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The BULLETIN

of the

VANCOUVER MEDICAL ASSOCIATION

Vol. XIX MAY, 1943 No. 8

With Which Is Incorporated
Transactions of the

Victoria Medical Society

the

Vancouver General Hospital

and

St. Paul's Hospital

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THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

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VOL. XIX. MAY, 1943 No. 8

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VANCOUVER HEALTH DEPARTMENT

STATISTICS—MARCH, 1943

Total Population—Estimated	288,541
Japanese Population	Evacuated
Chinese Population—Estimated	5,541
Hindu Population—Estimated	301

	Number	Rate per 1,000 Population
Total deaths	404	16.5
Japanese deaths	2	Population evacuated
Chinese deaths	18	38.3
Deaths—residents only	345	14.8
BIRTH REGISTRATIONS:		
Male, 365; Female, 332	697	28.4

INFANTILE MORTALITY:	March, 1943	March, 1942
Deaths under one year of age	28	12
Death rate—per 1,000 births	40.2	22.3
Stillbirths (not included in above)	8	4

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	February, 1943		March, 1943		April 1-15, 1943	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Scarlet Fever	49	0	38	0	27	0
Diphtheria	0	0	--	0	--	0
Diphtheria Carrier	0	0	--	0	0	--
Chicken Pox	84	0	85	0	28	0
Measles	133	0	662	0	499	0
Rubella	6	0	8	0	6	0
Whooping Cough	30	0	28	0	13	0
Typhoid Fever	0	0	--	0	--	0
Undulant Fever	0	0	--	0	--	0
Poliomyelitis	0	0	--	0	--	0
Tuberculosis	45	12	43	24	15	--
Erysipelas	2	0	3	0	1	0
Meningococcus Meningitis	6	0	4	1	0	0

V.D. CASES REPORTED TO PROVINCIAL BOARD OF HEALTH
DIVISION OF VENEREAL DISEASE CONTROL

(Jan. and Feb.):	Burnaby	West Vanc.	Richmond	North Vanc.	Vanc. Clinic	Hospitals & Private Drs.	Totals
Syphilis	2	1	--	1	42	39	85
Gonorrhœa	2	--	2	1	123	77	205

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For use in the prevention of *both* diphtheria and whooping cough the Connaught Laboratories have prepared a combined vaccine, each cc. of which contains 20 Lf's of diphtheria toxoid and approximately 15,000 million killed bacilli from freshly-isolated strains (strains in Phase 1) of *H. pertussis*.

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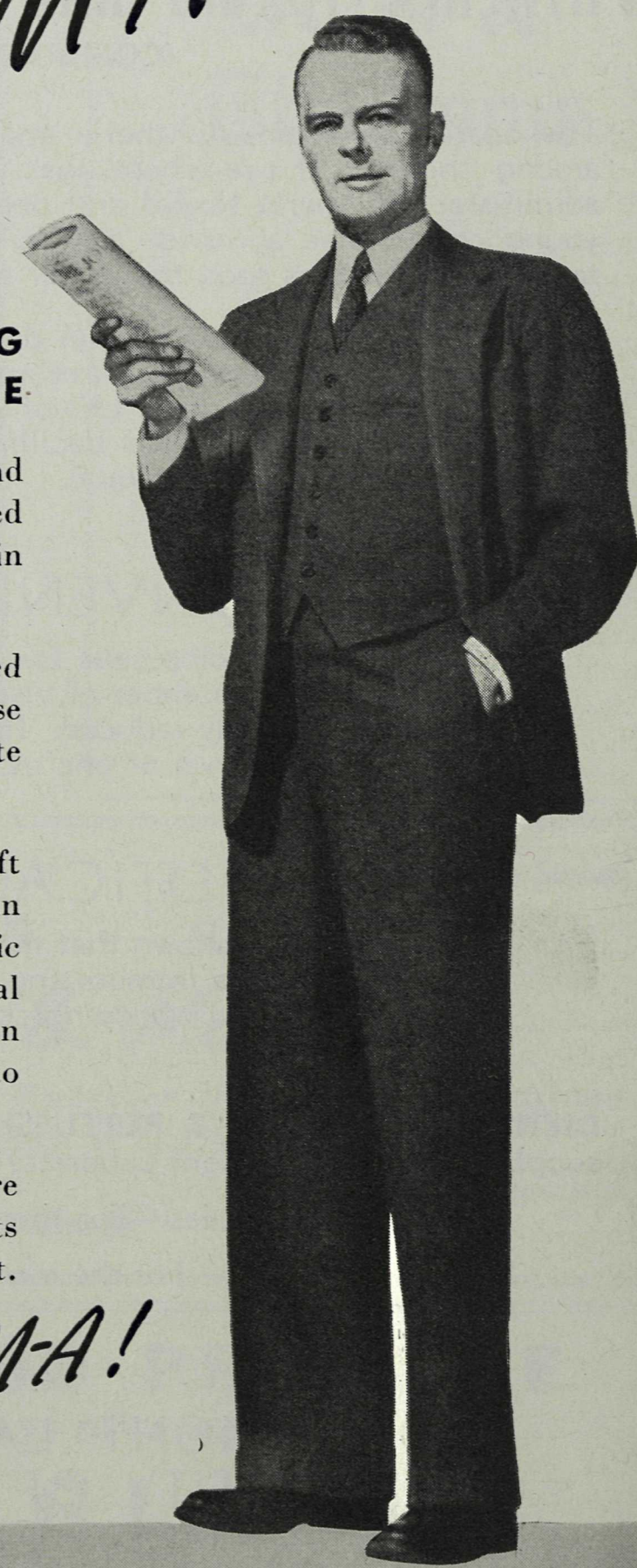

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THE EDITOR'S PAGE

This issue of the BULLETIN contains the Annual Reports furnished by the various Committees and Sections of the Vancouver Medical Association. Listening to these reports the other night, one was struck by the healthy condition of the affairs of the Association. Attendance at meetings has kept up amazingly well, considering the urgent demands on members' time and energy: clinical meetings have been well attended, and the work of the various Committees had been extremely well done: there has been no letting down of standards. Even from a financial point of view, the Association is in excellent condition. The Library particularly has functioned quite normally—if not a bit better than normally.

We take this opportunity to congratulate Dr. Neilson, our retiring President, and his loyal and hard-working Executive, on a most successful year's work. Their success, as is usually the case, is the result of their sincere devotion to their duties, and sheer hard work.

The attendance at the Annual Meeting was the largest we ever remember, for an Annual Meeting: it would have been a record for any meeting. Usually Annual Meetings are very poorly attended affairs: consisting chiefly of those whose unpleasant duty it is to make reports. But this year the Executive invited Dr. Peter A. McLennan of this city to be the guest speaker: and the success of the meeting was therefore a foregone conclusion. The large and attentive audience was a tribute that we all gladly paid, to a man who is one of the chief ornaments of the British Columbia profession. His address, "Some Memories," was what one would expect of him: shot through with wit and the wisdom born of experience and a keen intelligence and loyal devotion to his art: and couched in language the style of which owes much to a wide and liberal knowledge of the masterpieces of the English tongue. With generosity and in all modesty, Dr. McLennan led us back with him to an age of medical practice which all too few of us now can remember: an age which, nevertheless, had much to be proud of, and left a firm and wide foundation for the later, more scientific era that it preceded. Dr. McLennan was warmly thanked by his audience. In this connection we should like to pay a small, but we think well-deserved tribute to those who moved and seconded the vote of thanks. Dr. Ross Davidson (we forget his military rank, and fear to underestimate it) especially, made as neat a speech as mover as we can ever remember hearing —so many of these efforts are merely something that has to be said: and Dr. Gordon Matthews as seconder, while much more brief in his remarks, was also very apt and refreshingly witty.

We regret that owing to exigencies of space, we were unable to publish in our last issue some material furnished by the B. C. Medical Association through its Secretary, Dr. M. W. Thomas. We thought long and earnestly before postponing it to this issue: because it is material that needs to be published, and that we are glad to have. Drs. Routley, General Secretary of the C.M.A., and G. F. Strong are the chief contributors, and we publish it in this issue. Unfortunately, we are limited as to space, and the auditors of the Vancouver Medical Association's balance sheet look unfavourably on anything that savours of recklessness in our use of extra pages: it is surprising how a few extra pages add to the cost. Postage is one of the chief items that advances by a sort of geometrical progression, when one exceeds one's allotted limits.

VANCOUVER

SUMMER SCHOOL

June 22nd to 25th, inclusive
1943

HOTEL VANCOUVER

★

SPEAKERS

Lieut.-Colonel J. D. Adamson, R.C.A.M.C.,
Consultant in Medicine.

Dr. Brien T. King,
Seattle, Wash.

Brigadier J. C. Meakins, R.C.A.M.C.,
Deputy Director General of Medical Services.

Dr. Edwin M. Robertson,
Department of Obstetrics and Gynæcology, Queen's University, Faculty of Medicine, Kingston, Ont.

Dr. Max M. Cantor,
Assistant Professor of Biochemistry, University of Alberta, Edmonton, Alta.

Lieut.-Colonel G. S. Fahrni, R.C.A.M.C.,
Consultant in Surgery.

Dr. Foster Kennedy,
Professor of Clinical Neurology, Cornell University Medical College, New York, N. Y.

PROGRAMME

Tuesday, June 22nd—

9:00 a.m.—Brig. Meakins: "Effort Syndrome and Allied Conditions in Civil and Military Practice."

10:00 a.m.—Dr. Cantor: "Hormone Therapy in General Practice."

11:00 a.m.—Dr. Robertson: "The Symptoms, Signs and Management of Labour; a Lecture Demonstration."

12:30 p.m.—LUNCHEON—Guest Speaker: Dr. Foster Kennedy: "De Propaganda Fide."

2:30 p.m.—Medical Clinic—Shaughnessy Hospital—Conducted by Brigadier Meakins.

4:15 p.m.—Film—Hotel Vancouver—"The Sulphonamides." (Colour and sound.)

MEDICAL ASSOCIATION

TUESDAY, JUNE 22nd—Continued

8:00 p.m.—Lt.-Col. Adamson: "Pneumonitis: Definition and Classification."
9:00 p.m.—Dr. Kennedy: "Neuroses Following Accident in Civilian Life."

Wednesday, June 23rd—

9:00 a.m.—Lt.-Col. Fahrni: "The Management of Burns."
10:00 a.m.—Brig. Meakins: "The Syndrome Called Shock and Its Place in Medicine and Surgery."
11:00 a.m.—Dr. Robertson: "Prolapse of the Pelvic Organs."
12:00 Noon—Film—"Peptic Ulcer." (Colour and sound.)
2:00 p.m.—Surgical Clinic — St. Paul's Hospital — Conducted by Lt.-Col. Fahrni.
8:00 p.m.—Dr. Kennedy: "The Treatment of Both Open and Closed Head Injuries."
9:00 p.m.—Dr. Cantor: "Evaluation of Renal Function."

Thursday, June 24th—

9:00 a.m.—Dr. Cantor: "The Clinical Application of Research in Nutrition."
10:00 a.m.—Dr. Kennedy: "Allergic Manifestations in the Nervous System."
11:00 a.m.—Dr. Robertson: "The Management of Labour in Cephalic, Occipito-posterior, and Breech Presentations; a Lecture Demonstration."
1:00 p.m.—GOLF TOURNAMENT: Point Grey Golf Club.
8:00 p.m. } Round Table Discussion: "Thyroid Disease."
9:00 p.m. } Chairman: Dr. Wilfrid Graham.
Brigadier Meakins, Lt.-Col. Adamson, Lt.-Col. Fahrni and Dr. Brien King participating.

