R. H. Wilson, M.D.

President, Minnesota State Medical Association

President's Letter

To Members of the Minnesota State Medical Association:

This is my first message to you as President of your Association, and I want to take this opportunity, first, to wish you all a very happy and prosperous New Year. I want to take this opportunity, also, to express my deep appreciation of the honor you have conferred on me. I hope I may prove worthy of it.

I would also like to be the worthy representative, especially, of that great group of men who practice good medicine outside the big cities of the state, some of them hundreds of miles from the great centers of teaching and research. These are the men who man the battle stations of medicine, and I hope that I can say, when January rolls around again next year, that I have helped a little to protect their freedom as doctors and to keep their standards high.

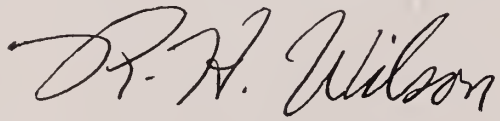
To do so, I shall certainly need the help of the Council and officers of the State Association for their invaluable wisdom and experience. I shall also need the help of county medical society officials all over the state. They are busy men, I know, and they have little time for anything outside their own programs and problems. But I am going to count heavily on them, too, because the success or failure of our work as an organization depends largely on how well we meet their needs.

It is certainly true that times are good as we begin this year of 1956. Furthermore, our patients have confidence in us, as many recent surveys have shown. But the millenium in medicine has not arrived, for all that.

There are still threats of regimentation on the horizon, though they are taking on new forms. Welfare costs are rising, and physicians unfairly get the brunt of the blame for that. Some Minnesota towns are still without doctors, and more doctors and hospitals are needed in many areas of the state. These seem to be perennial problems. There are others, and our state organization must be geared to meet them all.

As chairman of a committee which has dealt for many years with welfare and relief, I have seen how the close and conscientious co-operation of medical organization with the official agencies can operate to solve many of the major welfare problems in this state. I am confident that the same kind of co-operation in other fields will go a long way toward keeping medicine free and standards of practice high in Minnesota.

I follow a long line of distinguished and dedicated men who have devoted themselves to that end. I cannot do better than to follow in the spirit in which they have led.



President, Minnesota State Medical Association

President's Letter

GROUP LIABILITY INSURANCE

The marked increase in malpractice insurance rates in 1952, and again in 1954, resulted in our Council's appointing a special committee to survey the entire field of malpractice insurance. On recommendation of this committee, the House of Delegates in May, 1955, voted to sponsor a group plan of liability insurance for Minnesota doctors, underwritten by the St. Paul-Mercury Indemnity Company.

At the same meeting, the Association also sponsored a group disability insurance program, and, though I believe both plans were explained to most of the component medical societies by our Mr. Harold Brunn, the group disability was pressed because it was necessary to have 50 per cent participation by a certain deadline to put the plan into effect. From numerous inquiries received, I feel some confusion exists and many doctors have forgotten the advantages of the group malpractice plan.

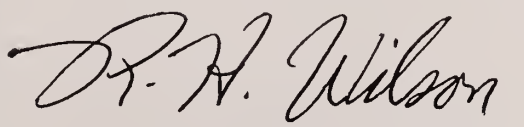
The advantages pointed out by the committee are, briefly: that increased volume of business by an experienced company will permit increased specialization of investigative personnel, defense attorneys, et cetera, needed for the peculiar problems involved in malpractice insurance; insurance will be available to members in good standing without the compulsion of buying other types of insurance to get it; an extensive and co-ordinated educational program of prophylaxis and control will be implemented; vigorous defense against all non-meritorious claims will be stressed with the purpose of eliminating the so-called "nuisance-claim settlements" which only lead to more future unwarranted claims.

The final and most important advantage is that it will afford close liaison between the insurance company and our Association in all matters, including selectivity of risks with possible exclusion of chronic offenders, furnishing of expert testimony in defense of these cases, and medical judgment as to whether a case should be defended in court or settled out of court. This same liaison will provide statistical facts and figures on which future rates will be based. This close liaison between the underwriters and the Association, in my mind, is the greatest advantage. Our Association has an exceptionally capable Medical Advisory Committee that has always been willing and anxious to serve any member threatened with a malpractice action, but they have too rarely had the opportunity. Under this plan, they will be in close consultation with the insurance company on all threatened actions and their knowledge, judgment, and experience will be invaluable.

The rates on the group plan will run about 5½ per cent lower than present standard rates. The more doctors joining the group, the greater will be the opportunity for more efficient and economic handling of cases. More important, a future reduction will be possible in the number of cases, and a corresponding probable reduction in rates.

This does not in any way involve any discrimination or condemnation of other plans or companies. It is simply that we believe that the plan and the company selected most suitably meet the needs of the Association at this time.

