THE

BULLETIN

OF

The Vancouver Medical Association

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Wednesday, 9:00 a.m.—Clinicopathological Conference.
Thursday, 9:00 a.m.—Medical Clinic.
12:00 noon—Clinicopathological Conference on Newborns.
Friday, 9:00 a.m.—Paediatric Clinic.
Saturday, 9:00 a.m.—Neurosurgery Clinic.

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Regular Weekly Fixtures

2nd Monday of each month—2 p.m. ..... Tumour Clinic
Tuesday—9-10 a.m. ..... Paediatric Conference
Wednesday—9-10 a.m. ..... Medical Clinic
Wednesday—11-12 a.m. ..... Obstetrics and Gynaecology Clinic
Alternate Wednesdays—12 noon ..... Orthopaedic Clinic
Alernate Thursdays—11 a.m. ..... Pathological Conference (Specimens and Discussion)
Friday—8 a.m. ..... Clinico-Pathological Conference (Alternating with Surgery)
Alternate Fridays—8 a.m. ..... Surgical Conference
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Wednesday, 10:45 a.m.—General Medicine.
Wednesday, 12:30 p.m.—Pathology.
Monday, 11:00 a.m.—Psychiatry.
Friday, 8:30 a.m.—Chest Conference.
Friday, 1:15 p.m.—Surgery.

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Every Monday—9:00 a.m.-10:00 a.m. ..... Ear, Nose and Throat Clinic
11:45-12:45 p.m. ..... Therapy Conference
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12:00 noon-1:00 p.m. ..... Therapy Conference
Every Wednesday—11:45 a.m.-12:45 p.m. ..... Therapy Conference
Every Thursday—11:45 a.m.-12:45 p.m. ..... Therapy Conference
Every Friday—9:00 a.m.-10:00 a.m. (during February) ..... Lymphoma Clinic
10:15 a.m.-11:15 a.m. (as of March 6) ..... Lymphoma Clinic
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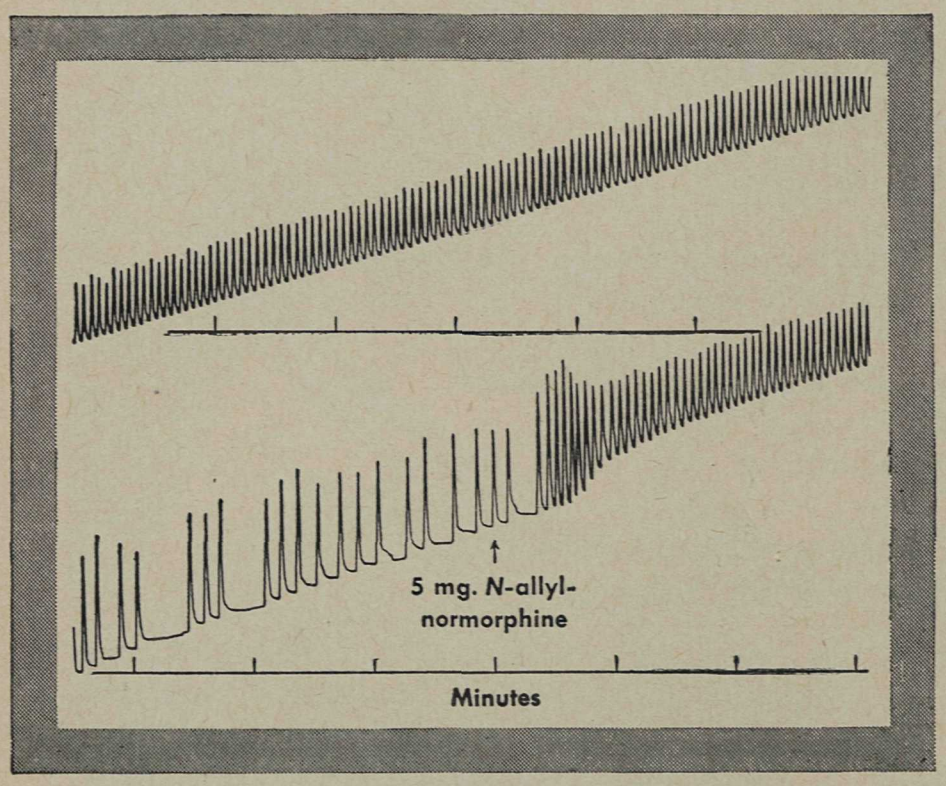

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Literature available

[1]Eckenhoff, J. E., Elder, J. D., and King, B. D., *Am. J. Med. Scs.* 223:191, February 1952. [2]Eckenhoff, J. E., Hoffman, G. L., and Dripps, R. D., Annual Meeting of the American Society of Anesthesiologists, Washington, D. C., Nov. 8, 1951.

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VANCOUVER HEALTH DEPARTMENT

Statistics—January, 1953

Total Population (estimated) 390,325

	January, 1953 Number	Rate per 1000 pop.
Total deaths (by occurrence)	452	13.9
Deaths, residents only	416	12.8

Birth Registrations—residents and non-residents (includes late registrations)

	January, 1953	
Male	515	
Female	496	
	1,011	31.1

Infant Mortality—residents only

	January, 1953
Deaths under 1 year of age	21
Death rate per 1000 live births	29.0
Stillbirths (not included in above item)	1

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	January, 1953		January, 1952	
	Cases	Deaths	Cases	Deaths
Scarlet Fever	46	—	99	—
Diphtheria	—	—	—	—
Diphtheria Carriers	—	—	—	—
Chicken Pox	156	—	196	—
Measules	96	—	367	—
Rubella	13	—	6	—
Mumps	275	—	58	—
Whooping Cough	25	—	—	—
Typhoid Fever	1	—	—	—
Typhoid Fever Carriers	—	—	—	—
Undulant Fever	—	—	—	—
Poliomyelitis	—	—	—	—
Tuberculosis	41	3	44	7
Erysipelas	1	—	—	—
Meningitis (meningococcic)	2	1	—	—
Infectuous Jaundice	15	—	—	—
Salmonellosis	8	—	2	—
Salmonellosis Carriers	—	—	—	—
Dysentery	16	—	2	—
Dysentery Carriers	—	—	—	—
Tteanus	—	—	—	—
Syphilis	10	1	15	—
Gonorrhoea	159	—	135	—
Cancer (reportable resident)	97	63	54	81

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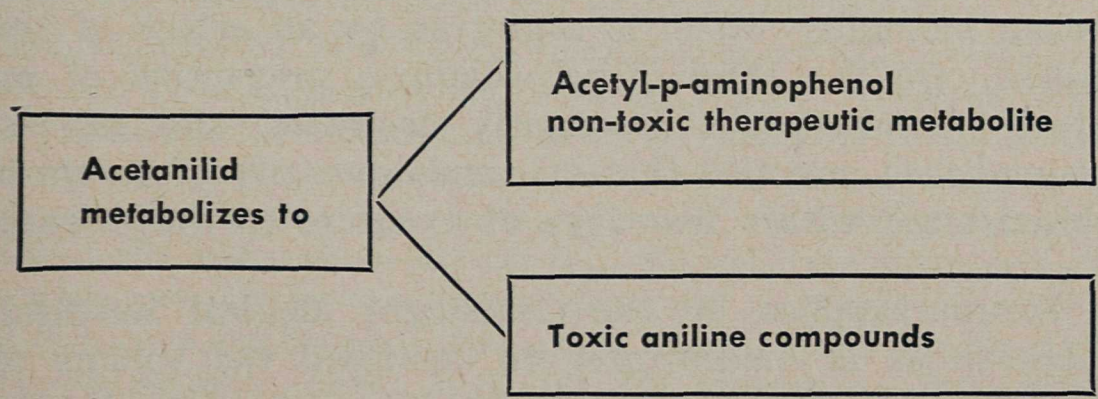

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The Editor's Page

Looking through an old number of the Bulletin the other day, we came upon an account of the Benevolent Fund: and it occured to us that probably very few men in the profession know much about this organisation, which is one of the most important and most beneficent features of organised medicine in this province. It is, as far as we know, the only Benevolent Fund in Canada which deals with cases of need in the families of medical men: and it has done a tremendous amount of good, in complete privacy, which, of course, is absolutely essential to its operation.

The Benevolent Fund was first organised in 1944 by the Vancouver Medical Association. The fund was the property of the V.M.A.—and was administered by it. Dr. W. E. Ainley was the Chairman of the Fund, as he has been ever since, and under his wise leadership the Fund was able to do a great deal of good work.

In 1947, the status of the Fund was changed. It was taken over by the B.C. Medical Association: since it was felt that this activity should be province-wide, and that the provincial body should administer it. The Vancouver Medical Association agreed readily to this, and at a special meeting voted to hand over to the provincial fund the moneys that it then had. The B.C. College of Physicians and Surgeons gave a sum of $10,000.00 and instituted an annual levy of $10.00 per member.

