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Vol. 6 No. 4

EDITED BY THE JAPAN MEDICAL ASSOCIATION

Special Edition

The 3rd Congress of the Confederation of Medical Associations in Asia and Oceania

April, 1963

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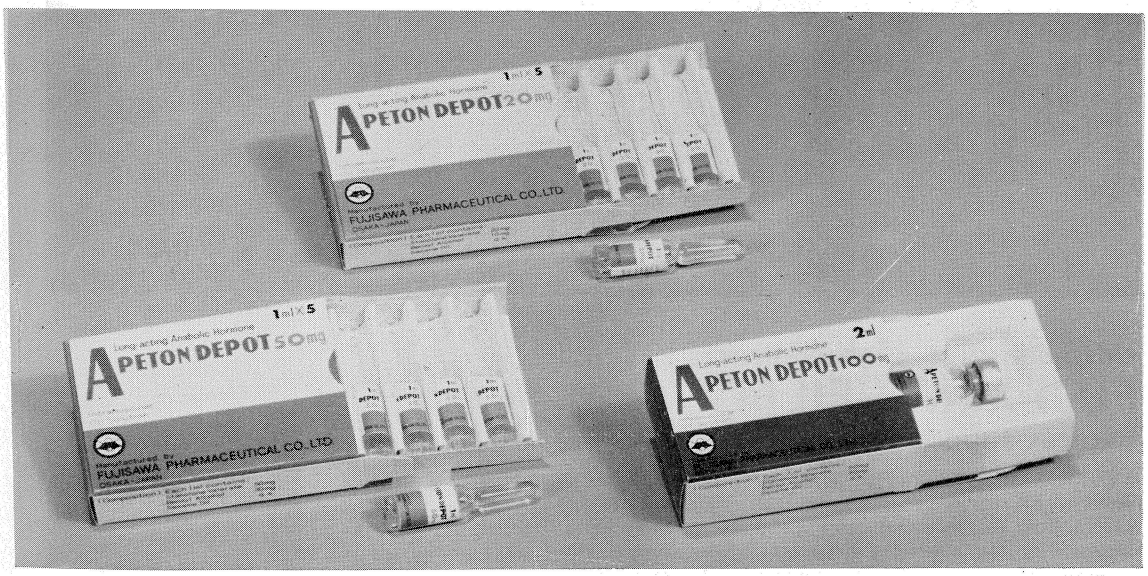

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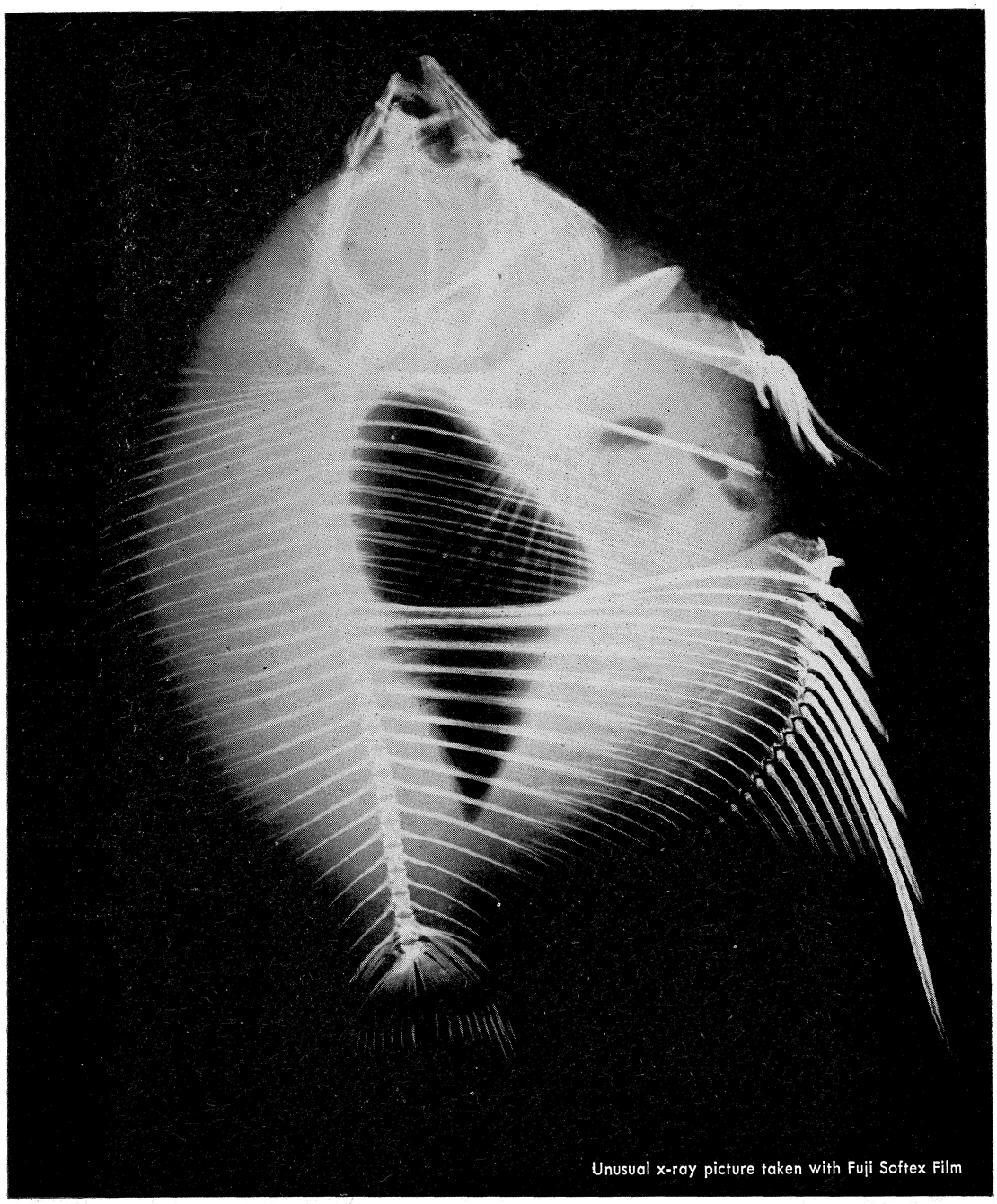

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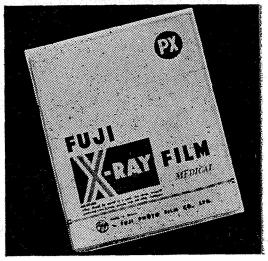

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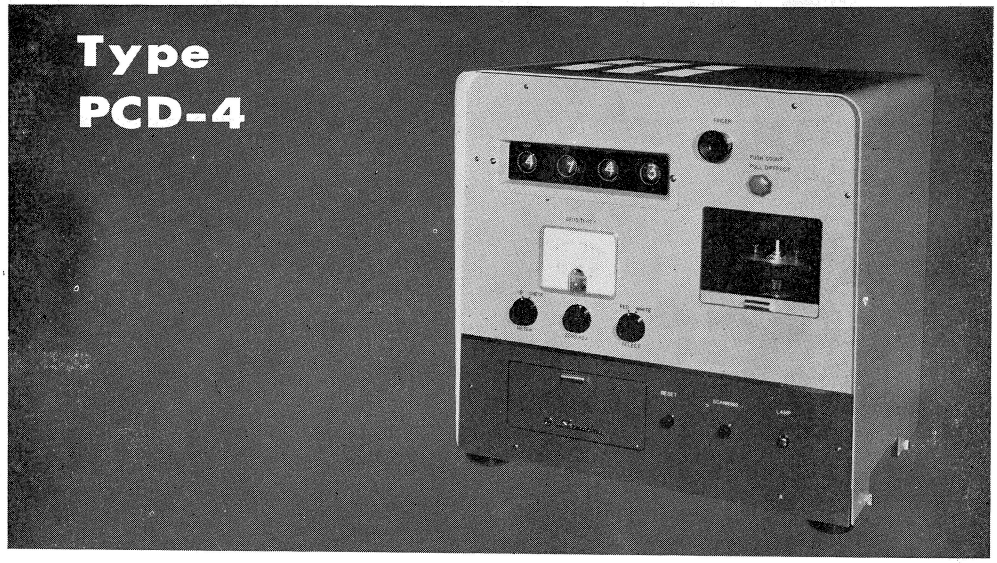

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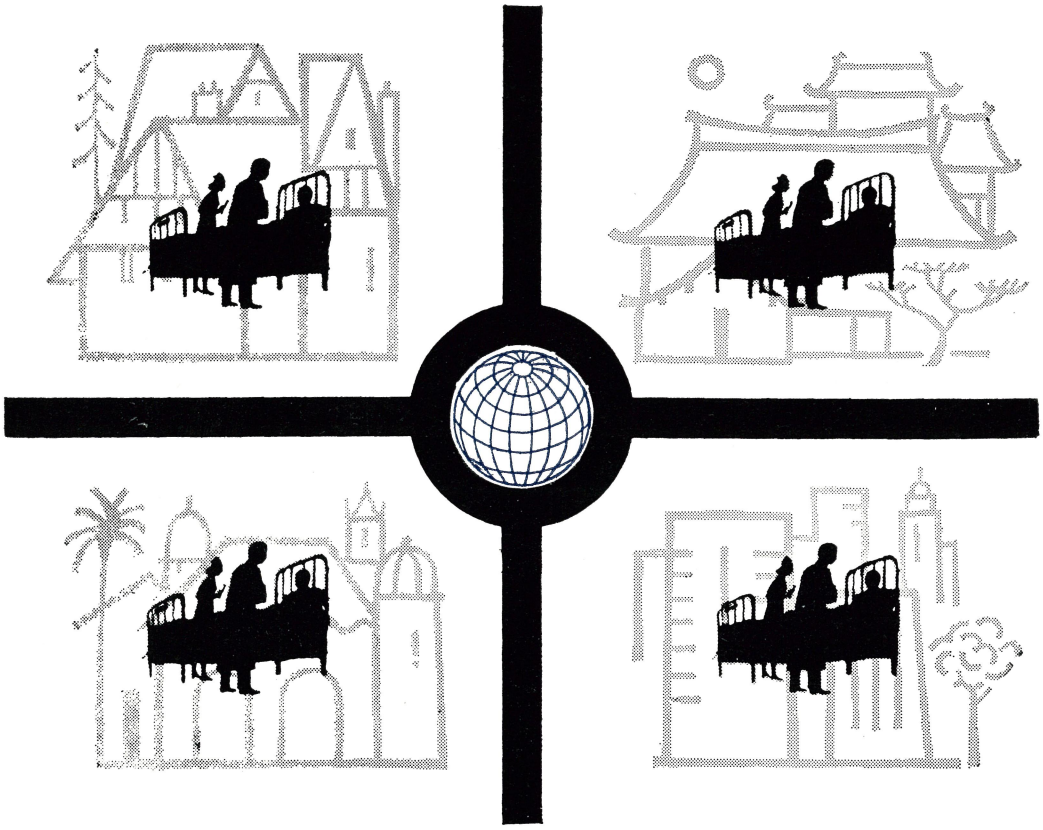

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Asian
MEDICAL JOURNAL

A Journal of Medical Sciences of Japan and Asian Countries

Vol. 6 No. 4 April, 1963

Special Edition

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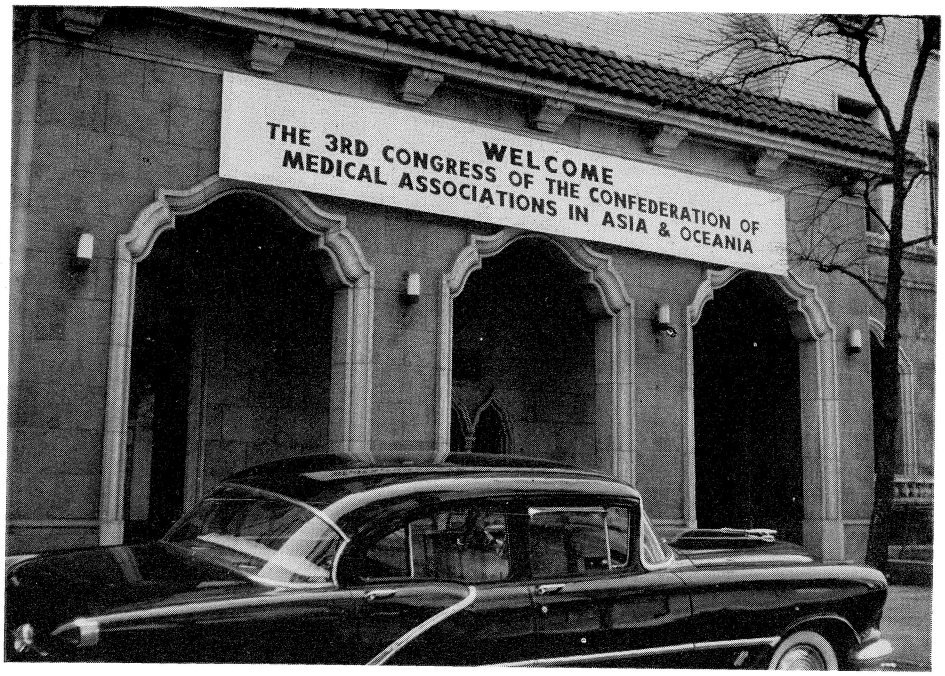
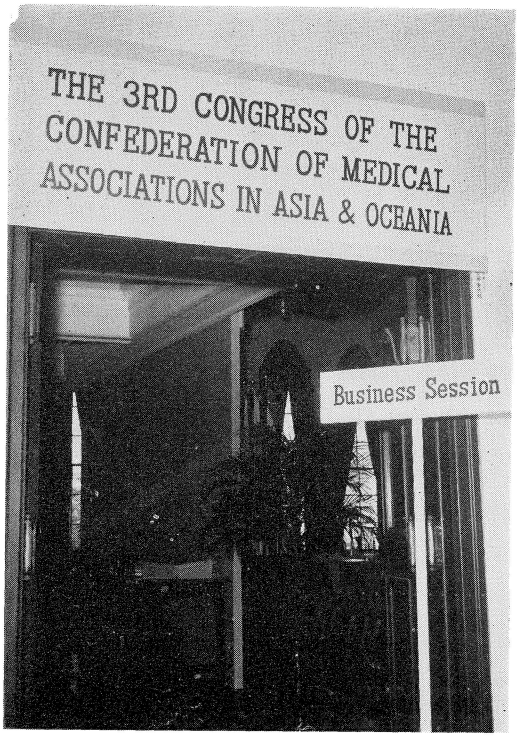
The 3rd Congress of the Confederation of Medical Associations in Asia and Oceania





The 3rd CMAAO
The site of Business Session,
J.M.A. House,

SHORT TALK TO WELCOME THE DELEGATES

It is a great pleasure to me that the 3rd Congress of the Confederation of Medical Associations in Asia and Oceania has been held in Japan with so many fine delegates and physicians attending.

The physicians in Asia and Oceania have a big role to perform today.

We should banish undeveloped countries from the area and create a model area from a medical standpoint.

The Asia-Oceania Area covers a whole range of climate and weather.

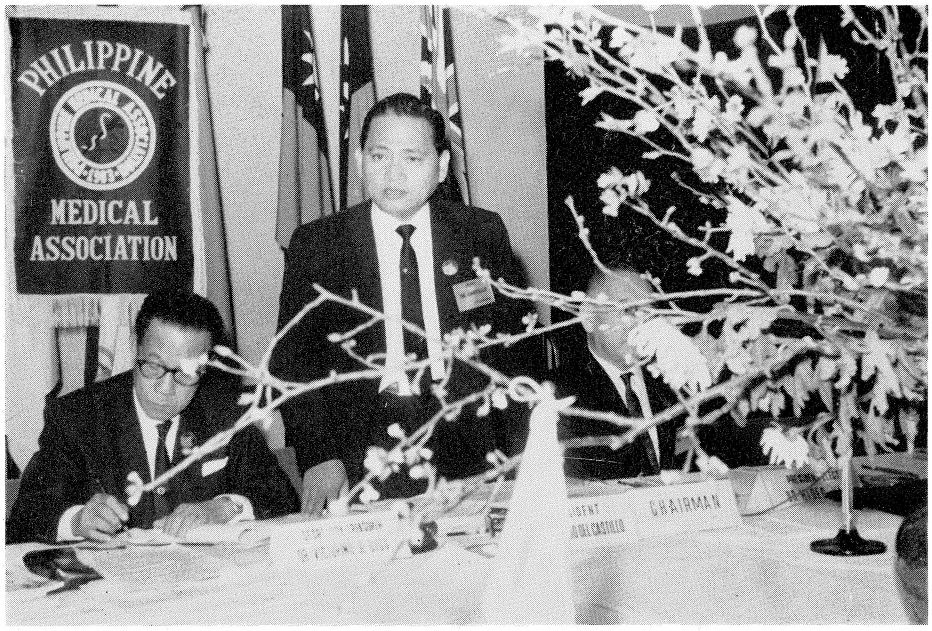
If we should succeed in reaching our goal, that would mean the entire mankind would benefit from medical science.

The meetings of the Confederation of Medical Associations in Asia and Oceania means that we are gradually approaching that goal.

The last time the convention was held in Manila, I came back with a week of pleasant memories.

I sincerely hope that the delegates to the Tokyo meeting will enjoy their stay in Japan to an equal extent.

Dr. Taro Takemi
President of Japan Medical Association



Report of The President of The Confederation of Medical Associations in Asia and Oceania

President
Heraldo Del Castillo, M.D.

As President of the Confederation of Medical Associations in Asia and Oceania, I have the honor to report to the members of the House of Delegates to the 3rd Congress of the Confederation, the activities and events that transpired during the period under my incumbency from April, 1961 to April, 1963.

Much water has flowed under the bridge since the formal organization of the CMAAO in 1956 and the holding of the 1st and 2nd Congresses in Japan and the Philippines, respectively. We are now holding the 3rd Congress again in Japan and no one will fail to note the increasing tempo of interest shown towards the activities of our organization. There is no doubt that we have the biggest number of delegates now present in this meeting and more countries represented this time, a clear indication of progress of this Society. I enjoin all of you and thru you the member-associations to forgo ahead and continue the furtherance of the noble aims of this organization. For those that will take up the leadership of our Society, I urge you to continue to keep the flame burning so that we may see in the very near future one solid group composed of Asia and Oceania.

In April, 1961, the 2nd Congress was held jointly with the 54th Annual Convention of the Philippine Medical Association with the cooporation of the

Women Medical Association of the Philippines at Quezon City, Philippines. This 2nd Congress, judging from the active participation of the delegates especially those from Japan, Australia, China and the Philippines in the discussions of the important subjects namely: "The Trends in Infant Mortality" and "The Answer to the Socialize Medicine", was a big success. The delegates also attended the various scientific sectional meetings.

There were 3 business meetings held during this 2nd Congress in which the following matters were thoroughly discussed and approved:

1. The approval of 4 resolutions sponsored by the Philippine delegates, which after the Congress, were sent to different member-associations for their comments and approval. Fortunately, all the resolutions were approved. Some of these resolutions were implemented by some member-associations like Pakistan Medical Association, offering a grant of Scholarship to foreign doctors and students. The Department of Foreign Affairs of the Philippines is also agreeable to a grant of study, research and observation on certain fields of medicine available in the Philippines under the Colombo Plan.