As our present liability contracts expire, I feel, in justice to each other and for the good of all, we should very seriously consider our Association Group Liability Insurance Plan.



President, Minnesota State Medical Association

President's Letter

SURVEY ON NATION'S PHYSICIANS

No doubt you have all been reading the results of the recently published survey on what the public thinks of the nation's physicians. It should be emphasized that although the AMA approved the questionnaire, the public, individual doctors, and the research agency really established the issues.

Interviewees were selected so that the proportion of people from various age, economic, geographical, and other groups matched the proportion of such people in the whole population; questions about general public attitudes were asked only of private individuals.

Some interesting major findings were revealed. One is that most Americans, 82 per cent, have a family physician. And they have a much higher opinion of their own physicians than of the medical profession as a whole.

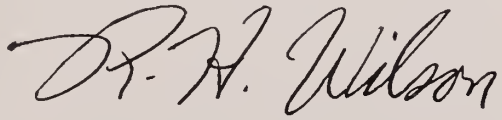
Only 19 per cent said it was hard to reach their own doctors in an emergency, but 51 per cent thought it was true of doctors generally. Only five per cent said their own doctors were too quick to recommend an operation, but 31 per cent thought it was true of the profession as a whole.

What people like about their doctors and expect from them, it appears, is sympathy, patience, and understanding: not guaranteed cures and "wonder drugs." Eighty-seven per cent thought their own doctors take sufficient personal interest in their patients but, again, only 54 per cent thought this true of the profession in general.

Among those interviewed 43 per cent thought most doctors charge too much, but only 16 per cent thought this was true of their own physicians. About 30 per cent believed "most doctors plan to get rich quick," but only 10 per cent thought this was true of their own doctors.

The basic purpose of this survey was to find out what might be needed to improve doctors' services. If it is to have a value beyond that of the ordinary statistical gimmick, each one of us must act as judge to see if any of the criticisms made in this survey of doctors in general can be applied to ourselves. The whole undertaking will have been futile if the results are not heeded and, certainly, the best guarantee for continuing our tradition of free enterprise in medicine will be to satisfy medical needs as fully as possible.

In closing, let me say that we can be justifiably pleased by the praise many interviewees had for our profession. Apparently most adverse criticism of the medical profession is directed at some other person's doctor.



President, Minnesota State Medical Association

President's Letter

MINNESOTA AND THE AMERICAN MEDICAL EDUCATION FOUNDATION

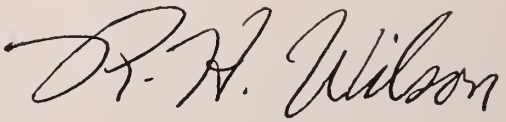
The National Fund for Medical Education was founded in 1951 for the purpose of securing voluntary contributions from industry, medical associations and individual physicians to help meet the rising cost of medical education. It was estimated that $10.000,000 annually in additional funds were needed by our eighty-one medical schools, if they were to maintain their high standards of teaching and research. The American Medical Association undertook to raise $2,000,000 of this amount annually from the physicians of the nation, on a voluntary contribution basis. The AMA generously contributed $500,000 annually for the years 1951-54, inclusive, then in 1955, reduced their contribution to $100,000, believing, that as the individual physicians became aware of the need, they would make up the difference. The AMA, in 1951, set up the American Medical Education Foundation as an agency to solicit and collect the physician's share of the voluntary contributions, and agreed to pay all operational costs of the agency so that every dollar contributed would be turned over to the National Education Fund to be distributed to the Medical Schools.

Minnesota, as did most of the other states, got off to a slow start. From 1952 to May, 1955, Minnesota doctors had contributed only $27,000. Minnesota's share of the needed $2,000,000 would be about $40,000 annually.

In 1954, 138 Minnesota doctors contributed $5,890.38. In 1955, 588 doctors contributed $17,147. In May, 1955, our House of Delegates voted to support the plan of Dr. H. E. Drill, State Chairman, to solicit on the County Society level with a chairman in each county society and a councilor district chairman to co-ordinate their activities. In September, 1955, Dr. Drill called a meeting of all the county chairmen and councilor chairmen at St. Paul for purposes of information and organization of a definite campaign period.

I am glad to report to you that as a result of this effort, Minnesota doctors are doing much better. In January, 1956, 248 contributors gave $7,590 and 142 contributors gave $2,996.75 in February, 1956, or a total of $10,733.75 in two months. But that accounts for only 390 contributors out of our membership of approximately 3,000, roughly 12 per cent. What has our Medical School received in return from the National Fund? In 1954, the University of Minnesota Medical School received $35,762.75, and total grants to January 1, 1955, have been $102,718.75. The 1955 figures are not yet available.