In 1952, when the B.C.M.A. became reorganised as the B.C. Division of the C.M.A. it took over the administration of the Benevolent Fund. It was not long, however, before the Directors of the Division came to the conclusion that, since the B.C. Division is a voluntary organisation, and cannot collect dues for such a purpose as this, a more satisfactory arrangement should be sought. Moreover, the Division does not yet include all members of the profession, as did the B.C. Medical Association—and so could not cover the whole province in administering the Fund. Accordingly, it asked the B.C. College of Physicians and Surgeons, through its Council, to assume the management of the Fund—and the latter agreed to do so. The transfer was made legally and the Benevolent Fund is now a function of the College, and its funds are the property of the College.

The Council promptly asked Dr. W. E. Ainley to continue as Chairman of the Fund, and he agreed to do so, which is, in the opinion of all who know anything about the work of the Fund, a most fortunate thing. Dr. Ainley has, for many years, been the presiding genius of the Benevolent Fund—and he and his Committee, of which Dr. Dan Busteed has long been, and remains, a most valued member, have steadily carried out the functions of administration in a way which could not have been bettered. The Fund has helped a great many people—where actual cash payments have been needed, they have been given—where loans would be of aid, they have been made, for educational purposes, as a temporary stopgap and so on.

And all this has been done with the greatest regard to economy. The only money spent has been the interest on the bonds, etc., owned by the Fund, and in nearly ten years of operation, there has been a deficit of only a very few hundred dollars, which could be made up at once. For the past two or three years, the Fund has not received any money from the College, as the annual levy was discontinued. Now, of course, the Fund is under the control of the whole College, and its financing is greatly simplified thereby.

This Benevolent Fund is one of our greatest assets—its work is of the greatest importance. Its administration reflects very great credit on the Committees that have handled it. We can all be very proud of the work that this Fund has done, without any publicity, with the greatest of tact and kindliness and consideration: and we know

that there are many who have great reason to be thankful for its existence, and who, in their time of need, have been helped over a rough place in the road, not by organised charity, or by public funds, but by the good-will of their own folk—the friends and colleagues who most gladly contribute of their own plenty to those who need it. It is not an insurance fund, and nobody has any claim on it—but while it exists, no medical man, and no medical man's family, who may have fallen on evil times, need want for the necessities of life. It is a family affair—and the family of medicine, through this fund, will take care of its own members.

Monday to Friday ..... 9:00 a.m. - 9:30 p.m.

Saturday ..... 9:00 a.m. - 1:00 p.m.

Recent Accessions

Transactions of the Ophthalmological Society of the United Kingdom, volume LXXII.
The Spread of Tumors in the Human Body by R. A. Willis.
An Atlas of Anatomy by J. C. B. Grant. Third Edition.
Textbook of Surgery edited by H. F. Mosely.
Connective Tissue, Transactions of the Second Conference 1951, edited by Charles Ragon.
The Metabolic Response to Surgery by F. D. Moore and M. R. Ball.
Tumors of the Eye by A. B. Reese.
Clinical Pathology of the Eye by B. Samuels and A. Fuchs.
The Significance of Heredity in Ophthalmology by J. B. Hamilton.

The journals listed below are those received in the Library in the fields of Obstetrics and Gynecology.

The American Journal of Obstetrics and Gynecology.
Journal of Obstetrics and Gynecology of the British Empire.
Surgery, Gynecology and Obstetrics.
Obstetrics and Gynecology.

* * * *

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SUMMER SCHOOL

June 1st to June 5th (inclusive)
Hotel Vancouver

Speakers:

Surgery—
DR. JOEL BAKER, Mason Clinic, Seattle, Washington.

Orthopaedic Surgery—
DR. R. GRAHAM HUCKELL, Professor of Orthopædic Surgery, University of Alberta, Edmonton, Alberta.

Obstetrics and Gynaecology—
DR. HOWARD STEARNS, Clinical Professor of Obstetrics and Gynæcology, University of Oregon, Portland, Oregon.

Medicine—
DR. MARTIN M. HOFFMAN, Professor of Medicine, Dalhousie University, Halifax, Nova Scotia.

Urology—
DR. CARL ABERHART, Toronto, Ontario.

Tickets for the five day session will be $10.00.

An Opening Day LUNCHEON will be held in the Georgia Hotel, and a GOLF TOURNAMENT followed by a GOLF DINNER and DANCE held on Thursday, June 4th, in connection with the School. For those who wish to participate in these functions as well as to attend the Sessions, a total price of $20.00 will be charged. (This may be deducted from income tax.)

Further information may be obtained from:

Dr. John A. Elliot,
Secretary of the Summer School Committee,
1807 West Tenth Avenue,
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Phone: BAyview 4158.

DOCTOR WANTED

For an area in Northern British Columbia on main line of Canadian National Railways. Doctor's practice would include two farming communities as well as two Indian reserves and an Indian residential school. Full particulars as to grants available from government departments and available living quarters on request. Enquiries should be directed to the Secretary, Fraser Lake Women's Institute, Fraser Lake, B.C.

In a letter addressed to the Bulletin, Dr. Naden promises to send further letters dealing with problems that arise in relations between the profession and the Workmen's Compensation Board. This seems to us to be an excellent and constructive idea—and we shall be glad indeed to publish these letters.

An observance by all of us of the point made by Dr. Naden at the end of this letter, viz., more complete and accurate reports on cases, would in itself probably do a great deal to remove misunderstanding and lessen any possible friction. —ED.

WORKMEN'S COMPENSATION BOARD
VANCOUVER

March 9th, 1953.

To the Members,
College of Physicians and Surgeons of British Columbia.

Dear Fellow Members:

The sincere hope is hereby expressed that this series of letters will lead to a much greater understanding of our common needs.

The Medical Officers of the Workmen's Compensation Board Head Office and Clinic wish they, individually, could have an opportunity of meeting the members of the College. Sitting across a table or desk face to face, outlining the day-to-day problems encountered in the handling of Workmen's Compensation claims has, in our experience, been a most useful means of ironing our difficulties. We are always glad to have you come to see us for any discussion about contentious cases.

Our Compensation Board has been in operation since 1917. During that period tremendous changes have taken place in medical practice and in all phases of activity in our Province. The Compensation Act has been expanded in all its phases and in most respects is one of the finest Acts in Canada.

It is not generally known that the powers of the Chairman and the other Commissioners of the Workmen's Compensation Board are very definitely governed by the limitations and controls outlined for the protection of all parties in the original Act and subsequent amendments.

As the new Chief Medical Officer I am encountering a great many intricacies of administration apparently unknown to the outside practicing physicians. Almost twenty-five years experience with the British Columbia Workmen's Compensation Board, from without, has only given me a very superficial knowledge of the complexities of management from within.

The answering of one of your greatest causes of complaint in relation to accounts, would, I am sure, be an excellent beginning. Discussion of the point had better wait until a later date.

Many of the members of the College have been annoyed and I am certain will, upon occasion, continue to be annoyed, by the seemingly petty requests for more information about the history and examination of a workman in relation to his injury.

The first request the Medical Staff would like to make, is for your cooperation in the complete and accurate submission of all reports. The powers of expression, by the writings of a pen, seem so inadequate in my hands in an attempt to convey the importance of this appeal. Your participation in this initial venture will eventually lead to a more enduring association for the mutual benefit of all.

With the deepest respect for and admiration of the practicing physicians of British Columbia, on behalf of the Workmen's Compensation Board, and particularly the Medical Staff, I remain

Sincerely yours,
J. R. NADEN, M.D.,
Chief Medical Officer.

TRANS-CANADA MEDICAL PLANS

By Dr. E. C. McCoy*

Ladies and Gentlemen:

In discussing with you Trans-Canada Medical Plans—and the part it could play in a national plan of health insurance, one should first outline for you what Trans-Canada Medical Plans mean—it is not a new super-plan on a national basis—it is a co-ordinating body set up to co-operate the activities of the various provincial schemes. That is why the name was recently changed from the original name of Trans-Canada Medical Services. Many people were interpreting this as a new plan and it is not. For any of you who know of Blue Shield in the U.S.A.—I might say that this is the Canadian coutnerpart. It is administered by a Commission consisting of one representative from each member plan plus one representative from C.M.A.—to date the Chairman of Economics Committee of C.M.A.

In my remarks, I shall attempt briefly to do four things—much of which is a repetition of a speech made in Montreal recently and with headlines so ably misinterpreted by some of the local papers.

(1) Give you a summary of T.C.M.P. to date.
(2) Outline to you what T.C.M.P. consists of to-day and show why service plans provide the best type of prepaid medical care.
(3) Try to show you where we believe T.C.M.P. could play a large part in a national health insurance plan in Canada.
(4) Outline decisions made in T.C.M.P. meeting in Montreal.

Trans-Canada Medical Plans were conceived in Montreal in June, 1951, after a two day conference of representatives from several prepaid medical care plans across Canada, under the Chairmanship of Dr. C. C. White. Discussions had gone on for four years prior to this at annual meetings of representatives—but until 1951 an apparent sterility had been the result and in reviewing these meetings, the apparent cause of the sterility was a constant failure to be able to produce a plan which would have uniform benefits and uniform rates across Canada.

