilution, or in other words, for a change in the haematocrit or haemoglobin. The fact that a patient comes in, following a severe haemorrhage, with a fairly normal haematocrit is no actual indication of the amount of blood she has lost. It takes a certain amount of time for that blood to dilute and you must treat the patient from clinical appearance and clinical symptoms — pulse rate primarily. Blood pressure is a very unreliable sign of haemorrhage. As all of us know blood pressure does not change in a patient that is bleeding, until the patient is pretty well into shock. If you wait for a fall in blood pressure, the patient may be in shock before you start your blood replacement. It is also very definite that blood replacement and its efficiency depends on the interval between the time of blood loss and blood replacement. Many studies and clinical experience have shown that the sooner you replace blood, the less blood it takes to bring the patient back into a proper circulatory condition. If, as we occasionally see, a patient that has been bleeding outside the hospital for possibly twenty-four hours — thirty-six hours or even forty-eight hours — before realizing the seriousness of the situation, and she comes into the hospital, even though her blood pressure is all right, even though her pulse is not showing any marked change, it takes a great deal more blood to get that patient in good condition than the patient that appears immediately after the haemorrhage. . I think that is a very important point to remember. It has been emphasized by many people, but it is still a clinical point of great value.

The classical picture of placenta previa, of course, is painless bleeding in the last trimester. However, painless bleeding in the last trimester varies

a great deal in amount and the diagnosis is not always clear from the clinical history. I think one of the most important clinical findings and symptoms in the history is the fact of previous haemorrhages. We rarely, if ever, see a placenta previa come into the hospital in haemorrhagic emergency that has not bled previously during her pregnancy. Now that is a perfectly natural thing because a placenta previa is present, so to speak, practically from the time of conception until the time that it lets go and gets the patient into trouble. We are quite sure that many placenta previas are not diagnosed; in other words, many miscarriages, many premature labours, many terminations of pregnancy, before term, are due to placenta previa, which has caused trouble, irritation, and expulsion of the uterine contents. But the type of entity we are speaking of is the patient that probably has had a little spotting off and on throughout her pregnancy. At approximately seven months she has a small haemorrhage. If she has been properly instructed in her prenatal period she will notify the doctor and the doctor will send her into the hospital. One thing, at this point, I would like to emphasize. That is that there is no place for treatment of haemorrhage in the third trimester of pregnancy in the home. The only treatment is immediate hospitalization. We still find doctors that insist on packing the vagina or doing something like that before sending the patient to the hospital. If you think of your anatomy and physiology, you realize how ridiculous that type of treatment is. One cannot reach the source of the bleeding with packing. Not only do they not control the haemorrhage, but they obscure the amount of bleeding. They potentially induce infection into that uterus and therefore, again, the only treatment for a patient who starts to bleed in the third trimester, is to get her to the hospital just as fast as possible.

Now in dealing with placenta previa, we have a rather different situation than we have with abruptio placenta. A placenta previa, as you know, varies in extent and area; it may be either marginal, partial or complete. From the history of the bleeding, you can say that complete previa or central previas haemorrhage more than the less extensive previas; but that is not always clear. Another thing to remember is that in placenta previa loss of blood is entirely maternal. The loss of blood does not affect the foetus until the maternal loss of blood is sufficiently great to cause anoxia to the foetus itself. There is no change in the foetal heart or foetal embarrassment in a placenta previa unless the maternal haemorrhage has been severe. Actually there is no hurry as far as the foetus is concerned, in terminating the pregnancy. The only urgency is in relation to the mother. If the mother is not bleeding sufficiently to cause her any trouble, there is no pressure on the obstetrician to do anything immediately. Now, again, do not misunderstand me. Any patient that bleeds must be in the hospital. Once she is in the hospital, then, in this type of case you can take your time. By taking your time I mean, that in recent years we have come to assume an attitude — we call it a conservative attitude. I do not know whether that is the right name, maybe it should be called a radical attitude, but we have the feeling that in a placenta previa if a patient is not haemorrhaging severely, if she is in the hospital and if her foetus is not sufficiently mature for a good chance of survival, it is safe to wait on this patient. Not many years ago the mere sign of diagnosis of placenta previa meant an immediate delivery. That certainly has changed in

recent years and I think most all clinics have this conservative approach. When one of these patients is admitted to the hospital, if we make the diagnosis of placenta previa, we take a certain chance, if we do it from history and symptoms, because the only sign is painless bleeding.

Now, for instance, if a particular patient, say is twenty-eight weeks or thirty weeks along, we know that that foetus has little or no chance for survival. If we have nothing but painless bleeding of small amount, we are willing to take a chance that our diagnosis is correct. We do not examine these patients at this point. The moment you examine a patient with a potential placenta previa you are taking a chance. You may start haemorrhage. No matter how gentle or how careful you are, you certainly run a definite risk. I have seen a patient in the operating room, under double set up, just from inserting a speculum practically bleed out in ten or fifteen minutes. She was saved only by the fact that she was under double set up conditions and could be operated on immediately. You cannot examine these patients; you have got to take a chance on your diagnosis. So you put them to bed and watch them very carefully. Of course they are not allowed out of bed, except under close observation. The majority of them will carry on for two or three or even four weeks, with occasional spotting or staining. When you get a mature infant or an infant that is considered to have a better than even chance of survival, you can take the patient to the operating room and examine them under double set up conditions. If you do start a haemorrhage at that time, you can handle it. If the treatment appears to be rupture of the membrane that can be done at that time. Every once in a while one of these patients, that you are observing, will let go with a haemorrhage in bed. In a hospital with proper supervision this is rarely a serious complication, because a Caesarian can be done within a very few minutes, and the situation can be controlled.