The week of April 23-29, 1956, has been designated as National Medical Education week, of which you will hear much more in the immediate future. I trust you will all participate in the week's activities in your respective communities and will become inspired to join the increasing numbers contributing to the American Medical Education Foundation in our state.



President, Minnesota State Medical Association

President's Letter

A TRIBUTE TO ORGANIZED MEDICINE

A few days hence we shall be gathering at Rochester for the 103rd Annual Meeting of the Minnesota State Medical Association.

To most of us this is primarily a scientific meeting, providing an opportunity to bring ourselves up to date on medical knowledge and equipment, but the meeting also provides some 100 commercial exhibits where you can see and study the latest in equipment, drugs and techniques. For your relaxation, there are special society luncheons and dinners and the usual assortment of sports events on the Sunday preceding the meeting.

This is what the annual meeting means to most of us. We have splendid meetings, and Minnesota can justly be proud of their caliber. But I wonder whether we ever give much thought to another side of our annual meeting.

Have we ever realized and appreciated the months of organization and preparation that the committee on local arrangements of the host city must engage in so that everything runs smoothly? Do we ever think of the effort put forth by Executive Secretary Rosell and his staff in providing the exhibits which are so vital to the financial success or failure of such a meeting?

Do we realize how much easier it makes the job of selling exhibition space if we stop to register with the exhibitors?

Do you realize that the Council and officers of the Association arrive on the scene the Saturday preceding the meeting; that from then until the close of the session they are in almost continuous session, usually starting with a 7 a.m. breakfast?

Do you appreciate the fact that the reference committees meet at 10 a.m. on the Sunday preceding the meeting?

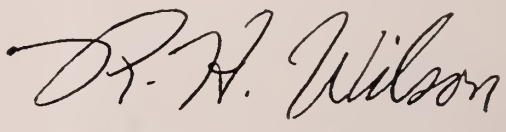
To the House of Delegates, the annual meeting means two long sessions on Sunday preceding the meeting and another one on Monday, and, believe me, those chairs get harder and harder!

Do you set aside time at your succeeding component society meeting for your delegate to make a report so that you may be kept informed on current problems, or do you make him fight for a few minutes' time? I was a delegate for fifteen years from my component society and I am embarrassed to state how few times I was asked or given the opportunity to make a report.

So much for the annual meeting. There is much more to organized medicine in Minnesota and every other state. Do you know that there are twenty-three state scientific committees with a total of 239 devoted men serving on them, giving freely of their time and knowledge that the people of Minnesota might have better health?

In addition, there are approximately twenty-five non-scientific committees with a total of 190 members. These committees are concerned with editing and publishing our journal, with medical economics, medical relations, malpractice insurance, physicians' assistance, and numerous other phases of organized medicine. Mention must also be made of the fine group of men who over the years have given so generously of their time and talents in representing us as delegates to the two annual meetings of the American Medical Association and meetings of national committees on which they serve.

This letter is not meant to be critical, but rather as a tribute and expression of appreciation of the time and talents all of these members have so graciously and devotedly given to the cause of organized medicine. Their only reward is the satisfaction of a most worthy job well done.



President, Minnesota State Medical Association

President's Letter

PHYSICIANS AND SOCIAL SECURITY

Many doctors in Minnesota and the nation are still asking why organized medicine is opposed to social security coverage for their profession on a compulsory basis. For a profession that has been and still is threatened with socialization, this is hard to understand. Certainly, anyone who has taken the time to read the numerous articles appearing in the J.A.M.A., our own MINNESOTA MEDICINE and special articles prepared by Dr. Frank H. Dickenson, director of the Bureau of Economic Research of the American Medical Association, should be convinced that the whole Social Security program or Old Age and Survivors Insurance program, as it is now designated, is not actuarially sound, is definitely socialism. rapidly approaching Townsendism, and is putting an enormous financial burden on our children and grandchildren for generations to come.

In the first place, OASI is not insurance. Insurance means a contract; one party agrees to provide certain returns for certain definite premiums paid in. Once the contract is made, it is binding; the rates cannot be changed; the rewards cannot be altered. But in OASI, the Act that established it definitely states in Section 1104: "The right to alter, amend or repeal any provision of this act is hereby reserved to the Congress." Through Title Two of the Social Security Act, Congress has created a system providing statutory rights to statutory benefits. Such rights are not natural, constitutional nor contractual rights.

Social Security tax rates have already risen and at present are 3 per cent of the first $4,200 of the self-employed individual's income.