In 1951 the thinking changed somewhat and it was decided to form Trans-Canada Medical Services to co-ordinate the activities of the various provincial schemes—but to retain provincial autonomy—and not create a new super-scheme.

Since June, 1951, there have been four Commission Meetings and a Meeting of the Executive Committee. These have been held in Montreal, Toronto, Edmonton, Banff and Saskatoon, respectively.

A full time Director—Mr. Howard Shillington—has been engaged.

The present coverage across Canada and the needs—have been studied at considerable length—and much spade work has been done in attempting to get a more universal coverage across Canada.

A Constitution and By-laws have been worked out and revised with many revisions already made as need became evident.

A "Dependents of servicemen Prepaid Care Plan" has been studied at length—and negotiations are in the preliminary stages.

T.C.M.P. to-day consists of nine Prepaid Care Plans across Canada—other applications are pending. The total membership of the plans in T.C.M.P. at present is over a million. During the past year, these plans paid out $15,394,075.68 for medical accounts, so you can see that we are already pretty 'big business'.

These plans are all service plans, except one, and this is a point we wish to emphasize. To the best of my knowledge there are only five ways that medicine may be practised and paid for:

(1) Private contract
(2) Indemnity plans

*Address given before Vancouver Medical Association, February 3, 1953.

(3) Government sponsored plans
(4) Service contract
(5) Private practice

In looking these over, I think we already know most of their advantages and disadvantages. The private contract denies the free choice of doctor which is one basic principle in which we believe—but it does work adequately in some small isolated communities.

Indemnity plans certainly have a place but do not answer the people's demand for complete coverage. Also, doctors don't particularly favor indemnity plans on a large basis unless the doctors are adequately represented on the governing board because if over 50% of the people in any area become covered, the doctors tend to lose control of the fee schedule. The schedule the company pays comes more and more to be accepted as the schedule. On a small basis this is not an important factor. They have a place—but certainly are not the full answer from either patient or doctor point of view.

Government sponsored plans have many advantages and disadvantages and I need not outline many of these for you. However, in most places where the government sponsored plans have been introduced, the free choice of doctor has been lost—or at best there remains a restricted choice. Also the doctor tends to get involved in a lot of 'red tape' and spends too much time filling in papers instead of practising medicine. Also it seems very hard to retain the proper doctor-patient relationship. Again, it usually becomes expensive.

The service contract where the patient's full bill is paid for—on as full a service basis as possible—seems to approach more nearly what both patients and doctors desire. In working out such a scheme, the service as I mentioned should be as complete as possible—getting rid of all exclusions, if possible, and paying the bills in full. If doctors believe what they say when they say people should be able to prepay for their medical care, then it would seem realistic that this type of plan should be the objective.

The 5th method is that of private practice with the patient paying his own bill. I'm sure many doctors would desire that this method remain—as it had been in Canada for many years. However, medical care is becoming very expensive with newer methods of investigation and treatment, etc. Also I believe one must face the fact that the world is changing with resultant changing philosophies and changing standards of living—with a greater emphasis on security and collectivism—and making as much of everything available to as many people as possible, with the cost spread over groups as a whole—in other words some socialistic trend. Hence, people want to prepay for medical care and not suddenly be faced with a financial catastrophe. I think the doctor who can't see this or understand this, must just have his head buried in the sand—and he had better get it out—and realize that prepayment for medical care is coming whether he likes it or not—and perhaps it would be better if he used his knowledge and ability to help plan some way so that people could prepay.

In other words, I think that private practice where the patient pays his own medical bill—much and all as it has many desirable features that are very difficult to achieve under any plan—is on the decline—and we might as well face it and help mould the new method.

I have attempted to point out to you why the service plan is the best plan available —and that is why, under T.C.M.P., we are primarily co-ordinating service plans. We believe this will give what the people want—and at the same time retain the patient-doctor relationship on a proper level.

In trying to point out to you where we believe T.C.M.P. could play a large part in a national health insurance plan in Canada, one must attempt first of all to answer several questions that must be answered and one must outline what one means by health insurance. Certainly, many of those who to-day are discussing this problem across Canada know very little about it—but are attempting to play politics with health

insurance—and one cannot help but feel that the provision of medical care is too personal a service to be brought into the realm of politics. Health insurance not only enables individuals to prepay their medical costs, but does this in such a way as to secure a wide pooling of risks and distribution of costs in much the same manner as any other form of insurance. Such questions as, "Should such a plan be voluntary or compulsory?" "Should it be run by government or by doctors?" "Should it be provincial or national?" "How should it be paid for?"—are all important questions that we should be prepared to answer before we can intelligently deal with the problem.

I believe there are two main aspects to the provision of medical care. The first is the field of public health and preventive medicine on a community basis—the other is the field of curative medicine which also involves preventive medicine on an individual basis and to have a proper health insurance plan, we must consider both of these fields. Curative medicine is the more expensive part while public health and preventive medicine is much less costly. On the other hand, public health and preventive medicine on a community basis must be compulsory. From a public health point of view, there is not much sense in your being immunized against diphtheria if your neighbours aren't also. The only place where such a compulsory scheme properly fits into our way of life is under government sponsorship, therefore, this part of medicine could properly be provided by the government out of the tax dollar—personal contribution here is not necessary. Prevention cannot be properly done by individuals—it must be done by all. Individuals as individuals just aren't sufficiently interested in prevention.

On the other hand, individuals should be vitally interested in curative medicine. It is high-priced as stated before and the individual must share part of that cost at least. This should be done on a voluntary basis—if we are to retain two of the basic principles which we believe to be essential—those are (1) free choice of doctor by the patient and (2) free choice of doctor to refuse any patient. I know of no compulsory scheme that does not interfere with one or both of these principles to a greater or lesser degree. However, if any individual small group wished this to be compulsory for their group, they could have it so without interfering with the desires of the people as a whole to keep it on a voluntary basis—as a matter of fact under some plans at present, compulsion is in effect—as it is a condition of employment in certain groups—agreed upon by management and unions.

One frequently hears it remarked that doctors are against health insurance. They are not—they want health insurance—the C.M.A. has gone on record as being in favor of it—they realize the need of it perhaps more than most laymen as they are dealing with sickness continually. Quite rightly they do not want to become government employees as they believe a personal service like medical care must retain the above mentioned two basic principles—and as government employees it becomes very difficult if not impossible, to retain these two basic principles.

If one accepts the above, one next comes to whether such a scheme should be administered by the Government or by doctors. I don't believe it should be by either one. I don't believe the Government could administer it even on a voluntary basis without getting too much politics and red tape mixed up in it. I don't believe the doctors alone can administer it adequately because it is most important that the subscriber have a choice in the provision of his care.

I believe the plan should be administered by a board composed of representatives of the two groups of people primarily involved—the consumer and the provider of the care. That is, the subscribers and the doctors both—such a board to be elected and selected from the two groups. Several plans in Canada now operate under such a system and operate very well.

Next, we should consider whether such a plan should be provincial or national. I believe that it should be no greater than provincial at outside. Centralization of such a scheme leads to more red tape and book work—and certainly doctors in Nova Scotia or B.C. are not going to take the certain amount of regimentation that must go with

such a scheme, from someone sitting at a desk in Ottawa in the same way that they would from someone in Halifax or Vancouver. By the same token, the patient isn't going to accept rulings, etc., from one central office in the same way that he would from a provincial office and more important he isn't going to remain so much interested in keeping down the costs as he would if the scheme is on a more local basis. As a matter of fact, the more local it is the more interested he is in keeping down the costs—but there is a limit to how local the scheme can become and remain economical. I believe that provincial plans or plans of about that size are best. Another point here is that conditions vary tremendously across Canada as we have seen in our deliberations to date in T.C.M.P. Costs of living vary—different provinces have different types of government—some of which provide more medical care than others—also doctor's fees vary as costs of living varies— thus it is most difficult if not impossible to set a fee schedule for all of Canada that is fair. That is one place that indemnity schemes do have an advantage. They can do national coverage fairly readily because they pay only a certain amount toward a bill and the patient pays the rest which varies from province to province. Thus, I'm sure we are on the right track when we say these plans must be no larger than provincial.

This now brings us up to where T.C.M.P. fits into this plan. Provincial schemes alone are not enough—people frequently move from one province to another—usually from any one of nine provinces to British Columbia—and they should not have to lose coverage or undergo new waiting periods, etc. This is where T.C.M.P. fits in. It will co-ordinate these various provincial plans—allow subscribers to move from one to another, without loss of waiting periods and without loss of coverage. Also it provides a means whereby national employers can arrange coverage for employees in several provinces—and at the same time it will be working towards getting as nearly as possible a uniform type of coverage—at possible fairly similar rates.