Thus you have the patient either coming in, say at thirty-six weeks or having been in the hospital for two or three weeks, until she has reached approximately that time of pregnancy the time has come to examine the patient, confirm your diagnosis and decide upon your treatment. When you come to this point, you have definitely come to the point of action. You are going to do something. The patient is taken to the operating room, with everything ready for a double set up, as we call it. Either with or without anaesthesia, depending on the individual case or the individual symptoms, you examine that patient. Now I think there are certain rules from then on. I think there is one rule which we certainly can abide by and that is — if you find a complete previa the only treatment is Caesarian section.

If you find a marginal or partial previa it depends entirely on the state of the cervix and the state of the patient. Generally speaking, if you have a favourable cervix and if placenta is only partial and you can get by the placental area to the membranes, rupture of the membrane is the treatment of choice. Now, rupture of the membranes, at least in our opinion, is the treatment for placenta previa if you are delivering from below. I was brought up in the days, and I guess Doctor Atlee was, when we were pretty radical or pretty dramatic in our treatment of placenta previa. The so-called Braxton-Hicks version was a very famous and favourite treatment in that day. That consisted of pushing your fingers through the cervix, dilating it up, causing a great

amount of haemorrhage, of seizing the foot of the child and doing a version, pulling the foot through the cervix, tying a cord on the foot, tying a weight on the cord and hanging the weight over the foot of the bed. Sooner or later the patient would deliver, usually a dead baby, and frequently would be in a state of shock by the time she was delivered. The other treatment that was common was the use of the Voorhees bag, which was a cone shaped bag which you put through the cervix, again sometimes with considerable haemorrhage. Once the bag was in, it was filled with water and distended and then again a weight was tied to the bag and the pressure was put, theoretically, on the placenta. It stopped the bleeding and at the same time dilated the cervix. Once the bag came out, you were supposed to deliver the child. There again there was a terrific foetal loss, there was occasional rupture of the uterus, there was considerable haemorrhage. The bag, though not completely, is certainly on its way out along with Braxton-Hicks version. To-day we feel that we get just as much pressure on the placenta from a presenting foetal head as we did from the bag or from the version with the traction on it, in any previa that is sufficiently favourable for induction from below. That is the procedure of choice and the safest, both for the mother and child.

The so-called Willets forceps are used in a good many clinics. That is still, I think, an accepted method. It is simply a pair of forceps which grasps the foetal scalp. A cord with weights attached is fastened to the forceps increasing the pressure against the cervix. This does not injure the foetus like the other methods. It possibly gives you a little more pressure on your placenta and many clinics still like that procedure. However, in our own hands we have found the simple rupture of the membrane does equally well. Once that has been accomplished there is rarely any serious or severe haemorrhage during the labour and the results are very good. When your baby is delivered, you still run a very definite risk in placenta previa, because the placenta is implanted in the lower uterine segment and on the cervix.There is very little, if any, decidua between the trophoblast and the uterine wall and therefore the trophoblast, the same way as in the placente accreta, invades the actual muscle and tissue of the uterus, and in many cases you have acually a refore the trophoblast, the same way as in the placenta accreta, invades the actual muscle and tissue of the uterus, and in many cases you have actually a placenta accreta with placenta previa. That means difficulty in separation of placenta, it means haemorrhage in many cases. Following delivery of the child you frequently have to do something further to handle this condition; occasionally you have to go as far as hysterectomy to stop the bleeding in some of these cases. Most of them will respond to less radical treatment.

I have not asked Doctor Atlee about this so he may be entirely on the other side, but we are against packing the uterus in our clinic for any of these haemorrhagic states following delivery. We feel that we do better if we simply use bimanual compression, because the condition is less disguised, and the haemorrhage is evident. It is more physiological to try to get the uterus to contract than to put a big pack in, which prevents the uterus from contracting and also conceals the amount of haemorrhage. If you have a doctor sitting with the patient and holding the uterus, bimanually, the haemorrhage is visible and evident. He is not going to leave the patient until that haemorrhage

is under control. He is not going to go and see another patient or go to another hospital — because he cannot — the patient is bleeding. On the other hand, we have seen too many cases where a patient is packed following delivery, for one reason or another. The haemorrhage is obscured. The general condition of the patient is good. The doctor leaves and the next thing he knows he gets a call from the hospital that the patient is in shock. This is a very debatable problem and if Doctor Atlee disagrees with me I know he will disagree strongly, because many of my friends and colleagues also disagree strongly with my opinion on the subject.

Now, just to finish up placenta previa. Aside from the haemorrhage, I think a most important sign is the engagement of the foetus. If you have a floating head, if you have a transverse position of even if you have a breech and if you have your bleeding, it is an added indication that you are dealing with a placenta previa. I must admit that we have been very unfortunate in our experience and trials with X-ray to ascertain the position of the placenta. Possibly here you have had more success, but certainly our results, trying all the accepted methods of placentography, have been very disappointing. In fact, we have reached the point now that we do not dare admit a patient to the hospital, take a picture trying to localize the placenta and treat the patient according to the X-ray report. We feel that way simply because we have been mistaken — we have had mistaken reports — so many times. We have had patients cleared who had previa, and we have had patients reported as previa which were not. We do not feel that, at the present time, until something new develops, we can rely very heavily on placentography.