Provision is now made for this to increase to 3.75 per cent from 1960 to 1964, 4.5 per cent from 1965 to 1969, 5.25 per cent from 1970 to 1974 and 6 per cent starting in 1975. On earnings of $4,200 per year, the projected raises will increase the tax from $126 per year to $252 by 1975. If the controversial H.R. 7225 pertaining to cash benefits to disabled at age fifty should pass through Congress, this percentage would rise to 3.75 per cent immediately. Already the tax base has risen from $3,600 income to $4,200 income, and there is nothing to prevent any future Congress from raising it to $4,810, $6.000 or any additional figure.

The parties pressing for OASI for physicians make much of the survivors' benefits. Let us look at survivors' benefits for a moment. A physician has a wife and two children, and a net income of $3,600 per year. He dies. His widow collects $168.75 per month until the eldest child reaches eighteen years of age; then the amount drops to $127.50 per month until the second child reaches eighteen. Then it all stops until the widow reaches sixty-five, at which time it resumes at the rate of $63.80 per month unless she remarries.

However, if this same self-employed physician were carrying a $20,000 ordinary life insurance policy, which he should be, he could add a twenty-year family income clause to his policy which in event of his death, would provide $200 per month to his family for twenty years from the date of the policy, or if he died three years after taking out such family protection, it would pay $200 monthly for seventeen years after his death. Such coverage would cost him approximately $85 additional premium on his ordinary life policy, much less than the $126 for OASI, and his wife would get this income for the stated period, whether she was gainfully em-

ployed or not and whether she remarried or not. Such insurance is a definite contract provided by extra premiums, has a definite scale of benefits and is enforceable in the courts.

The situation of the employed persons covered under OASI and those persons, now some 20 million, covered under various industrial pension plans or profit-sharing plans, is definitely different. Under the Social Security Act, both employe and employer contribute to the fund by taxation and returns to the employe in retirement benefits after reaching the age of sixty-five will amount to approximately $30 for each dollar paid into the fund.

In December, 1954, the Ways and Means Committee of the House released a report entitled "Social Security after Eighteen Years." These statements in that report are significant:

"When eligible persons aged 65-75 (now 65-72) earn too much, they must forego their benefits, as well as continue to pay OASI taxes," or:

"There is not enough in the OASI trust fund of $17 billion to pay future benefits to the present beneficiaries," or:

"Today's OASI taxpayers who become beneficiaries tomorrow must look to those working and paying OASI taxes for their benefits," or:

"Total benefits to some aged couples may aggregate several hundred times the amount they paid in OASI taxes."

This certainly does not sound like an actuarially sound insurance program.

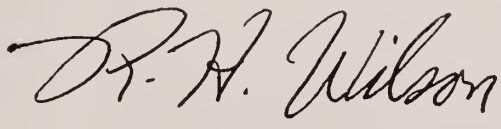
Under the many profit-sharing plans set up by companies to provide for retirement pay, the employer may set aside as much as 15 per cent of the employe's annual pay each year and not have to pay income taxes on this amount.

Under some pension plans, an employer may contribute as high as 200 per cent of the employe's annual wage, without violating the internal revenue code, that is without making the contribution currently taxable income to the employe. These contributions to pension plans by employers are tax deductible as a business expense to the employer and the employe pays no income tax on such amounts until he starts to participate in the pension benefits after retirement.

The self-employed have never had any similar opportunity to defer payment of income taxes on whatever they may be able to set aside for their retirement. The Jenkins-Keogh bills (H.R. 9 and H.R. 10, January 15, 1955), are designed to provide similar tax deferment for the self-employed up to 10 per cent of earned income in any year up to age 65.

Last month, our state office conducted a poll of all our members asking them to vote on the question, "Do you favor extension of the Old Age and Survivors Benefits coverage of the social security program to physicians? And if so, do you approve of it on a voluntary or on a compulsory basis?"

I hope the information provided here will help you decide whether you want to participate in such a program or whether you want to provide your own retirement fund, aided in so doing by adoption of some plan of deferred income tax such as that incorporated in the Jenkins-Keogh bills.



President, Minnesota State Medical Association

President's Letter

THE GOLDEN AGE OF MEDICINE

EDITOR'S NOTE: The following message is an excerpt from an address Dr. Wilson delivered at the annual banquet of the Minnesota State Medical Association May 22, 1956, in Rochester. Its theme was so well-chosen and well-received that we felt it deserved repeating.

You and I have had the privilege of living in a wonderful generation, a period of scientific discovery and progress such as the world has never known and, one is tempted to say, such as the world will never know again.

Medicine, as we know it, has also had its golden age in the last half century. I knew the medicine of 50 years ago because I was brought up in a doctor's family. My father grew up as a farm boy, started a sort of "hang-around" apprenticeship with a nearby country doctor and later went to medical school in Chicago for about one year. He then returned home to start practicing medicine.