Friday, June 25th—

9:00 a.m.—Dr. Robertson: "How to Treat the Toxæmias of Pregnancy."
10:00 a.m.—Dr. Cantor: "Evaluation of Hepatic Function."
11:00 a.m.—Lt.-Col. Fahrni: "The Newer Concepts in the Treatment of Wounds."
12:00 Noon—Film—"Plasma." (Colour and sound.)
2:00 p.m.—Neurological Clinic—Vancouver General Hospital—Conducted by Dr. Kennedy.
8:00 p.m.—Lt.-Col. Adamson: "Chronic Non-tuberculous Pulmonary Disease in the Army."
9:00 p.m.—Dr. Kennedy: "The New Medical Attack on So-called 'Mental Disease', including a Report on the Results of Electric Shock Therapy."

SUMMER SCHOOL

JUNE SESSION

This year, the Summer School will be held at the usual time, from June 22nd to 25th inclusive in the Vancouver Hotel.

PROGRAMME

Your Committee feels extremely fortunate in being able to present a most outstanding list of speakers and the choice of subjects is such that all will be interested. One feature this year is the inclusion of three R.C.A.M.C. staff officers: Brigadier J. C. Meakins, Lt.-Col. J. D. Adamson and Lt.-Col. G. S. Fahrni, all well known as outstanding men in our Canadian medical schools. The Summer School Committee feels deeply indebted to the Medical Command for supplying these well-known lecturers.

ATTENDANCE OF SERVICE MEDICAL OFFICERS

It is anticipated that a large number of medical men on Active Service in the Navy, Army and Air Force will attend the School Sessions this year. Arrangements are being completed by the three Services to make the Summer School Clinics available to as many of their medical officers as possible.

FEE

In order to cover expenses it has been found necessary to place the fee at $6.00 this year.

GUEST SPEAKER AT LUNCHEON

Dr. Foster Kennedy of New York will be the Guest Speaker at the luncheon to be held in the Mayfair Room on the opening day. The title of his address will be "De Propaganda Fide."

ROUND TABLE DISCUSSION

A Round Table Discussion will be held on the evening of Thursday, June 24th. The subject will be "Thyroid Disease." Dr. Wilfrid Graham, the Chairman, will be glad to receive questions for discussion. A "Question Box" will be provided at the Registration Desk for this purpose.

TELEPHONE SERVICE

As usual the Summer School will have its own private telephone service in order to facilitate transmission of messages for the doctors attending.

FILMS

Arrangements have been made to show three moving picture films during the Session. The first, to be shown Tuesday, June 22nd, at 4.15 p.m., belongs to Lederle's. The subject is "The Sulphonamides." The second film, slated for Wednesday, June 23rd, from 12:00 to 1:00 p.m., is the property of John Wyeth & Bros., and is entitled "Peptic Ulcer." The third film, on "Plasma," belonging to Sharpe & Dohme, will be shown on Friday, from 12:00 to 1:00.

GOLF

The Golf Tournament will be held on Thursday at Point Grey Golf Club. Due to the excellent opportunity of hearing our speakers, your Committee felt that meetings should be held on Thursday evening. Therefore no dinner has been planned.

Dr. J. E. Harrison has been selected as Chairman of the Golf arrangements and it has been decided by Dr. A. E. Trites and Dr. Leith Webster, the committee in charge of medical tournaments for the season, to combine this tournament with the second regular golf tournament being held by the physicians in the Vancouver District.

Attractive prizes are being provided.

LIBRARY NOTES

RECENT ACCESSIONS TO LIBRARY:

Medical Clinics of North America, Symposium on Nutrition, March, 1943.
Text-Book of Psychiatry, 5th ed., 1941, by D. K. Henderson and R. D. Gillespie.
Manual of Industrial Hygiene, 1943, William M. Gafafer, Editor. (Gift of Division of Industrial Hygiene, National Institute of Health, U. S. Public Health Service.)
Year Book of General Medicine, 1942.
Year Book of General Therapeutics, 1942.
Year Book of Neurology, Psychiatry and Endocrinology, 1942.
Cancer of the Uterus, 1942, by Elizabeth Hurdon.

BOOK REVIEW

MANUAL OF INDUSTRIAL HYGIENE AND MEDICAL SERVICE IN WAR INDUSTRIES—Prepared by the Division of Industrial Hygiene, National Institute of Health, United States Public Health Service: W. B. Saunders Company, Philadelphia and London, 1943.

In a foreword it is stated that this book is intended as a source of information for industrial physicians who must meet the changed conditions in industries converted to war purposes, and as a guide for those who patriotically volunteer to take the places of industrial physicians who have gone into the services.

The unprecedented growth of industry and the rapid development of industrial facilities to meet the needs of the nations at war demand a corresponding increase in industrial health practice. This means the organization of programmes and the adoption of policies which, in a large measure, should be uniform in structure. Although the literature is abundant in its coverage for the many variables in medical and engineering industrial hygiene, there was not before available a book small enough to give compact knowledge and yet large enough to cover the entire subject.

The list of contributors reveals the wide field of specialists whose many years of experience in the realm of industrial hygiene give their chapters added interest and practical value.

The first part, comprising eight chapters, deals with organization and operation of plant medical departments including medical, nursing and dental services. Herein can be found much valuable data for the beginner in this field, as well as those who have already undertaken work of this type.

Part Two covers the prevention and control of disease in industry. Some of the specific problems discussed are the occupational dermatoses, control of respiratory diseases, venereal disease control, industrial psychiatry, health education, causes and control of fatigue, nutrition, sanitation, illumination, noise, heating and ventilation. Clinical descriptions of industrial diseases of present importance are given with their appropriate methods of control and treatment.

Part Three is devoted to the manpower problem. With the growing demand of the armed forces there is resulting a rapid depletion of able-bodied workers in industry. Consequently women and physically sub-standard workers must be placed at productive work in order to attain maximum production for the war effort with limited manpower. Absenteeism with its problems is given a whole chapter. Suggestions are made for studying this ever-increasing threat to maximum production. Some suggestions are given for the control of this problem of holding workers on the job.

Each chapter is followed by a list of up-to-date references for those who may require more detailed information. The index lends itself to easy reference to any topic which the reader may wish to read up.

After reading this book one is struck by the large amount of valuable practical information which has been compressed into 465 pages, yet the presentation remains interesting reading, especially to one who helped pioneer in the establishment of an industrial hygiene department in a war industry. The section on occupational diseases should prove interesting and helpful to private physicians who, periodically, are faced with the problem of deciding whether a patient is suffering from some disease arising from his occupation. Here he may also get some idea of what the scope of industrial hygiene is.

J. C. T.

Vancouver Medical Association

ANNUAL REPORTS FOR 1942-43

REPORT OF THE HONORARY SECRETARY, 1942-43

Mr. President and Members:

I wish to submit herewith my report for the past year.

Eight General Meetings were held, one of these being the Osler Dinner in March, at which Dr. D. E. H. Clevveland was the Lecturer. As the usual Annual Dinner was not held in November, the P.G.F. Degree was conferred at this time on Dr. W. A. Whitelaw and Dr. D. F. Busteed.

Two Special Meetings were also held, one to consider the question of chlorination of the Vancouver water supply and the other to discuss the arrangements for medical care of Old Age Pensioners and recipients of Mothers' Allowance.

The average attendance was 55, as compared with 49 last year. In view of the increased duties of doctors still in practice it was felt that this attendance was satisfactory.

MEMBERSHIP

The total membership of the Association, including applications for membership which are pending, is 312. This number is made up as follows:

Life Members	10
Active Members	256
Associate Members	40
Privileged Members	6

Ten new members were elected during the year.

Twenty-two additional members entered the Armed Services, bringing the total to 67.

The Association has lost four members during the year: Dr. C. A. Eggert, who was a Privileged Member; Dr. A. S. Lamb; Capt. J. M. McDiarmid, formerly of New Westminster; Dr. N. J. Paul, Squamish, B. C.

The Executive Committee held 13 meetings throughout the year.

A. E. TRITES, *Honorary Secretary.*

REPORT OF THE HONORARY TREASURER

Mr. President and Members:

I herewith submit the following financial report of your Association for the year 1942-43, which has been duly audited by Plommer, Whiting & Co., Chartered Accountants, under date of March 31st, 1943.

RECEIPTS AND EXPENDITURES:

Receipts:			
Income from members' annual dues		$4,066.00	
Interest on invested funds		303.96	
In addition there is from the Relief Committee	$ 600.00		
and profit on Osler Dinner	11.76		
		611.76	
			$4,981.72
Expenditures:			
Salaries	$2,836.44		
Rent	1,377.00		
Total	$4,213.44		

Received for C.P. & S. of B. C.—their share	1,860.00		
		2,353.44	
Other running expenses		656.77	
Total expenditures apart from library maintenance		$3,010.21	
The Association has also expended on the library	$1,319.87		
Expended on Bulletin	3,407.71		
Less receipts	3,031.93		
Loss on Bulletin		375.78	
			3,385.99
Excess of income over expenditure			$1,595.73
Depreciation:			
Library	$1,363.95		
Furniture and equipment	129.55		
			1,493.50
Net Transfer to General Surplus Account			$ 102.23

GENERAL FUND BONDS:

Present value $10,287.91

One $500 Dominion of Canada Bond was purchased during the year from the Current Savings Account.

TRUST FUNDS:

Historical and Ultra-Scientific Fund Savings	$ 115.73
Stephen Memorial Fund Savings	8.71
Sickness and Benevolent Fund Savings	708.72
Benevolent Endowment Fund	700.00
John Mawer Pearson Lecture Fund Savings	418.49
John Mawer Pearson Lecture Fund Principal	3,018.75

COMMENT

Income—Decrease in Dues: The net income this year from annual dues is lower by some $250.00, which is accounted for by the entry of additional members into the Armed Forces.

Bulletin: The loss of $375.78 on the *Bulletin* represents the excess of disbursements over receipts, outstanding accounts at the commencement and close of the year being disregarded. Details of this will be given by Dr. MacDermot in his report, and it is not as serious as it might appear at first glance.

Investments: The income on future investments will be lower, owing to the fact that the Government interest rate is now 3 per cent.

Summer School: Of the total invested funds, $3,380.93 represents a cumulative surplus from the Summer School profits, the surplus having been increased in the past year by the amount of $363.93.

Library: The over-expenditure of the Library budget is largely explained by the increased war tax on American journals and books, and by the cost of the microfilm projector. Provision has been made to reduce the expenditure on journals in the ensuing year. This will be covered in detail in the report of the Library Committee.

Sickness and Benevolent Fund: This fund is being gradually built up by the imposition of the annual levy on dues of $1.00 for each member. It is proposed to continue the levy next year.

All of which is respectfully submitted.

GORDON BURKE, *Honorary Treasurer.*

PUBLICATIONS COMMITTEE REPORT

In listening to the Auditors' Report tonight, you will have heard that there is an operating deficit of some three hundred dollars debited to the *Bulletin*. This is not as bad as it sounds. I will read, in a minute, the report furnished me by our manager, Mr. W. E. G. MacDonald, from which you will see that our operating loss, as shown by a comparison of the Net Revenue from advertising, and the Operating Costs each month, is really very slight. Our income comes very largely from various firms whose advertising is national in scope, and who pay their bills once or twice a year. Their accounts are perfectly safe, and when they are paid, the apparent deficit will be wiped out. As a matter of fact, we have a great deal more due to us than would be necessary to cover the deficit.

Your Committee has been operating under some difficulties during the past year, since regular meetings of the committees have been very hard to arrange, and I think we shall have to try again during the coming year to resume these meetings. The mere pressure of daily work seems to leave no time for any outside activity, and yet it would seem only right that regular conferences should be held. Your Editor is, I fear, chiefly to blame, and can only promise to try and do better in future.

The *Bulletin* has come out at rather irregular intervals, but in the end, we have managed to get in the required number of issues. This is, of course, very important to the advertisers, to whom we extend our apologies for this irregularity. Again, we have only one excuse, that of real difficulty in fitting in the work into one's schedule, and again we can only promise to try to do better.