Premature separation of placenta, abruptio placenta, ablatio placenta, or whatever term you choose to use, is the other, acute and serious haemorrhagic problem in the third trimester. Half the cases of premature separation of placenta happen in patients with clinical pre-eclampsia. In fact, if you have a patient with clinical pre-eclampsia you must consider the danger of premature separation as a part of your estimate in the treatment of that patient. However, half or even more, according to statistics, separate without any clinical sign of pre-eclampsia. Some people feel that premature separation is a symptom of pre-eclampsia even though the other symptoms are not present. That still is a theoretical assumption. A premature separation is not characteristic of essential hypertension. It is not chascteristic of patients with renal disease. It is characteristic of patients with pre-eclampsia. Many causes have been mentioned during the years of premature separation, such as a short cord, blood dyscrasia, trauma, but I doubt very much if any of these have any serious relation to it. One of the things which surprises me, in my obstetrical career is the amount of trauma a normal pregnancy can take. We see, at the Boston City Hospital, patients brought into the accident ward, in shock, that have been in serious automobile accidents, in all kinds of really severe trauma — head injuries and skull injuries — and they do not lose their pregnancies. They do not miscarry as a rule. They do not separate their placenta. A healthy pregnancy is something really terrifically strong and terribly difficult to upset by any traumatic experience. In premature separation a haemorrhage behind the placenta separates the placenta from its attachment to the uterine wall. This haemorrhage usually takes place in the spongiosa layer. We know that

it takes approximately one-third separation of the placenta to injure the foetus. Anything much over that will kill the foetus. If the placenta is attached low in the uterus and if it is the lower border that separates, most of the blood escapes from the uterus through the cervix. There is profuse external haemorrhage and very little internal irritation, spasm or pain in the uterus. On the other hand, if the separation is high up or in the upper part of the placenta, the blood cannot escape from the uterus. All the classic signs of separation will be present, such as pain, spasm, tenderness and possibly a change in the foetal heart. A separation of low implantation frequently is extremely difficult to differentiate from a placenta previa at examination. On the other hand, in classical separation, high up in the uterus, where the blood is largely confined to the uterus, the differential diagnosis is rarely of any difficulty. The uterus will react according to the amount of bleeding that takes place. If there is any serious haemorrhage in the uterus, which is confined to the uterus, you will have a spastic tender uterus, with increasing symptoms. If at least a third of placenta or more are separated there will be a failing foetal heart or possibly, no foetal heart whatsoever. If the separation is complete, there will be no foetal heart and very frequently or usually approaching signs of shock will soon enter this picture. Now all this is known to you, and really the problem is twofold — how about treatment? — and how about complications? Generally speaking, I think, treatment for premature separation of the placenta is delivery from below, other things being equal. Certainly, if you have a dead baby, following premature separation of the placenta, there are only two indications for Caesarian section. One is, of course, disproportion. The other is in the group I mentioned earlier, where the haemorrhage is so acute, so severe and continuous, that you have to do a Caesarian section to stop the bleeding. Usually, following the original haemorrhage, one of two things happen — either the haemorrhage quiets down or becomes less, or the symptoms develop and increase in the uterus. The original tenderness and spasticity develops into a board-like abdomen and frequently there will be a rise in the fundus as it fills up with blood from the premature separation. Blood in the uterus is a marked irritant, and therefore, frequently, just the bleeding into the uterus will start the patient in labour. If the patient enters the hospital in a situation of premature separation, if she is in labour, it is probably smarter to let her continue in labour, with proper blood replacement, during the labour and let her deliver from below. If she has a dead baby, the present feeling is that rupture of the membranes and induction of labour is probably the proper treatment of the situation. However, if she has a living baby, if the signs are sufficient to suggest a reasonably large area of separation, then in the time that one must consider Caesarian section for the sake of the baby. But even in these cases many people feel that delivery from below is preferable.

One of the reasons we used to do so many Caesarian sections for premature separation was because of so-called Couvelaires uterus. The Couvelaires uterus is the uterus in which the bleeding has been confined to the inside of the uterus. The pressure and other factors involved have caused an actual invasion of the uterine walls with blood and the blood dissects between the muscle fibres, eventually reaches the serosal surface. This uterus is a purplish mottled affair and it is a fairly impressive looking situation. Some of these

uterii, following delivery, would have severe haemorrhages. They would bleed uncontrollably, and we got the impression, many years ago, that a Couvelaires uterus should be removed, because of the danger of haemorrhage. That brings us to the new development in the problem which has come up within the past few years in the question of blood dyscrasia or afibrinogenemia. Haemorrhage in which the blood did not clot has been described years ago. There was a certain type of premature separation of placenta that continued to bleed during and after delivery. The blood would flow on the floor and did not seem to clot and there was no possible way of controlling it. The only way those patients were saved at all was by a hysterectomy, if done in time. This frequently involved a Couvelaires uterus and that is why we were all quite alarmed and felt this was a possible indication for hysterectomy. But in recent years, due to the work of many people, it has been definitely demonstrated that this is not a question of blood in the uterine wall or damage of the uterus, definite clinical entity. Now I will not get into that very deeply, but generally speaking, when the fibrinogen in the blood falls to a certain level the blood will not clot and therefore it will continue to pour out through the uterus in an unclotted state. There will be bleeding in other parts of the body. If you put in an intravenous, you are apt to get a large ecchymosis, involving a large part of the arm. These patients bleed through the gums and through the nose. Any slight bruise will give them an area of haemorrhage in the skin. It is a general condition. But the only open area, so to speak, the only open vessels involved, are in the uterus and that is where the dangerous haemorrhage is coming from. There is also another factor, which again is somewhat complicated. In addition to a lack of fibrinogen in these patients, there is present a certain lysin which even if the clot forms, is soon dissolved by the presence of this lysin.

If you follow the blood fibrinogen in these patients you will find many of them fall as the separation proceeds. Given a normal level of approximately 400 Mgms. — when they fall to 100 Mgms. they reach the clinical state of haemorrhage. We have found that many of them will fall to 200 or 250 without the clinical haemorrhage, but certainly they are progressing on the way. Briefly, the treatment for afibrinogenemia is the replacement of the fibrinogen. Fibrinogen is available. It is expensive. It is hard to get, but in certain centres it can be obtained. If fibrinogen is not available, the only treatment is massive transfusion of whole blood in the hope that sufficient fibrinogen will be given that way. A recent work appears to indicate that possibly the lysin is the more important factor, rather than the lack of fibrinogen and that again is another and difficult problem. But certainly in any case of treatment of separation of the placenta, the clotting of the blood should be carefully watched. A test tube should be taken, on admission, taped to the patient's bed at room temperature, and clot formation should be watched. If that does not take place, you are in trouble. But even beyond that, if the clot forms, you must watch it for lysin, which may take place anywhere from thirty minutes to an hour following the formation of the clot.