At the present time, the various provincial plans do not cover enough people—some will only take employed groups—some will not take individuals. T.C.M.P., if it functions efficiently, will have to have all of its member plans enlarging their scope and making prepaid medical care available to all. This applies to our own plan in this province—M-S-A which is our representative in T.C.M.P. It does not cover enough people. If all those were covered who are eligible under present regulations—we should only cover about 35-40% of the people in the province. We must begin relaxing our strict regulations a bit—and make the service available to more people if it is to answer to the demand for health insurance. Of the various members of T.C.M.P., our enrolment increased by the smallest percentage last year. At the same time, I must admit that we have the second largest enrolment—but we must keep enlarging—and quite rapidly—as our experience grows.

You may now well ask—who will pay for this? There is no doubt that the subscriber should pay if able—it might be done in conjunction with employers in some cases—if desired. However, the subscriber must pay at least part—or it becomes too expensive. You do not get anything in life for nothing and if the subscriber is not vitally interested in the cost, he will tend to abuse it. Even when he is interested in the cost, he tends to use it more than he would if he were paying the doctor's bill in full and this is why no government can estimate the cost of medical care in advance—regardless of estimates they may produce. Utilization is a big factor and we are just beginning to realize what it means. In B.C., for instance, under M-S-A, in 1945 one in 20 subscribers used the service each month—in 1952, one in 8 used it each month. This is one of the main reasons why such Plans must grow gradually. The human element in such a personal service is impossible to estimate—and the human element is what makes or breaks the plan.

For those who cannot pay at all, the government must pay—as I'm sure all of us agree that we must look after our indigents. However, I believe the government should contribute these costs—but should not administer the plan. As Raoul Poulin—

a very able parliamentarian from Quebec said in November, speaking in the House at Ottawa in referring to the problem of medical care which should be given to the needy:

"I believe, speaking in all sincerity, that governments can strive to attain this goal without intruding into the field of medicine."

Canada is not a poor country—we can afford good medical care—we can afford the best medical care—but we must make sure that what we get is good medical care without too much waste of money.

This, ladies and gentlemen, is where I believe T.C.M.P. could fit into a plan for national health insurance for Canada. I believe it would give up better medical care—better from both patient's and doctor's point of view—than any other plan in existence to-day—although I must admit that the U.S.A., after a lot of investigation and research, is now coming to strive for something that is not too unlike what we are trying to do in Canada.

Now,coming to the fourth part of my remarks—telling you what we did in Montreal. There was much discussion about development in Quebec and I must say that as yet the doctors in Quebec have not agreed to sponsor any plan to represent them in T.C.M.P. The two medical associations there—English and French—complicate considerably the matter of arriving at decisions.

It was decided that the Head Office of T.C.M.P. will be in Toronto and it is hoped that it will be established by this summer.

Maritime Hospital Service Association—A Blue Shield Plan—which also provides hospitalization benefits but is not a service plan was accepted as an Associate Member, after much discussion—and after being named by New Brunswick Division of C.M.A. as their representative. One quite agrees that as yet they do not meet the standards set up for membership in T.C.M.P. but they have the approval of the medical profession there and that is one of the chief points we insist on—that the doctors must approve the plan and apparently the doctors like this plan in New Brunswick, although I doubt that either doctors or subscribers would go for it here—to any extent.

I believe we aroused much interest on the part of the doctors in Quebec in the matter of service plans and it is hard to tell what may develop.

Many other matters were discussed which would be of no particular interest to you so I shall not waste your time with them.

However, we had a good round table discussion on national health insurance. We also had a very excellent representative from Blue Shield in the U.S.A., who participated in discussions. As a result, partly of this and partly of other general observations, I believe it is fair to assume that we have probably about two years to provide health insurance for the people of Canada—or it will be provided for them otherwise. We may have less time than this and we may have as much as four years. The Americans figure they have four years and I don't believe we will be too much different from them.

The important thing is that we, as a profession, must at least help to arrange provision of this care and must have a voice in its operation. As individuals or as groups, we may not like some of the regimentation—or other things that go with this—but at least we should keep our dislikes and disagreements within our own profession, and if we do not like some particular treatment we have received over for example same case, we should not take it out on the patients or express our dislike of the scheme to patients—we should get together with the other members of the profession and make the needed corrections and make prepayment work. Also we must remember that it is our effort, and if we abuse it we are only working against ourselves. If doctors and subscribers aren't both vitally interested in making prepayment work and in keeping down costs, then it won't work, and I'm sure we will all end up with much more regimentation and red tape than we would ourselves arrange.

In conclusion, I have attempted to outline to you what type of child T.C.M.P. is at present time—and to reveal to you some of our feeding problems and why we are being kept awake at night a bit. However, I am sure that it is a good healthy child—and I believe it should grow up to fulfill a very useful manhood—and to play a very useful part in the future of Canada.

E. C. McCOY, M.D.,
President, Vancouver Medical Association,
and Chairman, Trans-Canada Medical Plans.

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THE PRESENT STATUS OF STATE MEDICINE*

By G. GORDON FERGUSON, M.D.

When invited to speak to this Society, the suggested title was "The Present Status of 'the threat of' State Medicine." This will continue to be the theme of the talk, but for the first time in my experience I find myself cast in the role of a crystal gazer.

O wad some Pow'r the giftie gie us
To see oursels as others see us!
It wad frae mony a blunder free us,
And foolish notion:
What airs in dress an' gait wad lea'e us,
And ev'n devotion!

Burns—"To a Louse"

Before giving any prognostications it will be worthwhile to give a little time to examine the two important words in the suggested title:

1. The State
2. The Threat

If we are intelligently to understand our present position, we must be clear on the implications of both. The word "state" is used throughout in the broadest sense of being the opposite to the citizen as an individual. It may mean the local community, the national community or the agent of the community—which is the Government.

The State is interested in two ways.

1. *As a consequence of world wide social change.* This is inevitable in the twentieth century with its unparalleled industrial and scientific development plus the convulsions of two world wide wars.

The State believes it a proper function of government to be interested in the well-being of individuals. This varies only in degree within different countries. On the one extreme, the state has busied itself so much in the affair that it has supplanted the individuals' responsibility and even stolen his freedom. This latter catastrophe is a natural result when too many individuals live by that common and lazy rule "Let George do it."

However, since in all nations today the question of survival has moved from the individual to the national level, I accept that we must recognize that the state has a right to show interest in the wellbeing of individuals.

There are many indications of this acceptance in Canada today. The Old Age Pension—Child Welfare Allowance—Social Aid—Workmen's Compensation and probably many others I cannot recall at the moment. What must be apparent to you is that most of these innovations more or less intimately involve the work of the medical profession.

*Address given before Vancouver Medical Association February 3rd, 1953.

Our general responsibility as citizens and not just as physicians is that we must not be so enamoured of the "something for nothing" philosophy in respect to government beneficence that we surrender our individual freedom to the state.

However, it is because of the effect of a highly organized industrial society that some family units are in distress and are suffering a lack of essential things. Such a lack weakens the whole community. Here the state should extend a helping hand.

The family able to care for itself must do so, as in doing for itself it becomes more self reliant. We can strengthen the family and the individual by showing them how to assume their own responsibilities, that is, be more conscious of their own behaviour in particular respect to health.

However, it is important that we do recognize that some people need help and we should be prepared to act with the State to see they are not denied essential medical care. The S.A.M.S. is an example of the state picking up its responsibility and working it out through us. I think many of the seemingly irksome personal features of S.A.M.S will become more tolerable when the ultimate group objective is more clear.

These remarks indicate to me why the state is interested in health and in general what I hope is our considered and responsible attitude toward the general weal.

2. *The Practical Application of Medical Knowledge in Health Affairs.* As illustration I will consider the disease Tuberculosis—a subject familiar to all of you.

At the outset I can find no indication that the state is interested in tuberculosis because they believe they have a better treatment to offer. We practise as individuals, and given an individual tuberculosis patient, most of us can handle it with credit. However, that is not the point at issue.

What is the point at issue is that uncontrolled tuberculosis is a menace to the state. Undiagnosed disease leaves many healthy people in danger. Segregation of the family is not enough. It must be segregation of the individual. The long period of recovery is more than most individuals can afford and if it is the breadwinner who is affected then women and children are destitute.

The move to diagnose and segregate early in the disease, check contacts and extend a helping hand to the dependent of the patient as well as assure treatment over a sufficiently long period of time is a problem in which the profession needs the help of the community. The community is anxious to give its help, and in this province operates as a division of the Department of Health.

I have only discussed the medical aspect of the problem as it affects the community. Just for the record I will mention that the community has the added task of being interested in sanitation, housing and nutrition if it is to successfully attack this disease. Sometimes in this respect the State is slow and must be prodded.

Feeling a Threat

The use of the words "threat of State medicine" is interesting. Recognition of a threat against anything is an awareness of a possible danger, but degrees of apprehension against a threat can be measured all the way down the scale to absolute fear. I have no doubt that in the minds of individual physicians it does run from mild apprehension to fear, depending on the knowledge and understanding, that the individual has of the problem.