We have had very great help from various sources. The Vancouver General Hospital's Publications Committee has done splendid work. As ever, they have prepared their stuff admirably, and have made themselves responsible for proof-reading, etc. This section has been of very great value. St. Paul's Hospital, too, has given us excellent material from time to time, but it is much harder for their staff to contribute regularly, and we are only too glad to have the help that they are able to give.

Again, I would like to acknowledge with the greatest gratitude, the invaluable help given us by our friend, Dr. M. W. Thomas, who has made himself responsible for the News and Notes column. This is a very great service, and is very much appreciated throughout the Province.

In conversation with Col. Wallace Wilson, A.D.M.S., M.D., No. XI, the question of a special number of the *Bulletin* to be devoted to Military Medicine was mentioned, and he seemed to think well of the idea. There is ample material for such a number to be obtained from men in the R.C.A.M.C. ranks right here in British Columbia.

All of which is respectfully submitted.

J. H. MacDermot.

REPORT OF TRUSTEES

The President, Vancouver Medical Association.
Sir:

During the past fiscal year the Board of Trustees had several irregular meetings.

There were no disbursements from the Sickness and Benevolent Fund during that period of time. Four hundred and eighty-seven dollars and seventy cents were added to the principal sum of the Sickness and Benevolent Fund, making the present total of $5,002.27. From the General Fund the amount of $500.00 was expended in Victory Bonds.

The stock of the Pacific Great Eastern Railway was liqudiated and Dominion of Canada Bonds bought with the proceeds.

All this is respectfully submitted.

Signed on behalf of the Trustees.

Frederic Brodie.

REPORT OF THE LIBRARY COMMITTEE

Mr. President and Members:

I wish to submit herewith the report of your Library Committee for the year ending March 31st, 1943:

BOOKS ADDED TO LIBRARY—

General Collection:

41 new books at a cost of		$ 299.98
14 gifts		
7 gifts—Nicholson Fund, at a cost of		28.61
Total 62 Books added at a cost of		$ 328.59
Nicholson Fund:		
7 books purchased at a cost of	$28.61	
Leaving a balance on hand of	71.30	
MEDICAL JOURNALS:		
70 Journals subscribed to at a cost of		$ 578.92
42 Journals are received as gifts		
112 Journals are received in Library.		
118 volumes bound at a cost of		268.90
OTHER EXPENSES:		
Dues to Medical Library Association	$16.83	
Microfilm Desk Projector	85.00	
Table for Projector	23.50	
Sundries	18.13	
		143.46
		$1,319.87

Eight meetings were held during the year.

It was with regret that Dr. A. B. Manson's resignation as Secretary, was received in October, due to his entry into the Army. Dr. S. E. C. Turvey was appointed in his place.

Nicholson Fund—Dr. Nicholson requested that all available books by Harvey Cushing not already in the Library be purchased from this Fund. Three out of a possible seven were obtained, the other four being out of print.

The microfilm service, which was introduced a year ago, has evoked much interest, but your Library Committee would like to see it put to much greater use than at present. They feel that this service opens up a valuable field to members, giving access as it does to the files of the Army Medical Library at a minimum cost.

A number of books dealing with Industrial Medicine and Hygiene were added to the Library, and two subscriptions to industrial medical journals were donated by Dr. H. H. Milburn.

The budget was over-expended by $119.87, which is in part accounted for by the cost of the microfilm projector. Your Committee felt it advisable, however, to discontinue a number of journals which are not used extensively. The following American journals have been cancelled:

The American Journal of Physiology, Journal of Allergy, and seven British journals were also cancelled: British Journal of Ophthalmology, British Journal of Urology, British Journal of Laryngology and Otology, Journal of the Royal Institute of Public Health, Journal of Tropical Medicine, Post-Graduate Medical Journal, Proceedings of the Royal Society of Medicine.

Before discontinuing these British subscriptions a canvass was made of the various specialized groups concerned, and our decision was based on the opinion of the majority

in each instance. The Proceedings of the Royal Society will be donated henceforth by Dr. Turvey, who now subscribes to it.

Your Library Committee wishes to take this opportunity of making grateful acknowledgment to Dr. A. L. Yates, now of Calgary, for a gift of $10.00, and to Doctors R. E. Coleman, H. H. Milburn, S. E. C. Turvey, W. A. Whitelaw, Mrs. Wallace Wilson, the Department of Pensions and National Health, and others, for gifts of books and journals to the Library.

All of which is respectfully submitted.

J. R. DAVIES, *Chairman.*

REPORT OF THE RELIEF ADMINISTRATION COMMITTEE

The year ending March 31st, 1943, showed a marked decrease in the amount of medical relief in the City of Vancouver. This, no doubt, is due to the fact that there is very little unemployment and the city is assisting only those who are unemployable. The gross amount of accounts for 1942 was $74,897.00 and for 1943, $37,116.96.

Percentages paid during the year ranged from 35 per cent to 50 per cent, an average of 45⅓ per cent.

In September last year the Relief Administration Committee interviewed the Social Service Committee of the City of Vancouver for the purpose of improving the payment for medical relief and was successful in increasing the payment of 33 cents per person on relief as paid at that time to 38 cents per person, with the result that since September last the doctors have received 50 per cent of their accounts with a maximum amount of $50.00 being paid to any doctor.

The total amount of net accounts for the year was $29,018.98 and the amount paid to doctors $12,853.63.

During the year Dr. J. R. Davies, who had served on the Relief Adminsitration Committee since 1935, found it necessary to withdraw and it was with regret that his resignation was accepted.

The Committee now consists of: Dr. W. T. Lockhart, Chairman; Dr. J. A. Sutherland, Secretary; Dr. Colin McDiarmid, Dr. Gordon Burke, Dr. D. F. Busteed, Dr. A. O. Brown.

All of which is respectfully submitted.

J. A. SUTHERLAND, *Secretary.*

REPORT OF THE CLINICAL SECTION

Six Clinical Meetings were held during the year, alternately, at the various hospitals.

Two were held at the Vancouver General. (The January meeting was cancelled owing to weather conditions.) Three were held at St. Paul's. One was held at Shaughnessy.

This was the first year that Joint Clinical Meetings were held and proved very satisfactory.

J. W. MILLAR, *Secretary.*
For D. A. STEELE, *Chairman.*

REPORT OF THE PEDIATRIC SECTION

The Pediatric Section has held fairly regular meetings during the past year. Two more of our members, Drs. Stockton and James, have been taken into the Armed Forces. Another of our members, Dr. Eggert, passed away.

Respectfully submitted.

J. H. B. GRANT, *Chairman.*

REPORT OF THE EYE, EAR, NOSE AND THROAT SECTION

Mr. President:

In the absence of the Chairman, Dr. C. E. Davies, I beg to report on the activities of the Eye, Ear, Nose and Throat Section, Vancouver Medical Association.

Several luncheon meetings were held throughout the year at which various matters pertinent to the Section were discussed. The members continue to take an active interest and attend all meetings.

LEITH H. WEBSTER, M.D., *Secretary.*

REPORT OF THE HISTORICAL COMMITTEE

I regret to report that, owing to circumstances, I have been unable during the past year to make as much progress in the getting together of material bearing on the history of the Association as I had hoped. Some work has been done on it, however, and I am planning to devote more time to it during the coming year.

G. E. KIDD, *Chairman.*

There were no reports from the Metropolitan Health Board Advisory Committee, the V.O.N. Advisory Board or the Representatives to the Greater Vancouver Health League, these Committees having been inactive during the year.

An interim report of the Summer School Committee was given by the Chairman, Dr. J. C. Thomas, who reported satisfactory progress in plans for the Session to be held in June.

The letter appearing below is published for the information of all concerned.

THE WARTIME PRICES AND TRADE BOARD

5th Floor, Birks Building,
Ottawa, Ontario,
April 8th, 1943.

Dr. T. C. Routley,
Canadian Medical Association,
184 College Street,
Toronto 2, Ontario.

Dear Doctor:

The Health Supplies Committee of War Production Board is constantly considering the requirements of Canada and other claimant agencies for critical drugs and hospital supplies. Several different items have already been considered by them and allocations to the various claimant agencies have been made. We are making the submissions of the estimated requirements of the civilian population and in turn receive advices of the quantities which may be taken from the United States by our importers.

There is one aspect of this which I think your Association should consider. These quarterly allocations, if not availed of, may be absorbed by other claimants and may not be available when a belated requirement is lodged by our importers with supply houses. It seems advisable on that account that users of these materials in Canada should watch their own supply position and, when stocks tend to decline, orders should be lodged with the supply houses in order that users may be able to maintain a normal inventory.

The case of sutures is an example. It appears that orders for civilian requirements lodged with the United States since the first of the year have been rather less than normal and we have not taken up our quota. It is suggested that your members should now look to their stock positions and place their orders with their supply houses so that our right to these supplies from the United States may not lapse.

We will advise you of other situations of this kind as they come to our attention. It seems desirable to obtain our full allocations and assure ourselves of supplies within the country, without, of course, piling up here any undue stocks of them.

Yours truly, (Signed) R. GEDDES,
Chief, Supply Division.

GASTRIC MUCOSAL PATTERNS

By Drs. Prowd *and* Campbell

X-ray Department, St. Paul's Hospital.

(Read before the General meeting of the Vancouver Medical Association, April 6, 1943)

Limitation of time has made our selection of slides somewhat limited, and consequently we have tried to choose a few of the most representative.

Of necessity much that is of interest and perhaps more likely to stimulate discussion, has had to be left out. We have had to omit pictures illustrating the meniscus sign, the use of graded compression, demonstrated en face niches, increased gastric rugae in duodenal ulcers, and proven stomal ulcers following surgery, to mention a few examples. We have not had much to say about gastritis, a subject of wide interest in recent years.

As early as 1911 von Elischer described a technique demonstrating gastric mucosa by X-ray. In 1916 Schwarz of Vienna described unusually roughened rugae along the greater curvature and later was able to prove that definite gastritis was present in the patient. Following 1923 Rendich, Forssel, who had contributed a classic as early as 1913. Berg, and others, enlarged the volume of data and by patient correlation, added to our powers of interpretation.

The digestive system in primates and man is rather generalized. But in the mammalian gut the inherited element is clearly dominant, throwing significant variations into the colon: As a result, man has the single simple primitive stomach, relatively free of anomalies. Traces of specialization in primates may be seen in the elaborately sacculated stomach of Colobus; and in the human fœtus, the mucosa of the fundus is richly corrugated with a suggestion of abortive sacculation soon to disappear by absorption, as the more primitive, more undifferentiated, and more variable pattern becomes established.

We then can understand why the mucosa of the stomach is so variable in appearance. In fact, it may be considered almost as a separate organ—a plastic organ with continual changes in arrangement, in depth and consistency of rugal folds which are more or less independent of the muscular coats. Forssell pointed out that this was conditioned by an intrinsic motor function of the muscularis mucosæ. That the rich capillary network of the mucosa varies in blood content has been known since the time of Beaumont, and Forssell stresses this hydrodynamic factor, the basis of variations in appearance, and of the sense of resistance, one experiences palpating gastric rugæ.

Parallel rugæ leading down through the cardia along the magenstresse stamp the close affinity of the esophagus and the upper lesser curvature of the stomach. Rugæ radiate out from the lesser curvature, become more tortuous as they near the saw edge of the greater curvature, and turn distally to become parallel as they converge in the pylorus. They pass through, underlining the morphological affinity of the mucosa in the pylorus and first part of the duodenum.

The stomach is a barometer, registering tides of disease in many parts of the body. It is extremely sensitive to the guarded tension with which the patient approaches his examination on the first day. A recheck the next morning may find him relaxed, cooperative, quiet, and the stomach may lose its initial spasticity and become accessible to detailed study. In many patients, however, this condition is permanant, and a follow-up study of this group indicates such a large proportion, subsequently developing ulcer, that one is justified in thinking of a definite pre-ulcer syndrome.