2. Amendments to the Constitution and By-laws as presented by the Committee were unanimously approved.

3. In one of the business meetings there was a controversial point regarding the establishment of the Confederation of Medical Associations in Asia and Oceania in this part of the world which was brought out by Dr. Mitra, a representative of the World Medical Association to the 2nd Congress. Dr. Mitra was of the opinion that this Confederation will only duplicate the works of the World Medical Association in this region. But, after hearing the opinions of various discussants his opinion was over-ruled by the delegates, for it was pointed out that the social, cultural and medical problems in Asia and Oceania could only be solved effectively by the very same people living in these regions.

4. In one of the business meetings the heads of the different delegations were requested to give their observations on the existing medical problems affecting their respective countries. Their remarks have greatly enlightened the assembly regarding their actual problems and their efforts to improve the welfare of the medical profession as well as the health of the masses.

Soon after the 2nd Congress, the Secretary of the Executive Committee had been instructed to communicate to all member-associations as to what had transpired during the Congress and also to write to them from time to time regarding the preparations for the coming 3rd Congress. I am sure all the member-associations have received their copies of the proceedings of that Congress.

All the member-associations, with the exception of Indonesia, have already submitted the names of their delegates and the scientific papers which in turn the Secretary had already transmitted to Dr. Minamisaki, General Secretary of the Japan Medical Association. It is my pleasure to report that through the efforts of the members of the Executive Committee in the Philippines, the Con-

federation is now in official relation with the Western Pacific Regional Office of the World Health Organization. In fact, we have already received an standing invitation from the World Health Organization which is sponsoring a Conference of Deans of Medical Schools which will be held in Manila, Philippines from Nov. 18 to 27, 1963, requesting us to send an observer to the forthcoming conference of the Western Pacific Regional Organization. The CMAAO is also affiliated with the World Medical Association and it will serve as its mouthpiece in this part of the world. It is also my pleasant duty to report to you that the Executive Committee of the Confederation of Medical Associations in Asia and Oceania in the Philippines was in constant communication with the officials of the Japan Medical Association for the preparation of this 3rd Congress which happily coincides with the 16th General Assembly of the Japan Medical Congress.

All efforts were exerted by the Executive Committee, both from Japan and the Philippines, to make the sojourn of our delegates and observers to the 3rd Congress, scientifically fruitful, socially and culturally beneficial as well.

Victorino De Dios, M.D.

Secretary-Treasurer

Report of the Secretary-Treasurer of The Confederation of Medical Association in Asia and Oceania April 1961 to April 1963

The undersigned has the pleasure and honor to report to the House of Delegates of the 3rd Congress of the CMAAO the following:

The second congress of CMAAO held jointly with the 54th Annual Convention of the PMA and in cooperation of the Women Medical Association in April, 1961 at the Quezon City, was a success. Once more it played the important role of promoting medical service and strengthening the bond of cultural and social relation among people in Asia and Oceania.

Soon after the Congress, by instruction from the Local Executive Committee in the Philippines, I began writing from time to time to all member-associations so as to keep them abreast with the affairs of the Confederation. At the same time I have been asking to suggest any scientific subject or other matters that they would like to present in the forthcoming 3rd Congress and to send to the Secretariat the names of the delegates. It is a pleasure to report that all members-associations, except Indonesia Medical Association, had sent the list of names of their delegates and the titles of papers to be presented.

Proceedings: A few months after the Congress, proceedings were published Copies were sent to all members, different officials and to many other doctors.

Scientific Plenary Session: As published in the proceedings two important sub-

jects were presented—"The Trends in Infant Mortality in Asia and Oceania" which was thoroughly discussed by the delegates from Japan, Australia, Taiwan and the Philippines. Another subject was, "The Answer to the Socialized Medicine" which was discussed by Doctors and non-medical men. Various scientific papers were also read in different sectional sessions.

Business Meetings: There were three business meetings. Among the important matters taken and approved by the delegates were:

1. The four (4) resolutions as published in the proceedings.
2. Amendments to the Constitution and by-laws.
3. To propriety of the existence of the Confederation in Asia and Oceania which provoked some heated discussion.
4. Place for the next congress.
5. Annual fee.

Copies of all the resolutions approved by the delegates were sent to all members-associations for their comment and approval. After being approved by the members-associations those resolutions were sent to the corresponding agencies such as WHO, Colombo Plan, ICA, World Medical Association, and Rockefeller Foundation requesting them to extend to member-associations their help for the implementation of said resolutions.

Resolutions of affiliation with the World Medical Association was approved which was subsequently approved by the World Medical Association.

Resolution on Scholarship—Dr. H. R. Khan, General Secretary of Pakistan Medical Association informed the Local Executive Committee that the Government of Pakistan is offering a grant of scholarship to foreign doctors and students. Copies of Dr. Khan's letter were sent to all member-organizations for their information. The Department of Foreign Affairs of the Philippines is agreeable to a grant of study, research and observation on certain fields of medicine available in the Philippines to any doctors under the Colombo Plan. This offer was also transmitted to all member-associations. According to our information, some members are very much interested and they might take advantage of these offers. Concerning the rest of the resolutions on consultations and on sending experts to other countries which are in need of medical advice, no opinion or comment have been received from the members.

Annual dues: As approved by the delegates, each member-associations shall pay $10.00 as annual due and those who are better-off financially shall give bigger amount. Please see statement of Fees and Contribution given by the member-association herewith attached.

To implement the resolution on scholarship the members of the Local Executive Committee had approached the officials of the Philippine Department of Foreign Affairs requesting some help for the realization of the objects of the resolutions. After being impressed by the laudable objective of the CMAAO, the Philippine Foreign Affairs offered a grant of study, research and observation to doctors under the Colombo Plan.

For detail of the incomes and expenses of the Confederation, please see the financial report.

After receiving the letter of Dr. Yushichi Minamizaki, Executive Secretary of Japan Medical Association, I immediately sent letters with the copy of Dr. Minamizaki's letter to all member-associations informing them that all subjects and scientific papers to be present must be submitted to Dr. Minamizaki on or before November 30, 1963. I think the time given is too short for the members to sent directly to Dr. Minamizaki or to me as soon as possible all the subjects and names of the delegates. All member-association, except Indonesia, have already submitted the names of their delegates and title of their scientific papers.

In conclusion, on behalf of the Executive Committee of the Confederation, I wish to convey to all the members our sincere thanks and appreciation for whatever support and consideration extended to us, and I am confident that the members would look back to all past accomplishments of the Confederation with sense of pride.

INAUGURAL ADDRESS

Hideo Yagi, M.D.

President of The Confederation of Medical Associations in Asia and Oceania

Mr. Chairman and honored delegates to the Third Congress of the CMAAO,

It is my privilege and honor to extend on behalf of my colleagues in Japan our most cordial welcome to all foreign delegates, who are attending the Third Congress of the CMAAO.

I hope that this General Assembly and the aftercoming scientific session would be successful and also the 16th General Congress of the Japan Medical Association in Osaka would be able to show you recent advances of the Japanese Medicine and thus your stay in Japan will be pleasant and fruitful.

On this occasion I wish, as President of the CMAAO, to express my hearty thanks and gratitude to our former Presidents, Dr. Rodolfo P. Gonzalez, Dr. Taro Takemi and Dr. Heraldo del Castilla, who have done so splendid works for the CMAAO as to give it a solid basis for its future development. Also I would like to thank to Dr. Victorino de Dios, Secretary-Treasurer, for his untiring efforts he rendered during so long a period of time.

Thanks to those honored officers I mentioned and all others concerned, I am fully aware that the objectives of our CMAAO have been much promoted in recent years in developing closer ties among the national medical organizations and among physicians in countries of Asia in particular and of the world in general by personal contact and all other means available. It is a matter of fact that we have contributed through the CMAAO to the World Health Organization, the World Medical Association and UNESCO.

In the medical profession there are, however, too many problems, new and old, to be discussed and solved. It would require a considerable amount of time and tolerance to manage it one after another. But, I am sure, that our united cooperation and mutual understanding could answer difficult questions. Unity is power! Only by united strength we shall be able to realize our objectives. I do hope that you would share the efforts contributing to harmonious development of the Confederation.

Another objective of the Confederation is to maintain the honor of the medical profession and to protect it. This could be done and further promoted by medical education and professional morals of medical men. It is desirable that national societies affiliating to the Confederation would like to pay special attention to this important matter.

The scientific session, which is to be held in Osaka, comprises 7 important papers and three are dealing with the recent outbreak of cholera in Asia. It is no doubt that they are so fitted timely and characteristic to the Asiatic medical meeting that they would contribute a great deal to the world medicine.

I sincerely hope that our Confederation would be more and more developed in the future by your untiring efforts and contribute not only to the benefit and welfare of the people in Asia and Oceania but also to the permanent peace of mankind in the whole world.

I thank you.

Inauguration of New officers —from right to left—

Dr. Yagi (President) *Dr. Katsunuma* *Dr. Wu (Councilor)*

Haruo Katsunuma M.D., M.P.H.

Professor, Head of the Department of Public Health, Faculty of Medicine, University of Tokyo, Tokyo

Historical Development of National Health Insurance in Relation to the System of Medical Care in Japan

I. HISTORY

Since April 1961 all the Japanese have been made to join some kinds of health insurance schemes except some inhabitants in the particular remote islands and some who are under the relief of the Public Assistance.

As in the most of the European countries the Japanese Health Insurance was first established in 1926 for miners and industrial laborers only. Later in 1939 the scope of the application was broadened to clerical employees. The schemes of social insurance for seamen and government employees were established respectively in 1939 and 1940.

After the World War I, the economics in Japan was influenced, as the other countries, by the world wide panic and as the result a large number of farmers, fishermen and laborers in small enterprises were heavily exhausted. People in those situations suffered from tuberculosis, parasitic diseases, beriberi and infectious diseases such as typhoid fever, dysentery and trachoma. The detrioration of physical status of the youth revealed in the health examination for conscription and the military cabinet at the time started to worry about this situation. The people could not afford to pay medical expenditure even though they needed medical care. The Health Insurance could only cover a part of the nation, because the population engaged in agriculture amounted 60% of the total.

Thus on July 1 in 1938 the National Health Insurance Act (N. H. I. Act) was established and came into force. In the beginning the scheme was operated by the National Health Insurance Association, which was founded in each city, town and village. The establishment of the Association and the participation to the Association were completely voluntary.

In 1942 the scheme became compulsory by the revision of the Act, being enforced by the man power policy during the war time. The Associations were established in numbers without careful plannings. Most of them, however, collapsed under the destruction, confusion and inflation after the World War II, because they were not supported by the understanding and cooperation of the members.

The amendment of the N. H. I. Act was planned again and enforced in 1948, in order to reconstruct the scheme along the principle of the new constitution, which stipulated the responsibility of the state to secure a minimum standard of healthy and civilized living for the nation. By this new amendment, it was stipulated that the insurers of the N. H. I. should be cities, towns and villages. The establishment of the scheme was still voluntary as before, but if the chamber of the city, town or village once decided to set up the scheme, all inhabitants of the district were to join the scheme, except those who were already protected by some other kinds of health insurance. In spite of the amendment of the Act, the number of insurers did not seem to increase, because there were financial difficulties in the existing insurers since it was not an easy task to collect sufficient insurance premiums meeting the increased cost by increasing medical care needs.

In 1951 the further amendment of the Act came into force, on condition that the contribution shall be collected as the N. H. I. Tax, stipulated by the Taxation Act.

In October 1952 the national subsidy for the expense of medical care benefits was introduced—until then only the administration cost was subsidized by the state—and in 1953 the amount of the national subsidy was fixed on 20% of the medical care costs. This financial support by the state was very effective to encourage local administrative bodies, cities, towns and villages for establishing the new N. H. I. schemes. By the end of march 1957 the number of persons protected increased to the number, which reached roughly 80% of the population who were eligible to be covered by the N. H. I.

At the beginning of 1958 the new N. H. I. Act was enacted. By the Act the subsidy of the state for medical care costs levied to 25%, 5% of which was to be granted for financially poor cities, towns and villages. The Act also stipulated the obligation for cities, towns and villages to establish the N. H. I. As for medical organization, which hereafter was fixed by the contract between insurers and medical institutions, the new system was adopted which was almost the same with that of the Health Insurance. There were particular difficulties for large cities to operate the N. H. I., because in these cities most of the middle class people were covered by some health insurance schemes for employee, and

the rest consisted of the borderline class, such as employees in household and small enterprise, who were excluded from the H. I.

But the six large cities, Tokyo at first in December 1959, then Kobe in February 1961, the rest of the cities, i.e. Osaka, Kyoto, Nagoya and Yokohama in April 1961, opened the service, and the universal coverage by health insurances was completed at last.

Table 1 shows the rise and fall of the number of insurers and subscribers following the development of the N. H. I. mentioned above. In the process of this development, we can find the same circumstances as the health insurances in the Scandinavian countries, which at first started as voluntary health insurances, comprising district inhabitants, then turned to be supported by the governmental subsidy by the Act, gradually covering up the whole population, giving the obligation to participate for a certain class of the population.

II. OUTLINE OF THE SCHEME

Insurance carriers:

Cities—regions (ku) in large cities—, towns and villages should be insurers compulsory. There are also 165 N. H. I. associations, established by the approval of the governor of the Prefecture, eligibility of which bases on the occupational groups mainly composed of independent workers such as food-sellers, barbers, doctors and advocators, etc.

Persons protected:

All of the householders and their families shall join the N. H. I. of the cities, towns and villages where they live. Anyone who is covered by any other health insurance programme, or is receiving daily life allowance by the Public Assistance Act is excluded.

Insurance benefits:

As a rule, benefits are service ones for medical care. Benefits for delivery and funeral expenses are granted in cash.

Medical care benefits as a rule comprise:

1. Consultations of doctors and dentists at their offices and patients' home.
2. Hospitalization and all the treatments necessary in hospitals.
3. All the necessary drugs and applicances (eye-glasses are excluded).
4. Dental care including dentures.

Insurers are allowed for a period to exclude some of the following items from medical care benefits, i.e. home visits of doctors, dentures and dietary and linen services in hospitals. The number of insurers subject to the restriction of the benefits was 1,113 in May 1961; this is 30% of the total insurers. The maximum period of the medical care benefits for a similar sickness or injury should not be less than three years, and in most programs there is no limitation on the duration of benefits. The sickness and delivery allowance is the supplementary benefits.

In addition to the insurance benefits mentioned above, insurers may provide other services for the purpose of health promotion and prevention of diseases such as home visiting of public health nurses, health examinations, services to

improve the nutrition and providing rest homes, in close coordination with the public health service of local governments.

Provision of Medical Care :

Hospitals and clinics—national, public or private—which are willing to participate the health insurance practice shall apply and be designated by the governor of the Prefecture, where the medical institutions are situated. The doctors and dentists who practice under the N. H. I. in the "designated medical institutions" should be registered as the N. H. I. doctors. As most of the hospitals and clinics are actually designated as the N. H. I. medical institutions, free choice of doctors are guaranteed for patients within the Prefecture.

The terms of service and the medical fees schedule for the "designated institutions" are regulated by the Minister of Health and Welfare in consultation with the Central Social Insurance Medical Council, whose members consist of six delegates out of public interest, six out of insurers, six out of professional bodies and six out of the insured and employers.

Medical fees are paid on a fee-for-service bases. Also there are 526 hospitals and 2,440 clinics directly operated by the insurers in 1959. A part of the cost of medical cares is shared by patients, but the patients' liability should not exceed more than 50% of the cost. The patient's share is paid directly to a medical institution on consultation. The bills submitted by the medical institutions are examined by the Medical Fee Committee of the Prefectural Association of the N. H. I. insurers. Unnecessary treatments are sometimes cut off by the Committee, which often causes complaints of doctors.

Financial resources:

The main source of income is the N. H. I. Tax. The amount of the Tax is set to meet the financial ability of each house-hold. The 40% of the total is collected in proportion to the income, 10% to the property, 35% to the number of persons of each household and 15% on flat rate to each. The tax is collected directly by the insurer.

The National Treasury shares the total business expenses, 20% of the total medical care costs including the costs shared by patients, one third of salary of public health nurses and one third of the capital expenditure of the hospitals and clinics operated by insurers.

In addition the amount equal to 5% of the total medical care costs is allocated to the insurers in the case of financial difficulties. Only few local governments contribute to the N. H. I. from the general accounts.

III. PRESENT PROBLEMS AND FUTURE TREND

Now we have succeeded in attaining the universal coverage of health insurances for the whole population, the next step to be taken is to level up the standard of benefits under the N. H. I.

In comparison with the other sickness insurances, the N. H. I. stays quite low on the level of medical care benefits. As shown in Table 2 the average cost of medical care benefits for a protected person per year of the N. H. I. is less than one sixth of the benefit for an insured person and two third of that

of a dependant of the H. I.

The fact seems to be caused by the following reason. Inhabitants in rural districts do not consult with doctors as often as those in urban areas owing to the low standard of living and the traffic inconveniences. Besides there are shortages of hospitals and clinics in rural areas and the quality of medical care does not reach as high as that of urban areas. A few insurers exclude some items of medical care benefits. Patients must pay 50% of medical care costs, therefore in case of serious or chronic illnesses, the financial liability prevent for the patients to receive the necessary and sufficient medical care.

This fact mentioned above, however, produces another phenomenon—an unequality of receiving medical care benefit among different income groups. The result of the survey in May 1961 proved that the consultation rate of the higher income group is much more frequent than that of the lower income group. In these circumstances there is a paradox, that the higher income group receives more medical care benefits than what they ought to be granted corresponding their premiums, instead of their assisting the lower income group.

Those who can not afford to pay patients' shares in case of chronic diseases such as tuberculosis or mental illness are able to receive medical relief by the Public Assistance Act, after means tests. Such cases are 80,000, nearly one half of the patients in hospitals who are receiving the medical relief. To decrease these cases, from October 1961 medical care benefits for householders in case of the diseases will be raisd up to 70% of the medical care costs and also the public medical service for the tuberculosis and mentally ill patients, without means tests, will be expanded under the amendment of the Tuberculosis Prevention Act and the Mental Hygiene Act.

In the coming year it is planned that medical care benefits for householders will be raised up to 70% in case of all diseases and injuries.

In order introduce the improvement of the benefits it is considered that the leveling up of the national subsidy to 30% of medical care cost, 5% of which is spent to keep balance among insurers, is necessary. To lessen the differences of benefits among various health insurances, the integration of the health insurances is debated but in the present situation the solution turns out to be quite hopeless.

As the result of the survey of public opinions in October 1960, 70% of the interviewed agreed to raise the rate of benefits for long or serious illnesses that cost plenty of expenses, while they even have to pay up to 300 yen in case of minor ailments. It seems to me that this idea is worthwhile being considered; the government, however, does not accept it, considering the disagreement of the Medical Association.

Another problem is the continuous tension between the Ministry of Health and the Medical Association, concerning medical fees and directions of insurance practice. The Medical Association withdrew the delegates from the Central Social Insurance Medical Council, having been unsatisfied the amount and method of raising fees in October 1958, which increased 8.5% of the total medical care

costs. In 1960 the Association moved to make campaign against the Ministry, insisting on raising medical fees by 30%, abolishing the limitation of medical care under health insurances and reforming the Central Social Insurance Medical Council. In April 1961 the Minister submitted the bill with regard to the revision of the Council Act in order to ask for the Association to participate the Council which would be expected to recommend the Ministry to raise medical fee. According to the new bill the members of the Council consist of 8 representatives from insurers, employers and employees, 8 from professional bodies such as medical dental and pharmaceutical, and 8 representatives of the public interests. The government failed to pass the bill owing to the opposition of the Medical Association. The Minister raised the medical care fee to increase the total medical care costs by 12.5% on July 1, referring to the Council, which debated the problem in the absence of the representatives from the professional bodies. The Medical Association directed in August 1961 the insurance doctors to go on strike in order to protect the professional freedom and prestige, but before the confusion occurred the Government party cut into arbitrate of the Ministry and the Association. The conventions of representatives concerned were frequently held and in the consequence medical fee was raised further by 2.3%, the limitation of the medical care was partly released and the Social Insurance Medical Council Act was revised, according to the opinion of the Medical Association who contended to decrease the number of the representatives of the public interests to 4 instead of 8, and to exclude the representatives of the Hospital Association from the representatives of professional bodies. Thus the hostility between the Ministry and the Association which continued for several years was resolved, but the problems are not completely settled, because the Association of Health Insurance Societies oppose this time to send the representative to the new Central Social Insurance Medical Council.