One other complication that we see occasionally following premature separation is renal cortical necrosis. You see it occasionally following acute infections, infected abortions and certain other entities, but, renal cortical

necrosis is something that occasionally occurs following premature separation of the placenta. It is probably due to some type of arterial spasm or due to loss of blood volume or some toxic factor. It is shown clinically by the rapid appearance of anuria and sometimes it is a fatal condition. But, fortunately, we do not see that too often. Afibrinogenemia does not always develop, but we must realize that it is always a potential problem in premature separation of the placenta. As a result, we have come to the feeling that a time limit should be put on patients between separation and delivery. Our present procedure is, if a patient comes in with a premature separation, to rupture the membranes, and eveything else being equal, try to stimulate the uterus with intravenous pitocin drip. If the patient goes into labour, which fortunately, most of them do rather readily and delivers, everything is fine. However, we feel that if these patients are not delivered in twelve hours, immediate delivery should be done by Caesarian section. This is to prevent the occurrence of afibrinogenemia and of renal cortical necrosis. We have good reason for that attutude, as I have mentioned, by following the blood fibrinogen levels in these patients, following separation. The great majority of them show a gradual fall in the fibrinogen level. They tend to approach the danger line and we feel that twelve hours is enough in the average case to wait for delivery. Fortunately most of them will deliver during that period.

Now, in conclusion. This is an old subject, and you have heard it many times. If I can leave one word with the young men here it is to take bleeding in the last trimester seriously. Do not, because the patient is smiling, laugh it off. It is true that occasionally you can get a little staining or spotting from an eroded cervix, but then it is also true that a little staining or spotting may be the first warning of a very serious, possibly fatal, condition in the patient. If you are ever involved in that situation, get the patient to the hospital as quickly as possible. If she is haemorrhaging dangerously and severely — terminate that pregnancy. If she is not, if she is just staining moderately or slowly, then you have time to make your differential diagnosis. Then you can add up the different factors involved and make your decision.

Thoughts and Reflections About Medical Education, Education in General and Synthesis in Medicine

O. J. Pudymaitis, M.D.,
Dartmouth, N. S.

ALPHA

"And God said, Let us make man in our image, after our likeness. . . So God created man in his own image, in the image of God created he him." (Genesis. Creation of Man).

OMEGA

The Beast of the Earth. . . "deceived them that dwell on the earth. . . saying to them that they should make an image to the beast. . . And he had power to give life into the image of the beast, that the image of the beast should both speak, and cause that as many as would not worship the image of the beast should be killed. And he caused all, both small and great, rich and poor, free and bond, to receive a mark in their right hand, or in their foreheads. And that no man might buy or sell, save he that had the mark, or the name of the beast, or the number of his name.

Here is wisdom. Let him that hath understanding count the number of the beast: for it is the number of the man. . . (Revelation, Chapter 13).

It would be dreadful to think that this is the path of mankind. . . from the image of God to the image of the beast. The Alpha and Omega, the beginning and the end of all things. To refute the spiritual-moral and to worship the mechanistic-materialistic only.

With the dawn of the twentieth century the *science* of medicine stood firmly on its feet. The germ origin of diseases, Mendel's genetic laws, the theory of immunization, the cellular pathology, the psychology of the unconscious are only a few examples among many other important achievements. And during the following 50 years the proud march went on: x-ray and radium, insulin, sulphonamides, liver therapy (B_{12}), penicillin, streptomycin, etc. The medical profession may feel very proud of its achievements, and is already at the brink of committing the ancient sin of *hubris*. . .

But how comes the awakening. All is not gold that glisteneth. . . Strange things happen to the doctor. He knows so much, has so many good therapeutics at his disposal. Why, then, do so many "stupid" patients run to the quacks? In Germany before Hitler there were 40,000 graduated doctors and already 20,000 "Kurpfuscher," quacks. In France there are 38,000 doctors, but more than 40,000 quacks. Pendulum swingers, clairvoyants, mesmerists, bone-setters, big quacks and little messiahs, — all are doing well. We have them here too. One of the most successful is Joseph Anatole Desfosses, in Montreal. From his mother he had learned a considerable lore of home remedies. His father had taught him a great deal about treating sick horses. . . He travels around the country, showers his leaflets from a plane to announce

forthcoming offices. His income averages $100,000 a year. Again, the "Hoxsey Cancer Cure." The Hoxsey Clinic in Dallas, Texas, pretends to cure cancer (for a $400 fee) with a pink and a black medicine, both containing an assortment of prickly ash, red clover blossom, cascara, potassium iodide, buckthorn, sugar, etc. The traffic is great, the business flourishes. The "Christian Science" — healers get still a large number of faithful through their new booklet "Healing Through Spiritual Awakening" and through their radio programs (Radio Boston, Mass.). The osteopath in Haverhill, Maine, keeps two assistants and secretaries to handle the traffic. And the old Indian in Shubenacadie has quite a few patients too. . .

Why all this flight from the graduated doctor to the "ignoramuses"? What is it the quack has and we do not possess? It is the strong faith in himself, the uncritical, blind fanaticism from which radiates the sureness of the quack. And it is the simple human "touch." On the other hand, there is the faith in him of the patient, disillusioned by impersonal doctors, who were unable to establish the necessary doctor-patient relationship. The human being looks still for something more than a purely mechanistic-laboratory approach. Or, why do so many patients get relief from the healing powers of Lourdes, or from a confession to a priest?