In war time an army commander will recognize a threat to his position from certain directions but is not apprehensive unless he is either unprepared or has no knowledge of the situation. In other words, if we are concerned about the threat of State medicine and are apprehensive about it, our first task is to remove ignorance of the problems involved from among ourselves and develop our own strength through knowledge.

We must make certain that we understand clearly whether the threat is against ourselves and involves something personal with us or whether it is a threat to our concept of good medical care. Are we concerned because we feel that the position we

hold, either for ourselves or for a good medical service, is unjustifiable and cannot be maintained?

The Threat to Ourselves

If any of us are apprehensive about the threat to ourselves, then that apprehension also stems from a lack of knowledge of the situation or full knowledge of the situation but realizing that the position we hold is indefensible.

"No good doctor remains cold, hungry or unliquored for long."

Fischerism.

Granting we must have some self interest, it seems to me that if we adequately demonstrate that as a group we are ready to lead in health affairs, and are good doctors, we do not have to blow our own trumpet too loud to win adequate attention.

It has not been my experience that patients complain about the cost of medical care, or envy their doctor some of the luxuries of life, when they have received good attentive service.

We believe our system of practice to be the best for today. It would be foolish to think it must necessarily be best for tomorrow. Our professional minds must be alert and receptive to improve methods of distribution as well as improved technical methods.

Knowledge is strength and there is strength in unity. Knowledge and unity will overcome the threat to ourselves.

The Threat to the Service

We believe that free choice of patient and doctor, and individual responsibility in health matters are essential for a good health service. These are things we must always defend. Threat to these beliefs come from opportunist politicians and uninformed people. We can do much to remove the threat to our service by educating the people, which in turn will nullify the politician.

Education of the citizens (who are our patients), comes about in several ways, not the least of which is how the doctor acts in relation to his patient. Does he help the patient get the best for his medical dollar? Think twice before ordering the diagnostic tests? Think twice before ordering fancy and expensive medications? Be a friend and counsellor with patience and tact?

The cost of a good medical service is high and growing higher. Not because our fees are so much higher, but because there are so many more ways of helping a person. We believe that some system or planning is necessary if the great bulk of our people are to benefit from these advances. We believe that the Insurance Principle is the one to be applied.

What are our people to think when we publicly endorse the insurance principle while some members privately still refuse to cooperate with those who are trying to work it out through voluntary prepaid care plans?

Judging from some correspondence I receive too many doctors think of S.A.M.S. and M.S.A. in the terms of the teenage song "Somebody else - not me." These are professional commitments through the Association and require to be honoured by every member.

The threat to the service is entirely one of ignorance on the part of the people generally, which can be dispelled only by intelligent and united action by a well informed and disciplined profession. If we cannot unite and act by our own free will, then certainly the threat becomes a reality and we may expect to have someone try to force compliance on us from outside the profession.

I believe no other body of citizens has such a potential to influence the course of history than the medical profession. Should all the doctors of the world manage to work together, I am sure we could stop the Four Horsemen of the Apocalypse in their tracks.

What is Our Present Position?

The State is interested in health now, and always will be. Their responsibilities however need not be antagonistic to ours.

Every political party promises to do something about Health Insurance. The type and amount of 'State Health' will depend on the political party in power, which in turn is a measure of the mood of the voters. There is today a swing away from the strong left position which followed the war. This swing is in Canada the same as over the world.

More people are realizing there is no such thing as 'free medical care'. They are skeptical about "Pie in the sky", and are reckoning cost. Most people realize that if they want medical care they cannot dragoon the medical profession into some unjust and unsatisfactory system. In Canada our slower development toward Health Insurance is likely to result in a more universally acceptable change. Socialized medicine as such is receding.

However anything can happen in the event of another world war when our whole medical man power will have to be mobilized for the big task of protecting the nation in its civil and military committments. What comes out of a war may not be recognizable to the system we took into it.

Summary

I have reviewed the position of the "State" in medical affairs, but wish to say that knowledgeable action on our part can remove the "threat". What counts is participation in the group discussions and honouring in every action these group decisions. Failure to belong to the Medical Association and failure to honour its work is the surest way I know for the medical profession to destroy itself and its place in society.

Look up and not down,
Look out and not in,
Look forward and not back,
And lend a hand.

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PREPAID PLANS

The work of Medical Directors and Assessment committees as well as the Reference Committee of the Association, will be greatly eased, and most misunderstandings between individual doctors and all approved plans, including M.S.A. and S.A.M.S., will be reduced, if the following points are noted:

1. The Schedule of Fees forms the basis of understanding in accounting between the profession and plan.

2. Accounts varying from the Schedule should be accompanied by an explanation. The back of most account forms has a place for this.

DOMINION INCOME TAX RETURNS BY MEMBERS OF THE MEDICAL PROFESSION

As a matter of guidance to the medical profession and to bring about a greater uniformity in the data to be furnished to the Taxation Division of the Department of National Revenue in the annual Income Tax Returns to be filed, the following matters are set out:

Income

1. There should be maintained by the doctor an accurate record of income received, both as fees from his profession and by way of investment income. The record should be clear and capable of being readily checked against the return filed. It may be maintained on cards or in books kept for the purpose.

Expenses

2. Under the heading of expenses and following accounts should be maintained and records supported by vouchers kept available for checking purposes:

(a) Medical, surgical and like supplies;

(b) Office help, nurse, maid and bookkeeper; laundry and malpractice insurance premiums. (It is to be noted that the Income Tax Act does not allow as a deduction a salary paid by a husband to a wife or vice versa. Such an amount, if paid, is to be added back to the income);

(c) Telephone expenses;

(d) Assistants' fees; The names and addresses of the assistants to whom fees are paid should be furnished. This information is to be given each year on Income Tax form known as Form T.4, obtainable from your District Income Tax Office;

(e) Rentals paid; The name and address of the owner (preferably) or agent of the rented premises should be furnished (see (i));

(f) Postage and stationery;

(g) Depreciation; A description of the treatment of depreciation may be found on page four of the Income Tax Return form T.1 General under the Part XI Method.

The method of computing depreciation for tax purposes is the same as that used last year and you should have no difficulty if you have a copy of last year's return available.

Simply carry forward the balance remaining in each class after deducting last year's allowance. Add to this figure the cost of any new equipment purchased and deduct the proceeds from any disposal of property in each class. The rate you wish to use not exceeding the maximum rate (see below) is applied to this new balance for each class to obtain the depreciation you may claim this year.

The maximum rates for the classes of equipment most used by doctors follow:

Capital item

Medical equipment	*Class*	*Annual maximum depreciation*
(a) Instruments costing over $50 each and medical apparatus of every type	8	20%
(b) Instruments under $50 each	12	100%
Office furniture and equipment	8	20%
Motor car	10	30%
Building (Residence used both as dwelling and office)	3	5%

Instruments costing less than $50.00 each belong in class 12 and have a maximum allowance rate of 100%. They should not be included in expenses but should be recorded as additions in column 3 of the schedule.

Where a doctor practises from a house which he owns and resides in, the allowance may be claimed as above on a portion of the cost of the residence, including land. For example if the residence were a brick building costing $12,000 and one-third of the space were used for the office, the doctor would use $4,000 as the business portion of

the cost and apply the building rate of 5% to determine the maximum depreciation allowable in the first year.

For further information on the subject you may refer to the Regulations or you may consult your District Income Tax Office.

(h) Automobile expense; (One Car). This account will include cost of license, oil, gasoline, grease, insurance, garage charges and repairs;

The capital cost allowance is restricted to the car used in professional practice and does not apply to cars for personal use.

Only that portion of the total automobile expense incurred in earning the income from the practice may be claimed as an expense and therefore the total expense must be reduced by the portion applicable to your personal use.

The mileage rate permitted in years prior to 1950 may no longer be used to estimate the automobile expenses.

(i) Proportional expenses of doctors practising from their residence: (a) Owned by the doctor: Where a doctor practises from a house which he owns and as well resides in, a proportionate allowance of house expenses will be given for the study, laboratory, office and waiting room space, on the basis that this space bears to the total space of the residence. The charges cover taxes, light, heat, insurance, repairs, capital cost allowance, and interest on mortgage (name and address of mortgagee to be stated); (b) Rented by the doctor: Only the rent and other expenses borne by the such as heat and light will be apportioned inasmuch as the owner takes care of other expenses.

The above allowances will not exceed one-third of the total house expenses or rental unless it can be shown that a greater allowance should be made for professional purposes.

(j) Sundry expenses (not otherwise classified).—The expenses charged to this account should be capable of analysis and supported by records.

Claims for donations paid to charitable organizations will be allowed up to 10% of the net income upon submission of receipts to your Income Tax Office. This is provided for in the Act.

The annual dues paid to governing bodies under which authority to practice is issued and membership association fees, to be recorded on the return, will be admitted as a charge. Initiation fees and the cost of attending postgraduate courses will not be allowed.