Table 1
Annual Trend of the Number of Insurers and Protected Persons of the N. H. I.
(at the end of the fiscal year)

Year		Number of insurers	Number of protected person (in thousand)
1938		176	523
1939		456	1,313
1940		937	3.045
1941		2,061	6,705
1942		6,569	22.661
1943		10,300	37,960
1944		10,474	41,161
1945	(1)	10,431	40.925
1946	(1)	9,526	41.821
1947	(1)	6,958	32,124
1948		5,446	25,827
1949		4,987	24.057
1950		5,050	24.354
1951		5,126	24,596

1952		5,008	23,089
1953		5,122	24,966
1954	(2)	3,669	26,633
1955		3,169	28,711
1956		2,870	30,582
1957		2,941	33,576
1958		3,167	37,239
1959		3,365	43,244
1960		3,670	49,019

(1) Number at the end of the calender year.

(2) Since 1954 according to the unification of cities, towns and villages the number of insurers decreased in spite of the increase in protected persons.

Table 2

Comparison of the Cost of Medical Care Benefit in Various Health Insurance Programmes in 1959

Name of health insurance	Patient's share	Cost of medical care benefit per person in a year (in yen)
Health insurance (by the government operated)		
Insured person	100 yen on the initial consulation, 30 yen a day in the case of hospitalization during a month	6,846
Dependent	50% of medical care cost	1,518
Health insurance (by associations operated)		
Insured person	same as the government operated H. I.	6,391
Dependent (1)	30% of medical care cost in average	2,508
Health insurance of daily workers		
Insured person	150 yen on the initial consultation	5,415
Dependent	50% of medical care cost	1,101
National Health Insurance	50% of medical care cost, exclusion of some item of medical care	1,081
Seamen's Insurance		
Insured person	100 yen on the initial consultation	8,357
Dependent	50% of medical care cost	1,662
Mutual association of government employee		
Insured person	same as the government operated H. I.	6,465
Dependent	50% of medical care cost	1,727

(1) Health Insurance Associations reimburse the medical care costs shared by dependents as one of the supplementary benefits.

Dr. Khurshid Hassan

Pakistan Medical Association

Medical Problems in Pakistan

It is a matter of great honour for me to represent Pakistan Medical Association in this Congress and to have an opportunity to meet and address such a distinguished gathering.

I would like to acquaint you in brief about the activities and problems faced by our Association.

During the last two years we have succeeded to a great extent in organizing branches at almost every place where number of doctors exceeds three, bringing practically all members of the profession, whether in service or in private practice, at one platform. This, I consider, is a big achievement as in our newly independent and developing countries it has become a fashion to have several contemporary parties in political as well as in social fields.

It is the result of this solidarity amongst our ranks that the Pakistan Government has come to recognize the Pakistan Medical Association as the only representative body of the medical profession.

The Pakistan Medical Association Central as well as its Zonal branches are now concentrating on other activities, e.g. of looking after the interests of the profession and pressing the Government for improving the standard of medical education, abolishing medical schools and have one overall standard of medical education.

The Government has agreed to meet these demands to a great extent and has upgraded three medical schools to Medical Colleges in East Pakistan and has promised to raise another three in an year or so.

It has also announced the establishment of a College of Physicians & Surgeons at Karachi to impart post-graduate training.

Government has also agreed to give representation to us at the following Committees: —

1. Drug Advisory Committee.
2. Pharmaceutical Survey Committee.
3. Narcotics Committee.
4. Tariff Commission.
5. Governing Bodies for Medical Colleges.

Pakistan Medical Association Central and its Zonal branches are taking out three journals in English meant for the medical profession and a few others in regional languages for enlightening public on commonwealth problems (Nutrition & Preventive medicines).

Though the standard of the journals is not very high but constant endeavour is being made to raise the standard and bring it at par with other goods journals of advanced countries.

Our branches are now having their clinical meetings more frequently, are holding symposia and arranging lectures by eminent men of science visiting our country.

Our Karachi and Khulna branches have started refresher courses for medical men acquainting them with the latest developments being made in medical science.

Certain branches have raised donations and have installed X-Ray plants in hospitals, opened "Drug Banks" for free distributions of medicines to the poor and needy.

Free hospitals are being run by certain branches. Quite a good number of specialists are giving free advice in various centers dealing with child health, tuberculosis, family planning and center for rehabilitation of crippled children.

Our members are imparting first-aid training to our children in schools and drivers of motor vehicles. General public is being informed by lectures and pamphlets about preventive measures to be taken against water-borne and other communicable diseases.

In times of any clamity our members have never waited for Governmen appeals but have always come forward to help in every possible way. Our branches at Lahore, Dacca, Rawalpindi and Lyallpur have taken in hand ambitious plans to construct P.M.A. houses where libraries and auditoria will be built and money got by letting out rest of the property would be spent to implement various welfare schemes and thereby lighten the burden of the Government which alone cannot cope with such a tremendous health problem.

This is one of the reasons that our Association is pressing the Government for expanding private sector by providing facilities to private practitioners to open nursing homes, laboratories and other specialized agencies to meet the health needs of the public.

Government has granted some facilities for importing laboratory and other electrical equipment to individual doctors but we hope that with more facilities in the shape of loans on easy terms and grant of land etc. this sector can

be expanded very soon.

A major problem demanding the attention of this Association is to save the ignorant masses from the hands of unscrupulous quacks who are a constant menace to the health of the nation.

So far our Association has succeeded in getting one ordinance called ALLOPATHIC SYSTEM (Prevention of mis-use) ORDINANCE 1962 enforced, as a result of which the quacks will not be allowed to use the word DOCTOR before their names, nor will they be allowed to prescribe or use ANTI-BIOTICS.

But we still feel that this provision is not sufficient to save the public from the onslaught of quacks, because under this Ordinance they can still practice. So our efforts are continuing to get some amendments passed in the National Assembly making this Ordinance more effective in erradicating quackery in all forms.

To facilitate the Government in manning its increasing number of hospitals and health centers in villages we have offered to get our new graduates conscripted for a period of two or three years to serve in the rural areas.

In the international field we are trying to enlarge our sphere of contacts with other sister organisations in other countries.

In this context I would like to mention that we have been affiliated with the British Medical Association since 1961, are members of the World Medical Association, Commonwealth Medical Association and CMAAO. We are negotiating affiliation with American and Canadian Medical Associations.

Last year we participated in the following Conferences:—

1. World Medical Assembly held in New Delhi.
2. British Medical Association Meeting held at Belfast in July/'62.
3. Commonwealth Medical Conference held in Ceylon in November/'62.
4. Inaugural Meeting of the Australian Medical Association, May/'62.
5. Indian Medical Association Meeting held in January 1962.

In July 1962 we held our biennial Seventh All-Pakistan Medical Conference at Hyderabad in which delegates from the following countries participated: Australia, People's Republic of China, U.S.S.R., U.S.A., U.K., India, Italy, Ireland, Sweden and World Medical Association.

Apart from this we are exchanging our journal with most of the countries of the world.

I am glad to mention that due to our efforts the Government of Pakistan has agreed to grant a few scholarships to students of this region for studies in basic sciences and post-graduate studies, the period of scholarship ranging from one to seven years.

In the end I would like to thank the sponsors of this Conference and the Japan Medical Association for providing us an opportunity to find our answers to the various health problems of this region and by personal contacts further cement the bonds of fraternity and friendship already existing between us an thereby increasing and improving still more collaboration and coordination already existing between our Associations.

Roster of the Attendants from Abroad to the 3rd Congress of the CMAAO

Australia (13)
- Delegate (1)
  - F. R. Fay
- Observers (7)
  - T. Morley
  - H. E. W. Lyons
  - N. Kerkenezov
  - W. H. Hill
  - Gurry
  - Kelly
  - Dimond
- Families (5)
  - Mrs. H. E. W. Lyons
  - Mrs. N. Kerkenezov
  - Mrs. Gurry
  - Mrs. Kelly
  - Mrs. Dimond

Burma (5)
- Delegates (4)
  - Myint Han
  - Min Sein
  - Ohn Maung
  - Saw Ba Heng
- Observer (1)
  - Sann Lwin

China (17)
- Delegates (4)
  - Chi-Fu, Wu
  - Jau-Chin, Lii
  - Tung-Shiang, Pen
  - Yin-Ho, Su
- Observers (13)
  - Tsai-Liang, Shew
  - Po-Tui, Liu
  - Chun-Kuei, Hsu
  - Tu-Shu, Ho
  - Chueng-Cheng, Yang
  - Shin-Ming, Chang
  - Ming-An, Su
  - Chin-Cheng, Tseng
  - Shen-Ho, Tsai
  - Shao-Hsung,Hung
  - Ju-Chuan, Hsieh
  - Wang-Tsh, Lu
  - Chiang Chung

Iran (2)
- Delegate (1)
  - Saïd Hekmat
- Observer (1)
  - Mohamad Shajari

Philippines (45)
- Officers (6)
  - Heraldo del Castillo
  - Rodolfo Gonzalez
  - Victorino de Dios
  - Rafael Enrile
  - Dalmacio Suaco
  - Julita Jalbuena
- Observers (20)
  - Honorio Montoya
  - C. Gonzalez
  - C. Gonzalez (Drs.)
  - Ramon R. Angeles
  - Romeo Montes
  - Jose Torres
  - A. Bustamente
  - F. Fernandez
  - S. Pineda (Drs.)
  - Gregorio D. Dizon
  - Benito Tan
  - Manuel Galvez
  - Leopoldo Vergel de Dios
  - Leonor Rivera
  - P. Danganan
  - Castro Surla
  - Andries Y. Cruz
  - Thelma Clemente (Drs.)
  - Pedro S. Lopez
  - Hector Tagle
- Families (19)
  - Mr. Luis Clemente
  - Mrs. Romeo Montes
  - Mr. S. Co
  - Mr. L. Pineda
  - Mr. S. Navarrete
  - Mrs. S. Navarrete
  - Mrs. Flor de Dios Lorenzo
  - Mrs. Danganan
  - Miss Danganan
  - Mrs. Castro Surla
  - Mrs. Amelia de Dios Dizon
  - Miss Lourdes Surla
  - Mrs. Heraldo del Castillo
  - Miss Fe de Dios
  - Mrs. Gregorio D. Dizon
  - Mrs. Rosalinda Dungo
  - Mrs. M. Galvez
  - Mrs. Jose Torres
  - Mrs. F. Fernandez

Thailand (2)

Pakistan (1)
Delegate (1)
Khurshid Hassan

Delegates (2)
Songkrant Niyomsen
Snoe Indrasukhsri

The Total of Attendants from Abroad to the 3rd Congress of the CMAAO

	delegates	observers	families	Total
Australia	1	7	5	13
Burma	4	1	—	5
China	4	13	—	17
Indonesia	—	—	—	—
Iran	1	1	—	2
Pakistan	1	—	—	1
Philippines	6	20	19	45
South Korea	—	—	—	—
Thailand	2	—	—	2
Total	19	42	24	85

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Officers of the 4th Congress of the CMAAO
1963 —— 1965

Officer

President: HIDEO YAGI, M.D. (Japan)

President-Elect: A. J. MURRAY, M.D. (Australia)

Secretary Treasurer: VICTORINO DE DIOS, M.D. (Philippines)

Immediate Past President: HERALDO DEL CASTILLO, M.D. (Phillippines)

Council

Chairman: HIDEO YAGI, M.D. (Japan)

Vice-Chairman: A. J. MURRAY, M.D. (Australia)

Secretary: VICTORINO DE DIOS, M.D. (Philippines)

Councilor: TAKEO TAMIYA, M.D. (Japan)

Councilor: K. C. CRAFTER, M.D. (Australia)

Councilor: HARUO KATSUNUMA, M.D. (Japan)

Councilor: CHI-FU, WU, M.D. (China)

Business Session

Dr. R. Gonzalez (Philippines)

Dr. Myint Han (Burma)

Dr. C. Wu (China)

Delegates

Dr. H. Yagi, Dr. T. Tamiya (Japan)

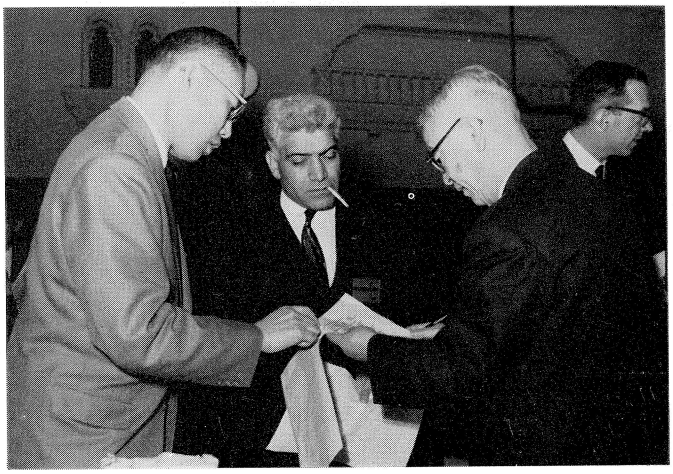
Dr. S. Indrasukhsri (Thailand)
— Left —

Dr. Ohn Maung (Burma)
— Middle —

Dr. Myint Han (Burma)
— Right —

Dr. Myint Han (Burma)
— Left —

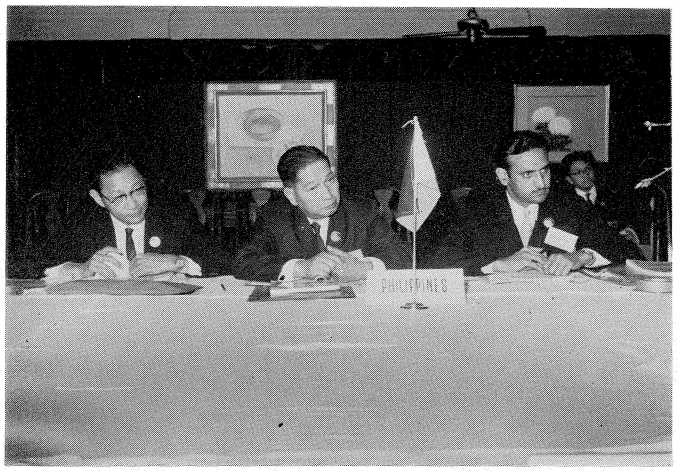
Dr. K. Hassan(Pakistan)
— Right —



Dr. H. Muroya (Japan)
— Left —

Dr. S. Hekmat (Iran)
— Middle —

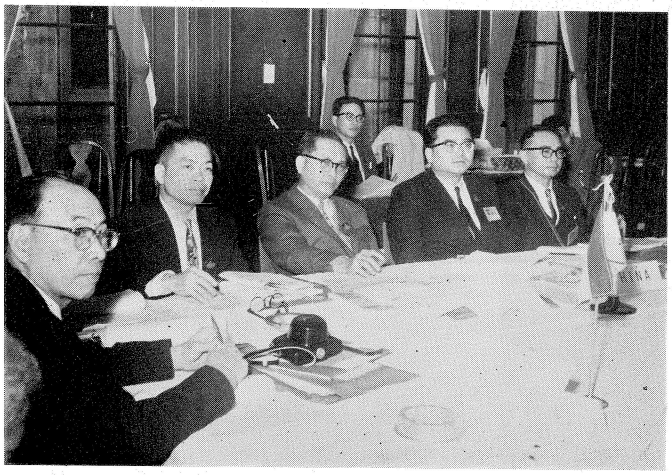
Dr. Y. Minamizaki (Japan)
— Right —



Dr. D. Suaco
(Philippines)
— Left —

Dr. R. Enrile
(Philippines)
— Middle —

Dr. K. Hassan
(Pakistan)
— Right —



Chinese Delegates

Dr. S. Hekmat (Iran)
— Left —

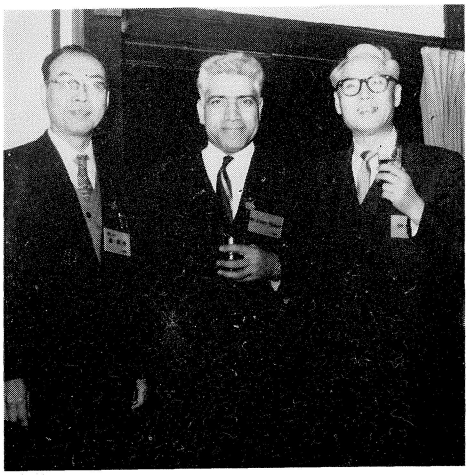
Dr. W. Lu (China)
— Middle —

Dr. P. Liu (China)
— Right —

Cocktail Party at Chinzan

— from Left to Right —

Dr. Nobechi (Japan)
Dr. Myint Han (Burma)
Dr. Hekmat (Iran)
Mr. Shajari (Iran)

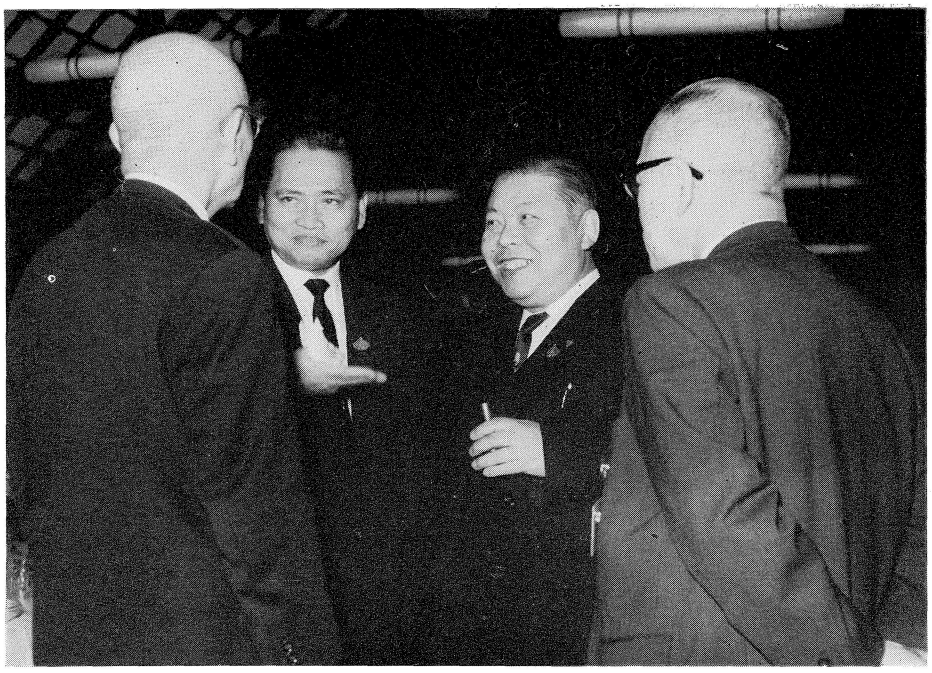


Dr. Lu (China)
Dr. Hekmat (Iran)
Dr. Kikuchi (Japan)