Here is the stumbling-block: faith and trust. It is at this point that the *science* of medicine halts. We can win back our patients only with the *art* of medicine. Indeed, there is much to be said about the modern trend in the medical profession and in the medical education in the last 50 years.

Firstly, there is the depersonalisation. The intimacy, the "human touch" between the doctor and his patient is often lost. A visitor in one of Canada's large teaching centers attended ward rounds for three weeks without seeing any teacher greet a patient with "Good morning!" "While medicine is getting better and better *in vitro*, it is growing worse and worse *in vivo*. The patient seems to be less, the test tube more" (Dr. Scarlett, Canad. M.A.J. March 1953). Nowadays many patients are over-investigated and over-treated. There is too blind a trust in the reports from the laboratory, from the x-ray departments etc. But we know that laboratories often err. In the U.S.A. every year from two to three million illnesses are wrongly diagnosed because of faulty laboratory tests and incompetent interpretation of x-ray and E.C.G. results. In 1947 the Pennsylvania State Medical Society, in co-operation with the Association of Clinical Pathologists, conducted a survey of sixty laboratories of that state. The results astounded the survey conductors. The range of error revealed was described as phantastic. Laboratory tests for cancer are still inaccurate. Tests for tuberculosis show from one to ten per cent error in stained smears.

Many operations are accomplished in an impersonal and stereotyped way. There are patients who never see their surgeons again after the operation. Add to this the matter-of-fact approach of the anaesthetist. . . But, what is to us a daily occurrence is, for the patient, a journey to the unknown! Patients are bled to exhaustion after innumerable tests, then they are refilled by substitution fluids. . . There are so many unnecessary torments for the patient! Needle biopsy of the kidney is one of the most recent "adjuncts" to medical diagnosis. Only about one-third of these biopsies were successful. The test

as a reliable clinical tool is now "dismissed." Another example; some clever doctor overburdens medical journals with a series of publications. He claims that a measurement of the serum lipoproteins provides a way to forecast the likelihood of human subjects developing coronary artery disease. An "impressive" terminology is invented: "atherogenic index," "alpha value", "accumulated coronary disease value". . . The result? No relationship has been found to exist between these indices or values and the severity of the disease (Canad. M.A.J. April 1, 1956). Refuted now is also the theory of the quadruple-linked genes (Fisher-Race theory) with its supposedly important predictive value and its cross-over theory to explain the distribution of the various "chromosomes" of the Rh-Hr system. . . How many unnecessary human suffering did these tests cause! Much blood-letting is now expected from the "methods of determining the activity of the SGO-T," i.e. serum glutamic oxaloacetic transminase (Mod. Med. of Canada, April 1956). The human being is too often used as a guinea pig, That's one point too where we differ from the quack.

Secondly, the increasing tendency to know "more and more about less and less." Specialisation in medicine, as in other disciplines, is inevitable and even good if for the trees one doesn't forget the forest. Of course, it's time now to stop further "dismembering". One has no wide, bright vistas if one concentrates on the anus only. Sauerbruch, the famous German surgeon, demonstrated in Munich a patient who was treated by an E.N.T. specialist. What was wrong I don't remember now, only what Sauerbruch finally said: "The ear specialist forgot that a whole man is joined to the ear". . . To R. Asher (Lancet, Aug. 27, 1949) over-specialisation is one of the "seven sins of medicine," together with obscurity, cruelty, bad manners, love of the rare, stupidity and sloth. And the Tenth Report of the Nuffield Foundation warns: "Over-specialisation is one of the evils which accompany the growth of knowledge and skill in a variety of fields. It tends to encourage a narrow and impersonal approach which is particularly out of place where health and welfare of human beings are concerned."

Depersonalisation and over-specialisation, — this drifting away from the patient as a human being, as a whole, is a typical sign of our times. It is an over-evaluation of the mechanistic-materialistic and negligence of the spiritual moral. We are drifting away from the image of God to the image of the beast. Cardinal and immediate changes are needed, beginning with the Kinderstube.

On December 29, 1940 Walter Lippman delivered his brilliant address "Education Without Culture" before the American Association for the Advancement of Sciences" ("The Commonweal," January 17, 1941). Here are a few excerpts from this address of paramount educational importance: "The western tradition is no mere record of the obsolete falacies of the dead, — it is a deposit of living wisdom." "The men who wrote the American Constitution and the Bill of Rights were educated in schools and colleges in which the classic works of western culture were the substance of the curriculum." "Those who are responsible for modern education — for its controlling philosophy — are answerable for the results. They have determined the formation of the mind and education of modern men. As the tragic events unfold, they cannot evade their responsibility by talking about the crimes and follies of politicians, busi-

ness men, labour leaders, lawyers, editors and generals. They have conducted the schools and colleges and they have educated the politicians, business men, labour leaders, lawyers, editors and generals. What is more, they have educated the educators. . ." — "Having cut him off from the tradition of the past, modern secular education has isolated the individual. It has made him a careerist. . . who must make his way without benefit of man's wisdom.". "The school sinks into being a mere training ground for personal careers."

But President Eisenhower boasts, "We have the best educational system in the world" (Time, April 16, 1956). Fiddling while Rome burns. . .