(k) Carrying charges: The charges for interest paid on money borrowed against securities pledged as collateral security may be charged against the income from investments and not against professional income.

(l) Business tax will be allowed as an expense, but Dominion, Provincial or Municipal income tax will not be allowed.

Convention Expenses

"Effective January 1, 1948, the reasonable expenses incurred by members of the medical profession in attending the following Medical Conventions will be admitted for Income Tax purposes against income from professional fees:

1. One Convention per year of the Canadian Medical Association.

2. One Convention per year of either a Provincial Medical Association or a Provincial Division of the Canadian Medical Association.

3. One Convention per year of a Medical Society or Association of Specialists in Canada or the United States of America.

The expenses to be allowed must be reasonable and must be properly substantiated; *e.g.*, the taxpayer should show (1) dates of the Convention; (2) the number of days present, with proof of claim supported by a certificate of attendance issued by the organization sponsoring the meetings; (3) the expenses incurred, segregating between (a) transportation expenses, (b) meals and (c) hotel expenses, for which vouchers 'ould be obtained and kept available for inspection.

None of the above expenses will be allowed against income received by way of salary since such deductions are expressly disallowed by statute."

Professional Men Under Salary Contract

The employees' annual contribution to an approved Pension Plan and alimony payments may be deducted from salary income.

Amendments to the Income Tax Act, introduced in 1951 and made retroactive to the beginning of the calendar year 1951, provide for the deduction of certain expenses from salary income.

The allowable expenses include travelling expenses, annual professional membership dues, office rent, salary to an assistant or substitute and supplies consumed directly in the performance of the duties of employment.

The annual registration fee of the Provincial medical licensing authority would be allowable if paid by the doctor himself.

Certain conditions are attached to the allowance of the expenses and without trying to recite the exact provisions of the law the main points are:

(a) That the expenses must have been incurred in the performance of the duties of the office or employment.

(b) That the employee is required, under the contract of employment, to pay the expenses.

(c) To claim travelling expenses the employee must be ordinarily required to carry on the duties of his employment away from his employer's place of business. Travelling between the doctor's home and his office is not included.

Where the travelling expenses are allowable under these provisions, depreciation may be claimed on the automobile used for this purpose but no other claim for depreciation may be made.

Income from a Partnership

Additional expenses incurred by a partner, but not charged to the partnership, may be claimed as a deduction from the partner's share of income. However, the partner must be in a position to substantiate these expenses, to show why they were not charged directly to the partnership and that they were necessarily laid out to earn the partnership income.

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Dr. F. P. Patterson
Dr. P. O. Lehmann
Dr. G. C. Johnston
Dr. Ross Robertson
Dr. R. A. Gilchrist
Dr. J. Ross Davidson
Dr. R. A. Palmer

Kootenay
Dr. J. McMurchy

Standing Committees	*Chairmen*
Constitution and By-Laws	Dr. R. A. Stanley, Vancouver
Finance	Dr. W. R. Brewster, New Westminster
Legislation	Dr. J. C. Thomas, Vancouver
Medical Economics	Dr. P. O. Lehman, Vancouver
Medical Education	Dr. T. R. Sarjeant, Vancouver
Nominations	Dr. J. A. Ganshorn, Vancouver
Programme and Arrangements	Dr. Harold Taylor, Vancouver
Public Health	Dr. G. F. Kincade, Vancouver
Special Committees	
Arthritis and Rheumatism	Dr. F. W. Hurlburt, Vancouver
Cancer	Dr. Roger Wilson, Vancouver
Civil Defence	Dr. John Sturdy, Vancouver
Hospital Service	Dr. J. C. Moscovich, Vancouver
Industrial Medicine	Dr. J. S. Daly, Trail
Maternal Welfare	Dr. A. M. Agnew, Vancouver
Membership	Dr. E. C. McCoy, Vancouver
Pharmacy	Dr. D. M. Whitelaw, Vancouver
Public Relations	Dr. G. C. Johnston, Vancouver

THE B.C. DIVISION AND PREPAID MEDICAL CARE

A review of the articles in this Bulletin will indicate to the members of the Association the great extent to which the insurance principle has already been applied in the provision of medical care in British Columbia. It is important that we recognize that social change and advance in medical sciences have made it imperative that this insurance principle be applied. Indeed, the application of the insurance principle is the only solution to the present day problem. Our task has been to see that it is done on a voluntary basis and not by compulsion or government direction. The question arises: "Is it enough simply to understand or must we bend our energies to develop that which we believe is proper?" In other words, lip service or action.

Recently the Prepaid Plans Sub-committee of the Association had the opportunity of again meeting with representatives of all the Approved Plans. Approval means that the plans are fair to the subscriber, fair to the doctor and administered soundly. Approval is given so that their work might be better integrated with the individual members of the profession who bill directly to the plan. There has been give and take on both sides in order to make a working plan feasible. The Association will continue to work with these Plans toward a method of standard adjudication. Our Reference Committee will seriously study problems submitted by any doctor or plan and will recommend considered opinions that might be acceptable to both parties to a dispute.

The Association once more takes this opportunity of advising all its members that in giving approval to these Plans we are in fact recommending them and are prepared to work with them. And that payment of the account at the schedule of fees less 10% administrative discount will be accepted. It is clearly recognized that at times errors in adjudicating will occur, but if we are to advance the idea of voluntary health insurance, it is necessary for us to recognize that problems might exist and that they can be solved in a friendly manner.

It is also to the advantage of the profession to advise our patients who might be unaware that coverage is available to them, that they can obtain such coverage through the Approved Plans. We hope in British Columbia to make it possible to fulfil one of the tenets of the C.M.A. national policy that voluntary medical care will be available to every citizen.

The following is a list of Approved Plans in British Columbia:

Medical Services Association (M.S.A.)
B.C. Government Employees' Medical Services Association
B.C. Telephone Employees' Medical Services Association
B.C. Teachers' Federation Medical Services Association
Vancouver School Teachers' Medical Services Association
C.U. & C. Health Services Society
Cunningham Drug Sick Benefit Association

In order to further complete your understanding some of these Plans have been good enough to forward a short resume of their history, the persons they serve, the numbers of people covered, their benefits under the plan, and any information which it is thought advisable for you to have at the present moment. The space available is limited but we are glad to do this at this time and hope you will keep this copy of the Bulletin for reference. Through this information it is hoped you will have a broad understanding of what is being done in voluntary health insurance and that you, along with all your colleagues, will put your shoulder to the wheel and see that it proceeds fairly and rapidly as possible.

GORDON FERGUSON, *Executive Secretary.*

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C. U. & C. HEALTH SERVICES SOCIETY

The Credit Union & Co-operative Health Services Society was formed the 1st of November, 1946, to provide medical and surgical services at cost to credit union and co-operative members and employees. For those of you who are not familiar with credit unions, the following is a brief outline:

> Credit Unions have no connection with Labour Unions and are not concerned with labor problems or conditions; neither are Credit Unions concerned with political, religious or racial activities, as such, but keep a strictly neutral attitude on all controversial subjects. A Credit Union, as its name implies, is a union of credit. It is an association of persons, united by some common bond in a co-operative effort to assist its members in saving through sound investment and

to borrow at cost. Through its associate organizations it supplies life, fire, casualty, savings and loan and health insurance at cost to its members.

The Society was approved by the College of Physicians and Surgeons of British Columbia on November 1st, 1949.

MEMBERSHIP

Approximately 7,500 heads of families, that is, about 18,000 people in B.C. are covered, under either the individual plan or the group plan. For individuals there is a three month waiting period for illness only; under the group plan there is no waiting period.

MEDICAL REFEREE

Dr. T. Dalrymple is employed on a part time basis as medical referee. This appointment was approved by the College of Physicians and Surgeons.

RESTRICTIONS

For individual members the C.U. & C. collects a first call for any new illness from the member. The Doctor is paid in full for all services subject to the following limitations:

(1) The Society will pay a maximum of $350.00 for any one illness or accident in any one membership year. The total amount payable for or on behalf of any one member and, or, his dependents for each membership year shall not exceed $1400.00.

(2) No benefits will be payable in respect of gall stones, thyroid, varicose veins, hernia, dilation and curettage, stomach ulcer, hysterectomy, tonsillectomy, adenoidectomy or appendectomy, emergencies excepted, unless such operation is performed, or treatment necessary originates at least one year after the date of acceptance of the person on whom the operation is performed or to whom the treatment is given as a member or a dependent.

Under the group plan, the above restrictions do not apply, but the treatment of any accident or illness is limited to one year's duration.

TERMS OF SERVICE

(1) All members are supplied with a membership card stating the date coverage commences.

(2) C.U. & C. provides a billing form available to all doctors upon request. It is important that a separate billing form be used for each new illness.

(3) Payment is made direct to the doctor on the basis of the 1952 minimum schedule of fees, less 10%. The C.U. & C. will pay all accounts received up to the last day of each month by the end of the month following with ten days grace.

