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Contents March, 1947

Socialized Medicine Today

An Editorial

FOR some time past the editors of this publication have felt that some notice should be taken in its pages of the important movements which are being made in the field of so-called "socialized medicine." Since we have not been able to find within our own literary ranks writers who feel themselves qualified to deal broadly with this subject, and since the editors think themselves ill-equipped to do so, it was decided to devote an issue of the *Bulletin* to reprinting material from other sources. Such an issue we now place before our readers.

On first thoughts the preparation of such a number promised to be an easy task—just the selection and combination of the outstanding articles of recent months. But the selection has presented certain difficulties. First of all, the volume of material to be surveyed proved much greater than we thought, and the problem of what to include and what to leave out has been a hard one to solve. Then, too, some of the most significant publications are too long to print in full—and yet so condensed that they do not lend themselves to further extraction. To some extent we have been guided by the availability to our readers of the article under consideration. Since we believe that the Canadian Medical Association Journal comes into the hands of all readers of this *Bulletin* (it should!), we are reprinting no material from its pages, but will refer in a subsequent paragraph to certain items in recent numbers.

The writer has been brooding for some days on the proper definition of the words "socialized medicine." Dictionaries do not provide any assistance here. According to the Concise Oxford Dictionary medicine is "the art of restoring and preserving health." This we all accept. But "socialized?" According to the same dictionary the verb socialize—of which one presumes "socialized" is the past participle or verb adjective—means to "make 'social' or arrange socialistically." Among the many meanings given for social—which is both noun and adjective—the following seems of particular significance in this connection— "social contract or compact: agreement among men to exchange the individual freedom of the state of nature for legal restriction." (From this it might fairly be taken that "socialized medicine" would consist in the subjection of the art of restoring and preserving of health to legal restriction, with a greater or less degree of consent to the subjection, as implied in the word agreement.) This is an awe-inspiring and even ominous pair of words —which to-day are being used by many who may not be aware of their full meaning. However, we are aware that in this day many words, terms and phrases have had their connotation changed, if not their primary meaning. It seems probable that the basic idea involved in socialized medicine is that both prophylactic and curative services shall be put within the reach of each member of a state or community. This is so broad and loose a description that it certainly cannot be called a definition. It makes no mention of the two burning questions: "Who foots the bills?" and "Who administers?" It is these questions—together with a third "which services?"—that are agitating the medical world of to-day.

The storm centre of most of the agitation is in England—where the National Health Service Bill for England and Wales has been passed and become law. The Canadian Medical Association Journal for January contains a special article by Dr. T. C. Routley on this bill. No Canadian doctor should neglect to read this with careful attention. In the February number of the Canadian Medical Association Journal, on page 216, is further material on the bill, reprinted from the British Medical Journal.

The correspondence columns of the British Medical Journal are interesting, instructive and sometimes depressing. It is a sad commentary on the morality of a profession that prides itself on its ethics, to note how many writers express the opinion that at least a proportion of those who voted "no" in the plebiscite will turn out to be yes-men when the bill is put into force.

Speaking of plebiscites, the province of Ontario had one in November. Details may be found in the Ontario Medical Bulletins for December and February. The replies received to letters sent out were 47.5 %.! In England the poll of civilian doctors was just over 80%. With no wish to point morals, or to seize texts for little sermons, we cannot refrain from observing that the proximity of the wolf makes quite a difference in the reaction time of the proposed victim—as Confucius might have said.

Two attempts have been made to make it obligatory for doctors, and incidentally nurses, to join trade unions. One was in the Borough of Willesden in London, and the other in Toronto. For details of the former—now called the Willesden affair—readers are referred to the British Medical Journal of December 14, page 159 of the supplement. For details of the "Toronto affair" see pages 82-84 in the Ontario Medical Review. Neither attempt was successful, and in Toronto the question was settled with little difficulty. But in London, the efforts of the Willesden council were referred to by a government spokesman as "premature." If a thing is premature it must be assumed that had it come later in time it would have been mature—a disquieting thought in this case.

Some legislation of a medical sort has gone on with which most of us can find no fault. The Quebec legislature accepted a bill of the Health Minister granting $1,000,000 to assist the establishment of doctors in outlying regions of the province. This is the extension of a previous bill which grants bursaries to medical students and doctors willing to practise in sparsely-populated districts. The province of Ontario has undertaken to provide one free prenatal examination for all expectant mothers—the examination to be complete and documented and to include a haemoglobin examination, urinalysis and blood serology. For this the provincial government will pay $5.00 to the doctor. The province of Saskatchewan has passed an act making pre-marital Wasserman tests compulsory. The financial and other details of the act are still being worked out.

The foregoing is a bird's eye view of a small section of medical literature dealing with "medicine for the masses." We now present in full four articles:

1. The Address of Dr. C. C. White, the president-elect of the Ontario Medical Association, delivered at the annual district meeting in 1946, and reprinted from the Ontario Medical Review of December 1946.

2. Prepaid Medical Care—a Social Need and a Medical Weapon, by by Dr.W. V. Johnston in the Ontario Medical Review of February 1947.

3. An Article by Wellington Jeffers, financial editor of the Globe and Mail, on the C.C.F. bill to take over disciplinary powers in the professions. This article appeared in the Globe and Mail of Saturday, December 7, 1946, and was reprinted in the Manitoba Medical Review of January 1947.

4. An address on Medical Etiquette and Ethics by N. E. Waterfield, M.B., B.S.,F.R.C.S.; being the presidential address delivered at the annual meeting of the Surrey branch of the British Medical Association, and reprinted from the British Medical Journal of December 14, 1946.

The latter is presented as a timely reminder of those delicate relationships between physician and patient and physician and public which have existed for a long time, and which might be subject to radical adjustment under certain schemes of socialized medicine.

MARGARET E. B. GOSSE, M.D.

Address of the President-elect of the Ontario Medical Association*

Delivered at the Annual District Meetings 1946

Mr. Chairman and Fellow Members of the Ontario Medical Association:

IT is indeed an honour for me to serve this great organization in the office of President-Elect, and I appear before you today deeply sensible of that honour and the responsibility that it entails. I am also very conscious of my own shortcomings and insufficiencies; and it is with some temerity that I address myself to you, and seek to discuss some phases of the many problems with which we all, in this our Association, are having to grapple.

One problem seems to me to so overshadow all others in importance and urgency of solution, that I propose to limit my remarks to it. (I refer to the problem of making available to the public the benefits of medical care. That this is a problem no one who has taken even a passing interest in sociology, will deny.) A great deal has been written and spoken on the subject—a great deal of nonsense—a great deal of superficial sentimentality and half-baked economic theory. But beneath it all there is a serious problem and we should pause to consider it, and in doing so, let us lay aside prejudice, and approach it in a spirit of intelligent interest and concern. "Prejudice" has been stated as "being down on something one is not up on." There has been all too much prejudice displayed in medical organizations in the discussions of this problem.

Let us look for a moment at the attitude of the public in this matter. One does not need to look very far or very deeply to be convinced that there is a very real and widespread demand for access to medical care without danger of financial catastrophe. This would seem to be a reasonable demand.

