

developing in any fireman or policeman is accepted as an industrial illness unless unequivocally proved otherwise. Consequently, this case was considered industrial in origin in a legal sense.

S. G., a 49 year old Russian mechanic, suffered a coronary occlusion on July 15, 1946. The attack occurred while he was driving his private automobile at the beach. He had not worked for three days prior to the onset of this occlusion. The clinical findings were typical of myocardial infarction due to coronary occlusion, which was followed by congestive heart failure. This case was subsequently determined to be industrial in origin, with medical costs of \$1,451.28 and compensation of \$1,410.00 for a total cost to the insurance company of \$2,861.28.

One must consider the difficulty in arriving at insurance rates under the conditions that prevail at the present time. The premiums must be revised upward at frequent intervals. I believe a great deal could be gained by having a board composed of medical persons appointed by the state medical association, insurance actuaries appointed by the insurance companies and legal persons appointed by the governor. This group could sit down and decide certain limiting factors of industrial illnesses. This board could decide broad policies along the lines of the above discussion. For example, they could decide that no coronary occlusion would be acceptable as an industrial illness and that only myocardial infarctions due to acute coronary insufficiency, without coronary occlusion, would be accepted as industrial. Of course, they could take the opposite attitude that all myocardial infarctions which occurred in workers on or off the job would be acceptable as industrial injuries. Regardless of what stand this board took, the insurance companies and the referees would have a definite, clearcut basis for their decisions. This would eliminate much of the long debate in each individual case. Thus the legal and medical expenses would be markedly reduced, and the patient would receive better medical care either privately or through insurance, because the long period of litigation and indecision would be eliminated. This same board could establish a standard fee of settlement which would take into consideration the underlying degenerative cause of the illness likely to exist in any age group. I believe a definite black and white arrangement for the acceptance or the nonacceptance of coronary occlusion, with a definite rate of compensation for all cases, regardless of severity, would work less hardship on the individual patient than does the present system.

SUMMARY

Certain aspects of the differential diagnosis of coronary occlusion, angina pectoris and acute coronary insufficiency have been discussed, with the extent to which these conditions relate to activity.

It has been pointed out that from the standpoint of industrial medicine the acceptance or the nonacceptance of the industrial origin of an injury or an illness is determined by the legal profession and public opinion as this is carried out by the administration at state and possibly national levels. The gradual inclusion of more and more clinical conditions as industrial injuries is well known to all of us and the example of myocardial infarction is used to illustrate the progress being made toward this end.

The suggestion is made that a medical board be set up to rate various diseases, particularly those of degenerative origin. Standardized compensation and settlements would be granted accordingly. In this way the patient would know exactly where he stood early in the course of his disease, which would facilitate the best treatment for the patient at the earliest possible date.