do not misinterpret plans and fear abolition of the present municipal structure, which is not intended. (This has been of great concern to many rural communities).

The conciliatory tones have not allayed the fears of all doctors, who recognize that evolving social patterns can exert coercion in the long run more effectively than revolutionary changes that provoke resistance. Few oppose the idea of using in a new way rural hospitals too small to provide effective conventional hospital care. The real concern centres on four urban facilities much closer to the minister's hand for health care experiments: the three remaining community health clinics at Regina Saskatoon and Prince Albert and the Grey Nuns Hospital.

Last March, the Government began to finance the community clinics in a new way, bypassing the fee-for-service system, allowing them to broaden their health and social services.

Community Health Clinics were created during the 1962 crisis by pro-Government citizens' groups and a few Saskatchewan doctors dedicated to the concept, such as Dr. Sam Orville K. Hjertaas of Prince Albert. They were staffed mainly by doctors brought in from Britain on short-term contract to serve during the crisis. Some settled in Canada, such as Dr. David A. Road and Dr. Peter Beaglehole of the Regina clinic.

The clinics and their doctors were the focus of the greatest resentment in 1962 because they supported the Government, directly opposed the profession's stand, accepted salaries and worked with lay groups in running the centres.

This bitterness took years to diminish and has not totally disappeared, but few practical problems arise now.

From the beginning the clinics espoused the use of non-medical staff, such as social workers, to provide preventive and treatment services, but medicare, designed only to pay doctors, made no provision for such people. Clinics which used them paid them from the doctors' fees, which are pooled and paid out to doctors in salary, much as in conventional medical group practice.

The clinics ran into financial trouble with this arrangement and appealed to the Government to pay them a global budget as they do to hospitals: a total sum to be allocated more broadly. Global budgeting for the three clinics began last March.

Cost control is exercised through routine scrutiny of medical claims by the commission, confirmed by regular, routine random checks of patients through letters seeking verification of services reported. Detailed profiles are compiled on every doctor's practice which permit comparison of his pattern of practice with the average for doctors in similar types of practice. If a profile shows marked deviation information is sent to the Saskatchewan Medical Association which refers it for detailed scrutiny to the professional review committee.

For years the review committee was poorly backed up by the college, which formerly had the job done now by the SMA, because the college saw discipline in terms of suspending a doctor from practice for negligence and was uneasy about applying economic sanctions. The Government says it is better satisfied with the profession's approach during the past year.

Surveillance is still resented in some quarters, but Dr. R. G. Murray, chairman of the commission, said, "If doctors believe in the fee-for-service system they should not exploit it."

Profiles on medical practice have a potential far greater than simply cost control. Medicine is not an exact science: doctors can honestly differ in how many X-rays or tests they order or how often they see a patient.

Prior to detailed, computerized information from medicare there was no way valid comparisons could be made across the whole medical profession. The potential for raising medical standards through such studies was outlined last March in the Canadian Medical Association Journal by two officials of the Department of National Health and Welfare. Publication in the Journal itself was an interesting commentary on the greater acceptance accorded such far-reaching concepts.

The Saskatchewan Government's introduction of medicare in July, 1962, swept away the status quo forever; never again can the profession be uninvolved in social planning in its broadcast sense. To that extent the profession lost, but loss of a narrow freedom can be the gain of a greater and more influential position if the public, as well as the profession, remembers the issues and the results.

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