The man who provides for his wants from a weekly or biweekly pay envelope is well educated to the values of budgetting. Indeed it is the only way he can successfully live in his environment. How is he to budget for his medical care? How but by means of applying the insurance principle to his problem? With this principle he is acquainted, and in attempting to apply it, he needs and looks for guidance and leadership. Who provides it? The politician. Why? Because he recognizes the demand. Some politicians seek to turn it to ulterior uses as a means of building a bridge to power, or as the thin edge of the wedge of socialism and as such it is extremely appropriate. I am not one who sneers at politicians and politics, which is the science of government. This all too prevalent attitude is the greatest curse that democracy has to endure and will eventually destroy all the freedoms of man which are so essential that we can scarcely conceive of life without them. Why is it that people in a democracy select by their own choice their fellow-citizens best suited to represent them and then at once begin to belittle, malign and libel them until the very name of the science of government becomes stigmatized? There are many of our political leaders, at all levels, earnestly and sincerely seeking for a means to supply to their constituents an answer to this problem and an opportunity to obtain for themselves and their families freedom from fear of the catastrophic financial results of serious illness.

They are searching and floundering because they are attempting to find a way through a maze, the intricacies of which they know not. They

*Reprinted from the December, 1946, issue of *The Ontario Medical Review*.

have a right to look for guidance in this matter to our profession. What is more, they have a right to look to our profession for a solution.

The average practitioner is not interested just now in the problem, and let me emphasize the "just now" for future reference. Times are good, and the doctor is much too busy seeing patients to think about the problem. His patients have so much money that the financial aspects of practice present no difficulty. He is satisfied with the status quo. Not having thought about it, and being satisfied with things as they are, he is annoyed at the suggestion of change just because it is change. He is highly resentful of outside interference and is inclined to be haughty or patronizing or scornful of lay and medical proposals, according to his nature. At the same time he refuses to take an intelligent serious interest in the problem himself and he is enough like other people to elect one of his fellows to represent him and then become highly suspicious of the one whom he has placed in office. He suspects not only his motives, but his common sense and even his sanity. He takes no personal interest and gives so little study to the problem that all he can say is "no."

I said a few minutes ago that the average practitioner is not interested in the problem "just now." My mind goes back a few years to the early thirties when in Convention our members directed to the government of the day a resolution which said in effect: "You've taken our money and our years in training, now you must see to it that in return for our services we can obtain the necessities of life." Will those days return? You remember them. Shall we wait until the problem becomes of personal emergent import to the rank and file of the profession? If we do, can we expect sound thinking and long-term planning and a worthy solution? Gentlemen, you cannot shelve this problem. It just will not be shelved. As soon as you place any man in a position where he speaks for organized medicine, he is immediately faced with some aspect of this problem, and it must be confronted. No matter how many times the profession vote against any solution of the problem, regardless of how they ignore it, it is still present and will continue to be there until it is solved, either by us or by some one else.

In Ontario we have been fortunate. No plans of medical service originated by governmental or other lay sources have been forced upon us. You may feel that we who are expressing concern about the future trends of medical practice are promoting a "phoney war." We have been granted a period of grace to organize our own solution to the problem but we have not utilized this time effectively. The sands of time are, however, running out and it is late now, much later than you think.

In other Provinces, they have not been so fortunate. I have been greatly interested in the situation at Saskatoon. Recently we wrote to a prominent medical man of that City and asked him to bring us up to date on the situation. He was kind enough to write a complete summary of the situation there to which I shall refer in telling you of it.

In 1939, the Saskatoon and District Medical Society was about to organize a prepaid medical service plan but on request the doctors stood aside to allow the Saskatoon Mutual Medical and Hospital Association,—a lay organization, to be formed to sell and administer prepaid medical care. This organization soon came to be known as the Medical Co-op. This, as I have said, was a

lay organization, lay controlled and operated, with no real liaison with the medical profession. They would not agree to the setting up of a mutually acceptable advisory committee, although they were approachedby the Medical Society on several occasions.

There are several objectionable features in regard to this arrangement, some of which may be listed as follows:—

1. The improper handling of matters of confidence between patient and doctor.

2. The handling of medical reports by lay people.

3. The arbitrary adjudication of accounts by lay people.

4. The interpretation of pathological reports as a basis of payment by lay persons.

5. The absence of any medical advice or direction during the past five years.

6. The release by this organization at every possible opportunity of propaganda aimed at a radical control and dictation of the medical profession.

The Medical Co-op had used as one of its basic themes the freedom of choice of doctor by the subscriber. However, it is a matter of record that, during the past year, with a membership of 16,000, they announced their intention of establishing a clinic in the City of Saskatoon with a large outside program of health centres. The subscribers were to receive medical care from doctors employed on salary by the Medical Co-op. To carry out their program, they undertook to float a loan of $1,000,000 by the sale of certificates and put on an intensive radio, newspaper and pamphlet advertising campaign. They have purchased property in the City of Saskatoon, at a cost of $25,000, and are erecting an administration building and pharmacy thereon at a further cost of $25,000.

In April of this year, a determined effort was made on the part of the medical men of Saskatoon and district to obtain a round table meeting with the Board of Directors of the Saskatoon Medical Co-op. in the hope that some mutual understanding of difficulties could be obtained. However, the Co-op. was unwilling to have such a meeting. This led to the prompt formation by the medical men of Saskatoon and northern Saskatchewan of Medical Services Saskatoon Incorporated, a non-profit mutual company of doctors offering a prepaid medical service to the people of the northern half of the Province. This organization has provision in its membership for all doctors in the northern part of Saskatchewan. Its Board of Directors consist of six medical men and five well-known lay citizens of high repute.

This was the situation when I talked to several Saskatoon doctors at Banff. They told me of the urgency to get their own prepaid medical services underway, of the cost to themselves to provide operating capital, the problem of establishing premium rates, the uncertainty of the fees returnable and the many difficult and varied problems of administration, all under the stress of time. More recent information, gathered at the annual meeting of the Saskatchewan Division of the Canadian Medical Association, is that the Medical organization was functioning well with some 5,000 subscribers at that time. The medical men in that community are to be congratulated that by their energetic, though belated, action they have protected their patients in their freedom of choice of doctor and have proved a serious deterrent to overly ambitious plans of a lay group, which seemed to be making a determined effort to place the medical profession within its grasp. How much simpler and smoother and

better it would have been had they not stood aside in 1939, but insisted on their rights as free men in a free economy to market their own services. Is there not a lesson here for all of us? I could tell you other stories too about the situation at Swift Current where a full dress government experiment in health insurance is being tried out in miniature; of the situations in Manitoba and elsewhere, all interesting and timely, but time prevents.

What should we do here? The vote at the annual meeting in May would at first thought appear to tie the hands of the Board of Directors, or to give them ample excuse to disregard the question. But as I have pointed out, it cannot be disregarded; it is present in a dozen aspects all the time. I feel that this is the profession's problem and we must accept the challenge and come up with the answer. In a free economy, we must market what we have to sell in a manner in which the customer can and will buy, and happily. If we are alive to the situation, we will not invite the introduction of the parasitic middleman with his regulations and red tape and his profit on our labour. There is sufficient evidence now accumulated to justify the belief that the profession can come up with the answer, can provide the solution if the individual members seriously undertake to do so.

In the United States there are now 37 voluntary prepaid medical service plans sponsored in whole or mainly by the profession with a membership of 2,845,000 subscribers. In Ontario there are at least four; others exist in Manitoba, Saskatchewan and British Columbia. I have been unable to obtain all the figures of enrollment. I would think that 100,000 in Ontario would be a conservative estimate. I was told in June that the Medical Services Association in British Columbia had upward of 19,000. "It had no selling problem but was kept busy keeping its organization growing fast enough to take care of groups seeking entry." And how true that was. Their present enrollment is over 80,000. In the face of this Continent-wide situation, what are we of the Ontario Medical Association to do?