On the day that I was born, April 30, 1895, his total business was $1.00, and that was charged.

Those were the days of bromidia for the nerves, calomel for the bowels, tincture or infusion of digitalis for the heart, creosote and heroin for the cough and morphine for pneumonia. Those were the days when people died of inflammation of the bowels instead of living with appendectomies. Those were the days when a woman stayed in retirement when she was pregnant. Those were the days when doctors diagnosed diphtheria by the smell. There were no x-rays; fractures were diagnosed and reduced by touch and you bought your spectacles from the grocery store.

Now let us consider in contrast what progress has been made in the past half century.

In the field of public health, for example, we have the protection of the Pure Food and Drug Act passed fifty years ago; everyone in Minnesota drinks Grade-A pasteurized milk, and I am proud to say that my home city of Winona was the first in the country, to my knowledge, to pass an ordinance requiring pasteurization of all milk sold in the city. We have strict standards for municipal water supplies;

we have public health nursing in most counties, cities and schools. And I cannot leave public health without paying a well-deserved tribute to our late beloved Dr. Chesley, a man with an outstanding national reputation in his field.

To go on to other fields: Can you imagine trying to practice medicine today without the diagnostic x-ray, the chest studies, the gall bladder, kidney, stomach and colon studies? Then, too, we have blood typing and cross-matching for safe transfusions; we have the Wangensteen suction for postoperative ileus and small bowel obstruction; we have the modern treatment of pulmonary tuberculosis with the new drugs and improved surgery.

We have modern laboratory procedures, blood chemistries, electrolytes and fluid balance. My father never heard of such things.

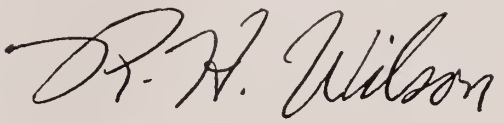
During the past half century radical changes have also taken place in medical education. The quack schools and diploma mills have gone out of existence. Continuation courses and post-graduate opportunities have multiplied until no man lacks unlimited opportunities to keep in step.

It has been a golden age of medicine, and progress is continuing at such a terrific pace that I am sure it is taxing the mental capacities of all of us to keep up with it.

I am reminded of a lovely lady of ninety-three years who sustained a fracture of the hip some twenty years ago. While convalescing in the hospital, she did a lot of reading. She would start daily with her Bible, then the morning paper and a good book and so on. She developed some eye strain, and I cautioned her about reading too much. She eased off a bit but again in a week or two she had developed quite a conjunctivitis, and I became firmer with her and told her she must ease up on her reading or I would be forced to take all the reading material from her room.

At ninety-three she looked up at me with a little twinkle in her inflamed eyes and said, 'But, Doctor, I don't want to grow up ignorant.'

Yes, with this golden age for our profession, we'll have to continue to read and read until our eyes fatigue, if we too are not to grow up ignorant.



President, Minnesota State Medical Association

President's Letter

CANCER DETECTION IN THE PHYSICIAN'S OFFICE

Frankly, I cannot understand the reluctance of our Minnesota physicians to participate in the program of cancer detection in their own offices.

I do think some mistakes have been made in the past regarding cancer detection and these mistakes have discouraged many physicians. I believe the first mistake was made several years ago when societies were prevailed upon to set up free cancer detection centers where people could come to have free physical examinations at stated times. Under this system, the doctors of the communities donated their services on a rotation basis. The theory apparently was that many people delayed examination because they could not afford it. But who appeared for examination? Some of your best-paying patients, whom you have been trying to get to have complete work-ups for some time. Most of these had already had routine histories and physical examinations in your offices, but they seemed to think because this was a cancer detection center that physical examinations would be different. Again it was rather silly to see a radiologist, psychiatrist, an eye, ear, nose and throat man or a dermatologist doing rectals and vaginals for detection of cancer. The free detection centers soon faded from the picture and rightly.

Then the University cancer detection center was set up strictly as a research project. Its only purpose was to examine asymptomatic individuals in the cancer age group—people who believed they were perfectly well—in order to see what incidence of asymptomatic cancer could be detected in such a group.

This detection center has been in operation for several years now, and asymptomatic cancer has been found in one of each thirty-eight patients examined, 50 per cent of these found on the first examination and 50 per cent on subsequent examinations.

There are two criticisms to be made of the University cancer detection center, as I see it, and neither is the fault of the center itself.

The first criticism is that the center did not get asymptomatic persons to examine. From my own experience and from the experiences of other physicians with whom I have talked, I am sure that the majority of those reporting to the center were patients who have had multiple symptoms and cancer phobias for several years.