One illustration will serve to emphasize the sensitive response of the gastric barometer to remote conditions. While palpating the lower right quadrant of a patient with a visualized fixed tender appendix, we chanced to observe marked pyloric spasm. This spasm, with deepened peristaltic waves ,was repeated on every attempt to palpate the organ, indicating a specific response under direct control.

The radiologist is a silent partner in the diagnosis and, to some extent, in the treatment of gastric disease. He is a signpost in diagnosis, who may point at times to the latent lesion, latent otherwise to the hour of perforation or fatal hæmorrhage; he observes

the progress of medical care, and judges without bias the end results of more radical methods.

No one questions now the significance of a true Haudek niche. It is not in cases with positive findings that our chief difficulty lies, but rather in negative cases, where we are concerned that our examination may not have been thorough enough. Here we need as much co-operation as possible, and in the bed patient, our difficulties increase in geometrical proportion with the disability of the patient. Also, the discomfort to the patient must be carefully weighed.

Gastroscopy is not a competitive, but rather a supplementary method of examination. It is a large field, and the recognition of the frequency and importance of gastritis must be credited to this diagnostic aid. We now know that many cases formerly labelled functional dyspepsia belong in this group. Gastritis commonly occurs in association with ulcer, and is so frequently seen along with carcinoma, that one is justified in speaking of a possible predisposing element, reviving an old hypothesis of Cruveilhier. Again, peristomal changes are invariable following a gastro-enterostomy. In pernicious anemia, changes in the mucosa are variable, the common atrophic type may occur, or we may get definite hypertrophic changes with pseudo polypoid projections, in one of which carcinoma may occur. It is this type of mucosa that gives a specific X-ray picture. Localized ragged irregular hypertrophic mucosal folds with wart-like granulations and small erosions, can be demonstrated especially in tangential views of the lesser curvature, and this data is supplemented by a definitely increased sense of resistance in palpation of the folds due to the increased turgidity and hydrodynamic content. In this regard one may mention the difficulty of demonstrating ulcer after recent gastric hæmorrhage. Three factors at least contribute to our difficulties here. First, the patient cannot fully co-operate in the examination. Secondly, the crater may be filled with a clot or fibrin plug, and thirdly, in line with what we have said above, the steep edematous walls of the crater may be reduced by the venesection effect of a sharp hæmorrhage.

The size, shape, position, capacity, tone, mobility, flexibility of walls; motility, depth, frequency and rhythm of peristaltic waves; the presence or absence of spastic areas, filling defects, localized tenderness; the visualization of areas blind to the gastroscope; emptying time, and extrinsic pressure effects, all belong to the X-ray examination alone. In a word, the dynamics of the stomach are revealed only by this method. And with a combination of methods in a co-operative patient, error, in general, should be in the vicinity of about 5 per cent, a figure which compares favourably with reports on microscopic tissue. The visualized mucous membrane helps us in recognizing early lesions, *e.g.*, the en face niches, in demonstrating early malignant changes with destruction of mucosal pattern, and in helping to determine the extent of a malignant lesion. This may contribute a little to an estimation of operability, remembering always that this is a function of many variables, the clinician integrating many considerations besides the X-ray appearances, into a summation that includes among other things, his own bias toward the radical or toward the conservative side.

The study of mucosal relief also plays a large part in the diagnosis of intestinal conditions. The study of polyps, ulcerative colitis, regional ileitis, and intussusception, and the determination of mucosal destruction in suspected malignancy are a few representative examples.

In conclusion, one may say that the study of gastro-intestinal mocosal patterns by spot radiographs is a large and growing field.

" 'Tis true: there's magic in a web of it."—Othello.

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British Columbia Medical Association

(Canadian Medical Association, British Columbia Division)

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COMMITTEE ON ECONOMICS

Chairman: Dr. G. F. Strong

"HEALTH INSURANCE — HOW SOON?"

T. C. Routley, M.D., LL.D., F.R..P.(C.)
General Secretary, Canadian Medical Association.

To a considerable degree, the future of medical practice in Canada may have been placed in the hands of 41 members of Parliament who constitute the Select Committee to whom has been entrusted the responsibility of examining and reporting upon Social Security proposals including health insurance.

The Committee first met on Tuesday, March 16th, on which occasion it was addressed by the Honourable Ian Mackenzie, Minister of Pensions and National Health and Chairman of the Cabinet Committee on Reconstruction. After dealing briefly with a number of general proposals, Mr. Mackenzie plunged into the subject of health insurance. He had much to say on the measure, reference to which will be made in this communication; but, before dealing with his comments it would be well to have a look at the proposals.

More than eighteen months ago, there was established within the Department of Pensions and National Health an Advisory Committee on Health Insurance with Dr. J. J. Heagerty as Chairman. Associated with him was a group of civil servants interested in the legal, actuarial and statistical aspects of the subject. The Heagerty Committee has worked hard for a year and a half, has taken counsel and advice from many people and has tabled draft proposals which will now become the subject of careful study at the hands of the Select Committee.

Briefly stated, the proposals are as follows:

(1) There shall be an enabling federal act relating to health insurance, public health, the conservation of health and the prevention of disease.

(2) There shall be a model provincial act of health insurance which in substance shall be accepted and adopted by any Provincial Government desiring to obtain federal subsidies for health insurance.

The enabling act is brief. It permits the Minister of Pensions and National Health to set up within his department a Health Insurance Branch which shall have the power to carry on negotiations with any province which may be agreeable to introducing health insurance legislation which guarantees benefits of the standards, under conditions and for the classes of persons as set forth in the enabling act. A province entering into negotiations with the federal authority with respect to health insurance must also guarantee to carry on simultaneously a public health programme of a character, scope and extent which will be satisfactory to the federal authority. The federal authority in turn undertakes to provide financial aid to the provinces both for the actual carrying out of health insurance and for public health benefits. The federal authority also has the right to appoint inspectors to visit the provinces to see that the money which has been voted to the provinces is being properly and adequately expended.

The model provincial health insurance act sets forth the following:

The provision shall be applicable to *all* persons in the province coming under an economic level to be set by the Province.

Funds shall be provided by the federal and provincial governments, insured persons and employers.

The financial arrangements suggest the sum of $26.00 per insured person per year be set up to cover all benefits, including administration.

Administration shall be under a Commission, the Chairman of which shall be a medical practitioner who has had at least ten years' experience in practice.

The benefits shall include the following:

Medical, surgical and obstetrical benefits;
Dental benefit;
Pharmaceutical benefit;
Hospital benefit;
Nursing benefit.

There shall be free choice of doctors by patient, and *vice versa*.

There shall be no exclusions; *i.e.*, the act will cover all persons within the economic level, *including indigents;* and it shall also provide all necessary services, including general practitioners, specialists and consultants.

The insured shall be obliged to name a family doctor or general practitioner.

Specialist services may be secured ordinarily through the family doctor.

The medical profession shall be paid on a tariff and by a method agreed upon between the medical profession and the provincial commission. This may be by capitation, fee for service, salary, or a combination of any two or more methods.

There shall be set up in each province administrative regions in each of which there shall be a regional medical officer who must have had years of experience in private practice.

Provision has been made for the establishment of Medical Advisory Committees, both regional and provincial.

The act also provides for representation on the commission of those receiving the benefits as well as those providing them.

Safeguards are being introduced to guarantee that ample clinical material will be available in teaching hospitals associated with medical schools.

Hospital benefits include general ward service and laboratory facilities. Pharmaceutical benefits will probably be assisted by a formulary. Dental benefits will apply particularly to children and some remedial services.

In presenting the proposals to the special committee, the Honourable Mr. Mackenzie said that he considered the plans and the report associated with them the most comprehensive that had ever been compiled. He advised the committee that in his opinion they would have an opportunity to consider, clause by clause, suggestions which were calculated to make possible a health insurance measure for Canada on a sounder and broader basis than is to be found in any other part of the world. Mr. Mackenzie's presentation to the committee was marked by its clarity and forcefulness. Here are some extracts from his address:

"Health insurance is unquestionably the greatest present lack in Canada's system of social security."

"If we are to do something practical and useful for the people of Canada, quickly and effectively, it may be more to the point if, for the time being, we concentrate our efforts on filling out the gaps in our existing social security system. . . . The most conspicuous gap is in the field of health."

"Forty-one countries have adopted health insurance. Thirty-three of these are compulsory schemes."

"There is no doubt that public opinion in the New World with regard to social legislation has changed and progressed rapidly in recent years."

"Here in Canada, with a simple stroke of the knife, we cut through one of our constitutional difficulties and inaugurated Unemployment Insurance."

"The British Columbia Government completed a draft bill of Health Insurance in 1934 and enacted a provincial statute of health insurance in 1936. This Act has never been put into operation chiefly due to the fact that the medical profession objected to certain features of the Act and declined to co-operate."

Referring to House of Commons debates on Unemployment Insurance, Mr. Mackenzie said:

"It is fairly clear from the debates on this Bill that it was the Government's intention that, if Unemployment Insurance stood up to the constitutional test in the courts and its operation proved a success, the Dominion would in due course move on to the field of health insurance."

Referring to his early interest in health insurance, the Minister said: "When in 1939 I found myself responsible for the administration of a department in which active planning for health insurance was being carried on, I gave my strongest support and encouragement to those efforts."

Speaking of the Health Insurance Committee which, for a year and one-half under Dr. Heagerty's chairmanship, had developed the present report on Health Insurance, Mr. Mackenzie said:

"The Committee did not work in a back room. It reached out into the country and it sought the advice of a great variety of organizations and institutions considered likely to have a direct interest in this important subject."

Referring to the C.M.A., Mr. Mackenzie had the following to say:

"Perhaps the culminating achievement of the Committee, aside from the draft proposal which constitutes its report, was the unprecedented assembling between annual conventions for the first time in 75 years of the General Council of the Canadian Medical Association in Ottawa, January last, when this great and influential body formally went on record in favour of the principle of health insurance. That decision was not reached until after members had familiarized themselves quite thoroughly with the general principles of the committee's report. The resolution is not to be interpreted as an endorsement of this or any other specific plan. The Medical Association reserved its right to comment on any particular provisions, but it was nevertheless a great milestone in the path of progress in Canada when the medical profession of Canada, through its General Council, formally pledged itself to the principle of health insurance."

Proceeding to elucidate considerations leading to the form in which the Advisory Committee's proposals were couched, Mr. Mackenzie said the following six principles might be stated as concisely underlying the plan:

(1) That no scheme of health insurance can be successful without a comprehensive public health programme of a preventive nature.

(2) That a real health program as distinguished from a policy of cash benefits can be effective only if it embraces the entire population.

(3) That the principle of compulsory contributions should be embodied in any plan of health insurance to the greatest possible extent.

(4) That public opinion and efficiency demand to the greatest possible extent a national plan.

(5) That the constitution, as at present understood and interpreted, prevents the Dominion Parliament from adopting a single comprehensive national Health Insurance Act.

(6) That, for practical reasons, a constitutional amendment is not desirable.

The draft proposals place particular emphasis upon Public Health and preventive medicine. Mr. Mackenzie added that it is proposed that there should be attached to the Dominion Act, as a list of types of health measures with respect to which the Dominion is prepared to enter into agreement with the Provinces for the purpose of instituting a health programme, the following:

1. The provision of free treatment for all persons suffering from tuberculosis, including the construction of additional buildings and bed accommodation.
2. The provision of free treatment for persons suffering from mental illness and the care of mental defectives, including buildings and accommodation.
3. The provision of preventive and free treatment for persons suffering from venereal disease.
4. The provision of training facilities in public health work for physicians, engineers, nurses and sanitary inspectors.
5. The undertaking of special investigations concerning public health or public health measures.
6. The establishment and undertaking of a programme of physical fitness development for youth.