Education has to begin with the Kinderstube. Love and understanding, combined with discipline and authority, are the sine qua non, the basic requirements of a sound education. Even an occasional whipping will do good, maybe it will prevent in the future a much more severe electro-convulsive therapy and leucotomy. . . The child's mind is very receptive to a variety of influences. Without proper guidance it can be easily damaged in character and morality. The traffic in crime comics in the U.S. is terrifying. About 90 million copies are sold every month, and a million dollars a week are taken from the pockets of children. Is this the "finest educational system in the world?" Is this the meaning of the "freedom of the press?" On the other hand we see how the parents are misguided to teach their children or to "explain" their behaviour. Consider the torrent of so-called educational literature, "guides for parents," which is poured out for consumption by a thirsty, but uncritical public. One example: "Nightmares are a part of the Oedipal period, and when one probes deeply enough, they are invariably related to the child's adjustment to his parents, his discovery of sexual organs, curiosity about how babies are born, the desire to have babies, and the fears associated with these desires and discoveries". . . "Sleep walking is associated with some symbolic, unconscious problem. For example, it may indicate a desire to see what is going on in the parents bedroom". . . "Obesity in girls is commonly connected with pregnancy phantasies" (from "The Educational Problems of Children: A Guide for Parents", by Joseph and Zern, 1954). It seems self-evident that such an educational void must have a debasing and demoralizing effect.

Outside home and school too there is not much to be gained to-day in education and self-development. The whole society is running amuck. The "myth of conformity, the big lie of adjustment" (Dr. R. Lindner, Baltimore), "the sterile, unimaginative and shrill life of the society" (Dr. E. P. Scarlett) are factors which preclude solitude. But "it is in the solitude that the works of hand, heart or mind are always conceived" (Dr. Lindner). From this damage to the ego comes the loss of identity, which again leads to insecurity. We are in the grip of "security miasma" (don't fight against windmills, you soon will be taught to be reasonable: "Life insurance is one of the critical anchors of social order, patriotism and loyalty," — from an Insurance Calendar).

The American Institute of Public Opinion reports some sorry figures: 57% of the nation's high-school graduates have not read a single book in the past year. Asked to name the authors of twelve famous works—Gulliver's Travels, The Origin of Species, etc. — 9% of the college graduates could not give a single name, 39% could not name more than three. Walter Lippman gave us a gloomy picture of modern education in our higher and highest insti-

tutions. Sir Richard Livingstone warns also: "An education which ignores the humanities is disastrously incomplete" (B.M.J. Aug. 29, 1953). Doctors, men of high intellect and deep culture, wrote about medical education. The problem is recognized as urgent, although complex. In 1953 assembled the First World Conference on Medical Education. The July edition 1955 of the Canad. M.A.J. was chiefly concerned with medical education in Canada. All authorities agree in one point: education has to be based again on a broad cultural foundation.

True education is "the finest thing in the world;" it "fits you for nothing, but prepares you for everything; it "gives you nobility of character"; it "helps you not only to make a living, but teaches you too *how to live.*" . . These quotations are from an address by Dr. Flemington, President of the Mount Allison University, delivered at the annual meeting of the Halifax Medical Society on May 9, 1956. And he added one precious quotation from the Koran: "If I would have two loaves of bread I would sell one to feed my soul." We have many "loaves of bread," including cars, refrigerators, etc. The fortunate of us have even a lot of "loaves" put aside. But where is our spiritual recreation? Happiness is the activity of the soul, — says Aristotle.

University teachers with a broad cultural education can make their lectures more interesting by referring to history, religion, philosophy, to the works of literature and art. For instance, dealing with Pavlov's discoveries the teacher could tell the student about the great Spanish dramatist Lope da Vega, who already three hundred years before Pavlov gave an excellent description of conditioned reflexes (in "El Capelan de la Virgen"). From Adler's "inferiority complex" and "Arrangement" the teacher can go back to Spinoza ("One who despises himself is the nearest to a proud man"). Mendel's genetic laws will lead back to Goethe: "Nach dem Gesetz, wonach du angetreten, So musst du sein, dir kannst du nicht entfliehen." Comparative anatomy too will mention Goethe: os Goethei. The first recorded instance of the association of narcolepsy with obesity will lead to Dickens' "Pickwick Papers," loss of memory to "The Tale of Two Cities," etc.

The past is not dead. Thousands of books on education may not have been written at all, we would not miss them, but we would miss Plato's "Republic." That we are not yet intellectually dead, we have to thank the great men of Greece of the fifth and fourth centuries B.C. The spiritual ancestors of Copernicus, Galileo and Vesalius were minds shaped in the Socratic tradition. "Petrarch, Boccaccio, Machiavelli, and Erasmus, far more than the alchemists, must be considered the precursors of the modern scientific investigator. Likewise, Rabelais and Montaigne, who carried forward the critical philosophic spirit must be counted among the forerunners of the modern scientist." These quotations are from the book "On Understanding Science" by Dr. Conant, President of Harvard University. And, although a distinguished chemist himself, he adds: "With any idolatry of science I must confess I have little sympathy. . . In terms of general education, poetry and philosophy are of vastly more importance than science. . . A dictator wishing to mould the thoughts and actions of a literate people could afford to leave the scientists and scholars alone, but he must win over to his side or destroy the philosophers, the writers and the artists."

SYNTHESIS IN MEDICINE

"Nothing in the world is single;
all things in one another being mingle."

The study of medicine is the study of man. The first principle of medical art is to treat the patient, rather than his disease. The patient, the whole human being, is the concrete reality. We must always keep the general state of the patient in sight while observing and treating local pathology.

A short historical sketch will show us the different trends in medicine until the present times. Already the Neandertal man, some 50,000 years ago, left us indications of his medical skill. But all during the prehistoric period, and through the Sumerian and Babylonian cultures medicine was inseparable from religion and magic. Among the ancient Hebrews medicine as a science did not exist, disease was a punishment for sin. Even in Egypt medicine did not advance far beyond the "temple sleep." The Ebers Papyrus doesn't show the "remarkable standard of knowledge" which we find in some eulogistic statements. Medicine as art and science has its beginnings in Greece.