The second criticism, as I see it, is that it has led the people to think they must go to such a center to have early cancer diagnosed. It has created the impression that any community doctor, no matter how well-equipped with x-ray, proctoscopes, vaginal speculum and laboratory facilities, cannot do what they do at the detection center. The fact is that on the basis of tabulated examinations to date, the private practicing physician is finding the same percentage of cancer, including visceral cancers, the same percentage of precancerous lesions, and the same percentage of non-cancerous diseases as are found at the detection center.

This thinking has led to an accumulation of patients applying for admittance to the detection center until there is now a back-log of some 7,000 persons waiting to be examined. The center is becoming a service center instead of a research center. I am afraid these people will continue to wait for their turn at the center until many of them will have, not asymptomatic cancer, but possibly inoperable cancer.

I do not feel that the nominal fee of $25 is of much influence in their decisions to go to the center.

The University cancer detection center is anxious to refer this back-log of people back to their family physicians for examinations. All they ask is that the component medical societies agree to use the forms prescribed for the examination and forward a copy of the examination to the center for statistical purposes. This seems to be the fly in the ointment. Many physicians say they do not believe it is ethical to divulge such information to a third party. Some think it is illegal, that they are violating the confidence of the patient. I see no reason why the forms could not provide a place where the patient could sign his name, thus authorizing you to give the information to the detection center, the same as the patient authorizes a physician or a hospital to give information from their records to an insurance company. If a patient who has a cancer detection work-up refuses to sign for any reason, the physician would not report that case to the center. The patient has still had a cancer detection examination, and that is the important thing. Certainly, those 7,000 people waiting for the center would not refuse to sign, if they were referred back to you from the center.

Our state Cancer Committee has offered what I think is an excellent suggestion:

"Since the detection center is anxious to obtain asymptomatic cases only, it is suggested that the center require each and every applicant to obtain from his doctor a preliminary medical history before being admitted to the center. This procedure would serve the following purposes:

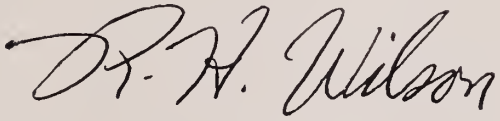
"1. It would eliminate symptomatic patients from the center.

"2. It would bring the symptomatic patients to the doctor's office for early investigation.

"3. It would afford the asymptomatic patient the opportunity of asking his own physician to perform a cancer detection examination without waiting to be examined at the cancer detection center."

The history required would not be burdensome, would justify an office call charge, and would eliminate the symptomatic patient from the center.

This matter is coming up for consideration at the September meeting of the Council, and I am sure your councilman would be glad to hear from you if you have any sentiments to express regarding the detection of cancer in your local office before that date. Personally, I feel very strongly that it is time we get this service back to the physician's office in his own community.



President, Minnesota State Medical Association

President's Letter

THE PRESIDENTIAL ADDRESS

Did you ever sit down on a hot evening in July to write a letter that must be submitted to the state office by the tenth of August so that it can be published in the September issue of a journal—a hot evening when you would much prefer being out on the river in your speed boat, and would be, if said speed boat had not been in dry dock for three weeks, right in the middle of the boating season?

Then add to that another question: "What's the use; who is going to read it anyway?"

Answer those questions and you will know one of the joys of being your president.

Seriously, because it is a hot night, I would like to limit this letter to a suggestion for a change in procedure at our annual meeting, or, more specifically, the program at our annual banquet.

Usually the president of the host society or someone selected from the host society presides, and our annual dinner program in general consists of: (1) Introduction of the president of the Woman's Auxiliary and other honored guests, (2) presentation of Southern Minnesota Medical Association Award, (3) presentation of Fifty Club certificates, (4) presentation of Distinguished Service Medal, (5) presidential address, and (6) the main speaker of the evening.

One reason for suggesting a change is that the program is too long; it is difficult to keep people from getting restless or bored for that length of time.

My second reason for suggesting a change is that it is difficult for the speakers, and probably more difficult for the audience, to have both the presidential address and a featured speaker on the same program. I'm sure most of our audiences get a little impatient with the president's address, because the featured speaker is to follow and the evening is dragging on.

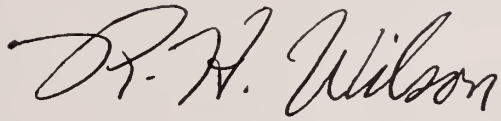
My third reason is that it is difficult for a president to prepare an address that will hold the attention of a mixed audience of physicians and their wives. The physicians expect you to discuss some phase of medicine, either scientific or organizational, as related to your Association. If you do this, the wives are apt to be bored, so the address must be on a rather general phase of medicine if it is to hold the attention of all, and that limits your subject material considerably.