Speaking of coverage—the people to whom health insurance should apply—the Minister said this:

"The plan is founded upon the principle that it must cover the entire population. Since our fundamental purpose is the improvement of the health of the people, we feel that this proposed legislation must apply to everybody."

But realizing that certain autonomy and flexibility must be left to the Provinces, the Minister continued:

"Since there can be no standard and uniform limitation, it is better that the Dominion should adopt the basic assumption that all may benefit, leaving it to the individual Provinces to determine whether or not certain classes could or should be excluded. In any event, the health ideal calls for total coverage."

Proceeding to the question of costs, the Minister said:

"The basic policy embodied in this proposal is the contributory principle. The modern trend throughout the world with regard to all forms of social insurance is that they be contributory. Under the contributory system the benefit becomes a right and not a concession. It is the very essence of insurance that the person who hopes to benefit shall pay a premium supporting a financial plan which provides the benefits."

"Industry also has a definite stake in the health of our working population. It has been estimated that every day fifty thousand workers are absent from work through illness."

Thinking in terms of optimum health, Mr. Mackenzie said:

"The Advisory Committee recommends not merely a health insurance bill—it is a health bill—a bill that is designed to do constructive work in raising the positive health standard of the people of Canada."

"The health of Canada is one single problem and we cannot break it up into geographical segments."

The Minister then spoke of constitutional difficulties and the advisability of provincial administration. He said:

"The provinces control the regulation of the medical profession. Each province has its statute setting up a medical council or medical college with the right to license practitioners and to discipline and regulate their activities.

"The Advisory Committee contemplates a federal statute as the foundation stone of the structure. Health insurance must go hand in hand with a broad programme of preventive health measures. The primary consideration is the health of the people.

"The Dominion Government will assist the Provinces, both with respect to a public health programme and with respect to health insurance, but will not help a Province with regard to either one of these projects unless both are put into effect."

Thus it will be seen how emphatically the Minister links preventive and curative medicine in an all-out health insurance programme.

Dealing with the time involved in bringing this measure into operation, the Minister had the following to say:

"Due to the fact that health insurance will require legislation by both the Dominion

and Provincial Parliaments, and the fact that the Provincial legislation is exceedingly complex and will require a great deal of study, it is considered that all this proposed legislation could not be brought into operation within at least two years."

In summing up his presentation to the Select Committee and making reference to the fact that health insurance in Canada along with other social security measures will cost money, Mr. Mackenzie said:

"If we can pay for victory over the curse of Hitlerism, can we not also pay for victory over the scourge of disease, insecurity and poverty?"

On Friday, March 19, the Select Committee began its consideration of the draft Bills which were outlined in detail by Dr. Heagerty, the Chairman of the Advisory Committee. The Committee proposes to meet twice a week. Witnesses and experts who have anything to say on the subject will be heard. The Canadian Medical Association is preparing a brief to present to the Committee and representatives of the Association will be in attendance upon the Committee more or less constantly. The medical profession of Canada may rest assured that its interests will not be lost sight of by those who represent the profession before the Committee. The proposed legislation may, and likely will, change the practice of medicine for generations to come. It is axiomatic to say that, if the Canadian public is to receive adequate medical care, using that term in its broadest sense, then those providing that care must receive adequate pay and recognition for their services.

How soon will health insurance become effective in any province?

Who can tell. Mr. Mackenzie says it will take two years to grind out the necessary legislation. But we have a war to win and pay for—factors which may play very important roles in "dating' health insurance.

Be that as it may. Health insurance is around the corner—in people's minds. They want it. Inevitably, it will come. We as a medical profession, more perhaps than any other group, are vitally concerned, and we must do our best to see to it that the legislation, when it is placed on the statute books, guarantees progressively better medical services to the people and conditions of work and remuneration which are eminently satisfactory to those who provide the service.

Reporting of Venereal Cases

The Division of Venereal Disease Control has asked that the following announcement be published in the *Bulletin*:

The attention of all registered practitioners in the Province of British Columbia is directed to the fact that they are *required by law* to report to the Division of Venereal Disease Control every case of venereal disease coming to their knowledge. These reports are to be sent in on the properly completed Forms N.1. (formerly marked V.D.1.).

NOTIFICATION FORM N.1.

With full recognition of the fact that the time of doctors is being encroached upon greatly by having to fill out various forms for all sorts of purposes, especial attention is drawn to Form N.1., the Notification Form of the Division of Venereal Disease Control. It differs from a great many other forms in that questions to which replies are asked all are designed to furnish information which is essential to the proper care of the patient reported. Special emphasis is to be laid upon certain spaces on the Form which are far too frequently left blank by the reporting doctor.

Date of Birth: This is important because there is a great deal of difference between treatment which might be advisable for a patient of 40 and another of 65. Give at least the year of birth, or if unobtainable from the patient, give your own estimate of the approximate year of birth.

Date of Onset: This refers not necessarily to the onset of the present symptoms, which may have arisen in the past few months only, in a case of many years standing. Here again if the patient cannot give the exact time, and it is not to be expected that he will unless it is a very recently contracted infection, give the approximate year as far as can be determined from examining and questioning the patient.

Consultative Service: If requested please be careful to give the information requested on the reverse side of the Form. Do not summarize the result of the spinal fluid examination by the word "positive"; it is essential that the cell count, protein estimate, Kahn reaction and colloidal gold curve all be given.

In the case of syphilis it is especially important that it be stated whether or not the disease is early or late, since the choice of treatment to be given will vary greatly in late as contrasted to early syphilis.

Too often Form N.1. is received bearing no other information than the name of the patient, and the fact that they have syphilis or gonorrhœa and requesting that drugs be sent. When these cards are received the only thing that can be done is to write the doctor asking for the other data which he has failed to give, since without it, it is impossible to know what drugs should be sent. This often means an important loss of time, but is nevertheless unavoidable and due to the neglect of the doctor sending in the Form in the first place.

B. C. Ph. A. HEALTH INSURANCE COMMITTEE SEEKS POLICY DEFINITION

(Reprinted from *The Western Druggist*, November, 1942.)

The Place of "Health Insurance" as One of the Curative Arrangements

If the possibility of improving the general health of the community could be approached on these lines, with the utmost emphasis from the start on the enlargement of the preventive services, some form of "health insurance" then might fall into its proper place merely as one of the several desirable mechanisms for the organization of the subsequent curative arrangements. Except by a few observers, like Sir Andrew Duncan and Professor Alexander Gray, who, as already mentioned, concluded that "the organization of a national health insurance scheme . . . is not even probably the best means of utilizing limited resources for the promotion of national health," the notion has become altogether too widely prevalent that the institution of some form of "national health insurance" would solve practically all the important problems that should be solved. It ought to be realized, for instance, that "health insurance" plans, with their almost negligible preventive services, can do very little actually to reduce mortality—indeed, despite extravagant claims which are often made to the effect that "national health insurance" is necessary because it would produce sharp reductions in the mortalities from such afflictions as tuberculosis, cancer, heart disease, kidney disease, etc., the truth is that the mortality statistics in Great Britain, as a good example, have remained altogether "recalcitrant" (as one impartial observer has well remarked), and under "health insurance" have shown no greater improvement than those of this continent with its present non-insurance methods of medical practice. Furthermore, it should be understood that "national health insurance," if it were to follow the general model of the schemes already adopted in several countries, would provide merely a state-assisted scheme of limited medical and other services for certain arbitrarily specified groups only—not for all the people.

For these reasons it will be important tht in Canada there shall be a wide realization that the British nd European schemes, for instance, which are generally advertised as providing the examples on which a Canadian health insurance plan should be based, are in reality of a standardized urban-industrial type, from which many very large and important groups of people are excluded, and by which restricted services only are

provided. The British plan, as the most prominent example, covers only a restricted urban-industrial portion of the population which they are "employees" earning incomes below an arbitrary figure (only £250 per annum until this year, and now £420 p.a.), and provides a narrow range of curative benefits based mainly on the services which only the general practitioner can ordinarily provide, with no hospitalization, dental, ophthalmic, laboratory, or nursing services, and no provisions for securing surgical or other specialists' advice or treatment (except that to a limited extent some of these excluded benefits can sometimes be sscured if the insured person happens to belong to one of the more prosperous of the "Approved Societies" through which the scheme is operated). The British plan—which, it should be remembered, provides cash benefits as well as the general practitioner medical benefits—was in fact, as one authority has well explained, "approached as a problem of poverty rather than a problem of health."

The Necessary Features of Any Canadian Insurance Plan

These weaknesses in the British scheme have been pointed out so often that it is now generally recognized that imitation of the limited British method would not prove acceptable under the wholly different conditions of a country such as Canada, where the background of Friendly Societies (which formed the basis of the Approved Societies) is not to be found in any comparable degree, and where a much more complete service, and coverage for dependents as well as "employees," would almost certainly be demanded. This is so clear, indeed, that it may be taken as axiomatic, for the purposes of this discussion, that any Canadian plan would have to cover "employees" (defined in some fashion) and their dependents, and also should include employers and independent persons in the same income range, and that the benefits ought to embrace the services of the general practitioner, specialists, and surgeons, hospitalization, laboratory, x-ray, etc., nursing, drugs and appliances, and dental and ophthalmic requirements.

A good deal of discussion, even disagreement, is likely to arise on the question of what that "income range" ought to be. Despite the standardized British-European practice which limits the coverage to those with earned incomes below some figure like £420 (say now $1870) per annum, and also notwithstnding the fact that the International Labour Office for years has concentrated its efforts upon attempts to secure the adoption of similar plans, it is certainly pertinent to enquire what there is in any such arbitrary figure, wherever it is placed, that calls for the provision of a government-regulated medical service for those earning up to that amount, while all those with incomes larger by even as little as a single dollar are excluded. In the British Columbia plan of 1936 in Canada, for instance, the income limit was first set at $2400, and then was reduced to $1800 per annum; the limit under the somewhat comparable Dominion unemployment insurance scheme of 1940 was originally $2000, and yet within less than one year of its establishment pressures have already begun to develop for the increase of that "ceiling," or even for its complete removal. What is a proper figure? If there is so much evident disagreement as to where the "ceiling" ought to be, is there not something wrong with the attempt to name such a completely arbitrary figurue at all? Wtihout necessarily endorsing in any other respect the plan which was proposed in Alberta in 1935 (but was dropped when the Social Credit Government came into power), it should be remembered that there the proposal was to cover every person, without any arbitrary income limit. It may certainly be conceded that a plan to incluude everybody, regardless of income limit, probably should not bring every person into the plan on precisely the same basis; but there would be much logical force, and very great social advantage, in devising a plan—if there is to be a "plan"—which would permit any and every person to become a member, regardless of what occupation he may follow, whether he is an employee, or an employer, or independent, and whatever his earned or unearned income may be—persons in the different income ranges, perhaps, to pay different rates of contribution, and in any event to be eligible under the plan only for certain types of benefit, with the understanding that more expensive treatment, accommodation, etc., could be secured in any income range on payment for the excess, as in fact is the case under present circumstances. Such a flexible insurance plan would

avoid the justifiable charge that the stereotyped British-European and International Labour Office schemes of "health insurance" are in fact "class legislation," of a character which it may not be desirable to perpetuate in the post-war economy from which many of the old distinctions seem likely to disappear. Nor would a widespread health insurance plan for all the people, rather than for the favoured group below an arbitrary income level, come any closer to "state medicine" than would one of the stereotyped schemes—so long, of course, whether the plan covers everybody or selected classes only, that the powers of government officials are properly controlled.

The Position of the Pharmacists Under Governmental "Health Insurance" Plans

The importance of thus gaining a much clearer understanding of the problems into which compulsory governmental "health insurance" would plunge the country will be appreciated better from an examination of the European and British experiences. Since this memorandum is written for the information of the pharmaceutical profession, and from considerations of space also, it will be advisable to give particular attention here to the manner in which pharmacists have been required to operate under the governmental regulations of health insurance plans abroad.

