

Psychotherapy in Medical Education *

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One of the most prominent trends in modern medical education, post-graduate as well as undergraduate, has been the progressively increasing emphasis of the role played by social and psychological factors in the etiology of disease. A number of reasons have led to the development of this trend. In the first place, there has been an accumulation of a vast amount of experimental evidence that social and psychological stress situations can and do give rise to so-called organic disturbances, interfering with normal function and leading to the production of demonstrable tissue changes. There are very few of the organ systems that may not at one time or another show the effects of such changes, the ones most frequently affected being the gastrointestinal, cardio-vascular, respiratory, endocrine and autonomic nervous systems. We have come to refer to these as psychosomatic diseases; but whatever name we call them, it has become quite evident that a large number of symptoms referable to these systems and showing evidences of distinctly demonstrable changes have been shown to be due largely or wholly to the effects of emotional conflicts or social stress.

Secondly, it has been just as adequately demonstrated that diseases that develop on the basis of organic factors are very likely to affect the personality organization, causing disturbances of emotional and intellectual functions and of the general ability of the individual to adjust himself to his social setting. Finally, it has become increasingly more evident that specifically psychiatric disturbances, and particularly the neuroses, are much more likely to reach the office of the general practitioner than they are to come under the care of the psychiatrist.

All of the above considerations have made it important to include in the education of the physician an awareness of these possibilities and a realization that in the practice of medicine in general it is of the utmost importance to pay attention to the psychological organization and social adjustment of the individual, no matter what the symptom complex may be with which the patient presents himself. This is important, of course, primarily because the adequate functioning of a physician in his profession makes it essential for him to understand the various factors that combine in causing the disease processes. From a practical point of view, however, it is still more important for him to have at his disposal adequate measures with which he can treat these diseases

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once they have developed and, furthermore, to be able to prevent their occurrence on the basis of eliminating the possible etiologic factors. In other words, in the teaching of the physician, it is of primary importance to include systematic instruction in the methods whereby such disturbances can be treated or prevented. Granted, for instance, that there is general agreement that such conditions as hypertension, colitis, migraine or conversion symptoms can be partly or altogether produced by psychological or social stress, the question that the practical physician will posit will be: Do we have adequate measures of treating these successfully, and can these measures be learned and adequately applied by the general practitioner?

The answer to this question is obviously *psychotherapy*. But the word in itself does not mean very much unless it can be made possible to teach this type of medical treatment in a systematic fashion within the framework of present day medical education and presenting it in such a way that the physician can be satisfied that he is in the possession of a systematic and logical therapeutic tool. Unfortunately, one starts out here at a disadvantage. On the one hand, the old time concept of this method of treatment has been too intimately connected with the primitive functions of the magic and incantations of the medicine man; and even in succeeding generations, it has been closely associated with the unscientific and highly subjective practices of mesmerism and hypnosis. Somehow it has left a taste at best of something mystical and at worst of charlatanism, which frequently causes the practically-minded student to shy away from it. On the other hand, it is also true that the more recently developed systems of psychotherapy, such as, for instance psychoanalysis and allied methods, have for a long time been presented in such a complex and highly technical manner, and presuppose such intricate and prolonged training that the general practitioner, quite naturally, is unable to devote the time and the financial means that are required in order to develop adequate knowledge of the use of such methods.

Until recently, the general practitioner, therefore, has found himself faced with an apparently insoluble dilemma. During the course of his medical education, he has become thoroughly imbued with the idea that in order to practice medicine adequately he had to take cognizance of the fact that the social and psychological factors involved must be considered and dealt with; and yet, it appeared either undesirable or impossible for him to learn how to deal with these factors therapeutically in a successful manner. This situation has, however, undergone an important change within the last few years. The realization of the need of simpler and more objective methods has led to experiments in making psychotherapy more generally available. The variety of methods which have been developed recently have all added enough of factual material which could be used in building up a simpler and more easily applicable as well as reliable procedure. At the same time, it became quite apparent that in psychotherapy, just as in any other form of treatment, we must distinguish the highly complex but also more infrequently occurring personality disturbances from those which develop under less complicated conditions and, therefore, are more easily accessible. For the treatment of the former, which one might refer to as specifically psychiatric problems, highly technical methods

will always be needed, and these will have to be practiced by physicians who have acquired specialized training and experience in that field. For the milder types of conditions, which fortunately are the ones that we encounter most frequently, less complex therapeutic methods are available, which can and should be learned by anyone who engages in the practice of medicine. A variety of names has been applied to the latter type of psychotherapy, one of the most widely used being "brief psychotherapy," and it is this particular form that I would like to discuss in this presentation.

Generally speaking, we can describe this type of therapy in terms of (a) the *goals* that we set for ourselves, and (b) the *techniques* which can be utilized in order to achieve these goals. To avoid misunderstanding, it is well to preface a description of this method by stating that in the first place, they are not intended to be used as a substitute for the more highly technical ones that must be applied in the case of the severe neurotic or psychotic disturbances. They are, however, very useful in the everyday work of the general practitioner in dealing with psychologically produced or accentuated somatic diseases, the personality disturbances that are introduced in the course of other physical illnesses, and in some of the simpler forms of the neuroses which so frequently come under the care of the general practitioner. It must also be appreciated that in this presentation no claim is laid for an exhaustive textbook discussion of this method, and that in the actual course of instruction, more detailed theoretical exposition and practical experience would be necessary for the purpose of training the physician adequately in the application of this method.