I feel that the profession in Ontario should sponsor a plan, and I have come to this concludion for the following reasons:—

First

The public demand. In addition to what I have said about such a demand, I would direct your attention to two short paragraphs from a recent speech by Claude Robinson, Ph.D., President of the Opinion Research Corporation in the United States. Mr. Robinson said: "The public is overwhelmingly optimistic that something can be done to ease the financial strain of medical expenses. And this optimism is growing. Eight per cent more people today than in 1943 say that something might be done," and then he made this very arresting generalization: "The first widely known and widely available plan of prepayment medical insurance to reach the American people, whether it be sponsored by the government, insurance companies, or organized medicine, can count on public acceptance."

The numbers who have sought a solution of their problem, however inadequately, by way of commercial insurance companies, also indicate the demand. A survey by the Life Insurance Association of America shows that 5,921,360 persons were carrying group accident and health insurance at the end of last year, involving premiums paid of $115,989,000. Group hospital expense was held by 4,371,350 employees and on 3,432,320 members of their families, and group surgical expense coverage was provided 3,948,565 employees and 1,587,669 members of their families. In addition, several hundred thousand

employees and dependents had group medical expense insurance providing general coverage against doctors' charges. These do not include such plans as the Blue Cross or Voluntary Prepaid Medical Plans. Surely this is ground for the premise that there is a public demand. I would also direct your attention to a resolution of the Canadian Medical Association passed at Banff this year: "The medical profession in each Province should attempt to meet public demand for prepaid medical care wherever it exists by providing a plan of prepaid medical care sponsored by the medical profession." So I feel that I am at least orthodox in my advocacy.

Second

We should market our own serviees. No other should make a profit on or dictate terms under which the professional man works. This is of the very essence of a profession and when we allow others to make a profit on our work and to dictate terms and conditions under which we labour, we will in large measure have ceased to be professional men.

Third

To demonstrate our ability to operate such a plan to ourselves, to the public and to the government.

Fourth

To forestall compulsory health insurance and/or influence government activity in this field. I make no apology in opposing compulsion. To me, it is the very antithesis of everything desirable in our civilization, every step toward regimentation, compulsion, collectivism (and compulsion is the key to collectivism) is a dimming of the lamp of freedom to which our civilization owes everything that is worth while. We must not, as educated persons, be a party to compelling people to do anything. They must be helped, guided to do things for themselves, not lulled into the false security of having the government do things for them, for down that road lies totalitarianism, and death of civilization. [Cattle in the field, or swine in the pen, or prisoners in the penitentiary have all the social security in the world, all they haven't got is "the right to do as they like."]

Fifth

The Plan for Hospital Care is insisting that someone evolve a plan of medical service to parallel and augment their hospital plan, and now is suggesting that they do it themselves. In fairness to them it must be said that for three years they have been asking and waiting for the Ontario Medical Association to do so, and were told in May that the Ontario Medical Association's answer was "no." But this was not the profession's answer, nor must it be.

The suggestion is frequently made that the Ontario Medical Association co-operate with the insurance companies, and we have been asked by the insurance companies so to do. To sit in with them, help write their policies and pass on their fee schedules. It is at first sight intriguing; it would be easy and would be effective over a short range. But to place our affairs in the hands of commercial organizations, operating for profit, would, in my opinion, be long range professional suicide.

It has been often advocated that the Ontario Medical Association should organize and operate such a scheme. That there be no misunderstanding on

this matter, and there apparently has been such misunderstanding, I want to say right here as I have said at the Council meeting last February and many times before and since, I am absolutely opposed to the Ontario Medical Association, as such, undertaking this activity. I think it would be disastrous were we so to do, and I say that for these reasons:—

First

The Ontario Medical Association is ill-organized for such an activity. For the purposes it was designed to serve, it is well-organized, but it was not conceived to operate big business and its structure does not lend itself to that function. The Board of Directors is too unwieldy, and the personnel are changed too frequently. The method of their selection is not suitable for a business undertaking, nor would it be desirable to change the consitution so that it would be suitable, for by so doing, our Association would be rendered unsatisfactory to carry on the primary functions for which it was organized and which must be maintained.

One must remember in this regard that, while authority may be delegated to a committee, a sub-Board, or to an individual, responsibility cannot be so disposed of and every member of the Board of Directors assumes a certain responsibility which he cannot delegate and for which he can be held responsible before the courts.

Second

The next reason why the Ontario Medical Association should not undertake this is that it would be too heavy a task for the individual members of the Board of Directors to assume as an avocation. All of the Ontario Medical Association's interest, plus health insurance, is too great a task for any busy practitioner. If he is not a busy practitioner, then he does not represent you and he does not represent me.

Third

The venture might fail and, if so, the reflection on the Ontario Medical Association and its influence on the public and on the profession would be disastrous. On the other hand, it might succeed, and, if so, it will grow and come to dominate all other interests and functions of the organization. The Ontario Medical Association would cease to occupy the enviable position it now holds, where its opinions are given courteous attention as representing those of a profession interested in the professional aspects of a problem, in the broad humanities of public welfare and professional responsibility, and not just the dollars and cents interest of big business.

Fourth

My experience with medical welfare, and I have been intimately associated with the administration of the welfare scheme ever since its inception, has convinced me of two things,—first, that medical men can operate such a scheme, and, second, that the Ontario Medical Association is not a suitable organization so to do.

So I have said the profession should sponsor a plan and that the Ontario Medical Association should not organize and operate such a scheme. Now, Mr. Chairman, my thesis is this,—the Ontario Medical Association should sponsor a separate professional organization specifically to undertake this

task, and let me accent the word "professional." An organization belonging to the professional medical men of this Province in which every doctor would be a member and have a vote. It would be an organization to carry on this activity of ours—the marketing of our services—our organization—not someone else's—even in part. We so often hear the cry, "But it must be under Ontario Medical Association control." But this is the cry of him who has not visualized the situation, the cry of the fearful. What he is saying in his heart is that it must be under professional control, and the Ontario Medical Association is the only professional organization he knows. His *instincts* are right. Going back to first principles. "We should market our own services". It is his *vision* that is defective. In this proposal, the profession has control. It's our organization—where then is the rationale of the fear that our organization will dominate us? Does one's left hand dominate his right? Such an organization would be solely for this purpose and would automatically bring to the front men interested from whom men qualified to handle the affairs of the organization can be chosen. Once underway, while it is a big job, it would not be too big for an avocation, and regardless of how big the organization ever becomes, it could never be other than what it is, a public utility operated by the profession to bring their services to the public. It will, of course, come to speak with the authority of knowledge in its own field, but it could never usurp the prestige and authority of the Ontario Medical Association, the custodian of professional opinion on any subject in which it is interested, or in which it may be asked to take an interest.

And so I repeat the Ontario Medical Association should sponsor an organization to take on this task. One would hope that those plans of prepaid medical care now in the field could be utilized, either amalgamated as a nucleus or incorporated as branhes. Certainly the profession must not be divided against itself, and the experience and knowledge gained by these experiments launched under Ontario Medical Association auspices should be utilized, and can be. No one knows better than I how close was that ideal eighteen months ago and no one more bitterly regrets its failure of materialization, a failure not to be laid at the door of the Directorate of Associated Medical Services or of Windsor Medical Services. I still feel that that was the right answer and I do not feel that the right solution should be abandoned now because of our failure then. The organization of which I speak should be established with branches in every county and we should facilitate its spread across Ontario, reaching the people of whom I spoke in the early part of my address ever so long ago!