Tokyo, March 30, 1963

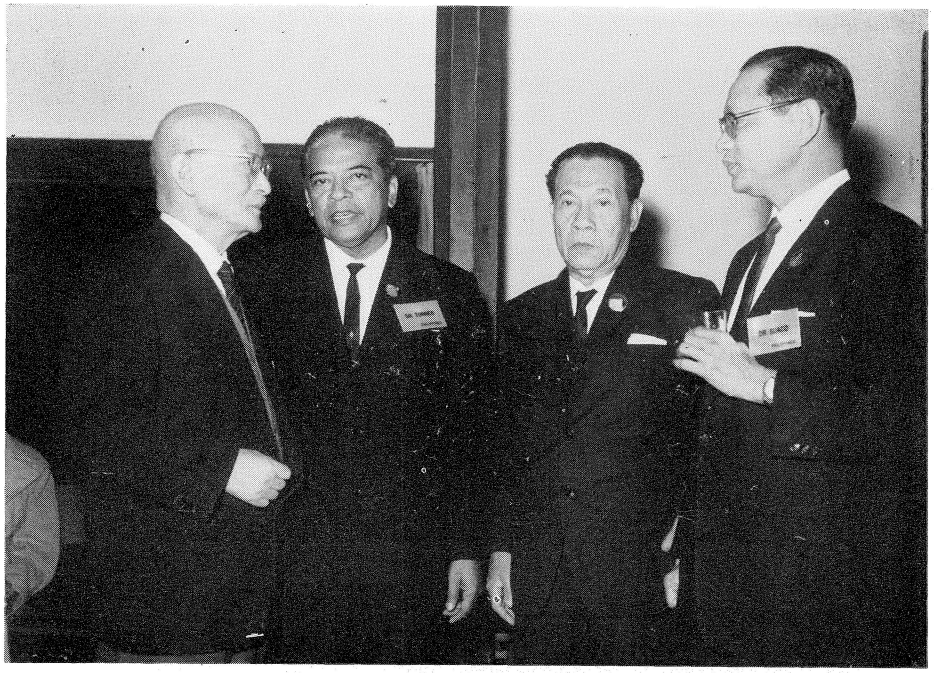
Philippine Ladies

Dr. Suaco (Philippine)
Dr. Takemi (Japan)
Dr. Katsunuma (Japan)



Dr. Tamiya, Dr. Castillo, Dr. Takemi, Dr. Kase

Mrs. Kelly, Mrs. Nishioka, Mrs. Gurry, Mrs. Shiraki, Mrs. Toyokawa



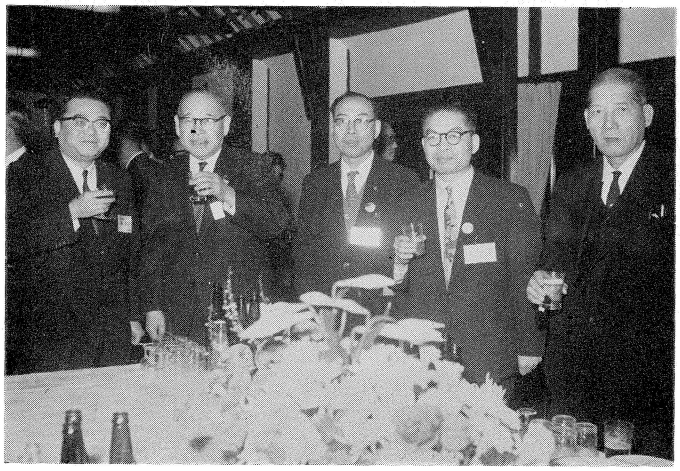
Dr. Tamiya, Dr. Torres, Dr. Dios, Dr. Suaco

Dr. Yamamoto, Dr. Toyokawa, Dr. Hekmat, Mr. Shajari
Mrs. Nishioka, Mrs. Kelly, Mrs. Yamamoto

— *from Left to Right* —

Dr. Kase
Dr. Abe
Dr. Castillo
Dr. Tamiya
Dr. Hekmat

Dr. Torres
Dr. Tamiya
Drs. Pineda
Mrs. Castillo
Mrs. Galvez
Dr. Galvez



Dr. Su
Dr. Yagi
Dr. Lu
Dr. Yang
Dr. Ho

Dr. Takemi with Chinese Delegates

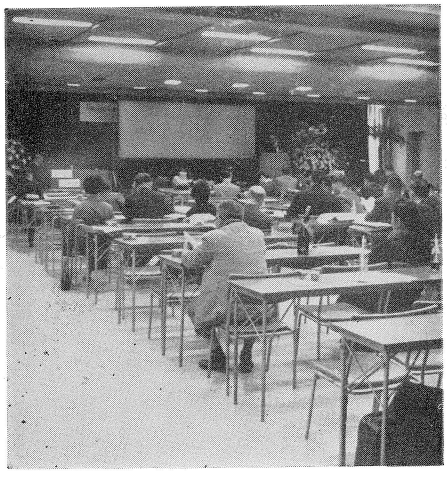
Philippine Ladies

Philippine Ladies

Scientific Session

Papers

1. Report on Study of Recent Medical Professional Liability in Taiwan.
   Dr. Chi-Fu, Wu (China)
2. Les Responsabilite's Medicales.
   Dr. Saeed Hekmat (Iran)
3. Deliveries after Cesarean Section.
   Dr. Julita R. Jalbuena (Philippines)
4. A Report on the 1962 Cholera (EL TOR) Outbreak in Taiwan.
   Dr. Yin-Ho, Su (China)
5. EL TOR Type Vibrio in the Recent Outbreak of Cholera.
   Dr. P. R. Aragon (Philippines)
6. Japanese Contributions to the Knowledge of Cholera due to EL TOR Vibrias.
   Dr. Keizô Nobechi (Japan)
7. Form of the National Health Service in Australia.
   Dr. F. R. Fay (Australia)



Dr. Saïd Hekmat

Prof. University of Teheran, Iran

Les Responsabilités Médicales

L'ORGANISATION PROFESSIONNELLE DE LA MÉDECINE

STRUCTURE DE L'ORGANISATION PROFESSIONNELLE

Généralités

Raison d'être d'une organisation professionnelle

La nécessité d'une forte organisation professionnelle résulte, pour les professions médicales, du souci de concilier l'indépendance des médecins avec un contrôle de leur activité et de leur moralité, destiné à justifier la confiance que leur consentent les patients. Les médecins qui ne seraient pas dignes de cette confiance doivent se voir interdire l'accès à la profession ou la poursuite de son exercise. Mais l'appréciation de cette indignité peut difficilement être confiée à une autorité administrative ou judiciaire sans que soit par là compromise l'indépendance de la profession. Elle oblige d'ailleurs à une connnaissance des usages des médecins qui n'appartient guère qu'aux membres les plus qualifiés de celle-ci. Il y a là une première raison d'établir une autorité jrofessionnelle chargée de contrôler l'accès à la profession et d'y fair régner une discipline.

Mais la défense de l'indépendance et de la dignité de la profession ne saurait se limiter à l'établissement d'une discipline intérieure à la profession. Elle doit s'éxercer contre les tiers, et même contre les pouvoir publics. Ceux-ci pourraient compromettre par leurs décisions ou leurs activités, le statut nécessaire à l'exercice du ministère des médecins, qui doit demeurer conforme aux impératifs techniques et moraux de la profession. La défense des intérêts moraux de la profession constituera donc une seconde raison d'être de l'organisation professionnelle.

Les médecins ont enfin des intérêts matériels, dont la sauvegarde est souvent difficilement séparable de celle des intérêts moraux de la profession. Dans un monde où se sont multipliés les groupements d'intérêts en tant que moyens collectifs de défense, il est lêgitime que les médecins aient les leurs. C'est un troisième objet de l'organisation professionnelle.

LA RESPONSABILITÉ CIVILE ET PÉNALE DES MÉDECINS

La responsabilité des médecins dérivant de la violation du contrat médical à un caractère contractuel

Ce principe est maintenant acquis en jurisprudence. Et la responsabilité médicale reste contractuelle même lorsque elle dérive d'une atteinte aux devoirs d'humanisme liés au ministère du médecin. La première obligation contractuelle du médecin est de les observer.

Cependant, en caractère contractuel de la responsabilité médicale n'est pas universel.

Il y a d'abord des cas où aucun contrat n'est consenti par le malade, soit parce qu'il en est physiquement incapable, soit parce qu'on lui impose le traitement. Même dans ces cas de relations paracontractuelles entre médecin et malade, la jurisprudence copie toutefois, dans son ensemble, la responsabilité des médecins sur celle qui dérive du contrat libre. Ainsi, la responsabilité paracontractuelle imite les régles de la responsabilité contractuelle.

Néanmoins, il ne semble pas que, dans le domaine de la médecine sociale, obligatoire ou hospitalière, on puisse considérer le médecine comme lié au malade par un contrat véritable. Nous pensons alors que sa responsabilité obéit aux règles du droit public. Mais ceux des tribunaux qui le nient sont amenés à la regarder comme délictuelle.

D'autre part, la responsabilité du médecin, sans cesser de présenter une face contractuelle, est, sous un autre angle, délictuelle quand la faute médical constitute une infraction pénale. Ainsi, en cas d'omission de porter secours. ou lorsque la victime subit une atteinte à son intégrité corporelle. Il appartient alors à la victime de choisir entre l'action contractuelle et celle née de la responsabilité délictuelle du médecin.

La principale conséquence pratique de l'existence d'une faute contractuelle concerne l'inéfficacité de la prescription pénale, qui emprécherait la victime de demander reparation d'un délit au bout de trois ans.

Cette prescription ne peut être opposée à la victime qui invoque la violation du contrat médical.

Toutefois, cette responsabilité contractuelle ne profite qu'au cocontractant, c'est-à-dire, au malade lui-même. S'il meurt d'une faute médicale, elle ne peut être invoquée pour la réparation du dommage que cette mort cause à des parents ou à un époux personnellement, à moins que les tribunaux d'admettent,

comme en matière de transport, que le médecin avait stipulé non seulement pour lui-même, mais pour ses proches.

Suivant le droit commun, la faute contractuelle comporterait une appréciation moins sévère que la faute délictuelle. Mais cette différence n'apparait que dans la jurisprudence de la responsabilité médicale. D'ailleurs, quand la victime invoque un fait constitutif de délit pénal d'imprudence, l'imprudence pénale s'identifie avec l'imprudence civile. Et toutes deux s'apprécient suivant le critère quasidélictuel.

On ne trouve pas non plus de trace, en jurisprudence sur la responsabilité médicale, d'une autre différence de droit commun entre les conséquences de la responsabilité contractuelle et le responsabilité délictuelle. Le contractant, dit l'article 1150 du Code civil, n'a pas, sauf mauvaise foi, à réparer les dommages imprévisibles lors du contrat. Mais, pratiquement, le dommages qu'une faute médicale peut apporter à la victime font partie des risque prévisibles dés le contrat médical.

.. Il ne faut pas croire davantage que le caractère contractuel de la faute médicale influe sur la preuve de la faute. Bien que contractuelle, la faute médicale ne se présume jamais et doit être prouvée par le malade. Car l'obligation contractuelle du médecin n'est qu'un obligation de moyen et non de résultat.

Enfin, le caractère contractuel de la responsabilité médicale ne saurait permettre au médecin de stipuler des clauses de non-responsabilité. Elles sont, en effet, interdites non seulement pour les fautes délictuelles, mais pour toutes celles compromettant l'intégrité de la personne humaine. Mais, sauf lorsque la victime se porte partie civile, le tribunal compétent sera celui du domicile du médecin défendeur.

Responsabilité possible envers les tiers

Indépendamment de sa responsabilité envers le malade, le médecin peut encourir une responsabilité qui est alors délictuelle, envers les tiers auxquels ses fautes causent dommage. Ce cas est surtout pratique pour les médecins aliénistes surveillant mal un aliéné dangeureux. De même, le médecin peut répondre délictuellement ou contractuellement des fautes dont seraient victimes des auxiliaires médicaux.

La faute médicale, source de responsabilité. Caractères généraux de la faute médicale.

Divers aspects de la faute médicale

La faute d'un médecin peut revêtir trois aspects: elle viole parfois des devoir d'humanismes, attachés par notre droit au ministère médical. Elle manque plus souvent aux règles de la technique professionnelle. Elle peut enfin être une imprudence ou une négligence banale, comme celle de tout autre homme.

Mais toute faute médicale suppose, conformément aux règles générales de la responsabilité civile, l'inobservation d'un devoir que l'agent avait la possibilitè de connaitre et d'observer. La Cour de cassation rappelle à ce sujet que le médecin doit à son malade des "soins consciencieux" "attentifs et, réserve faite d'hypothèses exceptionnelles, conformes aux données actuelles de la science". Et, c'est pourquoi les cas de responsabilité médicale se moulent si bien sur les devoirs examinés dans les deux chapitres précédents, que nous les y avons déjà examinés pratiquement tous.

Cette violation des devoirs médicaux n'est pas nécessairement intentionnelle. Elle peut consister dans une négligence, une imprudence, une ignorance, une maladresse ou une erreur. Il n'en faut pas conclure que la faute médicale, hors le cas d'une imprudence ou négligence banale, s'apprécie exactement suivant les règles communes. Les caractères propres du ministère et de l'art médical lui donnent une physionomie particulière.

Fautes contre la technique médicale

Ici apparait le légitime embarras du juge, simple profane au regard de cette technique, et chargé, pourtant, d'apprécier la faute du médecin. Difficulté croissante avec les progrès de la technique médicale, qui, dans as spécialisation, devient de plus en plus hermétique aux profanes. Cette constatation première domine en réalité, le vocabulaire et le sens vrai des décisions judiciaires appelées à qualifier les fautes techniqus ayant engagé la responsabilité du médecin.

A première vue, on distinguerait, sinon chez la Cour de cassation, au moins chez les juridictions inférieures, deux courants opposés.

L'un, dont le langage est souvent sommaire, semble affirmer que les médecins doivent être tenus pour responsables de toutes leurs fautes, même légères. Il est vrai que les décisions affirmant cette tendance s'appuyaient autrefois sur le caractère prétendu délictuel ou quasidélictuel de la responsabilité du médecin. En d'autres termes elles niaient que la faute technique fût la violation d'un contrat passé entre le médecin et le malade. Et elles invoquaient le vieil adage voulant qu'en dehors des contrats, toutes les fautes même les plus légères engagent la responsabilité de leur auteur.

Cette motivation est devenue incompatible avec les principes posés par la Cour de cassation quant à l'existence du contrat médical. Mais encore aujourd'hui, un certain nombre de décisions, appuyées sur des auteurs importants, continuent à affiirmer la responsabilité du médecin pour toutes ses fautes, sans qu'il y ait lieu d'examiner si elles sont graves ou non. De ce premier groupe de décisions, il faut rapprocher celles qui, pour rendre un médecin responsable, se contentent sans autre précision, de lui reprocher une imprudence, une négligence, une "violation des règles de prudence technique."

Un courant tout opposé d'arrêts d'appel et de jugements de première instance affirme qu'un médecin ne peut répondre que de ses fautes graves, lourdes, inadmissibles, grossières, inexcussables, de son impéritie évidente.

Entre ces deux parts extrèmes se situe une zone de décisions imprécises. Pour asseoir la responsabilité du médecin, elles parlent de sa "légèreté", de "l'ignorance de ce qu'il aurait dû savoir"; il leur arrive de constater une faute lourde, mais sans affirmer qu'elle soit nécessaire, ou de dire, d'une manière générale, que le médecin poursuivit a commis des "faute lourdes et des imprudences".

Mais il semble que ces formules, tantôt tranchantes, tantôt reservées, s'opposent surtout par leur verbalisme. Car, si désireux que soit un juge de sanctionner, chez les médecins même des fautes techniques légères, il n'est en situation de les découvrir et de les qualifier que si elles ont des dimensions suffisantes pour l'oeil d'un profane. Investment, si conscient que soit le juge de la nécessité de préserver les initiatives médicales d'une continuelle censure juridique, il viendra au secours du malade dés qu'il le trouvera victime d'une violation certaine, même involontaire, d'un devoir médical.

On ne peut donc, ici, séparer le fond de la preuve. Et il n'est pas douteux sous cet angle, qu'une extrème prudennce s'impose aux magistrats devant lesquels un médecin est argué de faute technique. Car plus de lumières leur sont indispensables pour affirmer la faute de ce médecin que pour reconnaitre celle d'un banal automobiliste.

D'une part, en effet, un véritable médecin ne peut remplir son rôle que dans un climat de liberté. La profession libérale exige l'initiative, le pouvoir d'affronter des risques, de décider rapidement, parfois souverainement, sans cette sorte de paralysie qui résulterait du poids constant d'une surveillance extérieure. Il faut ajouter qu'un médecin se doit à ses malades, même lorsqu'il se sent fatigué, et que la promptitude ou la sécurité de ses réflexes peut en être diminuée.

D'autre part, l'inévitable inexpérience du magistrat, en matière médicale ne lui permet de discerner, dans la technique du médecin, que les fautes suffisament grosses. Ce sont donc celles-ci, et celles-ci seulement, qu'il sanctionne.

Voilà ce que veulent marquer les décisions les plus modernes et les mieux rédigées, qui, souvent émanées de la Cour de cassation, ne retiennent, à la charge du médecin, que ses "fautes caratérisées' ou, avec plus de précision celles qui attestent" une méconnaissance certaine de ses devoirs". Conception dont il résulte nécessairement que beaucoup d'actes, qui, dans une activité banale, seraient qualifiés de fautes, ne pourront l'être en matière médicale. Comme le dit encore, et excellement la Cour de cassation: "Hors la négligence et l'imprudence que tout homme peut commettre, la responsabilité d'un médecin suppose qu'un égard à l'état de la science et aux règles consacrées de la pratique médicale l'imprudence, l'inattention, ou la négligence qu'on lui reproche révéle une méconnaissance certaine de ses devoirs".

C'est pourquoi on ne retiendra pas nécessairement la responsabilité d'un médecin ayant montré de la nervosité, manqué de coup d'oeil chirurgical, commis une erreur, même évitable avec plus de présence d'esprit, notamment, dans son diagnostic. Le défaut de pénétration de celui-ci n'est pas fautif, comme le

serait, chez un mécanicien, le défaut de diagnostic d'une panne d'automobile. A plus forte raison ne peut-on reprocher à un jeune médecin ou à un interne un simple défaut d'expérience.

Bien entendu, il en serait autrement de toutes les fautes consistant dans l'inobservation établie de l'un des devoirs étudiés dans les deux précédents chapitres. C'est donc à ceux-ci que nous renvoyons. Si les circonstances font apparaitre qu'un médecin a manqué à l'un de ses devoirs, alors qu'il avait la liberté de le remplir, ainsi que la possibilité, il est en faute et doit réparer le préjudice causé au malade.

C'est d'après les règles posées plus haut en matière de déontologie médicale qu'on déterminera notamment, dans quelles mesures le médecin était moralement autorisé à prendre le risque auquel s'est rattaché le préjudice dont se plaint le malade.

Fautes contre la prudence banale

Parmi les fautes suceptibles d'être retenues contre un médecin, la jurisprudence met à part celles qui n'ont, en réalité, rien de spécialement médical. Ce sont pour employer les expressions de la Cour suprême, celles "que tout homme peut commettre"; règles "de prudence commune" ou de "bon sens et de prudence vulgaire" applicables "à toutes personnes".

Pour apprécier de telles fautes, les juges n'ont évidemment pas besoin d'experts. Elles rentrent dans leur juridiction courante.

Tel serait le cas d'un chirurgien impotent qui commettrait l'imprudence d'entreprendre en dépit de son infirmité, une opération délicate.