It is requested that the doctor not collect the first call by individual members, as this only leads to confusion in the C.U. & C. office.

Any doctor who has difficulty and does not understand the C.U. & C. set up, please communicate in the first instance directly with:

C.U. & C. Health Services Society 96 East Broadway, Vancouver 10, B.C. Phone: EMerald 2021	OR	F. G. Greenway, 706 Courtenay Street, Victoria, B.C. Phone: Empire 7722

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B.C. TELEPHONE EMPLOYEES

HISTORY: The Telephone Employees' Medical Services Association of B.C. is a non-subsidized organization administered by the employees of the B.C. Telephone and Associated Companies in B.C. It was founded in 1936, reorganized in 1937, and after negotiations with the Medical Profession throughout the Province, became the first "Approved Plan" on the basis of 75% payment of fees, in full, on a fee for service basis, and free choice of doctors registered in B.C. A Medical Reference Committee was set up to study the affairs of the Association and, after three years, the accumulated

data was used in formulating plans for M.S.A. The Association served as a model for a number of private and commercial organizations.

BENEFITS for members and dependents cover necessary office, home and hospital calls and surgery in accordance with the Schedule of Fees; necessary diagnostic services (including laboratory and X-ray); half cost of drugs on prescription (within limits) and the services of a specialist on referral by the family physician. In unreferred cases the specialist fee is paid and the member refunds the difference over the general practitioner rate. Medical costs in accident cases are paid up to a limit of $100.00 and Anæsthetic Services in cases covered by benefits.

EXCLUSIONS: Treatment of congenital and pre-existing conditions; mental and venereal diseases; for cosmetic effect; conditions arising out of the use of alcohol or narcotics; maternity fees; services connected with dental work; refraction for glasses; physiotherapy and X-ray treatment; services that may be obtained free or at nominal cost through public institutions and injection treatments, or inoculations series, over the amount of three office visits.

MISCELLANEOUS: Members and adult dependents give written permission to ascertain details necessary for payment of accounts in accordance with the By-laws. Coverage is given outside the Province (emergency only) at rates payable in B.C.

There are 4,112 members or approximately 7,000 total persons covered.

The Association is an approved plan under B.C. Hospital Insurance Service and pays hospital costs for Association members in accordance with the Act.

Inquiries should be directed to Miss M. H. Harris, R.N., Administrator.

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B.C. GOVERNMENT EMPLOYEES

HISTORY:

The B.C. Government Employees' Medical Services Association, established in August, 1944, under the name of the B.C. Provincial Government Employees' Benefit Society, with an original membership of 400. The Society received the "Approval" of the College of Physicians and Surgeons some eighteen months later. The present membership of the Society is 5,700, and is serving some 14,200 persons. Membership in the Society is open to all employees of the Provincial Government, whether employed on a full or part-time basis. Membership is also extended to Superannuated employees who were members of the Society two years prior to retirement.

BENEFITS:

Medical and surgical services, home, office, and hospital calls on a general practitioner basis and specialist when referred. Members and/or their dependents obtaining the services of a specialist in the first instance may be held responsible for the difference between the general practitioner's fee and the specialist's fee. The foregoing benefits are subject to the limitations as set forth in these Regulations. These services shall be rendered by a physician or surgeon registered by the College of Physicians and Surgeons of B.C. Maximum liability $500 in any one membership year.

Anæsthetic and laboratory services; X-ray for diagnostic services (except dental services) up to a maximum of $25.00 for any one illness or accident in any one membership year; Blood transfusions and blood plasma up to and not exceeding $25.00 for any one illness or accident in any one membership year; Treatment for pre-existing or chronic conditions after a member has been enrolled for a period of one year, but such treatment shall not exceed the sum of $250.00, payment for any further treatment shall be at the discretion of the Board of Directors.

The sum of $67.50 will be paid the attending physician for obstetrical services, to include pre-natal, confinement, and post-natal care, when a female member has been enrolled as a member or when the wife of a member has been enrolled for a period of ten (10) months. Cæsarean operations will be paid for by the Socity, providing that the same ten (10) months waiting period has elapsed.

Injections that follow accepted therapeutic practice, up to the sum of $35.00 in any one membership year, providing that the Medical Director shall approve such treatment.

Out-Patient services in accordance with established hospital rates.

Members and their dependents shall be entitled to Physiotherapy when prescribed by the attending physician, up to a maximum of $25.00 in any one membership year.

EXCLUSIONS:

Diagnosis and treatment for injury for which the member or dependent is entitled to benefits provided by the Workmen's Compensation Board; Diagnosis and treatment for cosmetic effect; Diagnosis and treatment for functional or structural abnormalities which are not the result of illness or disease unless such treatment is approved by the Medical Director as necessary for the health of the individual concerned.

Refractions or treatment in connection with optical glasses.

Treatment for mental disorders, venereal diseases, voluntary abortions, rest cures, alcoholism or drug addiction, any disease or injury occurring during military, naval or air services, self-inflicted diseases or injuries, any illness, injury of riot or war, plastic surgery except of an emergency nature, tuberculosis, or any other illness or diseases that are provided for by the Government or Municipal authorities at a nominal or no cost.

Serums, vaccines, spirituous liquors, artificial eyes, artificial limbs, braces and appliances, or proprietary drugs or biological or endocrine products.

Radium treatment, X-ray or treatment by any electrical appliance or hydrotherapy.

Periodical medical examinations or examinations for the purpose of obtaining a certificate of health.

LIMITATIONS:

Members are not entitled to services during the first sixty (60) days of membership in the case of illness, and 14 days in the case of accident.

Enquiries should be directed to 902 Helmcken Street, Vancouver 1, B.C., TAtlow 8361-62.

Medical Director—Dr. G. L. Smith.

Secretary-Treasurer—Mr. J. P. Swansborough.

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VANCOUVER SCHOOL TEACHERS

Vancouver School Teachers' Medical Services Association was organized in January, 1940. Membership and coverage is restricted to teachers in the employ of the Vancouver School Board and dependents; members of the Vancouver School Board office staff and their dependents. Retired teachers and widowed spouses of teachers may continue coverage.

Present coverage, members 932, dependents 878—Total 1,810.

Benefits: Ordinary medical and surgical costs and specialist when referred by general practitioner.

Limitations of Benefits:

Any one illness covered for 12 months.

One person—$500 per year.

Two persons—$800 per year.

Three or more, $1,000 per year.

Member pays to the Association the first $10.00 of medical or surgical costs incurred by him in any fiscal year.

Total Claims Paid

Association has paid in claims a total of $105,773.29 during the past five years.

Enquiries should be directed to Mr. E. E. Barnes, Secretary-Treasurer, 1642 West Broadway, Vancouver, B.C.

B.C. TEACHERS

The British Columbia Teachers' Federation Medical Services Association was organized with the co-operation of the College of Physicians and Surgeons of B.C., in 1942. Its purpose is to provide prepaid medical care for school teachers and their dependents.

It operates with the paid help of one full-time stenographer-bookkeeper and part times services of another. It is administered by an elected board of trustees. The services of a medical referee, Dr. J. H. MacDermot, of Vancouver, are used by this Association.

The Teachers' Medical Services Plan offers free choice of doctor. Reference to use of specialist services are made through the general practitioner. A maximum of $500 for single members and $750 for those with dependents is allowable in any one year. Physio-therapy, X-ray, laboratory and other diagnostic services are also paid for by this Association. A maternity grant of $25 is payable to the member after ten months of membership. Pre-existing ailments are not covered under the by-laws. A sixty day waiting period applies to new members.

Account forms are provided and are forwarded to doctors upon request. Payment of medical accounts are made upon the basis of the schedule of minimum fees of the B.C. Division, C.M.A., less 10% administrative discount. In settlement of doctors' accounts, to date the Association has paid out approximately $150,000 in benefits.

Our present total membership is 1,454 members plus 1,755 dependents, being a total of 3,209.

Enquiries may be addressed to:

The Secretary,
B.C. Teachers' Federation M.S.A.,
1644 West Broadway,
Vancouver 9, B.C.

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SOCIAL ASSISTANCE MEDICAL SERVICES

Social Assistance Medical Service was first established in March, 1949, and since that time over three million dollars has been received from the Provincial Department of Health and Welfare and distributed to the Profession. The cost of administering this amount in the first three years has averaged 4.4% of this total sum.

One occasionally hears some criticism about various groups in the Profession receiving more than their share so for that reason the following figures are presented for your information and are self explanatory.

TABLE 1.
Percentage of monies paid in one quarter to various categories of practice.