Aesculapius, or Asclepios, son of Apollo, was the god of healing in ancient Greece. Many temples were dedicated to him. The most celebrated were those of Cos, Cnidos, Epidaurus and Pergamon. Apart from a central shrine and sleeping place for the sick, there were in these temples baths, gymnasia, theaters, hostels, — like in many health resorts of modern times. The patient was received by the priest-physician, bathed in water from a local mineral spring, then anointed. He made then his offerings to Asclepios and went to sleep. His dreams were interpreted by the priest who prescribed blood-letting, laxatives emetica, etc. The cures were written down on a tablet and hung in the temple.

A century before Hippocrates started his teaching Pythagoras left his native town Samos (532 B.C.) because of the tyranny of Polycrates and migrated to Croton in southern Italy where he founded his Pythagorean order. This Crotonian school was also the cradle of scientific medicine in Greece. One of Pythagoras' pupils, Alcmaeon, both physician and philosopher, wrote several scientific books. On the basis of dissection of animals he recognized the brain as the central organ of mental life. According to him health depends upon an equal distribution of the qualities warm and cold, dry and wet, bitter and sweet, etc., in bodies, while the predominance of one of them caused illness. The Pythagorean principle of harmony too was accepted in medicine. Alcmaeon also made the first steps in the field of psychology, in that he distinguished between thinking and sense-perception (E. Zeller, Outlines of the History of Greek Philosophy). From a papyrus in the British Museum we know about another Pythagorean physician, Philolaus (his disciples Simmias and Cebes are present at Socrates' death in the "Phaedo"). To him the causes of illness are to be found in the bodily juices, the blood, the gall and the phlegma. An excess or a lack of warm or cold or food can also bring about an illness.

In 460 B.C., on the island of Cos, was born the greatest of all physicians, Hippocrates. During his long life-time (he was 90 when he died) he pursued the study of man and of his ailments. He left a great collection of medical writings, the "Corpus Hippocraticum." And he left us, doctors, the Hippocratic Oath, a code of medical ethics, which has been accepted ever since by the medical profession. We find here a declaration of medical responsibility and

standards of conduct, professional and moral. From the eight precepts of the Oath the first and the fifth, as not applicable now, can be omitted.

2. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.
3. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion.
4. With purity and with holiness I will pass my life and practise my Art.
6. Into whatever house I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, or freemen and slaves.
7. Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.
8. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the Art, respected by all men, in all times! But should I trespass or violate this Oath, may the reverse be my lot!

The words "purity" and "holiness" show us the ethical standard of the physician Hippocrates, as show also his two other sayings: "Nil nocere" (never do any harm), and "Salus aegroti suprema lex" (the highest law is the welfare of the sick). From physicians-to-be he expects: "Whoever is to acquire a competent knowledge of medicine ought to be possessed of the following advantage: a natural disposition; instruction; a favourable position for the study; love of labour; leisure."

With Hippocrates began a rational system of medicine. All magical and religious methods were discarded, as well as the idea that disease is a punishment for sin. About the "sacred disease," epilepsy, Hippocrates said: "It is not any more divine or sacred than any other disease, but has like them a natural cause and its supposed divine origin is due to man's inexperience." He taught that most diseases can be cured by restoring the disturbed harmony in the elements and humors of the body, and such restoration has to be carried out by the powers of nature assisted by the physician. "Natura sanat, medicus curat." But Hippocrates also knew about the importance of the mind influencing diseases and by no means discarded the possibilities of cure through "temple sleep." Hippocrates was a contemporary of Socrates, Plato and Aristotle. Socrates tells us about the Thracians, who knew that the body cannot be cured without participation of the mind. Plato recognizes the importance of the mind in healing: "The cure of a part should not be attempted without the treatment of the whole. No attempt should be made to cure the body without the soul. . ." Aristotle (384-322 B.C.) believed in the importance of balance in the humors of the body in the maintenance of health.

Five hundred years went by from the death of Hippocrates and we find the last of the great ancient physicians, Galen, in Rome. His authority dominated medicine for the next thousand years. He too was well aware of the

importance of the mind in the treatment of diseases. Speaking of temple cures he said: "We have proof that many serious illnesses can be cured solely by a shock administered to the mind." But it was now a millenium of stagnation in medicine, of theoretical systematisation and of dogmatic interpretation. Only due to the Islamic Culture the heritage of the Hippocratic medicine was not lost for posterity. The Renaissance in Medicine began with three great men: Vesalius, Ambroise Paré and Paracelsus. In 1542 the young Vesalius (he was only 27) published his famous "De humani corporis fabrica libri septem," with excellent reproduction of anatomical pictures from the human body. The authority of Galen was shaken. . . now only was it evident that Galen's anatomy was that of animals, not of man. Ambroise Paré (1510-1590) trusted only his own senses and his clear judgment. To him "experiencia" was first, "auctoritas" the last thing. He was the first to discard red-hot irons to stop bleeding, instead he invented the ligature. He too, like Hippocrates, believed in the "vis medicatrix Naturae," the healing power of nature. Paracelsus was born the year Columbus came back from his discovery (1493). His best known book is: "De origine morborum." At the University Basel he taught not to trust to any authority, but to one's own observation and experience. But when he started to lecture in German, instead of in Latin, it was too much for the University and he had to leave Basel at night. . . All through his life Paracelsus taught medicine in the Hippocratic tradition.

Only two more great physicians of the sixteenth and seventeenth centuries will be mentioned here: Servetus and Harvey. Michael Servetus published in 1553 his "Christianismi Restitutio," in which for the first time the pulmonary circulation was described. A few months later he was accused of heresy and burned at the stake. William Harvey, a contemporary of Galileo and Descartes, learned himself and taught others anatomy not "from books but from dissections; not from the position of the philosophers but from the fabric of nature." In 1628 he published his work on blood circulation "De Motu Cordis et Sanguinis in Animalibus."