There should be machinery through with the organization would report to the Ontario Medical Association and be responsive to the expressed recommendations of the Ontario Medical Association. A close liaison one with the other could well be arranged. Any good corporation lawyer could easily draw up a constitution that would fulfill all of these suggested requirements.

But this cannot be accomplished by your officers alone. It must have the active support of, indeed must be initiated by, two or three interested energetic members of each branch society. That is all that is required,—local leaders. Given these, sufficient advice and help is available and waiting.

This problem must be answered. I have suggested one answer after

thought and consideration. If you approve, I solicit your support for it, if you do not approve, then bring forth your answer and lay it on the table, but the answer must be positive, not negative. "No" is not the answer. If "no" is to be *our* answer, then we will be passed by and some one else will provide the answer. On the answer depends your professional life. Yours and your children's and your children's children for once the control of medical practice leaves the hands of the profession, it will be generations before it returns.

In very truth, your future is in your hands.

C. C. WHITE

Prepaid Medical Care as A Social Need and A Medical Weapon*

W. V. JOHNSTON

A SUCCESSFUL scheme of prepaid medical care is dependent upon the public's enthusiasm for some protection against the hazards of accident and illness. A prominent busy doctor states that he does not meet with any such demand from his clientele, they do not discuss it or enquire about it from him. He is doubtful about this hue and cry, and suspects it may be propaganda of some of his fellow practitioners whom he fears may have dangerous socialist views. May we try to answer this gentleman?

There are two parties involved—those who receive the services and those who give them. In speaking of the party of the first part, that is the public, we must observe that it always is very difficult to gauge precisely what they want. At election time our politicians propose measures they believe popular enough to win votes. It is their business to put a valuation on popular opinion. It is a difficult task and they make many mistakes. If politicians have difficulty in assessing the public mind, it is reasonable to suppose it is even more so for the rest of us. As an example, how few people two years ago expected Family Allowances and yet, in a few months, it was law, and now no government would dare repeal it.

There is a growing demand from the public for some release from the ever-present possibility of a costly accident or illness. The fact that they are so eagerly buying the contracts of commercial companies offering prepaid medical services here and in the United States, indicates this. On studying these contracts with all their exclusion clauses, one can see how better contracts could be offered, increasing their popularity.

This demand from the public is still largely unexpressed due to a lack of clarity in its thinking. This does not mean our citizens may not act quickly when once they realize they may have nearly anything they wish through the ballot box. There is a very interesting sentence in the American Declaration of Independence. It is this: "All experience hath shown that mankind are more disposed to suffer while evils are sufferable, than to right themselves by abolishing the forms to which they are accustomed." The Anglo-Saxon seems to have a deep lethargy to too sudden social changes.

As individuals we learn at a very uneven rate, muddling slowly through a problem until suddenly the solution becomes crystal clear. It is the same with the body politic. When people, through their government, decide to do something about a matter, such as medical costs, we may be sure they will do it with little warning, as in England. It is a fact that the electorate of England is still the most politically mature in the world.

Also, we may note that, when changes involving the social structure are made law, they are seldom reversible. I do not think you can name a major enactment of recent years in the fields of education or health, bringing benefits to a large percentage of the people, that was later abolished.

Many of our young people from service in the armed forces have caught a vision of a better Canada, for in the services many were fed better, clothed

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better, and better treated medically than they were in civilian life. If you do not believe this, think of the many men who had their herniae repaired who otherwise would still have them. Many of these young folks know full well that there must be some way of getting the best that medicine has to offer when seriously ill and spreading the costs thereof so it is not too burdensome.

Voluntary prepaid medical care is a partial answer to the social need of bringing the best of medical care to the largest number. I say a partial answer because, where it is already available, only about 20% avail themselves of it. Whether or not society will be satisfied with a scheme reaching this percentage of the people is another matter. However, it is a beginning and in the British tradition of going slowly.

The other party to any plan of prepaid medical care are those who provide it, namely the doctors. General practitioners particularly, are faced very often with the problem of getting adequate diagnostic and treatment services for patients who are unable to pay for them, or if they do pay, we know full well they will be handicapped in providing themselves with some of the necessities of decent living. For instance, many a parent with rheumatic fever, or arthritis, or exophthalmic goitre has had insufficient investigation and treatment because of the cost of it all. To say that this is no concern of doctors is no answer at all. We see the results of poverty and near poverty more often than most, and as citizens why not let it excite us to action?

Sometimes we are so limited in our efforts to get people well by a paucity of funds that we feel like the woodsman who, instead of cutting down trees, has spent his time thrashing around in the underbrush.

To say that our people are getting too prone to take advantage of free clinics etc., and to get as much as possible for nothing, is an unhealthy viewpoint. Most of us desire the maximum social legislation without spawning parasites. I have never practised in the city but folks in the country and small towns are still essentially honest and wish to honour their debts. It seems to some of us that rugged independence frequently has been lost by the imposition of unbearable burdens.

In short, many doctors feel in many cases they could do so much more if the money factor could be ignored. It could be ignored largely if we had prepaid medical care. In other words this is a medical weapon.

In any scheme of prepaid medicine we all want the maximum of "free enterprise," consistent with good service. The principle of free choice of doctor must be kept as inviolate as possible. We admire the individualist, the man who has built a large practice by hard work and hard thinking. A wide-spread system of prepaid medical care will put some limitations on the doctor participating in that there will be a standardization of fees. Some of our men are such individualists they reserve themselves the right to assess their own worth and set their own fees.

In the O.M.A. fee schedule, the fee for each service is given as so much and up. There is a floor and no ceiling. The floor is to protect us from the public. A spirit of fairness requires a ceiling to protect the public from some of us. The unpredictably high fee to the wealthy may be justifiable, but to the average citizen it is hard to defend. At any rate the general practitioner has few opportunities to use the "and up" part of the schedule.

Some doctors ask; why start limiting our fees when others such as lawyers,

lumbermen and landowners can reap without limit? This is really unanswerable because it is fundamentally wrong to make the rewards of practitioners of medicine less than those obtainable in other fields of endeavour. The attractions of medicine must be as great as those offered anywhere, in order to appeal to our sons and others who come after us. However, we must note that governments to-day, in nearly all English speaking countries, feel that more and more they must take control of two departments of welfare, namely; education and health. In this way, willy-nilly we are becoming involved.

To doctors, prepaid medical care is a part of the larger field of welfare and a medical weapon. To develop this weapon, we must go into the political and governmental fields more and more. This is inevitable, and it is only right that we go there, if for no other reason than to protect ourselves. We are all familiar with the struggle of the teaching profession to get proper status and remuneration for its members from society. This fate must not overtake us. May we make a plea that the general practitioner, who comprises about 85% of the Ontario Medical Association, be the member of the medical team that leads the way in its thinking and actions in helping to bring better medical care to the public, and while doing this, preserve some of the precious gifts entrusted to us now. Prepaid medical care, with its many reasonable features, is one answer.

The public are asking for some method of being able to pay for the most expensive features of medical care, and thereby preserve their independence and self respect. The doctors are asking that, in doing this, we keep the profession of medicine attractive to the keenest minds amongst us. How well can we weave these threads into the social fabric? This is the challenge to all of us.

Watch C.C.F. Bill to take Disciplinary Powers and to make all Professions in Saskatchewan Operate Under Yearly License and to Set Fees*

WELLINGTON JEFFERS

Financial Editor, Toronto *Globe and Mail*

If the next session of the Saskatchewan Legislature approves legislation now being considered by the continuing committee of the Law Amendments committee, the Government will take over all disciplinary powers now exercised by doctors, lawyers, dentists, druggists, architects, accountants, nurses and other professional members throughtheir associations.

