the practitioner, and the profession should feel no hesitancy in combating this invasion.

Dr. Williams maintains that many patients resort to dispensaries to get better treatment, either because they could not be examined properly, on account of the lack of equipment in the office of the average general practitioner, or because the doctors whom they happened to consult were not efficient. The inefficiency of medical men should be a diminishing factor in driving patients to dispensaries, since medical colleges are turning out better educated and more competent men from year to year. When it comes to our specialties, there is no justification for a person in good circumstances to frequent a dispensary, for he will usually find the same physician conducting the free clinics. Now this physician could surely treat him just as well, if not better, at his private office, where he has more time at his disposal. If the patient does resort to the dispensary, it is merely to avoid parting with his cash. On the other hand, if one medical man treats him carelessly, he is at liberty to go to another who will treat him properly, but he has no moral right to go to a free clinic. As I have stated in the paper above referred to, the bestowal of free treatment on those who can afford to pay exerts an evil effect in many ways. Not only does it stunt the moral sense of the applicant, and weaken his self-reliance by making him a recipient of charity, but it also robs the deserving physician of part of an income.

Dr. Williams justly asserts that a private practitioner cannot compete with a well equipped dispensary, which has a number of trained nurses and a well organized social service department at its disposal. But why should members of an honorable profession be permitted to become victims of circumstances over which they have no control?

Socialization of medicine would probably be the best solution for many of the difficulties we are up against, but shall we, when so much can be done in the meanwhile to mitigate the evil, fold our arms and do nothing until this question adjusts itself in a remote future?

The dispensary abuse should be mitigated, and if the remedy is only temporary, it should, nevertheless, be applied until the relation of medical practice to society is properly adjusted. Dispensaries of the better type in this city have social service departments, and the one attached to the Johns Hopkins Dispensary is a model of its kind. However, it would add to its laurels by becoming a potent agency in wiping out an abuse which does great harm to a goodly part of our professional brothers. All that the dispensary authorities would have to do would be to refer every applicant whose personal appearance does not indicate that he is poor or needy, for investigation. It is an old axiom, "Where there is a will, there is a way."

Another means of overcoming dispensary abuse would be the adoption of medical partnerships, or the group plan, already in vogue in many communities. By means of this plan, men of various specialties would combine, e. g., a roentgenologist, the laboratory man, the internist, the eye, ear nose and throat specialist, etc. Consequently there would be no excuse for a patient to frequent the public dispensary for a diagnosis requiring either the use of different apparatus, not to be found in the office of the average practitioner, or the consultation of different specialists.

M. M. SAVAGE, M.D., Baltimore.

Statistics on Hay-Fever Plants Wanted

To the Editor:—As the fall hay-fever season commences in most localities in August, the American Hay-Fever Prevention Association requests interested observers in each state to report on any or all of the following points:

(1) Beginning of the florescence of the (a) common rag-weed (*Ambrosia elatior*), (b) giant rag-weed (*Ambrosia trifida*), (c) the western rag-weed (*Ambrosia psilostachya*), (d) the cockle bur (*Xanthium pennsylvanicum*), (e) marsh elder (*Iva ciliata*), (f) the western marsh elder (*Iva axillaris*), and (g) the gaetnerias. These plants bloom in most sections in August and September, and are all wind-pollinated and potentially hay-fever plants.

(2) The date of the beginning of fall hay-fever in these sections, and the coincidence of its development with the florescence of one or more of these plants.

A large number of replies will increase the statistical value of the reports. Any other statistical information will be appreciated. Address American Hay-Fever Prevention Association, Audubon Building, New Orleans, La.

W. SCHEPPEGRELL, M.D., President.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

CITY AND RURAL HEALTH

To the Editor:—Within the past several years, I have noticed some articles relative to country life conditions, and that the rural sections were less sanitary than the city. I think I have also seen somewhere the statement or opinion given that most of the epidemics in the city came from the country, and that the death rate in the country was greater than in the city. I cannot recall the article or writers. Have careful investigations been made in the last several years, and do they bear out the foregoing statements? I have seen some statistics, but some of these are thought inaccurate, as those of the city often include deaths of persons brought in for better care and treatment; there are usually no regulations requiring accurate records in the rural sections, and so on.

Any information regarding the foregoing will be greatly appreciated.

D. T. KIZER, M.D., Springfield, Mo.

ANSWER.—There can be no doubt that the average sanitary conditions are worse in the rural districts than in the large urban centers except so far as overcrowding and its direct effects are concerned. It is notorious that the means for the disposal of excreta are more generally bad in the country than in the town, although it is true that in some parts of some cities wretched conditions in this respect are still to be found. The chances of contamination of the water supply by such insanitary dispositions are evidently far less in the town tenement with its piped supply than in the village communities or farms where the water is taken from an open stream or from a shallow well. Animals which are liable to serve as distributors of parasitic diseases constitute a greater danger in the country than in the town. Breeding places for flies are the commonplace of farm conditions, the exception in the town. Finally, the administrative sanitary control of the towns is better. The statement that most of the epidemics in the city come from the country is evidently too general. The majority of epidemics commence with pre-existing cases, and those cases may as well exist in the town as in the country; and in the former, owing to the congestion of population, there is larger opportunity for infection by contact. On the other hand, certain diseases lend themselves peculiarly to propagation by means of products—notably milk—of the rural districts which are sold in the towns. It is therefore to be expected, and it has been proved, that a large number of urban epidemics of such diseases as typhoid fever, germs of which may lie latent in carriers and be propagated by products like milk, are traceable to a rural source. The insanitary conditions which prevail in the country are, however, largely outweighed by the overcrowding in the towns, as is proved by the relative death rates. The life tables just published by the Bureau of Census (United States Life Tables, 1910, Bureau of the Census, Department of Commerce; copy sent free to every medical man on application to Director of the Census, Washington) give a series of tables of the vital statistics for the white population in the cities and in the rural part, respectively, of the original registration states. These tables are based on the estimated population, 1910, and on the reported deaths in 1909, 1910 and 1911. We quote from pages 38 to 45, column 7. This column shows the numbers of the population living in age interval, to one death in the same age interval (calculated for a hypothetic stationary population). The higher the figure the lower the mortality.

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