Up till then medicine appreciated the reciprocal relation of mind and body; the psyche was not split from soma. The dichotomy started with Descartes' "Discourse on the Method," published in 1637. He insisted that in the study of man the soul and the body, metaphysics and biology, should be kept apart. He compared the animal body with a complex machine. And soon follows De la Mettrie's "L'home Mashine". . . It was due to Descartes that all functions of life, physical as well as intellectual, were finally regarded as the products of physico-chemical changes. Now begins the era of all the iatrophysicists and iatro-chemists. For them life was physics and chemistry. Life was only a form of matter. . . And the march of the *science* of medicine began! Here and there only a few men tried to keep their head above the purely mechanistic trend in medicine. Sydenham, the great English physician, went back to clinical observations. His description of gout is unsurpassed. His treatment of patients betrays a deep insight into human nature. On his grave-stone we find the words "medicus in omne aevum nobilis."

After this "journey" through the history of medicine we reached again the point from which we started. Medicine has to be brought back to man as a whole, we have to understand that in man we deal with imponderabilities and

qualities that can neither be analysed nor filtered. We have to discard forever the dichotomy of psyche and soma. Back to *synthesis* in medicine! Why all this talk about "psycho-somatic medicine?" One is amused to see all these published "textbooks of psycho-somatic medicine" (e.g. by Weiss and English; "Psycosomatics" by Hamilton). Now even a "Journal of Psycho-somatic Research" is announced. . . It seems to me all these "authors" and "researchers," all these enthusiasts of "psycho-somatics" did not yet get the idea what medicine is. All they do is to indulge in an unnecessary "mending" of the dichotomy. There is no "psycho-somatic medicine", no "comprehensive medicine" no "socio-medicine." But there is *medicine*, and nothing but medicine! Medicine includes mind and body, includes genetics, social influences. To treat man as a whole, with soul and body, is medicine.

THE ANUUAL MEETING OF THE MEDICAL SOCIETY OF N. S.

The Ladies Committee have swung into action and great preparations are being made for the entertainment of the ladies at the Annual Meeting in Halifax.

Mrs. A. L. Murphy is Chairlady and the other members of the Committee are: Mrs. Ray MacLean, Mrs. B. F. Miller, Mrs. J. S. Manchester, Mrs. N. B. Coward, Mrs. J. F. Cantwell, Mrs. John Merritt, Mrs. Douglas Murray and Mrs. D. J. Tonning.

The tenative program calls for a Coffee Party each morning at the Nova Scotian Hotel, a Luncheon at the Citadel Tea Room and a Luncheon at the Lord Nelson Hotel on Wednesday and Thursday. In addition a Luncheon is planned for the wives of the Executive Members on Tuesday. A Ladies Golf Tournament will be held separately this year.

Plans are well underway for the Annual Gala Dinner, to be preceded by the President's Reception and to be followed by a Gala Dance and Entertainment on Thursday evening.

A reception is planned for members wives at Ashburn Golf Club at 6.30 Wednesday, September 5th. Wednesday evening is to be left open for private entertaining.

The Men's Golf Tournament will be held as usual and Luncheons for the members will be held on Wednesday and Thursday Premier Hicks has kindly consented to address the members at one of the Luncheons

As stated in a previous Bulletin, Dr. Wilfred Caron, Surgeon, Quebec City and Dr Jean-Marie Deloge, Internist, Quebec City will accompany the President, Dr. Renand Lemieux and Mrs. Lemieux. Dr. A. D. Kelly, the genial General Secretary of C.M.A. will also accompany the Presidential Team.

While not finalized, it is hoped that Sir Geoffrey Keynes, F.R.C.P., London, N.W.I. eminently known Surgeon, will contribute to the scientific program. Sir Geoffrey has been appointed Sir Arthur Sims Commonwealth Travelling Professor and will visit Halifax on September 10th. Representation has been made to him to advance his schedule one week so that he may participate in the Annual Meeting of The Medical Society of N. S. All in all, an interesting program is planned, so all members are asked to make plans to attend.

A large volume of important business will be dealt with at the general sessions. Reports will be presented by the Chairmen of various committees. Of vital interest to all members will be the report of the Committee on Tariffs — please bring along the report which has been sent to you. Reports on a Premanent Secretary, Health Insurance, Maritime Medical Care.

Many other important items of great interest to the membership are certain to be discussed.

Do not forget to make use of the application form printed in the Bulletin, for hotel accommodation. Address all requests for hotel accommodation to Dr. A. W. Titus, 32 Connaught Avenue, Halifax, Nova Scotia — please make requests early.

M. R. MACDONALD, M.D.
Secretary.

HOUSING APPLICATION FORM

103rd Annual Meeting Halifax, N. S., September 4 - 7, 1956

The Medical Society of Nova Scotia

Dr. A. W. Titus,
Chairman, Committee on Housing,
32 Connaught Avenue,
Halifax, N. S.

I am planning to attend the Annual Meeting of The Medical Society of Nova Scotia at Halifax, N. S., September 4 to 7, 1956.

Will you please reserve the following:

..... Double room with bath or shower (double bed).

..... Double room with bath or shower (twin beds).

..... Room for.....persons (bath or shower).

In view of a large expected attendance no single rooms will be available at the Nova Scotian Hotel unless cancellations permit. If coming alone please check here.....(v) if you are willing to share a room. If you have a preference for some party to share with please insert name here.....

Name of persons who will occupy above reservations:

NAMES (Dr. and Mrs.).....

ADDRESS .....

Expected date of arrival in Halifax.....

There are in addition very lovely motels situated on Bedford Highway. If you prefer this type of accommodation please check here..... .....(v) and we will endeavor to arrange reservations for you.