De même que l'imprudence, une erreur matérielle n'a rien de spécialement technique quand elle est causée par une évidente inattention. C'est le cas du chirurgien qui, pour n'avoir pas sérieusement examiné le dossier ou le malade, opéré la hanche droite au lieu de la hanche gauche, ou bien encore la canine gauche au lieu de la canine droite. C'est même le cas du médecin qui se trompe de flacon.

Et la responsabilité d'un médecin n'a également rien de banal quand il commet un acte de nature à provoquer chez autrui une erreur fatale. C'est le cas du médecin écrivain qui, corrigeant mal les épreuves de son livre y porte comme normal, dans les remèdes qu'il recommande, une dose, en réalité toxique, d'un médicament. C'est le cas plus fréquent du médecin dont l'écriture est tellement illisible que le pharmaciens en croyant se conformer à l'ordonnance, empoisonne le malade ou même du médecin qui omet, sur l'ordonnance, d'indiquer la dose du médicament, de sorte que le malade absorbe celui-ci en quantité nuisible. Toutefois bien entendu, dans des cas de cette sorte, la responsabilité du médecin peut être partagée avec celle du pharmacien, qui professionnellement aurait dû être en évil. Elle peut même disparaitre dans les hypothèses où la faute du pharmacien éclipse celle du médecin: ainsi, quand un médecin a dosé son ordonnance pour une solution d'un produit à quatre

millièmes, le pharmacien est seul en faute s'il livre au malade, sans les avertissemenst nécessaires, un produit dosé à un degré supérieur.

Preuve de la faute

Il a été souligné plus haut que l'obligation assumée par le mêdecin n'êtait qu'une obligation de moyens et non une obligation de résultat. Le contraire a pu, il est vrai, être admis pour les dentistes ayant mal fabriqué ou mal posé un appareil de prothèse. D'autre part, nous avons nous mêmes que beaucoup de travaux de laboratoires exécutés par des médecins comportaient une obligation de résultat, par exemple, en matière d'analyses. La même solution a été admise en matière de fourniture de sang humain. Mais, dans le diagnostic et le traitement, le médecin n'étant tenu de garantir aucun résultat, ne sera jamais réputê en faute du simple fait d'un échec. Même le chirurgien, même le radiologue qui opérent ou traitent le malade ne sont pas présumé en faute du simple fait que l'opération n'a pas réussie, ou que le malade est atteint d'une radiodermite. Le patient qui leur réclame indemnité est obligé de prouver leur faute, bien que, naturellement, tous indices soient recevables quant à cette preuve.

Les tribunaux présument ainsi jusqu'à preuve contraire, qu'un médecin a été fidèle à ses devoirs. La règle s'applique à ses devoirs d'humanisme comme à ses devoirs techniques.

Puisqu'on présume le médecin fidèle à ses devoirs d'humanisme, c'est au malade qui prétend avoir été abandonné d'établir qu'il a manqué des soins nécessaires ou à celui qui soutient n'avoir pas consenti à une intervention grave de prouver que le médecin l'a décidé seul. Mais nous avons montré que la prétention de beaucoup de médecins à un pouvoir discrétionnaire de décision peut créer contre eux, sur ce dernier point, une présomption décisive. Il suffirait alors pour l'établir, de montrer leur excessive fidélité aux instigations initiales du Code de déontologie.

Le manquement à un devoir d'humanisme peut établir par tous les moyens propres à entrainer la conviction du juge. Au contraire celui-ci doit être particulièrement prudent pour accueillir la preuve d'une faute contre la technique médicale. Il luit faut y faire la part de l'inexpérience des témoins et de son inexpérience propre.

C'est pourquoi il recourra normallement à l'expertise. Certains juges regardent l'appréciation des médecins experts comme étant alors pour eux, souveraine, ou presque, tandis qu'a bon droit d'autres tiennent à maintenir, même en matière technique, le principe que le juge n'est jamais lié par l'expert qu'égarera d'ailleurs parfois, une solidarité prfoessionnele avec le défendeur.

Les divergences s'expliquent en grande partie, par la dualité des problèmes à résoudre. Il parait évident qu'un juge ne saurait guère prendre partie lui-même contre les experts, sur un point directement technique, tel que l'éfficacité d'une méthode de diagnostic ou de traitement, ou le danger d'une autre méthode. Les médecins seuls sont qualifiés pour lui indiquer sur de tels sujets, l'état des connaissances médicales, fussent-elles controversées. Mais son appréciation

peut, au contraire, démentir l'expert, lorsqu'il faut tirer, d'un point de science médicale, des appréciations rationnelles ou morales. Ainsi l'expert ne lie nullement le juge lorsqu'il justifié l'absence de certaines précautions par l'usage médical ou par la rareté relative des accidents auxquels ces précautions auraient paré.

La faute médicale serait, bien entendu, établie par la reconnaissance que le médecin en ferait lui-même. Mais le simple abandon de ses honoraires après une opération malheureuse ne signifie nullement de sa part, la reconnaissance d'une faute. Le malade est en droit pour le procès d'invoquer au besoin en la réclamant, l'ordonnance médicale. Mais il ne peut réclamer communication des fiches médicales.

Contrôle de la Cour de cassation

Conformément au droit commun, et ainsi qu'il résulte des espéces cités, la censure de la Cour de cassation s'exerce à l'égard des arrêts de cours d'appel qui auraient méconnu les principes déterminant les devoirs des médecins. Au contraire, l'appréciation de ces cours, quant à la conduite en fait par le médecin, ou quant à état actuel de la science ou de la pratique médicale, est souveraine.

L'ÉVOLUTION DU DROIT MÉDICAL

Gravité du problème

Nous avons dit que, dans la plupart de ces dispositions, la charte médicale ne marquait que le point actuel de l'évolution du droit médical. Cette èvolution se poursuit. Elle s'accélère même de telle manière qu'on a pu se demander si la charte médicale ne correspond pas déjà a une position juridique et technique dépassée par les événements.

Car la charte médicale est, par excellence, le droit de la médecine libérale. Celle-ci qui se sent menacée, se construit, par la charte, des armes défensives contre cette menace. Il n'est pas sûr qu'elle réussisse à la tenir partout en échec.

C'est pourquoi l'évolution actuelle du droit ne peut être ignorée, même dans un ouvrage qui, comme celui-ci, veut être essentiellement positif, et fournir un guide aussi clair que possible aux praticiens du droit de la médecine. Car, même l'esprit des règles existantes se modifie progressivement et la manière de les appliquer dépend nécessairement de cette évolution.

L'accroissement du pouvoir du médecin et ses conséquences juridiques

Ici, la révolution du droit médical était déjà fort avancée au moment où a été établie la charte. Et celle-ci a même quelque tendance à en alourdir les conséquences.

Jusqu'aux conquêtes modernes de la science et de l'art médical médecin et malade contractaient sur un pied d'égalité en fait comme en droit. Aujourd'hui,

en fait, la rupture d'égalité est fondamentale. Sa première manisfestation frappante date de l'anesthésie. Pour éviter la douleur physique, le malade a lui-même désiré que le médecin fut temporairement maître de son système nerveux; et, du même coup, il a lui, pendant ce temps, abandonné sa conscience et sa volonté. Le corps que le chirurgien à sur la table d'opération est toujours celui d'un homme. Mais le chirurgien le manie comme une chose; il est devenu le maître du malade par l'abandon physique que celui-ci a fait de sa personne.

C'est un abandon plus grave encore, peut-être, parce-que de conséquences plus lointaines, que connaît la médecine psychiatrique. Cet abandon est axé sur l'esprit lui-même. La volonté du malade n'est plus supprimée, mais assujettie. Par l'hypnose, l'insuline, la narcoanalyse, l'électro-choc, les opérations du cerveau, le médecin façonne, pour ainsi dire, le comportement de l'âme d'un autre homme. Il est vrai que la secité le traitait souvent moins humainement que le médecin, avant les progrès de la psychiatrie.

Ce ne sont que des manifestations particulièrement sugestives d'un état de chose générale, ou le médecin, dispensateur des sources de la santé et de la vie, est devenu, par le fait même, le maître du malade.

Cette transformation modifie la nature de la confiance que tend à réclamer le contrat médical. Cette confiance était autrefois contrôlée par le malade. Elle ne peut plus l'être. Et la tendance de bien des médecins est de la vouloir, non seulement incontrôlée, mais inconditionnelle. Le professeur Portes a longuement développé ce thème dans ces communications à l'Académie des sciences morales. Il a ouvert, avec la noble candeur d'un grand médecin, des horizons que le juriste croît redoutables.

L'homme qui devient maître d'un autre homme, fut-il idéalement pénétré du ministère qu'il exerce, s'ouvre à de graves tentations. Chez le médecin cette tentation est de considérer le malade comme juridiquement inférieur parce qu'il est biologiquement le plus faible.

C'est le paternalisme médical au sens, malheureusement péjoratif, où l'on parle aujourd'hui de paternalisme. Le malade devient dans l'esprit du médecin, un mineur, un être physiquement et psychiquement si dénué qu'il faut lui enlever, sur lui-même, tout pouvoir. Ce malade en se livrant au médecin, renonce par hypothèse, a toute participation à la direction de son être. Il abdique, entre les mains du médecin, sa condition d'homo sapiens. Il est du devoir du médecin de le conduire comme un enfant sans raison. C'est pourquoi le médecin se croira légitimement dans son rôle en lui "dissimulant" ce qu'il constate et ce qu'il sait, pour "imposer" au malade l'exécution de sa décision.

Implicite contradiction avec la confiance que, sur le plan traditionnel réclame le médecin le "colloque singulier" que cette confiance établissait au début de la médecine classique, entre le malade et le médecin, deviendrait ainsi un monologue du médecin avec lui-même. Monologue au terme duquel le médecin disposerait souverainement du "sujet", dans l'intérêt, croît-il de celui-ci! Le paternalisme tourne à l'impérialisme médical.

Cette conception a imprégné, sous l'influence éminente du professeur Portes les textes précités du Code déontologie. Elle fait du contrat médical quant à

la disposition de la personne du malade, une sorte de contrat d'adhésion. Par ce contrat, le malade s'emprisonne lui-même. Il donne, pour disposer de son être, un blanc seing au médecin, ainsi convaincu de son omnipotence.

C'est une dénaturation certaine du conntrat médical. Le malade n'y entend surement pas consentir à cet abandon inconditionnel. Et, le voudrait-il, ne le pourrait pas. La personne est inaliénable, si bien intentionnée que soit l'aliénation qu'on lui propose.

Et ce qui est contraire au contrat médical ne peut pas même être accordé par le ministère médical. Rien dans ce ministère n'autorise le médecin à cesser de traiter le malade en homme. Et, si l'égalité de fait a disparu entre médecin et malade, l'égalité de droit subsite. Les pouvoirs du médecin, pouvoirs déjà exhorbitants du droit commun, lui sont donnés pour assister la personne malade, non pour l'asservir.

Ce malentendu explique la jurisprudence des tribunaux civils et répréssifs en matière de responsabilité médicale.

Il y a précisément entre l'accroissements des pouvoirs du médecin et celui des responsabilitiés médicales, un lien étroit et logique. S'il est vrai qu'autrefois Molière a pu ramener la médecine à la purge et à la saignée, on conçoit qu'à son époque ne soient pas encore nés les procès de responsabilité mêdicale. Car la médecine, telle qu'on la pratique, ne disposait pas, comme la médecine moderne, de la vie et de la santé essentielle du malade. C'est à proportion de la maîtrise qu'il a prise sur ce dernier que le médecin a encouru, en même temps qu'une responsabilité morale a grandie, une responsabilité disciplinaire, civile, pénale, sans cesse croissante. Plus souveraine et plus décisive est la part du médecin dans le sort du patient, et plus s'impose un régime juridique sanctionnant sa responsabilité, car la responsabilité est le propre du maître.

La spécialisation de la médecine et l'équipe médicale

Il s'agit ici d'une évolution que, sans doute, n'ignore pas le Code de déontologie, quand il prévoit le contrôle des qualifications des médecins spécialisés et quand il réglemente les consultations entre médecins. Mais ne va-t-il pas au fond d'un problème de plus en plus grave, qui est celui de la substitution d'une équipe médicale à la personne d'un médecin. Dans la conception classique, le malade se confie à un médecin déterminé choisi en tant qu'homme. Et c'est précisement ce qui faît la valeur du contrat humain entre le malade et lui, et de la confiance de l'un pour l'autre. Aujourd'hui, pourtant le malade est de moins en moins soigné par un médecin, et de plus en plus par une équipe médicale.

Sans doute, il ne faut pas exagérer cette évolution qui n'a pas supprimé le médecin de clientèle, ni touché encore profondément la nature de ses rapports avec le malade. Pourtant même dans la médecine de clientèle, le médecin est devenu impuissant, dans un grand nombre de cas, à diagnostiquer le mal et à en assurer le traitement sans le concours de confrères ou des auxiliaires, et de subordonnés. Ce sont des confrères ou des collaborateurs qui font les analyses,

les radios, les examens spécialisés, grace auxquels il reconnait et suit le mal; ce sont des collaborateurs, des auxiliaires, et des confrères qui préparent les médicaments, les sérums, les vaccins, qui accomplissent une partie spécialisée des traitements nécessaires. Et tous utilisent sous leur direction, un peuple de laborantines et d'infirmières.

Surtout la médecine de clientèle céde de plus en plus le pas, quand il s'agit d'une maladie grave, pour laquelle des soins spéciaux sont nécessaires, à la médecine de clinique ou d'hôpital. Et c'est alors une sorte d'usine qui fonctionne autour du malade, avec toute son équipe humaine, comme avec tout son équipement.

Le risque, en dépit de l'humanisation historiquement croissante, de la médecine hospitalière, est de dégrader, par une sorte de déshumanisation le contrat médical traditionnel. Le malade, qui doit rester une personne y serait aisément relégué au rang d'anonyme, symbolisé d'ailleurs, à l'hôpital par un numéro sur son lit. Et les médecins deviendraient eux-mêmes des anonymes pour le malade. Le contrat médical perdrait son caractère personnel. Le climat de confiance directe qui résultait du rapprochement d'homme à homme menace de disparaitre. C'est à un mécanisme que le malade a souvent l'impression non plus de se confier, mais de se livrer, bon gré mal gré.

Et la responsobalité médicale sur laquelle nous avons insisté au numéro précédent comme la conséquence de l'accroissement des pouvoirs de la médecine, tend, en devenant anonyme, à perdre son sens. Certes, le pouvoir du médecin n'est pas diminué, au contraire, sur le malade, mais il cesse en partie d'être le propre d'un homme déterminé. On peut, et en doit néanmoins, sans doute, maintenir une responsabilité. Mais elle pert partiellement sa signification humaine. Ce n'est plus un homme qui répond de ses fautes personnelles, c'est, sous un certain angle, un mécanisme collectif qu'on astreint à compenser ses malfaçons.

Il faut sympathiser à la répugnance du médecin qui rejoint ici celle du malade devant ces déviations.

Pourtant elles exercent déjà sur le médecin leur influence. Et les institutions juridiques propres à combiner ici les progrès de la médecine avec le maintien de l'humanisme médical restent encore à découvrir et à contruire.

La capitalisation de la médecine et la tentation de la commercialisation

Le médecin d'autrefois opérait seul. Même les premiers instruments imaginés à partir de Laënnec, pour lui permettre d'explorer, par la révélation de signes cliniques, les phénomènes intérieurs du corp humain restèrent longtemps simples. On sait à quel point ils ont cessé de l'être. Tout le développement récent de la médecine a consisté à perfectionner à compliquer, à multiplier ces instruments. Leur coût de fabrication est élévé leur prix d'achat considérable, et le médecin qui veut convenablement s'équiper, doit surtout s'il s'agit d'un spécialiste, y dépenser dès l'abord une petite fortune.

La médecine suit ainsi l'évolution générale des entreprises depuis que la

domination des forces de la nature a conduit l'homme à s'appuyer sur un équipement de plus en plus important et onéreux, sur un capital de plus en plus lourd. Et, par là, la médecine, art autrefois libéral, risque elle-même de se confondre avec une entreprise. Ainsi que toute autre entreprise, elle exige, dans le monde modern un équipment et une équipe. L'un comme l'autre influent gravement sur son statut juridique et sur le caractère des contrats qu'elle passe.

Pour user des instruments nécessaires, lorqu'ils n'ont pas les moyens de les acheter eux-mêmes, les médecins recourent à diverses combinaisons du cycle capitaliste. C'est dans ce style que se sont souvent développées les cliniques auxquelles ils s'adressent contractuellement pour fournir à leurs malades les soins indispensables.

La nécessité de réaliser à frais communs l'équipement et l'équipe à pareillement inspiré le développement des sociétés de mêdecins.

Et cet état de choses est pour beaucoup dans les négociations pécuniaires qui entourent aujourd'hui les cabinets médicaux. Longtemps ceux-ci n'ont représenté que des biens peu importants. La masse croissante des capitaux indispensables à l'exercice de la profession médicale les a de plus en plus rapprochés des fonds de commerce. Par une telle voie, ce qu'on appelle improprement la clientèle médicale a progressivement accru sa valeur, puisque dans la médecine comme dans le commerce, ce qui se négocie entre un professionnel et son successeur, ce ne sont pas, à proprement parler, des clients, mais des moyens de les attirer.

Le Code de déontologie manifeste, d'une manière d'ailleurs surtout implicite son hostilité contre un tel développement. Sa conception du ministère médical est profondement opposée à la commercialisation de profession médicale. Cependant, il torère les contrats dits "d'association", qui sont, souvent, des vraies sociétés entre médecins; il ne met pas d'obstacle à la cession, contre des sommes importantes, des cabinets médicaux, qui comportent désormais les mêmes éléments que les fonds de commerce. Et le code de déontologie ne peut évidemment songer à empécher que, dans le calcul de ses honoraires, le médecin fasse entrer la rémunération du capital immobilisé par lui.

Dr. F. R. Fay

The National Health Service in Australia

INTRODUCTION

There are many different forms of Health Services in the world and many countries are considering the adoption of some type of health plan. It is for this reason that this subject has been selected to-day as it is felt that the Australian Plan is good, it maintains many of the ideal conditions under which we doctors like to practice our chosen profession, and it is a scheme whose principles might well be of interest to our colleagues in other countries.

There have been several comprehensive papers published on the details and historical background of Australian Health Care so I do not intend to discuss the political background of its development but rather to tell you how it works to-day, from the viewpoint of the patient, the doctor and the Government. I am able to see these view-points because I am a surgeon in private practice in Australia and I am also a Member of the Council of the Australian Medical Association, an Association to which 95% of the Medical Practitioners in Australia belong.

Australia's National Health Service came into being in stages about 10 or 12 years ago after several years of abortive attempts to introduce unacceptable and restrictive schemes by the previous Government party in power at the time.

Any National Health Scheme depends on the co-operation of the Medical Profession who are, when all is said and done, the citizens who make the scheme work. Whether the doctors co-operate willingly or unwillingly depends not only on the features of the service but also on the constitutional powers of the Government. In Australia, the constitution does not allow the Government to enforce civil conscription on any one section of the community and this fact enabled the profession to withstand and prevent the introduction of earlier medical schemes considered to be objectionable. It was not until 1953 that the late Sir Earle Page, a Minister in the present Government Party, introduced legislation bringing into effect the Medical Benefit Services, although the Hospital and Pharmaceutical Benefits had been introduced in the preceding three years.

