



of Seven to pursue their art and exhibits. In fact, in his time he was considered the most outstanding ophthalmologist in Ontario. His first position at the university was as lecturer in pharmacology and therapeutics, and he also assisted the professor of gynecology. He then did postgraduate ophthalmic study in London, England, before returning to work at the Toronto General Hospital and the Hospital for Sick Children. He was professor of ophthalmology at the University of Toronto from 1914 to 1929, published widely on ophthalmologic conditions and represented the university on the council of the College of Physicians and Surgeons of Ontario.¹ His patronage of the Group of Seven was without a doubt his major legacy.

Wilton's article on corneal transplants alludes to the university but neglects the important role it played in establishing the Eye Bank of Canada (Ontario Division) in conjunction with the Canadian National Institute for the Blind (CNIB). The concept of a Toronto eye bank arose during a discussion between Col. E.A. Baker and Professor A.J. Elliot in May 1950.

The CNIB contributed \$500 to the university's Department of Ophthalmology to help establish the eye bank. Its first medical director was Dr. Hugh Ormsby, who obtained funding from the federal health department in 1955 and established research programs in corneal transplantation under Elliot. In 1959 Elliot appointed Dr. P.K. Basu Stapells director of ophthalmic research. Anne Wolfe, who managed the eye bank and built up the donor system, eventually handed management responsibility to Dr. Marilyn Schneider, and Fides Coloma succeeded Schneider in 1996. Dr. David Rootman has been responsible for directing the bank since 1991, and Professor William Dixon, the senior medical adviser, maintains close links between the bank and the CNIB. Since 1966

the eye bank has been funded by a Ministry of Health contract grant and an operational grant from the CNIB. It is the only transplantation program housed on site at the University of Toronto.

The ophthalmology department is proud of its historical links to the Group of Seven and its continuing links, via the Eye Bank of Canada, with the CNIB and the provincial government.

Graham E. Trope, MB

Professor and Head
University of Toronto
Ophthalmologist-in-Chief
The Toronto Hospital
Toronto, Ont.

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The other side of the great divide

After reading "MD crosses great divide when moving between practices in Canada, US" (*Can Med Assoc J* 1996;155:1599-600), by Charlotte Gray, I feel obliged to respond. The article dealt with a plastic surgeon who practises on both sides of the Canada-US border. For the past 5 years, I have practised on both sides as a general practitioner.

In the winter I work part time for a nonprofit corporation that operates community clinics in 3 counties in South Central Florida. They provide care to low-income Americans. In the summer I do part-time work as a locum in my former practice in Ontario, where I spent 35 years in general practice.

In Florida, medical care is excellent if you can afford it. The community clinics have excellent providers, including board-certified specialists, general practitioners and nurse practitioners. Although primary assessments are reasonably complete, pro-

gression to more sophisticated studies such as echocardiograms, contrast studies of the gastrointestinal tract and endoscopic examinations require a cash outlay that most patients cannot afford. Even recipients of Medicaid, which provides care for destitute Americans, encounter difficulty, since specialists often refuse to accept these patients. For emergencies, hospitals make all modalities, such as MRI and CT, available.

For the patient population I serve in Florida, my treatment decisions are almost always severely restricted by the patients' poverty. Although great publicity is given to campaigns encouraging women to have an annual mammogram after age 50, for most of our patients the fee of \$60 or more is a real financial strain.

When I see patients in Canada, I know they will be seen by a specialist regardless of their income. A mammogram can be ordered without cost. In Ontario, patients are required to wait for bypass surgery due to overburdened facilities. In the US this procedure can be done promptly, but I have treated patients whose delay in having the surgery was due to their inability to pay. Meanwhile, they remained cardiac cripples. As a Canadian physician, I cherish the freedom to treat patients without concern for their ability to pay.

As a provider and a user, my plea is that the beleaguered Canadian health care system does not become Americanized into a two-tier system.

Donald H. Aikenhead, MD
Avon Park, Fla.

Revisiting Rick: more bad news on the HMO front

Last year, during one of my periodic visits to Los Angeles, my friend Rick (as I have been calling him), a primary care physician, recounted some of the difficulties he ex-