Practically all impartial observers are in agreement with the statement of Dr. G. F. McCleary in Great Britain that "it is the general experience of health insurance schemes that the cost of drugs and appliances tends to increase, and one of the most difficult tasks of insurance administration is to keep the cost within reasonable bounds." The influences which produce this condition are complex—the insistent desire of many people for "medicine," the tendency for doctors to prescribe expensive medicaments when the cost is met by insurance funds, and other human weaknesses which develop rapidly when once the individual is relieved from paying his own costs. The history of governmental health insurance shows clearly that, in order to meet these situations, the authorities rapidly build up systems which aim to control prescribing, from the time the doctor first sees the patient until the prescription is filled to the satisfaction of the authorities. In some countries (in France, Germany, etc., though not in Britain) the patient's desire for "medicine" is partly discouraged, first of all, by requiring that he shall make a direct payment for a portion of the cost. The kind of prescription which the doctor may write is then controlled—in Great Britain, for instance, the physicians are expected to prescribe "proper and sufficient medicines, but are discouraged from wasting expensive preparations or using proprietary medicines in the place of equally effective simpler drugs."

In order to check "overprescribing" under the Insurance Acts, an elaborate system of scrutiny and control has been evolved in Britain. The doctor is not restricted in his pescribing so long as he bears in mind the broad consideration that he is prescribing partly at the expense of public funds However, in order to maintain a continual supervision of the fact that he is so doing, his prescriptions are "priced" by entering against each ingredient its wholesale price from a Drug Tariff issued monthly by the minister, to which is added a dispensing fee according to the nature of the prescription. Then "the cost incurred by the prescribing of each practitioner" in the various areas is ascertained and compared with the average cost of all the practitioners of each area respectively, and if it appears that any practitioner's prescribing has been unnecessarily costly, he is visited by the Regional Medical Officer, who obtains his explanation and discusses with him how economy may be secured without loss of efficiency in treatment. If a practitioner is repeatedly extravagant after an interview with the Regional Officer or otherwise gravely in default, the Minister may refer the facts of the case for consideration by the Panel Committee; and if the Panel Committee decide that the prescribing has cost more than was reasonably necessary for adequate treatment, they must make an estimate of the excess cost, and inform the Minister, the Insurance Committee, and the practitioner accordingly. The practitioner may appeal to the Minister of Health against the Committee's decision. If he does, the appeal is heard by an independent tribunal of Referees appointed by the Minister, of whom one at least must be

a medical practitioner; in practice the membership is exclusively medical. No officer of the Ministry can be a member of this tribunal. It is the duty of the Insurance Committee to consider the report of the Panel Committee, or, if there has been an appeal, of the Referees, and to recommend the Minister either to withhold remuneration from the practitioner, or not to withhold, according to their view of the case, and the Minister may withhold such a sum as he thinks fit from the practitioner's remuneration. It will be seen that a question whether an insurance practitioner has made an unnecessarily expensive use of medicine is one that is decided by members of his own profession." (McCleary.) It is particularly significant to note here (in contrast with some of the official regimentations of doctors and others which were written, for example, into the British Columbia Health Insurance Act of 1936) that in Britain the citizen's right of appeal to a tribunal of his fellows in a true democracy is fully recognized.

Many difficulties, however, have arisen, and some have required the appointment of investigating committees for their resolution. In 1930, to give an instance, the Minister of Health found it necessary to appoint an "Advisory Committee on the Definition of Drugs for the purposes of Medical Benefit." The Committee dealt with the problem of defining the procedure "when a medical practitioner has ordered, or is alleged to have ordered, on the official prescription form, and 'substance or article' which is not a 'drug or medicine'." It classified "165 substances and preparations which have been referred to it into those which are never drugs, those which are always drugs, and those which are sometimes drugs. Articles in the last two classes are sub-divided into non-proprietary and proprietary; these last, again, may be of known composition or may be of a composition which is undisclosed." The questions surrounding the ordering of cod liver oil, extract of malt, and preparations of these substances were also examined. Attention was directed to a case where doctors of the highest reputation had ordered cod liver oil and malt "owing to the poor state of nutrition of a number of their patients." Although remarking that "it is unquestionably desirable on medical grounds that any under-nourished person should be supplied with further nourishment," the committee expressed the view that "there are plain reasons why such deficiencies should not in general be made good at the cost of a fund established for therapeutic purposes" —for "any other course might be held to justify the ordering of loaves of bread or pounds of butter or pints of milk for necessitous patients at the expense of the Drug Fund," so that "medical considerations alone should decide in each case whether cod liver oil and malt extract are to be regarded as food or as drugs." The fact that it was necessary to appoint a special committee to settle points of this kind is an interesting commentary on the problems which arise when the regulation of every hitherto personal activity is made the concern of government officials; and it is enlightening to read the admission (in contradiction of those who claim that British Health Insurance is a preventive health measure of great effectiveness) that the Drug Fund under the scheme is merely "a fund established for therapeutic purposes."

The position which the pharmacists now occupy under the British Health Insurance Acts has resulted, after strenuous discussions, from their insistence upon proper recognition of their work. When the scheme was first put forward by Lloyd George in 1911, no adequate recognition was given to the chemists' services—mainly because in England and Wales many of the doctors themselves were dispensing physicians (although in Scotland a different situation prevailed, for there the doctors used the dispensing chemists wherever possible). The pharmacists' position, however, was defended by a National Pharmaceutical Union, which was organized to fight their case. In consequence of this insistence it was ultimately realized that the dispensing pharmacists must occupy an essential place in any such health insurance scheme.

Their present position, accordingly, is summarized thus by one authority:

"The Act provides that Insurance Committees shall prepare and publish lists of persons willing to supply drugs, medicines, and appliances to insured persons. Those who may be included on these lists are chemists or druggists entitled to carry on business under the provisions of the Pharmacy Act, 1868, as amended by the Poisons and Pharmacy Act, 1908. . . . A chemist is required to supply to any person with reasonable

promptness drugs or appliances ordered on a prescription form provided by the insurance committee and duly signed by a doctor on the medical list of the committee. He has to keep in stock, as far as it is practicable, the drugs and appliances mentioned in the Drug Tariff, and supply such as are not inferior in quality to those specified in the Tariff. This Tariff is a statement prepared by the Ministry, embodying a list of drugs and appliances and indicating the standard of quality ordinarily supplied and the prices on the basis of which payment is to be calculated. . . . Payment to the chemists is made by the Insurance Committee and the money is derived from the Chemists' Central Fund. This fund is an amount appropriated by the Minister out of the sums available for defraying the cost of medical benefit. The sum payable to the chemist is calculated on the cost of the drugs and appliances supplied by him (excluding dispensing fees), as shown in accounts submitted by him and passed by the committee. In addition thereto he is credited, in respect of dispensing fees, with a proportional share of the residue of the fund." ("National Health Insurance," W. J. Foster and F. G. Taylor, F.I.A.)

Control of the pharmasists is effected through the following arrangements:

"Samples of medicines dispensed by insurance pharmacists are taken for analysis, and cases in which the medicine is not taken in accordance with the prescription, or is otherwise defective, are considered by the Pharmaceutical Sub-Committe of the Insurance Committee, which consists of three representatives of insured persons, three pharmacists, and a neutral chairman. On the report of the Sub-Committee the Insurance Committee decide whether the pharmacist is in default, and an appeal against a decision of the Committee may be made to the Minister" (McCleary). Furthermore, the Minister "may appoint such persons as he thinks fit, not exceeding three in number, to hear the appeal and draw up a report; the Minister's decision after considering such a report is final and conclusive" (Foster and Taylor).

Here again the mechanism for appeal should be noted particularly.

The Statistics Relating to Costs

In this Memorandum it is not necessary to devote much space to the consideration of costs, for the reason that it is obviously impossible to estimate costs under any plan until the mode of organization has been settled. It will be realized, however, as in all these matters, that the costs will depend largely upon whether the services are to measure up to a high standard, or whether, for reasons of expediency, they are to be controlled down to a price. There would be a vast difference between on the one hand the pharmaceutical costs under a restricted plan in which "bottles of medicine" became the patient's chief objective and on the other under a really valuable preventive and curative form of organization which would permit doctors to prescribe such medicaments and appliances as they consider (subject to some reasonable check) to be professionally desirable. For this reason alone the pharmacists of Canada will be well advised to reach their own opinions of the position which they may properly expect to occupy, and the nature of their collabortion with the physicians who also would have to serve under any type of scheme.

Although the cost figures are thus very elusive and must be interpreted with great care, we may recall that in the United States the Committee on the Costs of Mdical Care estimated for the whole country in 1929 that, under the present non-insurance organization of practice in that country, 18.2% of the total amount spent by the average family for medical care went directly to payment for medicines and drugs, whereas physicians in private practice received 29.8%, dentists in private practice 12.2%, and hospitals 23.4%. A correction of the figures to bring them to the year 1936 has similarly suggested that the distribution of total expenditures for the entire Uninted States was then about 17.5% for medicines and drugs, 30.5% to physicians, 9.8% to dentists, and 22.9% for hospitals. A field survey conducted for a year in 1930-31 by the Metropolitan Life Insurance Company of 8677 families (with an average number of persons per family of 3.9) showed that drug stores received 12.9%, physicians 39.8%, dentists 15.8%, and hospitals 13.6% of the total expenditures.

Since all these figures mainly represent expenditures in drug stores, it is necessary to subdivide them into the amounts incurred on the prescriptions of physicians, and payments for patent medicines and compounds. On that point the Committee on the Costs of Medical Care in the United States concluded that "less than one-third of the drugs and medicines consumed annually are used on the express orders of physicians, even when allowance is made for drugs utilized in physicians' offices and in hospitals." In Canada, somewhat similarly, the Report of the National Committee for Mental Hygiene noted that, on the basis of the 1931 census figures, the total expenditures in the whole country for physicians' prescriptions, patent medicines and compounds, and drug sundries (all of which together represented 55% of the total retail sales in Canadian drug stores) were distributed thus: Physicians' prescriptions, 23.5%; patent medicines and compounds, 66%; drug sundries, 10.5%.

Another set of estimates which is important and valuable in this problem concerns the relation between the expenditures in drug stores for physicians' prescriptions, and the earnings of the physicians from whom the prescriptions originate. In the United States the Committee on the Costs of Medical Care reported that in 1929 $665,000,000 were expended directly for drugs and medicines, of which $360,000,000 were spent on patent medicines, whereas $1,090,000,000 went to physicians in private practice; consequently, under non-insurance practice in the United States, about $305,000,000 represented expenditures for prescribed drugs and non-patent medicines, being 28% of the amounts paid to physicians.

This last figure is reasonable compared with the relative expenditures in Great Britain under the health insurance scheme, whereas the amounts apportioned for the costs of prescribed medicines and appliances are about 33% of the remuneration received by the doctors—the doctor until this year (when the mount was raised to 9s. 9d.) receiving a "capitation fee" of 9s. per insured person per annum, the pharmacists 3s., and the Insurance Committee 1s. for administration, out of the medical benefit fund of 13s. per insured person per annum. It should be noted that the number of prescriptions has averaged very close to 4.5 per insured person per annum; the chemists' remuneration in Britain under the health insurance scheme has therefore been about 8d. (say thn 16c) for each prescription, from which, after deducting the costs of ingredients, the pharmacist has received approximately 4½d. as a dispensing fee and profit for each prescription filled.

In those group medical service plans on the North American Continent where it is possible to separate the pharmacists' costs from those of the prescribing physicians, there is again considerable material to indicate that the cost of drugs and appliances lies in the neighbourhood of approxilately 25% to 33% (about 30%, say, as a round figure) of the physicians' remuneration (excluding drugs and appliances).