The National Health Act, 1953, was outstanding because it formulated a health service and at the same time preserved most of the features which the Profession had shown to be desirable. The philosophy of the Government was to introduce measures designed to help those people who, through participation in the insurance arrangement, had undertaken to help themselves. Even while providing assistance it preserved the responsibility of the individual citizen in the ordering of his own affairs in the provision for sickness for himself and dependants. It gave the patient free choice of doctor and it gave the doctor remuneration on a fee-for-service basis, rather than on a salary or capitation basis with all its attendant evils.

There are certain fundamental principles behind the National Health Act and these will become clear as I elaborate later. The most important feature is the freedom of both doctor and patient. The doctor has freedom to choose his patient; he is free to treat his patient however he thinks best; he is free to prescribe whatever drugs he thinks indicated; he is free to practice wherever he likes and to move elsewhere when he wishes, and he has freedom to charge his patients a fee which is not controlled except by the competition of medical practice. There are, of course, certain administrative requirements such as the detailing of accounts for services and the writing of prescriptions in duplicate but these are minimal and necessary restrictions to enable the scheme to work.

Similarly, in the case of the patient, there is freedom to go to any doctor of his choice. He may change his doctor if he so wishes and the may choose which hospital he would like to be treated in provided he can pay for it directly or through insurance.

In other words, there is no interference by any Government or third person between the doctor and his patient. We regard this as very important, because as stated in the Hippocratic principle over 2,000 years ago, a doctor's prime duty is to his patient, consequently in a National Health Service, a doctor must not be under contract or direction by the Government with the patient as the

subject matter of the contract or direction, and at the same time the patient must have free choice of doctor and the right to terminate that choice at will.

The basis of the Scheme is voluntary sickness insurance by the individual. For the payment of a sum which varies from 1% to 3% of an unskilled labourer's wage which is equivalent to the price of 1 - 3 packets of 20 cigarettes per week, depending on the amount of benefit desired (3/-to 4/6 for a single person or 6/- to 9/- for a family group) the individual may become insured so that when he or his family gets sick, he is able to present his receipted accounts to the organization or fund with which he is insured and receive back a major portion of his hospital or medical expenses. In Australia at present, there are 113 organizations which insure patients and about 70% of the population is insured in this manner. A further 10% to 15% of the population is covered by other Health Schemes such as the Pensioner Service (7%) and the Repatriation Service (7%) for ex-serviceman, so that in all about 85% of the population comes under one section or another of the country's health plan.

The main sections of the scheme which I now propose to discuss in some detail are as follows: —

(a) The Pharmaceutical Benefits
(b) The Medical Benefits
(c) The Hospital Benefits
(d) The Pensioner Benefits
(e) Other Ancillary Benefits

Pharmaceutical Benefits

In 1950, there was introduced a list of life-seving and disease-preventing drugs which were available *free* to every citizen of Australia on the prescription of a legally qualified Medical Practitioner. The list was chosen by an expert Committee of medical men and this Committee still decides what drugs shall be on the list. The Australian Medical Association is very well represented on the Committee which is known as the Pharmaceutical Advisory Committee. They advise the Minister of Health of their recommendations and their advice is almost always accepted. In 1959, there were 241 items listed. In 1960 a very large increase was made in the list (so it now contains any drug or combination of drugs listed in the British Pharmacopoeia (with few exceptions) plus a number of other drugs) and the total of drugs listed is now just over 1,000. They vary from Aspirin to Erythromycin and the list contains almost anything else one can regard as useful. These are paid for the Commonwealth Government and the cost has risen from £0.3 million in 1950 to £21 million in 1959. As a result of this alarming rise in costs the Government, in 1960, imposed a 5/- charge to the patient on all prescriptions dispensed under the scheme. In spite of this however, the cost of this part of the National Health Service is still rising alarmingly and in 1962, cost the Government £35.2 million, and it is estimated that it will cost £41 million this year.

There are a number of factors responsible for this rise. Firstly, the high

cost of many of the anti-biotics and diuretics as well as other drugs. Secondly, there is a rise in the population, and thirdly, there is a rise in the number of prescriptions written per head of population (2.67). The fact that the provision of pharmaceutical drugs for the Nation is accounting for over 40% of the cost of the National Health Service, is causing grave concern to the Government and to the profession, as the heavy expenses in this section affects the provision of benefits in other possibly more deserving sections of the Scheme. It is the opinion of the Council of the Australian Medical Association that the Government should revert to the original type of limited list of life-saving and disease-preventing drugs, but this politically is easier said than done, as once something has been given to the people, it is very hard, if not impossible to take it back.

In actual practise the doctor writes the prescription for his patient in duplicate and when the patient presents the prescription to the chemist, he receives his drug, he signs the prescription acknowledging receipt of it, and pays 5/-. The chemist is re-imbursed by the Commonwealth Government for his drugs and receives a dispensing fee.

A number (80) of the drugs are termed "specified preparations" and can only be prescribed by a doctor if he is satisfied certain indications are present. For example, Cyanocobalamin (Vit. B.12) may only be prescribed for a *proven* case of Megalocytic Anaemic or for Neuroblastoma. Chloramphenicol may only be prescribed if the patient has a specific disease or is resistant to Penicillin.

There are also regulations concerning the amount which can be prescribed and the number of repeats on each prescription.

There are no penalties for doctors for breaches of the regulations unless he commits a crime such as fraud. The investigation of such abuses in this and other sections of the Scheme, is carried out by a Committee of medical men in each State chosen by the Government from nominations submitted by the Association. In other words, a doctor is being judged by other doctors, not by laymen.

Medical Benefits

As indicated before, the Medical Benefits Scheme is based on voluntary insurance by the patient with an insurance organisation. When the Government entered this field in 1953, it drew up a list of all the services (some 1045) which are rendered by a doctor and allotted a benefit to each and asked the insurance organizations to administer the scheme, and in doing so they had to at least match the Government Benefits. In actual fact, most benefit organizations pay more than the Government contribution, some up to 1.2/3rds as much again for each service. For example, a patient may consult a General Practitioner and be charged 21/–. When he presents his receipted account to the insurance organization, he will receive back in cash 6/– from the Government and 10/– from the fund, i.e., a total of 16/–, leaving 5/– which he must pay himself.

It is a basic principle in this scheme that the patient must pay something,

otherwise patients attend for frivolous complaints. No reimbursement is allowed to total more than 90% of the doctors fee. The combined Government and Fund Benefits paid to the patient range from 12/- for a consultation to a maximum of £60 for major surgery (£60 is, in Australia, equivalent to four weeks wages for an unskilled workingman). This figure can be increased by benefits for ancillary services such as transfusions, anaesthetics, x-rays, pathology, etc. All these services and any other carry a benefit.

Originally it was intended that these combined benefits would cover the patients for 75% to 80% of their medical fees but with the passing of the years and the rising cost of living, medical fees have inevitably gradually risen, whereas the Government and fund benefits, with few exceptions, have remained fairly stationary, so that to-day the Government pays only 27% of the medical expenses, the fund pays 37% and the patient pays 36%. This means that the patient's share has risen by 10-15%.

This situation has the danger that if it progresses, the people may feel that they are not getting adequate return for their insurance, especially in cases of major surgery with its high expenses. To try and correct this a revised list of benefits to the Government which it hopes it may adopt. The main increase being in the field of major surgery which has a relatively low incidence in the overall benefits paid.

The total cost of professional services in Australia in 1962 was £39.2 million and the Government's share of this was £10.9 million.

In practise the scheme works as follows:— The doctor submits his account to the patient. The account must itemise all services in detail. After payment of the account, the patient takes it to the insurance organisation which assesses the benefits due and pays him the fund and Government benefit together. The fund is then reimbursed by the Government for its share. In case of financial stress, the patient may take the unpaid account to the fund and received a cheque made payable to the doctor only, so he can then pay the doctor this cheque and the balance due; 18% of accounts are paid in this fashion.

Although in fact there is no control of the fees a doctor may charge for his services, in practise the average fees are about 1/3rd greater than the combined benefit that the patient receives. The schedule of benefits is based primarily on general practitioner services and there are no special fees for specialists, except for the referred consultation. I hope you can appreciate that in this medical service there is no interference by the Government between the doctor and the patient or in the control of fees.

As regards the patient, the only stipulation is that when they first insure for medical benefits there is an initial waiting period of two months before benefits are available (or 9 months for obstetrics). There is no waiting period in the case of accidents. For patients who have a pre-existing complaint there was a waiting period for two years for insurance medical benefits arising from that complaint although the Government benefit alone was still payable. In

recent years the Government has subsidised special accounts for such people with pre-existing complaints so that they now receive both Government and fund benefits like anyone else, and if they cause a loss to the insurance organization, the Government reimburses that organization for this loss.

Hospital Benefits

In Australia there are both private and public hospitals; the total number is about 1,600. In most cases there is a means test on the public beds so that predominently the poorer classes of people alone are treated in these institutions, however, many of them also have private and intermediate sections where fees are charged.

The Hospital Benefits Act was introduced in 1952 and like the Medical Benefits Act, is based on voluntary insurance by patients with insurance organizations. This has enable many people to have private hospital treatment who previously could not have afforded to do so. The Government pays directly to the hospital 8/– per day for every patient occupying a bed. If the patient is insured the Government also pays an extra 12/– per day. These amounts may be deducted from the account which the hospital renders to the patient or may be paid to the patient by the fund. If the patient is insured he may also get back a further sum, the amount varying with the degree to which he is insured, and weekly total (which may be equivalent to one or two weeks wages for an unskilled labourer) (£15. 8. 0 to £ 21. 0. 0.) will pay for from 50% to 90% of the average private hospital charges (£32.0.0. per week). In the year 1962, it was found that 31% of the insured members or their dependants received a hospital benefit for a period in hospital averaging 8—10 days.

The cost to the Government of hospital benefits in 1962 was £22.2 million. The rising costs of hospital maintenance has meant that hospital fees are slowly rising whereas the Government subsidy is fairly constant. This has, from the patients' viewpoint, been partly overcome by the introduction by the insurance organizations of new tables of higher rebates with higher premiums so that the patient may insure to cover the increased hospital charges.

Penisioner Medical Service

In 1951 the Government introduced the Pensioner Medical Service to deal with the problem of the aged and infirm, the widows, and the chronically sick, all of whom were unable to earn a living and whose medical treatment largely depended on the doctor's generosity or else was carried out at a public hospital.

This Service provides for a family-doctor type of service in the office or home but does not include specialists' services. The doctor is recompensed on a fee-for-service basis by the patient signing a voucher at each visit which authorises the Government pay the doctor the set fee when the doctor presents these vouchers to the Health Department.

About 55% of the doctors in Australia voluntarily participate in the service, and this scheme provides medical care for about 7% of the population.

It is this service which causes some discontent amongst the profession.

Then the original legislation was proposed the profession agreed to participate and provide the service to this needy section of th community at a concessional rate of about 60% of the normal fees. With the passage of time and the gradual rise in medical fees together with the reluctance of the Government to correspondingly increase its offer, the present rate (of 12/- per consultation and 14/- per visit) corresponds to only 50% of current fees. This the profession feels is too low.

The Pensioner does not have to pay any medical fees except a 5/- out-of-hours fee and a small mileage fee, and has available all the drugs on the Pharmaceutical Benefits list without charge. Similarly, there is no charge to a Pensioner in a public hospital.

The Pensioner Medical Service cost the Government £4.4 million in 1962. As you may suspect, this Scheme could be abused by the unscruplous doctor. Over-visiting is the commonest misdemeanour. To control this, there is in each State a Medical Committee of Enquiry, as mentioned in reference to the Pharmaceutical Medical Scheme. Its function is to investigate any apparent abuses by doctors of the Pensioner Medical Service. The Committee reports to the Minister of Health who has power to reprimand, suspend, or disallow the claim of any practitioner. There have been enquiries into apparent abuses by a small percentage of the participated doctors, some of whom have been found guilty. This gives cause for grave concern to the Australian Medical Association, as abuses by a very small section of our members may bring restrictive and unpleasant legislation down upon the vast majority who do their work honestly. Both the Association and the Government are trying to solve this problem. Apart from this aspect and the dissatisfaction with remuneration, the Scheme works very well and has doubtless improved the health of this section of the community.

Ancillary Aspects of National Health Service

It is not intended to deal with these in any detail but merely to mention them.

1. Tuberculosis Allowance: Since 1949, an allowance (£7 for a single person, £11 for a married person plus extras) has been paid to Tuberculosis sufferers and their dependants to allow them to refrain from working and undergo curative treatment. Grants are also made to State Governments for Tuberculosis hospitals' maintenance. The death rate from Tuberculosis has fallen from 23.3 per 100,000 in 1949 to to-day's figure of 4.6 per 100,000. (2 per 100,000 in some States). The cost to the Government is now falling due to the success of this aspect of the National Health Service and the decline in Tuberculosis. The cost in 1962 was £5.6 million.

2. Free Milk Scheme for Children: Since 1950 the Government has provided a daily ration of 1/3rd pint (190 ml.) to school children under the age of 12 years. The cost in 1962 was £3.7 million.

3. The Government also spent in 1962 about £3 million on Mental Institutions and other health services.

This brings an end to the brief details of the various sections of the National Health Service in Australia. In 1962 the total cost was £85 million and this year it looks like reaching £100 million. I think you will agree it is a very comprehensive service and if one considers the other schemes covering ex-servicemen, social services, flying-doctor service, and so on, the health care of the nation is almost complete.

Before concluding, I would like to make a few remarks about the future development of the scheme and of the possible dangers it may face politically.

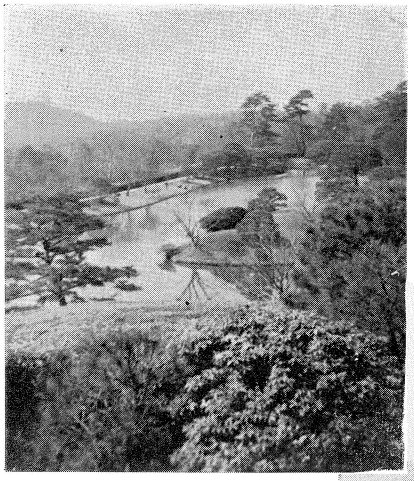
During the 10 to 12 years since this scheme was introduced there have been many modifications and eliminations of anomalies, some of which have been mentioned. There are still further minor modifications desirable. The profession in Australia enjoys close liaison with the present Government and the frequent informal meetings of representatives of both parties occur to discuss points of dissatisfaction and to work out solutions to the problems. Harmony between the Government and the profession is vital to a successful Health Scheme and so far in Australia, this harmony has been excellent.

It is possible however, that in the near future the opposition party may come into power and this party has very different ideas on National Health and has disregarded the profession's views. This part considers that remuneration should be on a capitation or salary basis; that completely free medical and hospital treatment should be available to all regardless of their financial status and regardless of any health insurance the patient may take out, and also that there should be no charge for prescriptions. If the profession is threatened with this situation it must resist the undesirable features which destroys the patient/doctor relationship, destroys initiative and self-reliance and depresses the standard of individual medical care which the people receive.

In summary therefore, at present we have in Australia a National Health Service which the public, the profession, and the present Government find fundamentally good. It is a service where freedom to choose is paramount, and whilst admitting that it is not perfect, and that the Australian Medical Association and the Government are still trying to reduce the few defects remaining, it is a service whose basic principles we would unhesitatingly recommend to you.

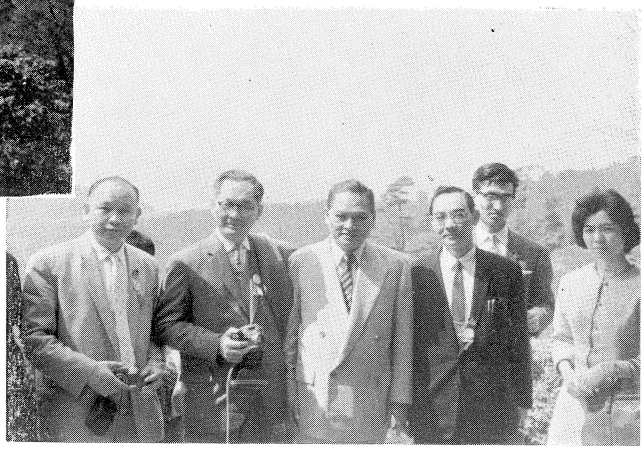
Excursion

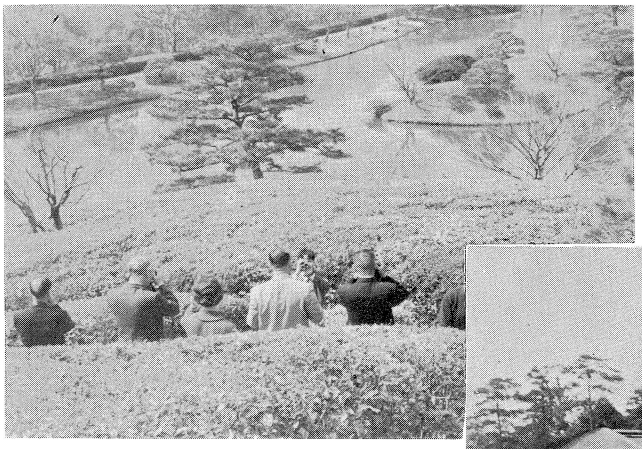
Matsushita Electric Industrial Co., Ltd.