Nineteen special boards would thus govern professions and practices instead of the professional associations which have developed codes of ethics and standards of practice and ability under which all members have been operating. A doctor, lawyer, chiropodist, osteopath, surveyor, engineer, music teacher, embalmer, optometrist, Chiropractor, therapist, agrologist, veterinarian, drugless practitioner, dentist, druggist, architect, accountant or nurse, under the new law as proposed, could only practise in Saskatchewan under license revokable by the appropriate special board.

Setting Professional Charges

I heard about this proposal when in Regina recently, but had the idea that the C.C.F. Government, with its high-pitched program for health and hospitalization and medical services, would not proceed to such lengths. I see by a news article in the Regina Leader-Post, however, that the matter is now moving ahead rapidly. There is one very important feature of this intended legislation which I do not see mentioned in the Leader-Post article, but which is of immense significance to all professions in Canada because it will be the "entering wedge." That is the proposal that the new boards shall prescribe the maximum fees chargeable by licensees for professional services.

The clause requiring every professional man to apply to be licensed before the end of 1947, on pain of losing his right to practise in the province, would be troublesome enough. The clause making these licenses renewable every year would also have an unsettling effect. The inquisitory powers of the councils of professional associations with regard to any professional man about whom there are complaints are kept, and indeed made obligatory, but the reports have to be made by government boards which will have formidable disciplining powers. Those would be dangerous powers for any government. The recent statement of Premier Duplessis that he was refusing a license to conduct a liquor establishment under the Quebec law because the licensee was a member of a sect whose belief seemed to him wrong and dangerous is an example in point; I might agree with him on the opinions, but would absolutely disagree with the right of any government to punish people for their beliefs by interfering with their means of livelihood. The only justification

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for refusing the liquor license would be that he ran the business improperly.

Any kind of government should avoid totalitarian exhibitions of power, and should bend backward to do it. I have no doubt that some of the promoters of this new legislation may have the best of benevolent intentions toward us all, once they get us where they want us, but somehow it always works out in the end in tyrannical acts. It is just now a suicidal sort of law for Saskatchewan to enact. It needs all its doctors and dentists and nurses, and more as well. The government made private enterprise bypass the province by its decision to enter industry in various lines. Many, who now reside in the province, would take such an act as this as an intimation that they would be well advised to move elsewhere. I do not believe that this is what was wanted by the great mass of farmers who voted the C.C.F. Government into power at the last election. A move like this will not stop with the professions. No one can suppose that his turn will not come some day to be required to get a license, to have it revokable, to be told what he can charge, what profit he can make, if any, and to be kept afraid to express an opinion different from that of his masters for fear of what might be done to him.

Should Be Watched

There are 19 acts now on the Saskatchewan statute book with regard to professions. Anything in them inconsistent with the new act would cease to have force if it is approved. The main change which would occur immediately is the provision of a number of civil service jobs on the 19 boards to be formed and thus the faithful would be rewarded. Once formed, they would exert the powers given under the leeway given by the bill for the government to make regulations about each association. The associations would remain but their powers and rules and ethics would be prescribed for them if boards ramed would have any duties at all.

This legislation seems to indicate that the promises that the Socialist government would not move far toward socialism in the province because so many non-Socialists voted for C.C.F. candidates in the last election are being forgotten. What the legislature does in this and other matters should be studied all over Canada. Likewise what it does in taking over and running industry should also be studied. It has not done too well even in this comparatively riskless period when competition is not operating as powerfully on demands as it will when production revives. A time is coming, however, when events and trends will hit rude blows any ill-conceived ventures.

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An article upon this subject has been forwarded to this office as it appeared in the Regina Leader-Post which follows:

Professicnal Groups May Lose Their Disciplinary Powers

Transfer of disciplinary powers now held by professional societies in Saskatchewan to special administration boards to be set up by the government is proposed under legislation now being considered by the continuing committee of the law amendments committee of the legislature.

The move is the result of a decision made at the last session of the legislature. At that time a resolution moved by Warden Burgess (C.C.F., Qu'Ap-

pelle-Wolseley) and seconded by Dr. H. E. Houze (C.C.F., Gravelbourg), recommended that the law amendments committee review the professional acts and suggest such amendments as seem "expedient and advisable."

Among specific recommendations contained in the resolution was that the committee study the professional acts for the purpose of ascertaining the powers and duties given to the various professions or practices under the acts: determining whether the exercise of such powers and the discharge of such duties by professional societies is in the public interest; the securing of such uniformity in the provisions and administration of the acts as may be found possible, and recommending such amendments as might seem expedient and advisable.

Nineteen different professions and practices, ranging from medical men to engineers, would be affected.

These are: Legal, medical surveyors, chartered accountants, agrologists, architects, veterinarians, engineers, chiropodists, *dentists*, physical therapists, pharmacists, music teachers, osteopaths, registered nurses, chiropractors, druggists, embalmers and optometrists.

Should the proposed legislation be approved by the legislature, it would mean the appointment of 19 government boards—one for each of the professions and practices—to deal with disciplinary measures, the setting of maximum fees to be charged for services, the licencing of the various professional people, examinations, and other regulations now held by the professions or practices under special acts.

Improper Conduct

With regard to the disciplinary measures it is understood that persons who might be charged with improper conduct or a breach of any of the regulations or of the code of ethics prescribed would have the right of appeal. If the appeal were lost, the person's name would be struck from the register. Provision would also be made for reinstatement at a later date.

Under these acts, the professions now have sweeping powers by which they can deal with the disciplining of their own members, licencing, fees, qualifications for practising in Saskatchewan, examinations and other matters pertaining to the various professions or practices.

Medical Etiquette and Ethics*

N. E. Waterfield, M.B., B.S., F.R.C.S.

WHAT is the difference between etiquette and ethics? Medical etiquette might be defined as rules of procedure which govern conduct of members of the profession in their relationship one with another, while ethical rules deal rather with the relationship of members of the profession towards the individual members of the public and also with their responsibility towards the State. These rules when formulated take into consideration not only the immediate consequence of their application but also the ultimate results. A Canadian writer on this subject says it is as impossible to define ethics as it is to define pain, that we can write the rules of ethics but cannot say what ethics are. I think there is much truth in this statement, and although I have not given a definition of ethics I have stated what is the function of ethical rules. These rules are often slightingly referred to by the public as medical etiquette, and, in its view, have been drawn up by doctors to protect their own vested interests without reference to the interest of the patients, who are often annoyed at the restrictions these rules sometimes place on the freedom of action of the individual patient or doctor.

Codes of rules regulating the conduct of members of the medical profession date back to the earliest times. It is stated that there was a treatise published in Babylon in 2700 B.C. which dealt with this subject. It defined the personal responsibility of the physician and fixed various fees for different services and the penalties for neglected practice. Among the ancient Egyptians a physician might be sentenced to death when a patient under treatment died in a manner not recognized as natural by the authorities.

Hippocratic Oath

The Hippocratic Oath is well known to all of you. It still remains a most appropriate code of conduct, and although it dates from 460 B.C. the maxims it contains are quoted to-day: and I believe that in at least one university the Oath is actually administered to the newly graduated. It states that when the physician has doubts about the diagnosis or treatment of a case it is his duty to call in a consultant; that he should not advertise; that he should be reasonable in his charges and if necessary should forgo them altogether; that he should lead a pure and moral life; that he should pay due respect to his teachers; that he should not give poisons or sanction the giving of them; that he should not bring about abortion; that he should not divulge matters which should be kept secret; and that he should not be ostentatious in dress or bearing. You will see from this brief summary how sound was the advice given, and that little modification or addition is needed to-day.