In general, as I have stated in "The Canadian Medical Association and the Problems of Medical Economics" (p. 70), the costs under the insurance of an urban group (including confinements, but excluding dentistry and preventive services) may ordinarily be expected to lie between about $17.50 and $22.50 per annum for each person included in the group, while the distribution of the various services might be in about the following proportions: General Practitioner, $5.00; Specialists and Surgery, $3.00; Hospitalization and Nursing, $5.00; Laboratory, X-ray, etc., $1.00; Drugs and Appliances, $1.50; Administration (15%), $2.75; giving a total of $18.25. Such figures, of course, may be subject to wide variations under differing urban and rural conditions.

Conclusion.

The considerations set out in this Memorandum clearly imply, as suggested earlier, that it would be well for Canada to look to the nourishment, living conditions, and even eugenics of its population as a first step in a national health programme; that then the preventive medical and other measures should be more nearly perfected; and that as a final measure—after, but not until, the former basic problems have been attacked

courageously—thought might be given to the much less important possibility of enacting "health insurance" legislation for special groups of people.

The problem is too large, and much too far-reaching, to be solved precipitately, or for political ends, or largely because pressure groups become vocal in advocating "health insurance" without confessing, or perhaps even realibing, the incompleteness of the measures they propose. In the hope of still further emphasizing the fundamental point that the inauguration of compulsory governmental health insurance for the particular benefit of certain groups would do little towards establishing the conditions necessary for the development of an improved healthiness in Canada, the following passages may be quoted from the conclusions stated in what is probably the most complete and objective examination of the British Health Insurance Acts which has been written yet, namely, the "Report on the British Health Services," by "P.E.P." (Political and Economic Planning), published a little over four years ago:

"While efforts at effecting the cure of diseases cannot be relaxed, effoffrts at prevention of ill-health can and must be increased. . . . To the extent that health is a positive element, mere negative attempts to palliate or even to cure specific diseases cannot be regarded as a solution to the problem. . . . It is important, therefore, to outgrow the attitude of confining the term health services to what are really sickness services. . . . This Report therefore emphasizes that a reorientation of the health services is urgently necessary. . . . The implications of such a re-orientation are very far-reaching. . . . It implies general efforts to promote healthy living. . . . Unfortunately, the general coordination of the health services is still fragmentary. . . . The production and distribution of ill-health in unhygienic and unsuitable factories and offices, and in overcrowded vehicles, await more attention from socially-minded doctors and from public bodies. . . . There seems to be widespread agreement that nutrition should be given the first priority on the ground that expenditure on nutrition should be given the first priority on the ground that expenditure on nutrition does more than anything else to eliminate ill-health, and therefore to avert the need for costly and often unsatisfactory curative treatment. . . . There is a constant danger in a humane, and at the same time hard-up, world for too large resources to be allocated to cases which stir pity and too little to constructive and preventive purposes. . . . Throughout the health services there is a constant need for considering what is done from the standpoint of the consumer, who with all his gains from the efforts of health workers is still liable not only to be exploited and misled by commercial influences, but to be inconvenienced in order to fit it with arbitrary and unnecessary administrative arrangements, or to be treated, contrary to the best traditions of medicine, as a case rather than as a human being.

"What does the Report show? To sum it up, it describes how a bewildering variety of agencies, official and unofficial, have been created during the past two or three generations to work for health mainly by attacking specific diseases and disabilities as they occur, and by maintaining the sufferers. To a much more limited extent attempts have successfully been made to find out and to eradicate the social and economic causes of sickness and disability such as bad housing, sanitation and water supply, and dangerous or unhealthy working conditions. . . . Perhaps the most fundamental defect in the existing system is that it is overwhelmingly preoccupied with manifest and advanced diseases or disabilities and is more interested in enabling the sufferers to go on function-in society than in studying the nature of health and the means of producing and maintaining it. From this it naturally follows that millions of pounds are spent in looking after and trying to cure the victims of accidents and illness which need never have occurred if a fraction of this amount of intelligence and money had been devoted to tracing the social and economic causes of the trouble and making the necessary readjustments."

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(5) Add 1 level tablespoonful (and a little extra salt) to 2 cups of meat stock gravy.

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Why not try this recipe at home? It makes good gravy taste meatier. Send for tested wartime recipes containing yeast.

MEAD JOHNSON & CO. OF CANADA, LTD., Belleville, Ontario

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Personalized Field Service on G-E Equipment Has Prevailed for Many Years

It is important that x-ray and other electromedical equipment be kept in tip-top operating condition during these busy days in hospitals, clinics, and physicians' offices. And to users of G-E equipment the need for expert technical and maintenance service in this wartime period has presented no problem. They continue to get it from the same G-E branch offices and regional service depots that have taken care of them for many years past.

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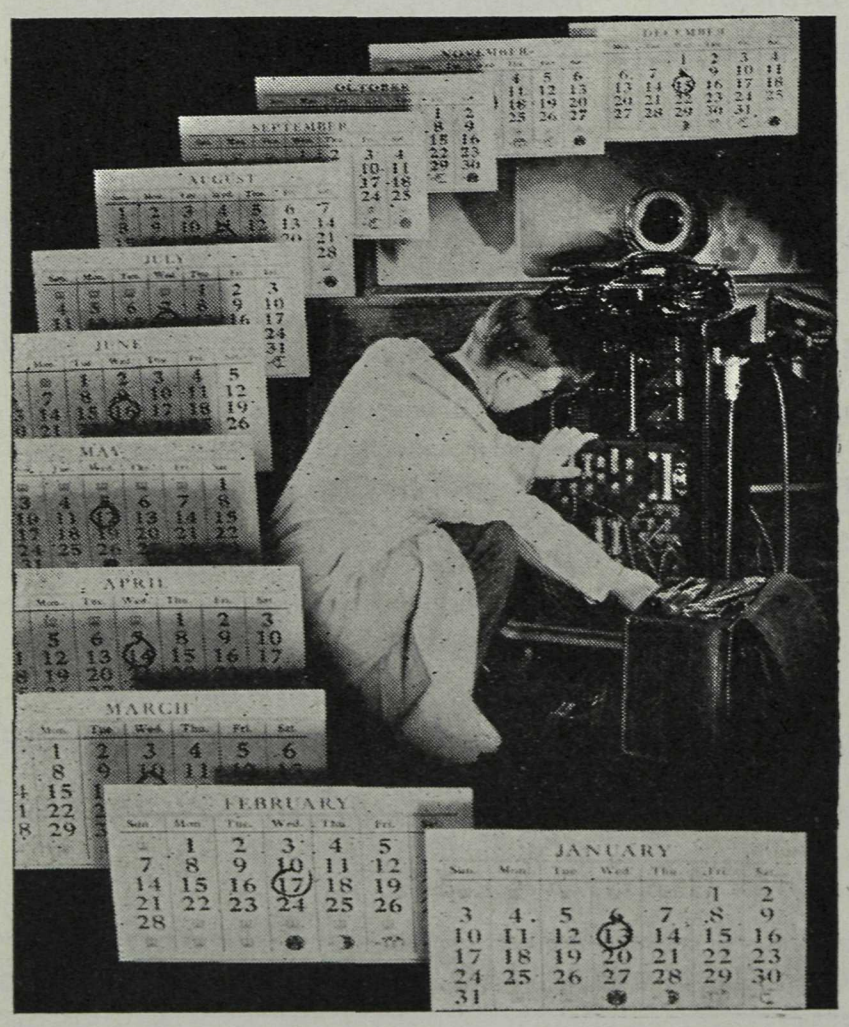
Therefore, to present and future users of G-E equipment, this competent field service will always be available—in wartime and peacetime, both.



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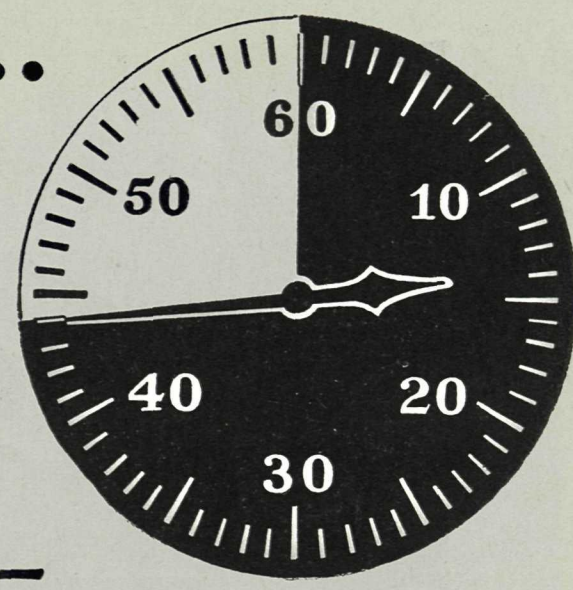
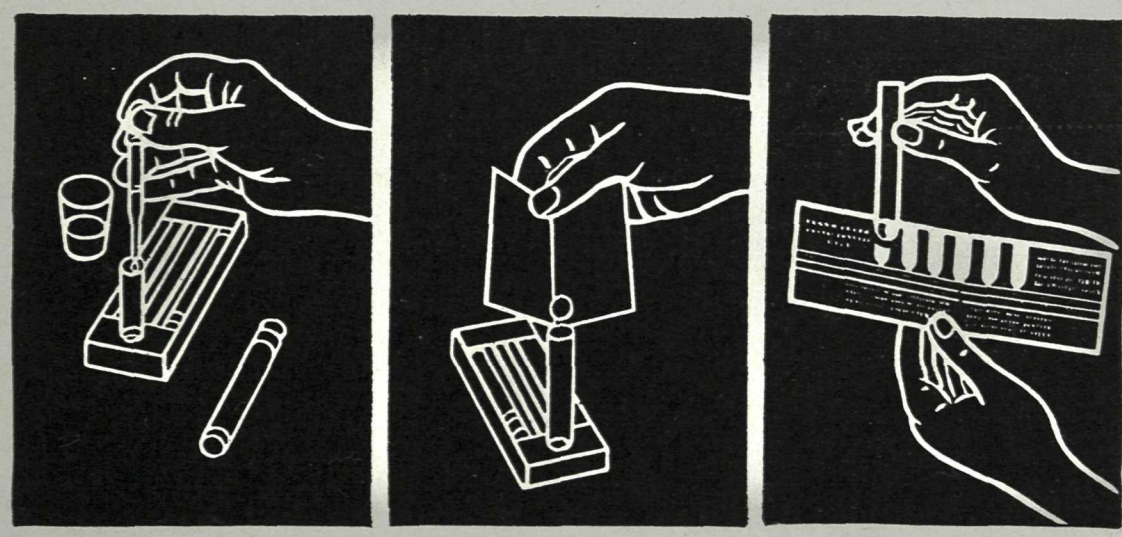


TO TEST FOR URINE-SUGAR WITH

CLINITEST

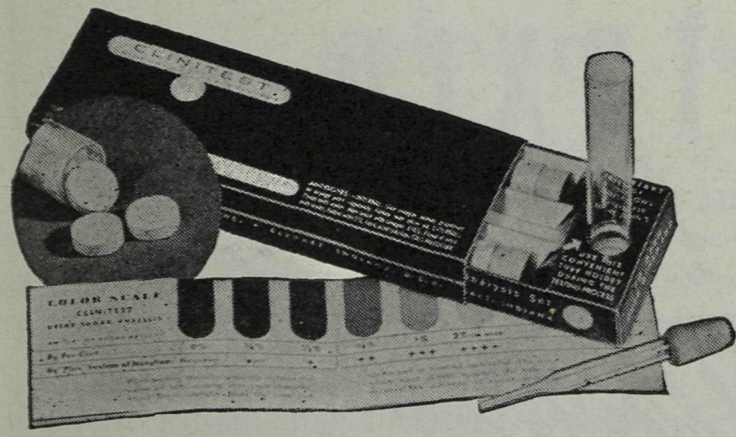
THE NEW TABLET METHOD

INVOLVES 3 SIMPLE STEPS—



1. **5 drops urine** *plus* 10 drops water.
2. **Drop in tablet.**
3. **Allow for reaction and compare with color scale.**

DEPENDABLE RESULTS—Clinitest Tablet Method is based on same chemical principles involved in Benedict's test—except—no external heating required, and active ingredients for tests contained in a single tablet. Indicates sugar at 0%, ¼%, ½%, ¾%, 1% and 2% plus.