Having gone through an annual meeting and agonized over preparing a presidential address, there can be no ulterior motive in the suggestions I am going to make. The annual meeting and annual dinner is naturally the high spot in any president's term of office, and I feel he should have recognition as the man you have honored by electing him to that office; so my suggestion is this:

First, have your president make his presidential address to the opening session of the House of Delegates. There he would be talking to the representatives of organized medicine, and could confine his remarks to problems of organized medicine, a brief review of problems during the past year, and a summary of problems facing the present House of Delegates. He would have something to talk about that would be purposeful.

Second, have your president preside at the annual dinner, make a few brief introductory remarks, introduce the honored guests, the president-elect, the men who are going to present the awards, and the speaker of the evening.

I feel this would make your president's address of some significance and much easier to prepare, it would give him recognition at your annual dinner, and would definitely shorten the program. May I submit this for consideration by the Council and the next local arrangements committee?



President, Minnesota State Medical Association

President's Letter

DEPENDENT MEDICAL CARE

The new Military Dependents' Medical Care Act which was passed by Congress on June 5, sets up the financial machinery for furnishing private medical care to hundreds of thousands of wives and children of servicemen.

For the first time there will be medical care available at government expense for individuals who are not necessarily veterans themselves nor in low income brackets. The act provides medical care for spouses and children of all military personnel. This care may be given by civilian physicians in civilian hospitals when military facilities are not readily available or are filled to optimum capacity.

The law goes into effect December 8 and medical associations were requested to make all arrangements for local administration by October 8 to give the Department time to implement the law.

The Act was discussed at a summer meeting of various committees of the American Medical Association. The importance of an early decision on methods for handling the matter on the state level became obvious, so in August a special meeting of our Council was held as well as a special meeting of the North Central Medical Conference for the purpose of co-ordinating actions taken by the conference states (Minnesota, Wisconsin, North Dakota, South Dakota, Iowa and Nebraska).

At our Council meeting, it was decided that the Minnesota State Medical Association should act as the contracting and fiscal agency for this dependent medical care program in Minnesota and that the program would be handled here in the same manner as the veterans' home town medical care program. Headquarters for the program would be in the state office. It was also decided at the same meeting that the various specialty groups concerned should be asked to determine the average fees to be set in Minnesota for the medical procedures within their specialties.

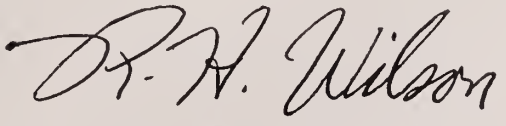
The Department of Defense sent out the official nomenclature of fees in August. This included approximately 1,400 items which are to be priced at prevailing average rates in the community.

Dependents of military personnel stationed in Minnesota who will be eligible for care under this program number 5,976.

The number of dependents of draftees and other personnel now stationed *outside* of Minnesota is unknown and Selective Service officials say they are unable to make any estimate of the figure.

The program is limited to medical care while the dependents are in the hospital but there are broad exceptions permitting diagnostic services and after care in the physician's office; also office care for injuries.

The patient will pay the first $25 of hospital expenses or $1.75 a day, whichever is greater, for a period up to 365 days for each hospital admission. The patient will pay nothing for medical services but the government will pay civilian physicians average fees prevailing in their communities as mentioned earlier. No prior authorizations are required and the fees are to be independent of either Blue Shield or welfare schedules.



President, Minnesota State Medical Association

President's Letter

CONTINUED SUPPORT FOR AMERICAN MEDICAL EDUCATION FOUNDATION

Yes, I did write a president's letter on the American Medical Education Foundation for the April issue of Minnesota Medicine. Our 1956 solicitation for contributions is under way now, and I feel it is so vital that we improve our giving that I want to use this opportunity to re-emphasize it.

Dr. Herman Drill, as general chairman of the State Committee in 1955, did an excellent job in organizing the State into local component society committees, working under an executive committee of one member from each councilor district. As a result of the effort put forth in 1955, $28,313.75 was contributed by Minnesota doctors, as compared with $5,890.38 in 1954. As a result of the success of his plan, Doctor Drill was asked to speak at the 1956 State Chairman's Conference in Chicago last February. In his report, Doctor Drill attributed the success of the Minnesota campaign to repeated committee meetings with county and district chairmen and the quick elimination of committee members who were not active. This stresses the importance of an active functioning committee on the local level. The enthusiasm of the local committee will inspire the membership. Dr. Charles Rea, as state chairman, is a worthy successor to Doctor Drill.