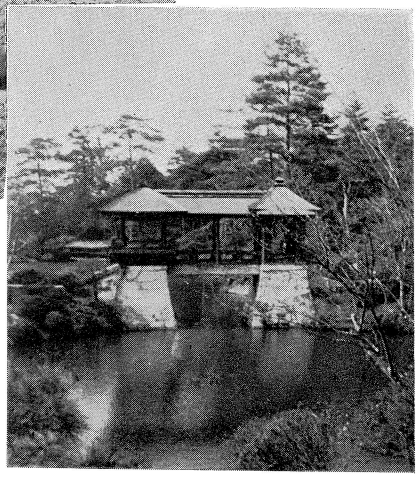


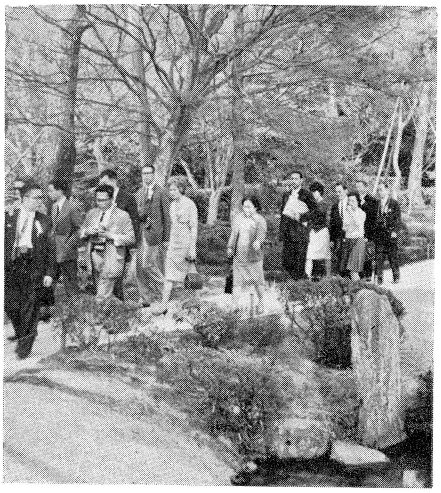
Shugakuin detached palace

— Kyoto —

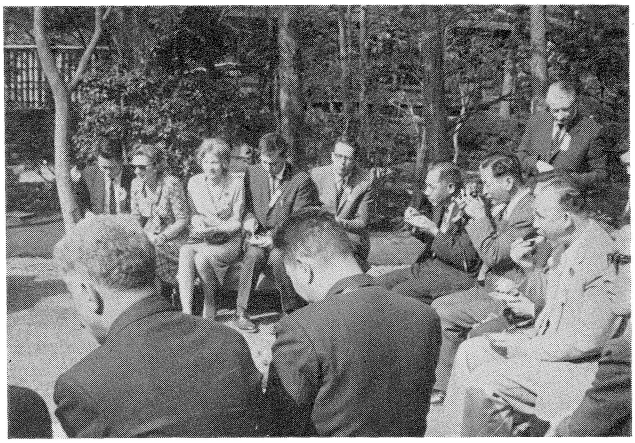






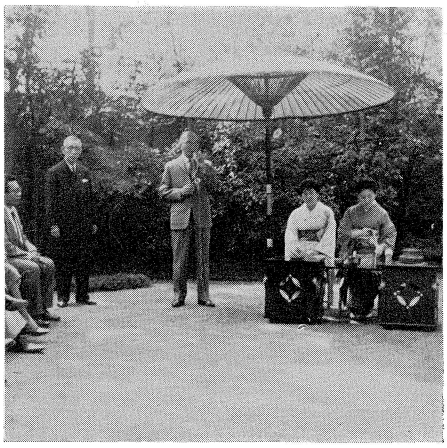


Shinshin-an Mansion, Kyoto

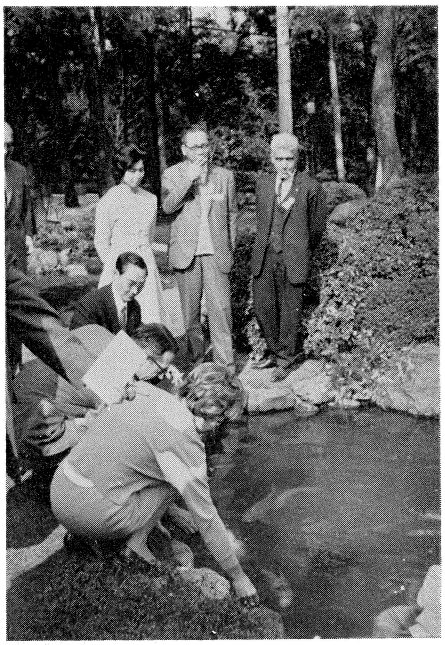


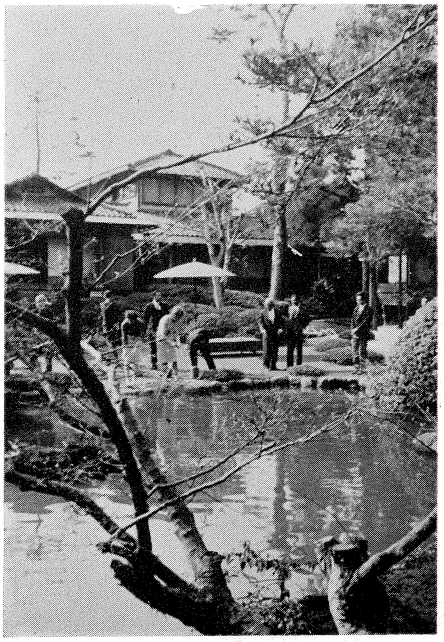
Tea ceremony

Shinshin-an is situated around Nanzenji district which is one of the most calm and quiet spots in Kyoto city. Its ground space is 5,600m². The mansion is surrounded with a typical Japanese garden with fine landscape of hills and pond. Green moss grows all over the garden and white sand makes and ideal base for the clump of cedar trees.

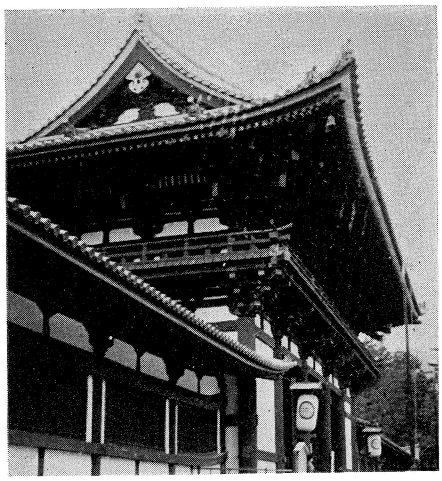


Mr. K. Matsushita (left)
master of the mansion, chairman of the Board Matsushita Electric Industrial Co., Ltd.

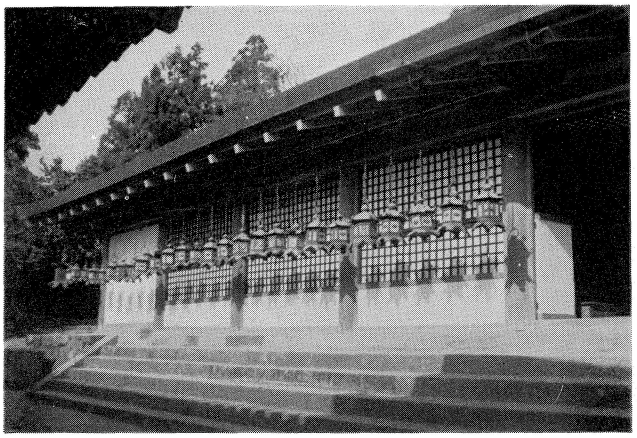


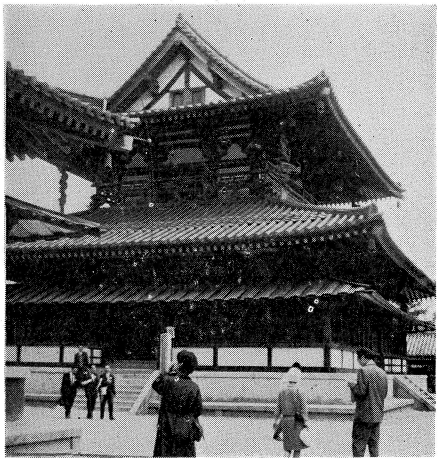


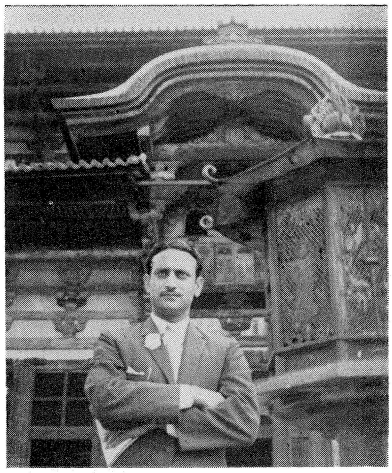
The Higashiyama Hills serve as an attractive background and the lake Biwa supplies water for the ponds through an aqueduct.

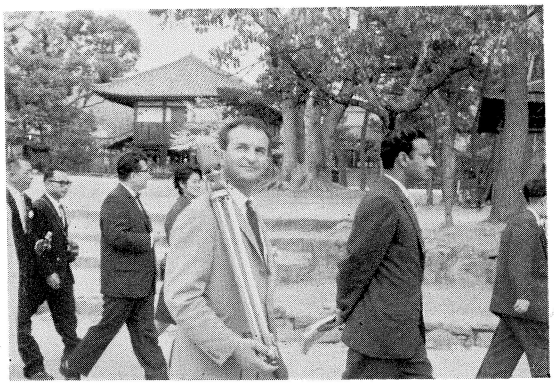


Nara









The Joint Meeting of The Japanese Society of Psychiatry and Neurology and The American Psychiatric Association

Under the Auspices of
The Japanese Society of Psychiatry and Neurology
MAY 13–17, 1963
HOTEL OKURA, Aoicho, Akasaka, Minato-ku, Tokyo

Registration will take place at the desk of the meeting hall from 8:00 a.m. on the first day of the Meeting, May 13 (Monday). Registration fee is 3,000 yen (around US$8.30) for a participant except members of APA. Ladies are also expected to register at the desk and to wear name plates. Registration fee is free for ladies.

Official Language of the Meeting is English.

Scientific Program is fixed as follows:

MONDAY, MAY 13
MORNING

OPENING SESSION

Chairmen: Haruo Akimoto, M.D. — Jack R. Ewalt, M.D.
Secretary: Teruo Okuma, M.D.

9:30	Welcome	Haruo Akimoto, M.D.
9:40	Response	Jack R. Ewalt, M.D.
9:50	Welcoming Address	Minister of Health and Welfare

SPECIAL LECTURES

Chairman: Haruo Akimoto, M.D. — Jack R. Ewalt, M.D.
Secretary: Teruo Okuma, M.D.

10:20	Retrospection on the History of Japanese Psychiatry	Yushi Uchimura, M.D.
11:00	A Short History of American Psychiatry	Walter E. Barton, M.D.

MONDAY, MAY 13
AFTERNOON

WORKSHOPS (2:30 – 4.30)

Room A — Transcultural and Epidemiological Studies of Mental Disorders (Transcultural Session)

Chairmen: Eric D. Wittkower, M.D. — Tonao Sakurai, M.D.
Secretary: Shogo Terashima, M.D. — Hisako Ueno

Speakers: Lyman C. Wynne, M.D. — Kenji Sakamoto, M.D.
Kenshiro Ohara, M.D. — William Caudill, Ph. D.
Byung Kun Min, M.D. (Korea) — S. C. Chang, M.D.
Yuji Sasaki, M.D. — Tatsuo Shikano, M.D.
Dan G. Hertz, M.D. (Liberia)

Room B Psychopharmacology
Chairmen: Butrum C. Schiele, M.D. — Shuzo Naka, M.D.
Secretary: Yukio Kawakita, M.D.
Speakers: Ziro Kaneko, M.D. — Naotake Shinfuku, M.D.
Kazutoyo Inanaga, M.D. — Atsuyoshi Mori, M.D.
Shokichi Shiozaki, M.D. — Chae Won Kim, M.D. (Korea)
Herman C. Denber, M.D. — Edwin H. Dunlop, M.D.
Leo Alexander, M.D. — Theodore Rothman, M.D.
Morris I. Vilkin, M.D. — Sol Levy, M.D.

Room C Child Psychiatry
Chairmen: Hale F. Shirley, M.D. — Shoshiro Kuromaru, M.D.
Secretary: Kiyoshi Makita, M.D.
Speakers: Kiyoshi Makita, M.D. — Toshihiko Kawabata, M.D.
Ryuro Takagi, M.D. — Kaname Hori, M.D.
Masao Sakamoto, M.D. — Shoshiro Kuromaru M.D.
Lauretta Bender, M.D. — Richard Green, M.D.
Marjorie C. Meehan, M.D. — John G. Howells, M.D. (England)

Room D Training of the Psychiatrist
Chairmen: R. W. Waggoner, M.D. — Taiei Miura, M.D.
Secretary: Atsushi Kishimoto, M.D.
Speakers: Isao Takamatsu, M.D. — Keigo Okonogi, M.D.
Arun B. Suwan, M.D. (Thailand) — Herbert Modlin, M.D.
Norman Rosenzweig, M.D. — Robert Stoller, M.D.
Howard M. Kern, M.D. — Daniel Cappon, M.D.

TUESDAY, MAY 14
MORNING

SESSION II

Topic: "Psychotherapy, East and West"
Chairmen: C. H. Hardin Branch, M.D. — Katsumi Kaketa, M.D.
Secretary: Takeo Doi, M.D.
9:30 Psychotherapy in the East
Morita Therapy — Akichika Nomura, M.D.
10:00 Psychotherapy in the United States — D. Ewen Cameron, M.D.
10:30 Discussion
Discussants: Kazuyoshi Ikeda, M.D.
Zigmond Lebensohn, M.D.

SPECIAL LECTURES

Chairman: Akira Kasamatsu, M.D.
Secretary: Takeo Doi, M.D.
11:20 Zen and Psychiatry — Daisetz Suzuki, Litt.D., Ll.D.

TUESDAY, MAY 14
AFTERNOON

WORKSHOPS (2:30 – 4.30)

Room A Transcultural and Epidemiological Studies of Mental Disorders (Epidemiological Session)
Chairmen: Eric D. Wittkower, M.D. — Hitoshi Murakami, M.D.
Secretary: Kenji Sakamoto, M.D.
Speakers: Masaaki Kato, M.D. — Caroline A. Chandler, M.D.
Petrus Suckjin Yoo, M.D. (Korea) — Thomas P. Lowry, M.D.
Haruo Akimoto, M.D. — Alexander Richman, M.D.
Kazuhiko Abe, M.D. — Tamotsu Asai, M.D.
Takeshi Hasuzawa. M.D. — Joo Yong Soh, M.D. (Korea)
Harry Schwenker, M.D.

Room B Community Psychiatry

Chairmen:	Peter A. Martin, M.D.	Masaaki Kato, M.D.
Secretary:	Moses Burg	
Speakers:	Shogo Terashima, M.D.	Hiroshi Yoshikawa, M.D.
	Hideyo Kosaka, M.D.	Sadao Ohshima, B.A.
	Shiro Nakagawa, M.D.	Shigemichi Kanno, M.D.
	Chong Eun Kim, M.D. (Korea)	Chira Sitasuwan, M.D. (Thailand)
	Morris Chafez, M.D.	Jean Munzer, M.D.
	Roletta O. Jolly-Fritz, M.D.	Leonard Maholick, M.D.
	Harry Brickman, M.D.	R. W. Medlicott, M.B. (New Zealand)

Room C Anti-social Behavior and Delinquency

Chairmen:	L. C. Kolb, M.D.	Naoaki Arai, M.D.
Secretary:	Migiwa Sakai, B.L.	
Speakers:	Ryuzo Sataks, M.D.	Kokichi Higuchi, M.D.
	Yoko Shibata, M.D.	Minoru Sugita, M.D.
	Osamu Nakata, M.D.	Takemitsu Hemmi, M.D.
	Hermut Ehrhardt, M.D. (Germany)	Edward M. Litin, M.D.
	Harry R. Lipton, M.D.	Hilde Bruch, M.D.
	Robert L. Eisler, M.D.	Herbert Winston, M.D.
	Walter S. Maclay, M.D. (England)	

Room D Genetics

Chairmen:	H. W. Brosin, M.D.	Eiji Inouye, M.D.
Secretary:	Masanao Kurihara, M.D.	
Speakers:	Keizo Okada, M.D.	Shin Ihda, M.D.
	Masanao Kurihara, M.D.	David Rosenthal, Ph. D.
	Jesse Rubin, M.D.	Karl M. Bowman, M.D.
	Daniel Freedman, Ph. D.	

WEDNESDAY, MAY 15
MORNING

SESSION III

Topic: "Present Concepts on Schizophrenia"

Chairmen:	D. Ewen Cameron, M.D.	Nozomi Suwa, M.D.
Secretary:	Kiyoshi Makita, M.D.	
9:30	Concept of Schizophrenia—With Special Reference to Biological and Socio-cultural Problems	Toshiki Shimazaki, M.D.
10:00	The Present Status of Schizophrenia	C. H. Hardin Branch, M.D.
10:30	Discussion	
	Discussants:	Ryosuke Kurosawa, M.D.
		Hilde Bruch, M.D.

WEDNESDAY, MAY 15
AFTERNOON

WORKSHOPS (2:30 – 4.30)

Room A Psychiatric Nosology, Similarities and Dissimilarities

Chairmen:	Walter Barton, M.D.	Tsunero Imura, M.D.
Secretary:	Masanori Kurokawa, M.D.	Yukiteru Machiyama, M.D.
Speakers:	Hisatoshi Mitsuda, M.D.	Shiho Nishimaru, M.D.
	Naotake Shinfuku, M.D.	Yoshio Kudo, M.D.
	Pow Meng Yap, M.D. (Hong Kong)	Hsien Rin, M.D. (Taiwan)
	Laurence C. Kolb, M.D.	Zigmond Lebensohn, M.D.
	Ari Kiev, M.D.	Jack B. Lomas, M.D.
	Milton Rose, M.D.	

Room B Neurophysiological Basis of Normal and Abnormal Behavior

Chairmen:	Jules H. Masserman, M.D.	Toyoji Wada, M.D.
Secretary:	Teruo Okuma, M.D.	Toshio Hara, M.D.
Speakers:	Yasuro Takahashi, M.D.	Yasuo Shimazono, M.D.
	Kazutoyo Inanaga, M.D.	Toshio Hara, M.D.

	Akira Kasamatsu, M.D.	J. D. Grabow, M.D.
	Rosalie Ging, M.D.	Y. Taketomo, M.D.
	Juhn A. Wada, M.D.	

Room C Addiction

Chairmen:	C. H. Hardin Branch, M.D.	Seijun Tatetsu, M.D.
Secretary:	Tsukasa Kobayashi, M.D.	
Speakers:	Yoshio Ikeda, M.D.	Naoaki Arai, M.D.
	Akira Mukasa, M.D.	Akio Goto, M.D.
	Seijun Tatetsu, M.D.	Robert A. Moore, M.D.
	Ruth Fox, M.D.	Frederick Lemere, M.D.
	Maria Z. Fuchs, M.D.	Leo J. Cass, M.D.

Room D Mental Retardation

Chairmen:	George H. Preston, M.D.	Osamu Kan, M.D.
Secretary:	Tomio Hirai, M.D.	
Speakers:	Shigemichi Kanno, M.D.	Masazumi Harada, M.D.
	Akihiko Takahashi, M.D.	Hiroyuki Kamide, M.D.
	Ken'ichi Kishimoto, M.D.	Takayuki Tsuboi, M.D.
	Frederick L. Patry, M.D.	Samuel Wick, M.D.
	Samuel Susselman, M.D.	Henry Viet, M.D.

THURSDAY, MAY 16
MORNING

SESSION IV

Symposium on "Psychiatry in Asian and Oceanian Countries"

Chairmen:	Karl M. Bowman, M.D.	Ziro Kaneko, M.D.
Secretary:	Y. Taketomo, M.D.	

9:30 – 12:00

The Development of Psychiatry in Korea	Suk-Whan Oh, M.D. (Korea)
Social-Psychiatric Research in Taiwan	Tsung-yi Lin, M.D. (Taiwan)
Psychiatry in Hong Kong	Pow Meng Yap, M.D. (Hong Kong)
The Concept of Psychiatry in the Philippines	Baltazar V. Reyes, Jr., M.D. (the Philippines)
Development of Psychiatry in Indonesia	R. Kusumanto Setyonegoro, M.D. (Indonesia)
Title unknown	Vincent Youngman, M.D. (Australia)
Mental Health and Psychiatric Services in Thailand	Prasop Ratanakorn, M.D. (Thailand)

THURSDAY, MAY 16
AFTERNOON

SESSION V

Topic: "Future Trends in Psychiatry"

Chairmen:	Zigmond Lebensohn, M.D.	Haruo Akimoto, M.D.
Secretary:	Takeo Doi, M.D.	
2:00	Problems in Psychiatry in Japan	Tsuneo Muramatsu, M.D.
2:30	Action for Mental Health	Jack R. Ewalt, M.D.
3:00	Discussion	
	Discussants:	Tsutomu Ezoe, M.D.
		D. Ewen Cameron, M.D.

CLOSING SESSION

3:50	Closing Address	Taiei Miura, M.D.
4:00	Closing Address	Henry W. Brosin, M.D.

Speakers, Chairmen and Formal Discussants are requested to report their presence at the desk in front of each meeting room 30 minutes prior to their Sessions or Workshops. Slides will be accepted here.

The Size of Slides is limited to the usual 35 mm Kodachrome size, mounted in 50 mm × 50 mm. Except Workshops there will be two slide projectors for simultaneous projection.

Committee Room is opened from 9 a.m. of May 13 (Monday) to 4 p.m. of May 16 (Thursday) at Chitose-no-ma, next to the main meeting room, Heian-no-ma.

Telegrams should be addressed to:
"Joint Meeting Hotel Okura Tokyo"

Telephone will be received at Chitose-no-ma. Okura Hotel is Tokyo 481-8011.

Messages and Mails will be delivered at information desk of the meeting hall.

Bank and Travel Agency are located at the main Lobby of the Hotel.

