has to work hard to remain valuable to the employer.

I do not mean to suggest that physicians respond only to these incentives, but it should be recognized that incentives exist and that they modify behaviour.

The success or failure of a particular system in a particular environment needs to be examined in the light of the physicians' belief concerning whether there are too many or too few physicians and their sense of security within the system. It also means that it is probably impossible to design a single system that will work optimally in both a rural and a metropolitan environment, let alone one that will work equitably across Canada.

**Ben R. Wilkinson, MB, MBA**
Nanaimo, BC

## Hep to hepatitis C

On behalf of the Hepatitis C Society of Canada, I would like to express our appreciation for the excellent articles "Hepatitis C" (*Can Med Assoc J* 1997;156:1427-8), "Viral hepatitis: know your D, E, F and Gs" (*Can Med Assoc J* 1997;156:1735-6) and "The Krever inquiry: time to drop the appeals" (*Can Med Assoc J* 1997;156:1401-2), by Dr. John Hoey.

We echo resoundingly your call for the Krever inquiry to continue unfettered by legal challenges from the Red Cross and its coappellants and for the Krever inquiry report to be released as soon as possible. We anxiously await the report's release and its recommendations to improve Canada's blood supply system. Justice Horace Krever alone knows what has to be done.

We would like to add some new information. As early as 1981 the Ontario Ministry of Health knew of the contamination of the nation's blood supply by hepatitis C virus and warned the Red Cross that it would publicize this information.

Furthermore, a historically and epidemiologically interesting argument can be made that the contamination of the nation's blood supply was largely preventable from 1973 onward, if surrogate liver-function tests on donor blood and imported blood products had been performed by the Red Cross. This appalling failure led to hepatitis C "spilling over" into the population at large through other forms of blood-to-blood contact.

Thank you for your encouraging realization of the significance of hepatitis C as a current and future health crisis facing all Canadians and all public health systems.

**Alan T.R. Powell, PhD**
Founding President
Board of Directors
Hepatitis C Society of Canada
Toronto, Ont.

## A look at 350 years of physicians' fees in Quebec

The earliest available records reveal that Estienne Bouchard, a master surgeon, came to Montreal (then Ville Marie) in 1653. He was to serve as physician to a military company for 5 years for 146 livres a year. In addition, he contracted with 42 families to provide treatment for an annual sum of 5 livres each. (Treatment of plague, smallpox, leprosy and epilepsy was not covered, nor was the provision of lithotomy.) He could take on 1 apprentice at a time for 150 livres per year. At the time, the annual salary of a young unskilled worker was 30 to 40 livres. Assuming that Bouchard had a trainee and earned an extra 120 livres a year from treating other individual patients, his annual income of around 500 livres would have been about 17 times that of the lowest salary of a young unskilled labourer.

About 70 years later, Michel Sarrazin of Quebec City, the first actual physician in New France, was earning 2000 livres per year. He also received an annuity of 400 livres that allowed his son to study medicine. At the time, the starting salary of unskilled labourers was 40 livres for local men and 50 livres for those engaged from France. Thus, his income of 2400 livres was 60 times that of a starting unskilled labourer.

In the 19th century many medical societies established recommended fee schedules to prevent physicians from undercutting each others' fees. In 1872 the one proposed by the Quebec College of Physicians and Surgeons listed $2 as the fee for a home visit within half a mile, with an additional 50 cents per mile. The fee was the same for an office visit, but rose to $4 between 9 pm and 8 am for home visits, and to $3 for office visits. Vaccinations, venesections, hypodermic injections and tooth extractions cost $1, and a first catheterization was $3. Health certificates were $5, routine deliveries $15. Fractures, dislocations and surgical procedures were relatively expensive; closed reduction of a thigh fracture cost $25 and of a dislocation $50, and a mastectomy was $50. At the time, a starting male labourer was lucky to make $5 a week. Thus, a visit from a physician would cost such a worker almost 2 days' wages. Counting only office or home visits, 10 visits a day during a 6-day week gave physicians an annual income 24 times that of a starting labourer.

Finally, consider the fees now paid to Quebec physicians, which are among the lowest in Canada. In my specialty (plastic and reconstructive surgery), consultations in the office earn $35, in the hospital $28. I receive $15 for routine office visits, $13.50 for hospital visits and $12 for hospital clinic visits. Principal examinations, allowed once a year, earn $30 in the office and $28 in the hospital.