Classification	*Number of Doctors*	*Percentage of money*
General Practice	563	62.1
General Surgery	106	12.5
Orthopaedic Surgery	7	
Ophthalmology	17	7.4
Otolaryngology	12	
Ophthalmology and Otolaryngology	18	
Internal Medicine	53	5.1
Urology	17	4.8
Anaesthesia	47	2.8
Radiology	17	1.9
Obstetrics and Gynaecology	22	1.3
Paediatrics	16	.8
Neurology and Psychiatry	4	.7
Neurology and Neurosurgery	7	
Psychiatry	7	

Dermatology	6	.4
Osteopathy	3	.1
Pathology	1	.1
Total Number of Doctors	923	100.0

In addition to above, 45 Hospitals submitted accounts.

Who receives Medical Benefits under S.A.M.S.?

Two new acts were established on January 1st, 1952, namely the "Old Age Assistance Act" (65-69), and the "Old Age Security Act" (70 years and over). In order to qualify for Medical Benefits under the above two acts the pensioner must pass a Provincial Government Means Test. For a single pensioner the annual income including pension must not exceed $720 and for a married pensioner $1,200 per annum. The pensioner is also required to have one year continuous residence in the Province before he can apply for Medical Benefits.

Table 2 shows the variations in the different categories covered over the first three and a half years of operation of S.A.M.S. It will be noted that the overall increase of almost nineteen thousand is made up chiefly of the 65-69 group and the seventy and over group.

TABLE 2.

Number of persons covered including dependents:—

Inception of Plan—March 1, 1949		*September 30th, 1952.*	
Category	*No. Covered*	*Category*	*No. Covered*
Japanese	312	M. A.	1,575
M. A.	2,235	S. A.	14,515
S. A.	13,763	C. W. D.	2,952
C. W. D.	515	O. A. P. and Blind	37,714
O. A. P.	28,672	O. A. A. (65-69)	7,691
Total per month	45,497	Total per month	64,447

Medical Identity cards are issued by the Provincial Government Department of Health and Welfare and not by S.A.M.S Prior to the 1st of January, 1952, only a spot check was made on account cards for correct medical identity numbers. Since then however it has been found necessary to check all accounts rendered for the correct medical identity number in order to establish eligibility. When at all possible we supply the correct medical identity number, but when this is not possible the card is returned to the Doctor's office and it is his responsibility to supply the correct number. Sample cards have been sent to all Doctors for their guidance.

This may seem like a rather bureaucratic rule, but it was only put into force to protect the profession at large, as many of the Old Age Security group felt they were entitled to free medical care and there appeared to be some confusion in the minds of some Doctors as to who was entitled to medical benefits under S.A.M.S.

H. SCOTT,
Medical Director.

E. L. DEIGHTON,
Administrator.

For Your Information

Fraser Valley Medical Dental Society

In the Fall of 1952 officers of this Plan again met with the Prepaid Plans Subcommittee in an endeavour to see if approval could be given. The plan, its benefits, its administration and the financial structure came under critical review.

After a very thorough study, the Economics Committee recommended to the Board of Directors that the Fraser Valley Medical Dental Society *be not approved at*

this time. This recommendation was accepted by the Board of Directors and the plan so notified.

Recently a considerable number of physicians have phoned the Association office or have forwarded letters that have been received from the Fraser Valley indicating that Fraser Valley has been asking certain specialists to do work at general practitioner rates, has suggested that patients might be referred to doctors if they do so, and has sent as payment of account in full the account less 10%. Moreover, a printed letter has been sent out to all physicians suggesting that recognition has been sought rather than approval and that the plan has amended itself in such a way that it would now be possible for physicians to accept a 10% deduction.

This opportunity is taken to assure you that this is not an approved plan, there is no understanding between our Association and Fraser Valley Medical Dental Society for a 10% administrative discount, and that physicians in their relationship to patients who are insured in Fraser Valley should deal with the patient, recognizing that any contract lies between patient and Fraser Valley.

POSITION WANTED

Toronto graduate (1951), with rotating internship, married, now in general practice desires immediate position in general practice in B.C., preferably in Lower Mainland, Okanagan or southern part Vancouver Island. Write: The Bulletin of the Vancouver Medical Association, 675 Davie Street.

FOR SALE

Beautiful privately-owned island for sale. 65 enchanting acres. 1½-hour drive from Victoria. Country farm estate. Abundant water. Splendid yacht harbor and lovely white beach. Wooded trails connect many hidden bays and coves inviting exploration. Oysters. Good salmon fishing. Close to shopping districts. 15 minutes by air from either Victoria or Vancouver. Write owner for full particulars.

David B. Conover **Ganges, B.C.**

NOTICE

Mr. F. J. FISH, having retired on superannuation after more than 20 years service to the Medical Profession through the Medical Records Department of the Vancouver General Hospital, wishes it to be known that his services are available on a part time basis to any doctor or group of doctors desirous of having their office medical records reliably collated. Occupation of greater consideration than emolument. Phone CHerry 2068 or write 3416 West Fifth Avenue, Vancouver 8.

PUBLIC HEALTH AND MENTAL HEALTH NEWS

G. F. AMYOT, M.D., D.P.H.,
Deputy Minister of Health, Province of British Columbia

A. M. GEE, M.D.,
Director, Mental Health Services, Province of British Columbia

INFORMATION REGARDING THE ADMISSION OF MENTAL DEFECTIVES TO THE MENTAL HOSPITAL

The Woodlands School in New Westminster where the mental defectives are cared for is at present administered under the Mental Hospitals Act. It is hoped to have this school operating under a separate act for the mentally deficient.

At present all admissions must be regularly certified under the Mental Hospitals Act; that is the regular certificates are necessary, an "A" form, two "B" forms or medical certificates and a "C" form signed by a magistrate or justice of the peace. These patients are then admitted in the usual way to the Provincial Mental Hospital at Essondale and are transferred to The Woodlands School as soon as accommodation can be proveded.

In regard to the mental defectives under the age of six, an order-in-council was passed in 1951 making it necessary to make application to the Medical Superintndent requesting admission of the child in order to determine whether or not accommodation existed. At the present time such application should be made through Dr. L. E. Sauriol, the Medical Superintndnt of The Woodlands School, who may authorize, when he has available accommodation, the admission of such child direct to The Woodlands School, providing of course that the regular certificates mentioned above are properly completed. This thus eliminates for the under-six child the necessity of being admitted to the Mental Hospital at Essondale and then later being transferred to The Woodlands School.

STAFF NOTES

Dr. Bruce Bryson was recently appointed Medical Superintendent of the Provincial Home for the Aged, Port Coquitlam, B.C. In this position he supervises the Geriatric Division of the Provincial Mental Health Services including the Homes for the Aged at Vernon and Terrace. Dr. Bryson's new appointment is made possible by the recent promotion of Dr. T. G. B. Caunt to the position of Medical Superintendent, Provincial Mental Hospital, Essondale, B.C.

Dr. F. E. McNair, for some years Assistant Clinical Director at the Crease Clinic and Provincial Mental Hospital, Essondale, B.C., was recently promoted to the position of Clinical Director of these units upon the appointment of the former incumbent, Dr. A. E. Davidson, to the position of Deputy Director of Provincial Mental Health Services.

Dr. N. L. Richardson of the Crease Clinic staff commenced a year of post graduate study in Psychiatry at the Allan Memorial Institute, Montreal, in January. Dr. Richardson has received a Federal Mental Health Grant Bursary for this training period.

The following is worthy of reading by all medical practitioners in this Province:

"Preventive medicine as practised by the general practitioner is not limited to his office, it is found wherever he goes—in his daily practice, in his postgraduate studies,

and in his civic activities through his community health council. Each decade preventive medicine occupies more of the general practitioner's time.

Without the cooperation of the general practitioners of America any preventive medical program, whether national, State, or local in character, is doomed to failure. Practicing physicians look to public health officials for leadership. The general practitioner, however, should be led, not pushed. Continuous education is the key.

Public health is a specialty. Few general practitioners have the time or the training to do a good job in part-time public health work. Organized public health units with full-time personnel constitute the essence of good health protection."

J. S. DeTar, M.D., Milan, Mich., speaker, House of Delegates, American Academy of General Practice; President, Michigan Health Council.

News and Notes

Dr. B. W. Cannon of New Westminster has retired from practice.

Dr. E. C. H. Lehmann is now certified in orthopedic surgery.

Dr. Helen B. Zeman is now resident in pediatrics at the Rosedale Hospital in New York.

Dr. A. S. McPhillips has opened a practice in endocrinology in the Broadway Medical district of Vancouver.

Dr. Paul Kepkay has been with the Leahey Clinic in Boston and is shortly returning to Vancouver to practice internal medicine.

BIRTHS

To Dr. and Mrs. C. G. McNeill of North Vancouver—a son.
To Dr. and Mrs. D. E. McKerricher of Vancouver—a daughter.
To Dr. and Mrs. J. J. Eakins of Nanaimo—a son.
To Dr. and Mrs. J. C. Rife of Cloverdale—a son.

GROUP LIFE INSURANCE

All members of the Canadian Medical Association, B.C. Division, under age 60 have received an invitation to join the Group Life Insurance Plan. The Board of Directors believes this is a good Plan and recommends your participiption in it. A reply one way or another would be appreciated.