Under the Romans in A. D. 138 there were regulations governing the number of physicians practising, and only those who passed certain tests of their qualifications and character were allowed to practise. In 1224 the Emperor Frederic prescribed a form of instruction for those wishing to practise medicine and regulated the fees a physician might charge. In the Middle

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Ages the religious orders were for the most part responsible for medical treatment and there were few, if any, independent practitioners.

In 1794 Thomas Percival drew up a set of rules which is really a code of medical etiquette rather than a code of ethics. It was published with a view to composing the quarrels of his contemporaries on the hospital staff. It pointed out that there may be two conflicting points of view: one that of the idealist, who lays stress on the interest of humanity as a whole, and the other which stresses the interest of the individual. The code lays down guides as to how these interests can be brought into harmony. One point of topical interest in Percival's code, when the average age of the G.M.C. is so much under discussion, deals with the age at which practitioners should retire from active work. Percival says: "The period of the commencement of senescence, when it becomes incumbent on the physician to decline the offices of his profession, is not easy to ascertain: so nice a point may be left to the moral discretion of the individual. But in the ordinary course of nature bodily and mental vigour must be expected to decay progressively, though perhaps slowly, after the meridian of life is past. As time advances, therefore, a physician should from time to time scrutinize impartially the state of his faculties, that he may determine bona fide the precise degree in which he is qualified to execute the active and multifarious offices of his profession." This is very excellent advice, but I wonder, even if we carry out this scrutiny, how many of us are capable of coming to an impartial decision. Perhaps under the new Health Bill the decision will be made for us by regulations drawn up by the Minister, who endowed with supreme wisdom, will decide at what age we must retire from practice.

B. M. A. Ethical Committee

The B. M. A. set up an Ethical Committee in 1902 for the guidance of practitioners in their relationship to one another, to their individual patients, and to the State. From that time on it has been responsible for deciding ethical issues according to the ethical standards formulated by the Central Ethical Committee, which, after having been approved by the A.R.M., become binding on members of the B.M.A. Fresh situations are constantly arising. Among those which have occupied the attention of the committee in recent years have been the relationship of medical men to medical auxiliaries and chiropodists, the relationship of industrial medical officers to their colleagues, the responsibility of a medical man who is financially interested in the running of a nursing home or clinic or who acts as a director in a company which deals in drugs or medical appliances, and just recently, the part medical men may rightly play in connexion with voluntary organizations—the one under immediate consideration being the Marriage Guidance Council.

Confidence and Consent

I have attempted to give you a very short summary of some of the landmarks in the history of medical ethics, and propose to devote the rest of my time to some of the questions which are of more direct interest to those in practice. I think one of the hardest problems to decide is when and what to tell. You will remember the direction on this question given in the Hippocratic

Oath: "Whatsoever, in my professional practice or not in connexion with it, I see or hear in the life of man which ought not to be spoken of abroad, I will not reveal as reckoning that all such should be kept secret." The golden rule, of course, is that the confidence of the patient should not be betrayed and that information which has been obtained by the doctor in the doctor-patient relationship must not be divulged without the patient's consent, either given or implied.

Consent may be implied when the information is given at the request of the patient for certificates or reports in order that he may obtain certain benefits from either the State or any clubs to which he may belong, or in order that he may be excused duty. You will notice the way in which the N.H.I. certificate is worded: "I hereby certify that I examined you on the under-mentioned date." This was originally done with the idea that you were informing the patient himself of the condition found, and it was the patient's own responsibility what he did with the certificate. There is, however, no particular point in having the certificate in this form, and the more ordinary form, "I certify that I examined (name)," is equally suitable provided it is handed to the patient himself. If the patient is an employee, say, of the Post Office or of a firm and presents himself for examination in accordance with instructions received from his employers, his consent to the making of an examination and the forwarding of a report may be implied. The same may be assumed when a person presen himself for a life examination or for a report to enable him to obtain compensation for an accident. But if a patient is under treatment and his employer rings up to inquire about him, no information of any kind which could possibly be considered a breach of confidence should be given without the patient's knowledge and consent, and in some cases it might be advisable to get this consent in writing. For example, if a patient were found to be suffering from T. B. and you thought that the employer should be informed, you would be well advised to get not only oral but written permission. I will give you some of the problems dealing with this matter which have been put to the Ethical Committee in recent years.

When to Give Information

I. The question is occasionally asked whether the police should be informed in the case of a patient being treated for the result of attempted suicide. This is considered a case where professional secrecy should be maintained.

II. Frequently inquiries are received from the police in a case where a dead baby has been found, and all the doctors in the area are circulated as to whether they have, about such and such a date, attended a woman who might possibly be the mother. The advice given by the B.M.A. is that under these circumstances the doctor should not tell, the reason behind this answer being that if it became known that such information would be disclosed, medical advice would not be sought and a double tragedy might result.

In 1914 a conference was held with the Lord Chief Justice, who said that the authorities desired (a) that information should be given by medical men in attendance on a woman who is suffering from the effects of abortion brought about by artificial intervention, and (b) that the circumstances in which it was desired that this communication should be made were subject to the three

following limitations: (1) That the medical man was of the opinion, from his own examination of the patient and/or from some communication that she may have made to him, that abortion had been attempted or had been procured by artificial intervention; (2) that he was of the opinion, from his own observation of and/or from a communication made to him by his patient, that such artifical intervention had been attempted by some third party other than the patient herself; and (3) that the medical man was of the opinion that his patient, due to such artificial intervention was likely to die and that there was no hope of her ultimate recovery. Subsequent to the conference the matter was considered by the Council of the Association and the following resolutions were passed: (1) That the Council is of the opinion that a medical practitioner should not in any circumstances disclose voluntarily information which he has obtained from the patient in the exercise of his professional duties; (2) that the Council is advised that the State has no right to claim that an obligation rests upon a medical practitioner to disclose voluntarily information which he has obtained in the exercise of his professional duties.

It is of course known to all of you that when appearing as a witness in a court of law the doctor is bound to disclose knowledge in his possession, unless he is prepared to go to prison for contempt of court if he refuses the judge's directions. The privilege of professional secrecy granted to clergy and lawyers is not extended to medical practitioners.

III. A doctor examining for an insurance company asked whether he should accede to the request of the insurance company for information as to how the candidate acquired the disease he was found to be suffering from. He was told that he should give the full nature of the disease but should avoid expressing an opinion as to how it was acquired.

IV. Another interesting case occurred recently in the divorce courts where the issue turned on whether one or other of the parties had contracted venereal disease. Both parties had agreed to the doctor's disclosing the information in his possession,and it was held that there was no reason why he should not have furnished a report.

V. In another case the M.O. of a trading company abroad was asked by the manager whether the illness from which an employee was suffering and which necessitated sick leave was due to alcoholic poisoning, since, if this were so, by the rules of the company, of which the employee was aware, he would not be entitled to a free passage. The reply given was that the certificate should state the true facts of the case.

VI. Advice has been sought whether the doctor should inform the employer in the case of a nursemaid whom the doctor was treating for lues venerea in an infectious form, the patient refusing permission for her employer to be informed. The doctor was told that, if every effort to obtain permission failed and the patient refused to give up her post until she was cured, he would be justified in informing the employer. You will have noticed that the Hippocratic Oath says that such things as ought not to be revealed shall be kept secret. This was considered one of the exceptional cases where information should be given without the patient's consent, and which did not come under the category of something that ought not to be revealed.