Several county societies, I believe, deserve special mention for their accomplishments. McLeod County had 100 per cent participation and reached over 95 per cent of its stated goal. Other counties rating high individual membership participation were Blue Earth, Waseca, Wabasha, Steele, Goodhue, and Blue Earth Valley Society.

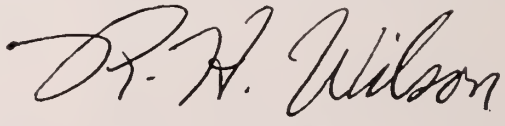
Our eighty-one medical schools are all suffering from lack of funds. In the tax-supported schools, such as Minnesota, all their tax funds are earmarked for specific purposes, salaries are fixed, research is limited by a strict budget. The mounting costs of education have hit the privately endowed schools also. Ten million dollars additional annually is needed for the medical schools to continue their research, keep their salaries up to where they will not be losing valuable men by salary budget limitations.

Unless private contributions from the doctors of the nation, from industry interested in medicine, and community-minded citizens are forthcoming to meet these needs, the schools will be forced into accepting federal grants. Federal grants mean federal control, another step toward socialization, and it seems that I recall we have been fighting socialization of medicine for some time.

Every medical school desperately needs unrestricted funds that can be called upon for research, equipment, and salaries that are not provided for in a rigid budget.

Have you missed the nominal contribution you made last year? Can you even recall what you gave last year? Would you suffer too much if you doubled it this year, so we could really point to our record with pride?

We are proud of the medical institutions in Minnesota. Let's make the medical institutions of Minnesota and the nation proud of us as Doctors of Minnesota.



President, Minnesota State Medical Association

President's Letter

SWAN SONG

Yes, this is my last message and I had hoped to make it just a chatty, pleasant farewell, without pleading a cause or exhorting you to action, or any of the other things that seem to need emphasizing at times.

However, as of December 8, 1956, we shall be participating in a new venture: the new Dependents' Medical Care Program. For the first time in our history, we are entering into contracts with a department of the federal government to furnish medical care to a group of people who are not indigents or needy people. This is not welfare work, and services are not to be furnished at any reduced rate, but rather at the usual fees charged in each respective state or area.

The purpose of this act is a worthy one, to help build morale in the armed services. And for that reason, it is well that we participate. But again, this can be just the beginning. Perhaps next year they will ask for the same coverage for all federal employes, then all civil service employes, and so on. This is socialized medicine, but under the present act the patient does have free choice of physicians where a civilian physician can be used, and such physicians are to be compensated by the same fees that are usual in private practice in his area.

Our State Medical Association, as our fiscal agent, is negotiating a contract with the Army, the administrative agent for the Department of Defense, and this contract will contain a maximum fee schedule. In my opinion, we are not interested in knowing the contents of the maximum fee schedule, and I hope that it will be locked up in the archives of the state office.

The Army has been generous in setting up maximum fees, and will use the schedule only as a guide, beyond which it will not go in payment of fees.

We, however, have agreed to furnish this service at our customary fees, and I can assure you that no customary fee in your area will be discounted. All claims will be processed through our state office. There is, perhaps, a temptation where a maximum fee schedule is established, for the vendor of services to submit a fee approaching the maximum.

Minnesota does not have a large military personnel, and the volume of work under this act will not be large, certainly not large enough to justify any attempt to take advantage of the program.

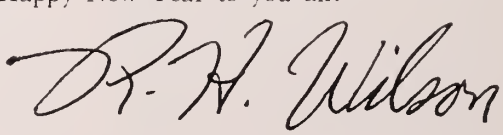
The eyes of the Department of Defense, the Congress and, through them, the nation will be upon us. By our actions shall we be judged. Need I say more?

I cannot conclude this last message without mentioning that the year was saddened for all of us by the loss from our Council within the past two months of two of our councilmen, Dr. H. J. Nilson of the Fourth District and Dr. L. R. Critchfield of the Fifth District. I liked to think of Dr. Nilson as the "great dissenter," a man of firm convictions, extreme devotion to his work on the Council, a man who always spoke his mind, let the chips fall where they might. Every council needs a man like him. Dr. Critchfield was one of the kindliest and most gracious of gentlemen, devoted to his profession and the cause of organized medicine and loving every moment of it. May the souls of the departed rest in peace.

I thank you all again for the great honor and privilege of serving you in my humble way as your president for this fiscal year. While it has been a strenuous year in many respects, it has also been a very pleasant one for me. Everyone has been very kind to me in my travels throughout the state, and I have enjoyed making many new friends.

I especially want to thank the Council and Mr. Rosell and his staff for their kindness, consideration, and assistance. They made it a very pleasant year.

A very Merry Christmas, a most Happy New Year to you all!



President, Minnesota State Medical Association