ECONOMICAL TO USE
Complete set (with tablets for 50 tests) retails to the patient for $2.00. Tablet Refill (for 75 tests)—$2.00.

Write for full descriptive literature.

Clinitest Urine-Sugar Test and Clinitest Tablet Refill are available through your surgical supply house or prescription pharmacy.

EFFERVESCENT PRODUCTS INC.

Sole Canadian Distributors

FRED. J. WHITLOW & CO., LTD., 187 DUFFERIN STREET, TORONTO

TREAT *Vitamin B_1 Deficiency* PREVENT ITS PROGRESSION

Patients with definite signs and symptoms of vitamin B_1 deficiency should be given large doses of this essential factor in pure form. This also applies when the intake of food has been so seriously restricted or its absorption so gravely impaired that the development of avitaminosis is to be expected.

Prescribe Betaxin THE FIRST SYNTHETIC CRYSTALLINE VITAMIN B_1 HYDROCHLORIDE

Betaxin may be administered by mouth and by injection (subcutaneous, intramuscular, intravenous).

TABLETS, ELIXIR, SYRUP, AMPULS AND VIALS ARE AVAILABLE

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to reduce industrial absenteeism due to urinary infections

In the vital battle of production, it is essential that every worker be kept on the job and at full production capacity.

When a war worker suffers with one of the common urinary infections, Pyridium is of decided service. This is especially evident in the milder, ambulant cases of urinary infection.

The prompt and effective symptomatic relief provided by Pyridium contributes to a more rapid recovery, with the result that the worker can be returned to his job sooner than would otherwise be possible. Pyridium is convenient to administer. The average oral dose is 2 tablets t.i.d. At this dosage level, it possesses the combined advantages of relative nontoxicity, effectiveness in the presence of either acid or alkaline urine, and local analgesic effect on the urogenital mucosa.

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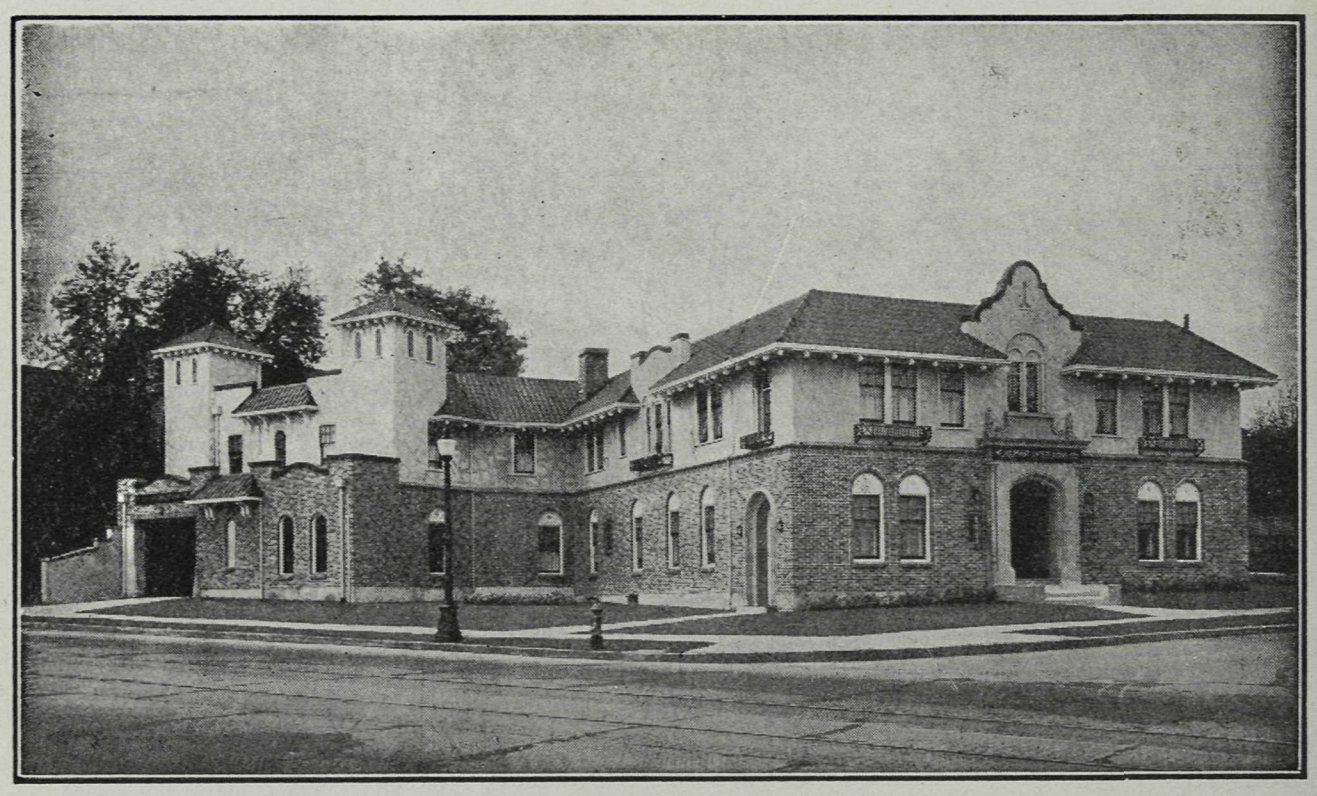
TRADE MARK

(Phenylazo-Alpha-Alpha-Diamino-Pyridine Mono-Hydrochloride)

A decade of service in urogenital infections

MERCK & CO. Limited *Manufacturing Chemists* Montreal and Toronto



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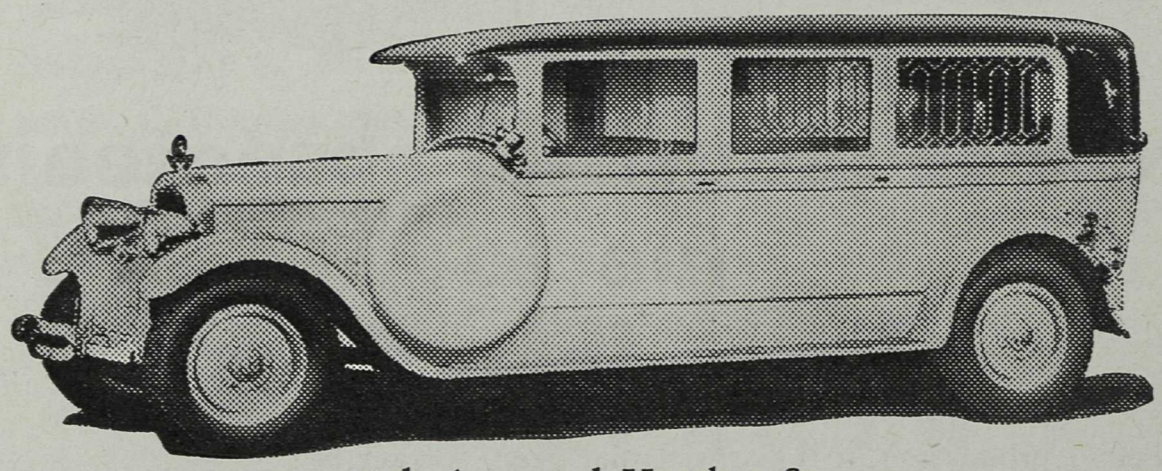

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IS EFFECTIVE IN ALL FORMS OF INSOMNIA, in sleeplessness of nervous origin accompanying worry and overwork or associated with neuroses, as well as in pyrexial conditions where restlessness and discomfort so often interfere with sleep. The hypnotic dose is from one to three tablets, or one suppository, half an hour before retiring.

HOW SUPPLIED

Pink Compressed Tablets for oral use —in containers of 20, 100, 500 and 1000 tablets.

Suppositories for rectal administration —boxes of 10 suppositories.

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Breaks the vicious circle of perverted menstrual function in cases of amenorrhea, tardy periods (non-physiological) and dysmenorrhea. Affords remarkable symptomatic relief by stimulating the innervation of the uterus and stabilizing the tone of its musculature. Controls the utero-ovarian circulation and thereby encourages a normal menstrual cycle.

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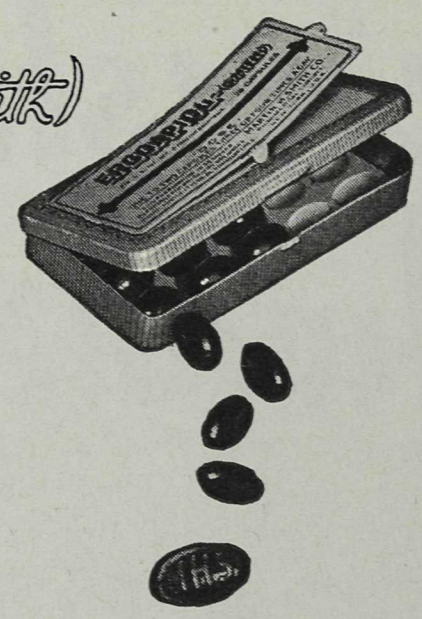

Dosage: 1 to 2 capsules 3 or 4 times daily. Supplied in packages of 20.

Ethical protective mark MHS embossed on inside of each capsule, *visible only* when capsule is cut in half at seam.

Full formula and descriptive literature on request

Head Colds Checked

WITH 3 DROPS IN EACH NOSTRIL . . .

PRIVINE "Ciba"

(1:1000 solution of 2-(naphthyl-1-methyl)-imidazoline hydrochloride)

NASAL DROPS

Clinical investigations on Privine Nasal Drops have proved that they are excellently suited for the treatment of all forms of naso-pharyngeal affections. In head colds, a few moments after the instillation of 3 drops of Privine in each nostril, the headache and sensation of heaviness in the head disappear, while the nasal respiration becomes easier, the watering of the eyes stops, the voice regains its normal tone and the sense of smell is restored.

ISSUED:
In bottles of ½ ounce with dropper, and bottles of 4 ounces.

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- ORALLY ACTIVE
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For the Relief of Symptoms of the Menopause
Suppression of Lactation
Involutionary Melancholia
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Dosage:

Complete information, dosage schedules and specimen packages of the particular tablets or ampoules required, gladly mailed on request.

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MODES OF ISSUE:

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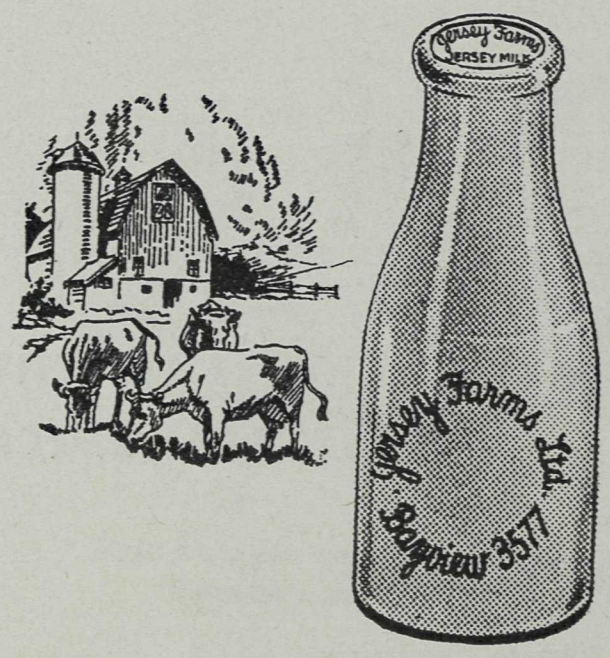

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