What to tell a patient when he is very seriously ill may be a very difficult question to decide, but it is obvious that if a patient demands to know what is

your opinion of his case he has a right to know it. There is no doubt that the will to live is a powerful factor in helping the patient to sustain the fight, and any expression that he has little or no chance of getting better should be made most guardedly and in terms which should not remove entirely all hope of recovery, for every one of us must have in mind cases where the seemingly impossible has happened.

Advertising

You will remember that the Hippocratic Oath condemns advertising by members of the profession, but there are methods considered ethical by which the existence of a practitioner can be made known to the public. The first of these is the doctor's plate. This should be of reasonable size and not unduly conspicuous. Forty years or so ago it was quite common to see the words "Physician and Surgeon" and not infrequently "Accoucheur" added as well, and in some poorer districts, where a shop window formed the front of a doctor's waiting-room, it was not unusual for a notice to be displayed which said that teeth were carefully extracted. The more usual and perhaps more dignified custom is to have either the words Dr. So-and-So, or the doctor's name followed by his qualifications. There is no objection to the hours of attendance at a surgery being displayed in small lettering.

Many queries are put from time to time with regard to the plate. Is it permissible to display it at a house the doctor proposes to live in but is not actually occupying, or at a site where a new house is being built for the doctor's occupation? The answer to these queries is that it is not considered an ethical procedure to do so. It is also not permissible to put up a plate where messages are taken in but where no patients are actually seen. The doctor's red lamp has, I think, almost disappeared. Another question sometimes put by practitions of a specialty is whether they are at liberty to announce their specialty on the door-plate, the plea usually put forward being that they are constantly troubled by people who think they are in general practice. The answer is that it is not done in this country although it is a common practice on the Continent; for the proper path to the specialist is via the general practitioner, and a notification on the door-plate might be considered an invitation to a direct approach.

Publications in the lay press should not be used as a form of advertisement. I may perhaps quote the paragraph in the *Handbook* of the B.M.A. which deals with this matter; it reads:

"From time to time there are discussed in the lay papers topics which have relation both to medical science and policy and to the health and welfare of the public, and it may be legitimate or even advisable that medical practitioners who can speak with authority on the question at issue should contribute to such discussions. But practitioners who take this action ought to make it a condition of publication that laudatory editorial comments or headlines relating either to the contributor's professional status or experience shall not be permitted, that his address or photograph shall not be published, and that there shall be no unnecessary display of his medical qualifications and appointments. There is a special claim that practitioners of established position and authority shall observe these conditions, for their example must necessarily influence the action of their less recognized colleagues. Discussions in the lay press on disputed points of pathology or treatment should be avoided

by practitioners: such issues find their appropriate opportunity in the professional societies and the medical journals."

Questions are sometimes asked whether it is permissible for a general practitioner to publish in the press change of address, return from a holiday, or the fact that he has taken a partner. The answer is that none of these announcements is considered suitable for insertion in the lay press, but that the desired information may quite properly be conveyed to the patients in a letter or by a notice displayed in the doctor's surgery. However, I would say that under the special circumstances of the war it was considered desirable to allow announcements of the return of practitioners to be inserted in the lay press by the Local Medical War Committee on their behalf. A similar privilege was asked for on behalf of specialists, but it was considered that the proper place for such announcements was in the medical journals. One other point I should like to make is that it is sometimes obligatory from a legal standpoint that the dissolution of a partnership should be announced publicly; when this is so, no objection would be taken to an announcement in the press. One other form of publicity which depends on a statutory provision is the exhibition in the post-offices of a list of the practitioners in the area who are doing N.H.I. work.

When a practitioner is appointed as medical officer to an organized body which provides medical care and attention to its members, it is the duty and responsibility of the practitioner to see that there is no improper publicity and no canvassing for members which might contravene the warning notice of the G.M.C. It must be remembered that the public has not the same ethical standard as the profession, so that the practitioner is well advised to be very much on his guard. Another trap for the unwary is that provided by the enterprising newspaper reporter in search of news. A few harmless remarks with reference to an article the writer has contributed to a medical journal made to a reporter of the sensational press may involve the doctor in a very awkward situation. The question of a practitioner's taking part in local politics is a matter for his own decision, but I think it might be said that it is unwise for a practitioner to take part in activities in which strong feelings are likely to be stirred up.

Rules have been laid down for the guidance of specialists who enter a district with the intention of starting to practise their specialty there and who wish to convey this information to their colleagues. The methods by which it is considered ethical to effect this are: (1) By calling on practitioners already established in the area and giving a personal explanation of arrangements and plans; (2) by sending a sealed postal communication to those practitioners who may be expected to be interested, provided such a communication contains no laudatory allusion to himself or his work; (3) by communications on professional subjects presented to the local Division of the B.M.A. or other medical organizations; (4) by sending reprints of his published works to those practitioners who may be expected to be interested.

Canvassing and advertising have both been most severely condemned and called forth the well-known Warning Notice of the G.M.C. The practices by a registered medical practitioner (a) of advertising, whether directly or indirectly, for the purpose of obtaining patients or promoting his own professional advantage; or, for any such purpose, of procuring or sanctioning or

acquiescing in the publication of notices commending or directing attention to the practitioner's professional skill, knowledge, services, or qualifications, or depreciating those of others; or of being associated with or employed by those who procure or sanction such advertising or publication or (b) of canvassing or employing any agent or canvasser for the purpose of obtaining patients, or of sanctioning of being associated with or employed by those who sanction such employment—are, in the opinion of the Council, contrary to the public interest and discreditable to the profession of medicine and any registered practitioner who resorts to any such practice renders himself liable, on proof of the facts, to have his name erased from the *Medical Register*.

Consultation

As laid down in the Hippocratic Oath, it is the duty of a doctor when in doubt about the diagnosis or treatment of a case to call in a consultant; but, in addition to this, certain circumstances may arise when it is, to say the least, advisable that a second opinion should be sought and a second doctor share the responsibility with the attending practitioners, for example, when it may appear that the performance of some operation, or the pursuit of some line of treatment, involves considerable risk to the life of the patient or may result in some permanent disability; before any operation for terminating a pregnancy for therapeutic reasons is contemplated; in the case of a drug addict where it is necessary to continue the administration of the drug solely for the relief of the symptoms of addiction; and, lastly, when there is reason to suspect that the patient has been subjected to an illegal operation or is the victim of criminal poisoning. Ordinarily the choice of consultant is in the hands of the attending practitioner, but, should the patient express a desire to call in a particular consultant it is usually wise to accede to the request provided the choice is not an unsuitable one. Consultations are not the formal proceedings they were in the days of the frock-coat, top-hat and gold-headed cane, the disappearance of which marked the end of an era.

With regard to the actual consultation:when this is carried out in the patient's house, after a preliminary talk in which the patient's doctor gives a history of the case and expresses his own opinion the practitioner precedes the consultant into the patient's room and introduces him. After an examination has been made the doctor follows the consultant out of the room and the consultation is held. Then the consultant gives his opinion to the patient or his representatives. If the practitioner is in disagreement with the view expressed by the consultant, he has the right to put his view before the patient, who should then be asked to make a choice as to which line of treatment he prefers to follow. Should the choice be on the side of the course recommended by the consultant, the practitioner, should he feel unable to co-operate would be well advised to hand over the case to a colleague.