Visiting Institutions of psychiatric interest is arranged on the last day of the Meeting, May 17 (Friday), on which there is no scientific program at Hotel Okura. Application for participating in one of the tours should be made at the desk of the meeting hall from May 13 (Monday) through May 15 (Wednesday). There are five tours as follows:

Tour A Visiting Mental Hospitals (Matsuzawa Hospital, Sakuragaoka Sanatorium)

Tour B Visiting Medical Schools (Department of Neuropsychiatry and Institute of Brain Research of University of Tokyo School of Medicine, Department of Neuropsychiatry of Keio Gijuku University School of Medicine, Seiwa Hospital)

Tour C Visiting Nakano Prison for Adult Criminals and University of Tokyo Branch Hospital

Tour D Visiting Musashino Gakuin, an Institution for Juvenile Delinquents

Tour E Visiting Institutions for Mentally Retarded Children (Chichibu Gakuen, Asahide Gakuen)

The Japanese Society of Psychosomatic Medicine will hold the 4th General Annual Meeting on May 17 (Friday) and 18 (Saturday) at Toshi Center, 2-6 Hirakawacho, Chiyodaku, Tokyo.

Climate and Clothing: Average temperature in the middle of May in Tokyo is 17.5°C (maximum 22.1°C and minimum 13.4°C). Average humidity is 73 per cent. No formal dress is required.

Official Address: Dr. Haruo Akimoto, President of the Joint Meeting, Department of Neuropsychiatry, University of Tokyo School of Medicine, Motofujicho 1, Bunkyoku, Tokyo, Japan.

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CHARACTERISTICS

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- Marked improvement of subiective and objective symptoms.
- Superior life-prolonging effect.
- Minimal side effects. Low leucopenic effect makes possible long-term treatment.

INDICATIONS

Alleviation of subjective and objective symptoms in malignant chorioepithelioma and Hodgkin's disease.

Cancer (Gastric cancer, uterine cancer, pulmonary cancer, rectal cancer, breast cancer, esophageal cancer. liver cancer, skin cancer, carcinogenous peritonitis, Grawitz's tumor, ovarial cancer, perineal cancer).

Sarcoma (Reticulosarcoma, lymphosarcoma).

ADMINISTRATION AND DOSAGE

The standard method of administration and dosage is as follows.

Intravenous injection.

Dissolve 0.5 mg. of Chromomycin in 10 ml of sterile water for injection or glucose solution, inject intravenously once daily or at suitable intervals. Avoid leakage from vein as induration or necrosis may be produced at the site of injection. A single course of treatment usually consists of a total of 30 mg. May be repeated as indicated. May also be administered intra-arterially, directly into the pleural space, into the tumor or by local infusion.

CASE REPORT

Effect of Toyomycin in a Case of Cancer of The Transverse Colon

Katsuya, Yoshinaga and Masanobu Akagi
Department of Surgery,
Kumamoto University Medical School

The concomitant use of antitumor agents together with surgery is quite new but in view of the rise in therapeutic rate, this method has come to be widely used. This method is based on the effect of the antitumor agent against the "floating cancer cell".

Various antitumor agents have been used together with surgery since 1958 in the department and quite satisfactory results have been obtained.

In the present study, Toyomycin was used in a case of giant tumor of colon and the results are presented here.

● **Case 1:** O. M. 37 year old male

Clinical Diagnosis: Tumor of the Abdominal Wall.

Present Illness:

In July of 1960, a painful tumor of unknown cause developed in the left epigastrial region. The tumor gradually increased in size. Localized peritonitis had been diagnosed elsewhere and a small quantity of purulent fluid removed by incision on Sept. 22. The tumor, however, continued to enlarge despite the incision and from Oct. 1, intestinal content began to be excreted from the site of incision and no trend for healing was noted for 2 months. The patient was referred to the Surgery Department on Dec. 15 and immediately admitted under the tentative diagnosis of malignant tumor of the abdominal wall.

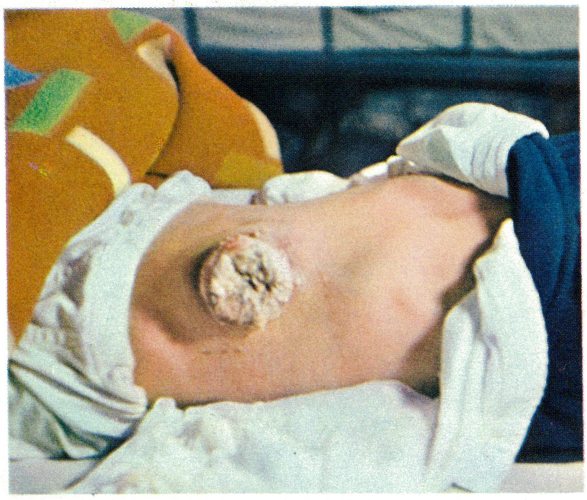


Fig. 1 cancer of colon (when admitted)

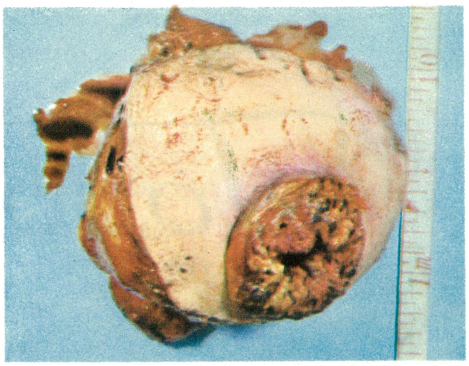
Toyomycin

Course:

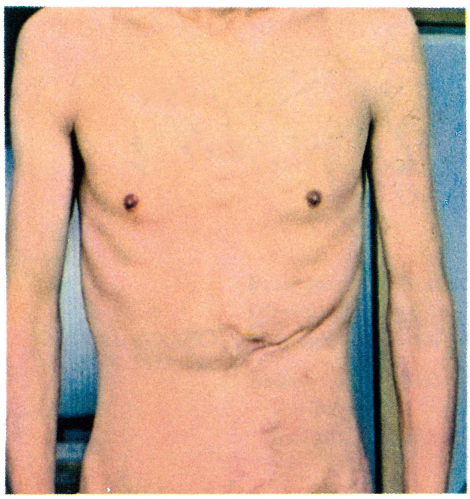
The patient was somewhat emaciated, and there was severe pain in the tumor region and there was a complaint of inability to sleep, anorexia and general lassitude.

Chart 1 shows the tumor in situ. A large goose-egg sized tumor was present in the left upper quadrant. A fecal fistula could be seen in the central part of the tumor and moist, elevated granulating tissue surrounded the fistula. Routine tests revealed moderate anemia, leucocytosis and 14% positive B. S. P.

Other tests were negative. Treatment with Toyomycin was started on Dec. 25 in a daily dose of 1,000 mcg. intravenously and given for 30 days. There was a slight decrease in the pain and some localization of the tumor at one time, but the tumor again began to grow larger. From Jan. 7, Prednisolone was given concomitantly in a dose of 50 mg a day intramuscularly whereupon, the pain almost completely disappeared and there was no further increase in size of the tumor. As the tumor was larger compared to the time of admittance, radiotherapy was then tried but there was no response. After a total of



▲ Fig. 3 isolated tumor



◀ Fig. 2 after healing

30,000 mcg of Toyomycin surgery was carried out on Jan. 25 and the tumor totally removed. (Chart 3).

The postoperative course was uneventful and the patient was discharged on May 10. There has been no sign of reoccurrence after 1 year 10 months and the patient is living a normal life.

Chart 2 shows the patient after the operation.

SUMMARY

Toyomycin was given for a total of 30,000 mcg in a case of malignant tumor of the colon. The tumor was then removed surgically. There has been no sign of recurrence or metastasis after 1 year 10 months. Side effects were not observed. It is believed that treatment by surgery together with an antitumor agent is the method of choice at the present time.

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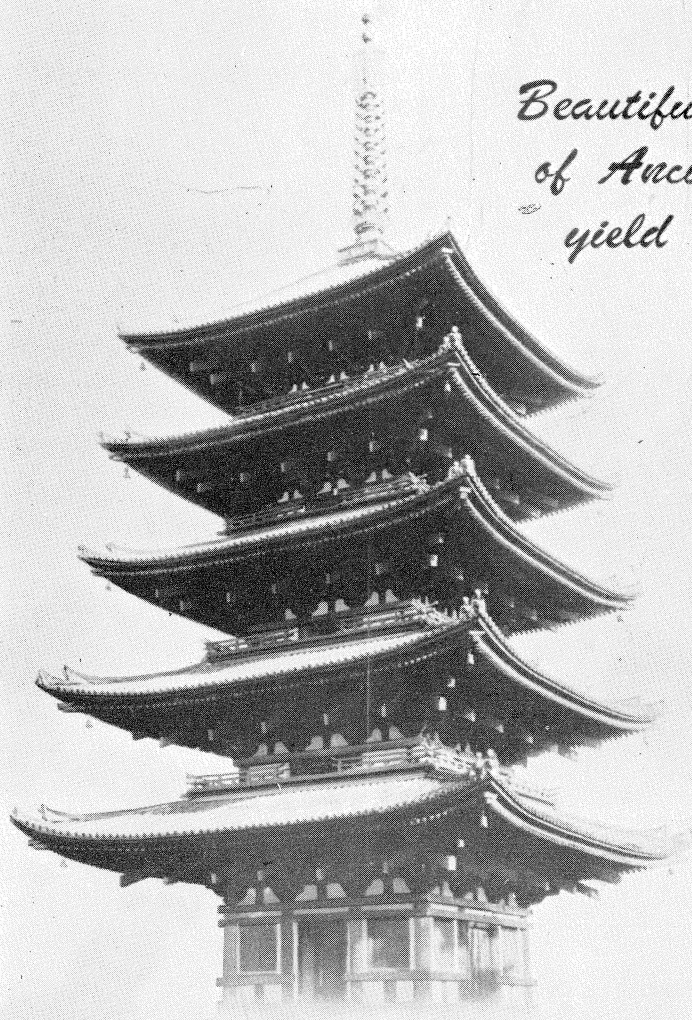

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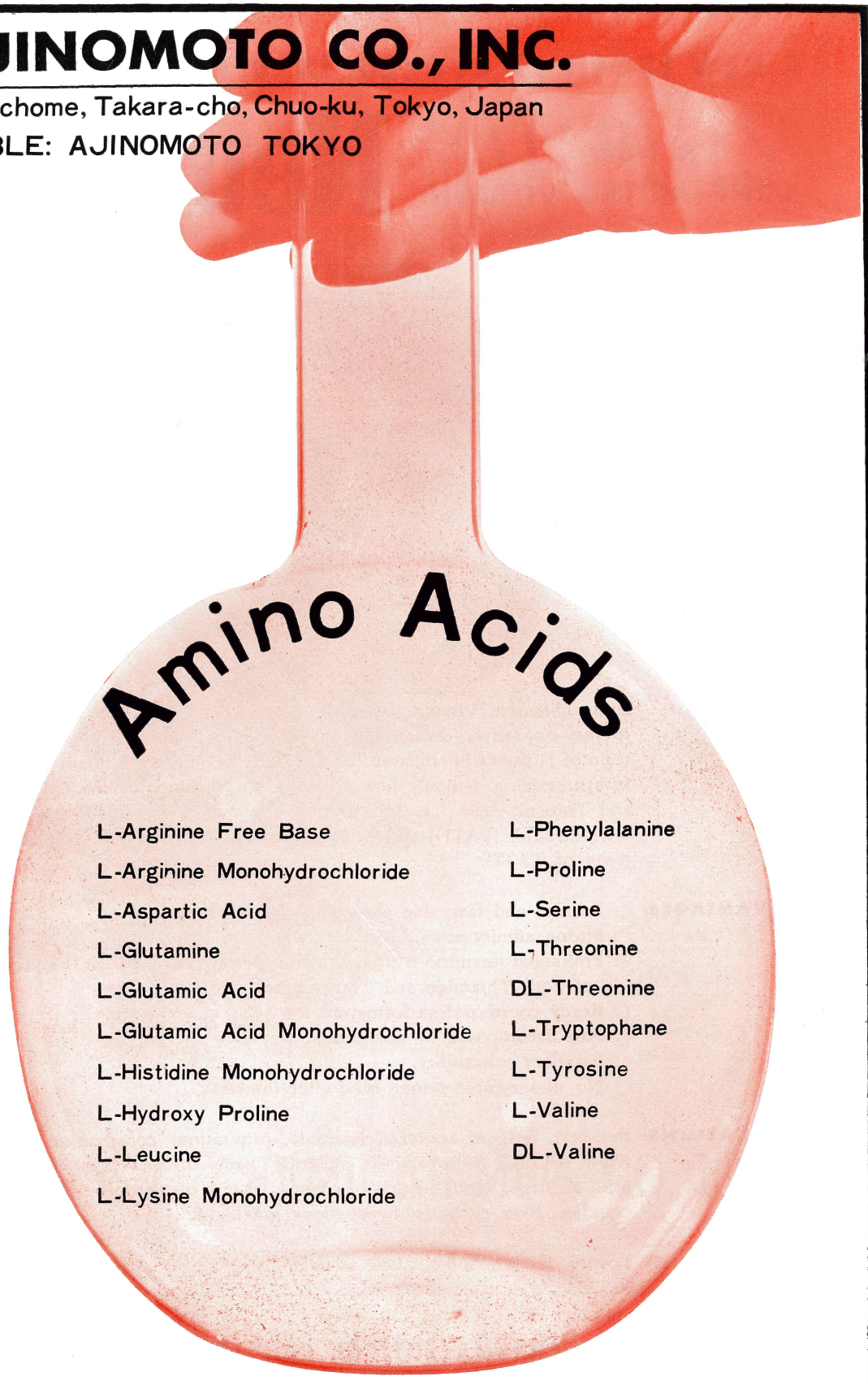

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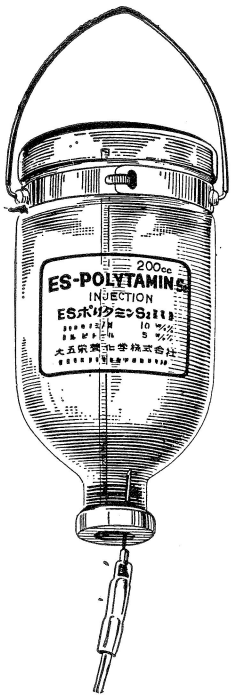

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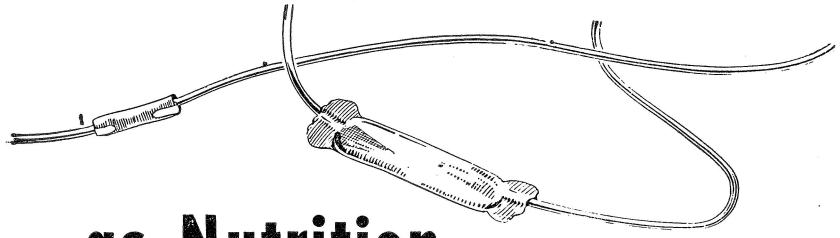

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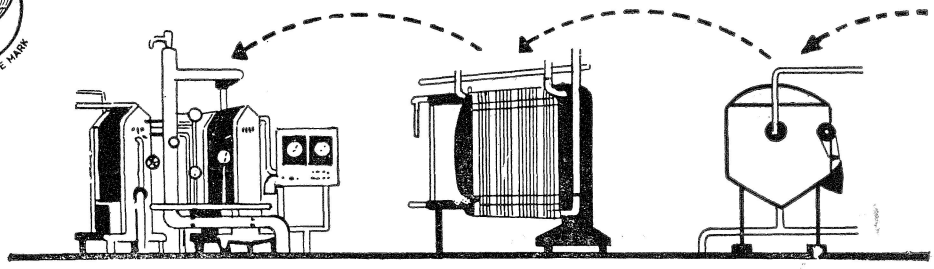

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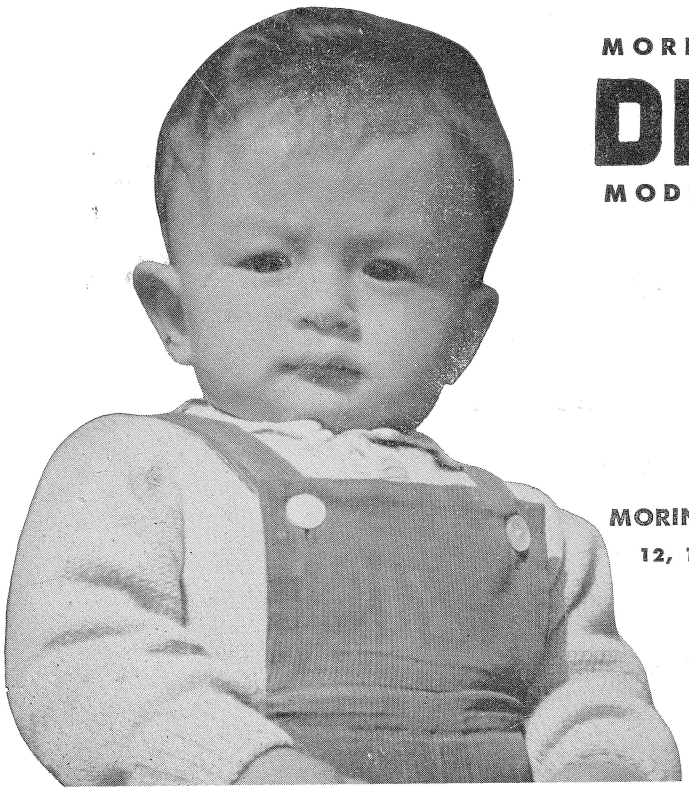

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CHARACTERISTICS

1. Broad Antitumor Spectrum

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2. Excellent Therapeutic Results

As anticipated from the above-mentioned results with experimental tumors of animal, Mitomycin C was proved to have potent and wide-ranged activities in clinical studies, too. Remarkable objective effects as followings were observed in many cases: diminution or disappearance of tumors, metamorphosis or disappearance of tumor cells in pleural or ascitic fluid, diminution or disappearance of metastatic lesions, etc

Subjective effects such as improvement of appetite, sense of wellbeing and complete or partial relief of pain were often observed. It is also expected that Mitomycin C will be effective even in those patients who have become resistant to other chemotherapeutics and radiation therapy.

3. Less Side Effects

Mitomycin C can conveniently be used as it causes subjective side effects such as nausea, vomiting and poor appetite only in limited cases.

Decrease in number of leucocytes and blood platelets are subjective side effect of this medicine, but the decrease is usually recovered rapidly by discontinuing the administration.

4. Prevention of Recurrence After Operation

Excellent follow-up results are being indicated in the postoperative recurrence.

INDICATIONS

Mitomycin C is indicated for improvement of subjective and objective symptoms of following diseases:

Carcinoma: Stomach cancer, uterine cancer, cancerous peritonitis, breast cancer, liver cancer, lung cancer, pancreas cancer, intestinal cancer, maxillary cancer, skin cancer.

Sarcoma: Reticulosarcoma, lymphosarcoma, melanosarcoma.

Leukemia: Acute leukemia, chronic leukemia

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TPD
ALINAMIN

Thiamine Propyl Disulfide

New thiamine derivative with wide range of utilization compared with common vitamin B_1.

CHARACTERISTICS

- Absorption from intestines not limited ; oral therapy effective as injection.
- Transferred and stored in various organs in high level and retained over a long period.
- Easily converted into cocarboxylase.
- Not destroyed by thiaminase.

INDICATIONS

- Thiamine deficiency.
- All types of neural disturbances, neuritis, neuralgia and rheumatism.
- As adjuvant in all marasmic diseases.
- Auditory disturbance due to streptomycin.

Supply:

Tablets	5 mg./tab.	100's & 1,000's
Injection	5 mg./1 cc.	10 & 50 amps.
	10 mg./2 cc.	10 & 50 amps.

TAKEDA CHEMICAL INDUSTRIES, LTD.

OSAKA　JAPAN