Sometimes patients are anxious to have what they call an entirely independent opinion. When this is so, it is regarded as ethically correct for a consultant to see the patient without a letter from his doctor, but it is his duty to try to persuade the patient to let him communicate with the patient's doctor. In any event the consultant should not do more than express his opinion of the case. He should not, under any circumstances, accept the patient for treatment. When the patient attends at the consultant's house without the practitioner being present, the consultant will of course communi-

cate his findings to the patient's doctor in writing, and if a second visit is desirable it should be left to the patient's doctor to arrange it. Likewise if another specialist's opinion is considered necessary, the choice of who should be employed should be left to the patient's doctor, who would doubtless fall in with any suggestion the specialist might make.

Recently the Minister of Health sought to establish the position that in the case of a patient diagnosed as or suspected to be suffering from tuberculosis and referred to the divisional medical offieer, the latter should have the right to refer the patient direct to the tuberculosis medical officer. The B.M.A. has strongly contested this view, and a reply has been received from the Minister stating that in those cases where the opinion of a specialist was considered to be desirable for reasons other than to enable the examining medical officer to report whether or not an insured person is incapable of work, no steps would be taken for the specialist's examination before obtaining the consent of the insured person's own doctor. The Ministry is being pressed to agree that *all* references to specialists shall be made only after consultation with the insured person's doctor.

In the event of a patient's being admitted to a nursing home or the pay beds of a hospital under a specialist, he then of course has the right to call in whatever help he requires. The question is not infrequently raised of who has the right to choose the anaesthetist when an operation is to be performed. The answer is that it is the right of the surgeon, as also in the case of dental operations, when the choice belongs to the dentist; it being understood that in both instances the patient's doctor has the right to be present at the operation. The responsibility for the fee of the consultant and of the surgeon rests with the patient's doctor. It may be paid directly by the patient at the time of the consultation or operation or may be collected by the doctor and forwarded to the consultant. In the latter case any account sent to the patient should make perfectly clear how the total is made up. Dichotomy, or fee splitting, between the surgeon and the practitioner is a most serious offence.

I think the two situations which the public most complain about are that medical ethical rules, or etiquette as the public choose to call them, place some restrictions on obtaining independent opinion and treatment from whomever they like, and that they are not at liberty to change their doctor without certain formalities being observed. The first question I have already briefly dealt with when speaking about consultations. The rules governing the other situation are, shortly, that when a practitioner supersedes another in the conduct of a case he must satisfy himself that the other practitioner has been informed that his services are no longer required; and when a practitioner is requested to visit a patient and has reason to believe that another practitioner is in attendance, it is his duty to inform the patient that he cannot attend without the presence or consent of the practitioner actually in charge of the case. If the attending practitioner, after being warned, declines to meet the practitioner invited, and if the patient or his representatives persist in the request, knowing of this refusal, or if the attending practitioner retires from the case, then the practitioner is entitled to take over the care of the case.

In the case of a practitioner acting as medical inspector—for example, for an insurance company in a compensation case—it is his duty to inform the patient's doctor and invite him to be present at the examination, but should the latter fail to respond the medical inspector, with the consent of the patient,

can proceed with the examination. No criticism should be made of the treatment adopted and if any modification in the line of treatment is in his opinion necessary he should personally or by letter discuss this with the attending practitioner.

Covering

This is another of the most serious of ethical offences. It means enabling an unqualified person to carry on medical treatment which he would not be able to do unless he has a qualified practitioner behind him who is willing to fulfil certain obligations or render such assistance as he may require to enable him to carry on his work. For example, an unregistered practitioner may run a nursing home and undertake the treatment of patients; but without the assistance of a registered practitioner willing to sign death certificates of any patient who might die while in the home it would be impossible for him to do so. Or an osteopath may carry out manipulations for which an anaesthetic may be required. Here again, without the help of a registered practitioner his activities would be very much curtailed.

A question is sometimes asked as to the responsibility of a doctor who employs an unqualified dispenser. The answer is that under no circumstances can the dispenser make up medicines which contain poisons in any shape or form, but provided the person works under the close supervision of the doctor she is allowed to dispense other medicines. There is one situation which has recently arisen about which practitioners have to be very much on their guard. This arises from the position created by the enactment making it illegal for a person who is not qualified or registered as a midwife to attend for gain a confinement or during the lying-in period, and the doctor would be held guilty of an offence if he attended a case where such a person assisted him in any way with the nursing of the case.

It may have occurred to you that there are some problems which from time to time are under discussion by the public, such, for example, as euthanasia, contraception, and more recently artificial insemination, about which the medical profession as a body might have been expected to pronounce and formulate rules for the guidance of the profession, but it is generally accepted that these are large moral questions on which an individual member of the profession is at liberty, in the same way as any ordinary member of the public to form his own opinion and to use his own judgment as to the attitude he shall take towards them. As an aside I should like to say a word on the practitioner's attitude towards the dying. There are two aphorisms which seem to help in defining this. The first is: Thou shalt not kill but need not strive officiously to keep alive; the other: There is no moral obligation to prolong the act of dying.

The title of this address is "Medical Etiquette and Ethics," but I have found in the course of preparing it that it has been very difficult to separate the two subjects, and many points of etiquette have been dealt with when an ethical point has been under discussion. There are, however, two points of etiquette which I should like to stress before finishing. First, the necessity of always sending a communication with the patient sent for consultation, either to the consultant or to a hospital, and of acknowledging any communication received after such a visit; and, secondly, I would mention the custom, which I am afraid is more neglected than it should be, of a practitioner newly entering a district calling on the practitioners living there.

Correspondence

Faculty of Medicine
Dalhousie University
Halifax, N. S.
March 19, 1947

TO THE DOCTORS OF NOVA SCOTIA

Dear Sirs:

Re—Third Year Medical Students

Last year a number of doctors in the province were kind enough to accept into their homes as assistants a number of our third year students. The students remained for two months and had a most valuable experience. I should like to continue this experiment this year. Would any doctor who would be willing to accept a third year student into his home from the middle of June until the middle of September, kindly let me know. The agreement last year was that the doctor kept the student but there was no salary paid.

Sincerely yours

H. G. Grant, M.D.
Dean of Medicine

PHYSICIAN WANTED

There is a physician urgently needed at Maitland, Hants County, Nova Scotia. Full particulars regarding the practice, housing accommodation, and so on, may be had from Reverend H. L. Chappell, Maitland, Nova Scotia.

Personal Interest Notes

THE BULLETIN extends congratulations to Dr. and Mrs. Carl Tupper on the birth of a son, Gary Donald, on February 7 in Halifax.

The marriage took place in Halifax on February 25 of Miss Margaret Merritt Jollimore, R.N., Halifax and formerly of Cape Breton, and Dr. Newton George Pritchett, Halifax and formerly of Gambo, Newfoundland. They will reside in Halifax where Dr. Pritchett is resident physician at the Tuberculosis Hospital and Mrs. Pritchett is on the Nursing staff.

The BULLETIN extends sympathy to Dr. J. C. Wickwire of Liverpool on the death of his mother, Mrs. S. P. Wickwire, who died on March 6 after a brief illness.

Obituary

Dr. Murdoch Gordon Macleod of Whycocomagh died on February 26 at the wheel of his automobile while he was returning from a night call. The car had plunged down an embankment. Death was pronounced due to a heart attack.

A native of Neil's Harbor, Dr. Macleod graduated from Dalhousie Medical School in 1919 and went to Whycocomagh soon after where he had since practised.

To his widow and four daughters as well as the other members of his family the BULLETIN extends sincere sympathy.

DOCTOR WANTED

The community of Stanley Bridge, Prince Edward Island, is looking for a doctor to take over the practice of the resident doctor who is now unable to carry on. Any doctor interested in taking over this practice should communicate with Reverend W. I. Green at Stanley Bridge.