In most medical schools today, courses are being offered on this subject, both to undergraduate students and in postgraduate refresher courses, and there are also a number of very adequate texts available for those who wish to avail themselves of the opportunity of adding to their knowledge of the subject. It is with this in mind, then, that I now wish to present both the goals of these methods and the techniques which can be utilized in achieving them.

THE GOALS OF BRIEF PSYCHOTHERAPY

(1) *Understanding of Relationships.* Starting out with the basic fact that emotional conflicts, traumatic psychological experiences and social stress situations play an important role in the development of certain illnesses manifesting either physical or psychological symptoms, we would first of all ask the question as to what is the nature of these causative factors, and what is their relationship to the illness with which we are dealing? The answer to this question will provide us with the fundamental material for the treatment, and therefore the understanding of these relationships becomes our first goal. This is, of course, true in the practice of any form of therapy; but there are certain features which are specifically more important in this procedure and should, therefore, be more firmly emphasized. We will, for instance, have to have definite information concerning the social setting, the family situation and the personal attitudes and experiences of the patient at the time when the symptoms first appeared. Can any definite relationship be shown to have existed either in time or in content between the problems in these areas and the

development of the first signs of the illness? Was the patient faced by some special stress situation? Did the course of the illness in its remissions and exacerbations bear any logical relationship to the rise and fall in the severity of these personal difficulties? Were the symptoms in any way useful in bypassing these psychological problems, or the necessity of dealing with them? In other words, has the sickness, even though it has incapacitated the patient, at the same time also furnished the means of evading some important issues?

We then proceed systematically to the study of the background preceding the onset of the present illness. We must consider whether there were any experiences in the patient's life which have made him more susceptible to the type of stress situations which he had to face at the time of the onset of the illness. At the same time, it is also important to discover whether anything has occurred in the life of the patient which has conditioned him to react to such stress situations with the particular type of symptom that he demonstrates now. Have, for instance, patterns of this type been established in the family or in the wider circle of the patient's social environment? Were there frequent occurrences of such disturbances in the family setup, and have they developed under conditions which are relevant to the problems under which the patient is laboring now? This means that a thorough knowledge of the family constellation and of the early environmental setting is essential to determine the presence of possible constitutional predispositions, or the establishment of precedents of certain patterns of reaction.

It is important to bear in mind that in treatment of this type, the very search for relationship in itself forms part of the therapeutic process. In the first place, the patient, as he recounts these experiences, begins to understand the reasons for the development of the symptoms and thus can begin to approach a more acceptable form of solution for these problems. This means, therefore, that not only the physician but also the patient must be encouraged to develop a clear understanding of these relationships. Secondly, as the process of the discussion of the life situation of the patient progresses, the patient cannot help but develop a strong emotional relationship with the physician. The latter becomes a friend, sympathetic listener, a person interested in the life and experiences of the patient.

(2) *Physician-Patient Relationship.* This, then, introduces the second goal towards which we are aiming, namely, the establishment of an adequate relationship between the physician and his patient, and the assurance of emotional participation by the patient during the treatment. It is important to keep this goal in mind, because frequently some of the problems involved may be near the surface and so clearly visualized by the physician that he may be inclined to seek shortcuts by explaining to the patient the meaning of these symptoms. Experience teaches us, however, that unless the patient brings forth these experiences himself and gains emotional insight by actually reliving them, the results are either not obtained at all, or remain on a verbal level without any lasting effect. As the treatment progresses, and the patient develops the proper feeling of confidence in the physician, it becomes possible for him to identify the physician with these persons who played the important

role in his early life, but who also have conditioned him to react pathologically to the settings in which he was at that time. By virtue of the fact that the physician remains sympathetically understanding but at the same time also objective, it is possible for the patient to break up these patterns and learn how to meet life situations on their face value rather than superimposing upon them early traumatic experiences. This renders the process of treatment perhaps more time-consuming, but the results are also more effective.

(3) *Removal of Some of the Causative Factors.* The understanding of relationships in the presence of a proper physician-patient relationship will lead the patient to visualize his problems more clearly and enable the physician and the patient to plan a way of dealing with them without having to take recourse to symptoms. At the same time, it is also quite clear that some of the actually existing social and psychological factors may in themselves be largely responsible for the illness. The presence, for instance, of incompatible family relationships or the threat of loss of economic security may in themselves tend to perpetuate the utilization of symptoms as an escape mechanism, even though the relationship between stress and symptom is understood. This makes it important, therefore, for the physician to try inasmuch as possible to lessen the actually existing irritating factors in the reality situation. We must of course here also keep in mind the question of complications arising out of a set of symptoms which have existed for a long period of time. The patient with a gastro-intestinal disturbance, for instance, even if it has been originally closely dependent upon emotional conflicts, may have in the course of time developed both physical and psychological sequelae which must be dealt with at their face value. Lowered resistance produced by irregular diet, and other disturbances of bodily functions that have followed the existence of symptoms over a long period of time, must all be dealt with on a symptomatic basis at the same time as the physician is attempting to remove the cause of the original disease. It is well to mention here that the physician must make use not only of the complete armamentarium of medical therapy which he has at his disposal, but also of any assistance that he can get from outside sources. The family and social agencies may be very helpful in reducing undesirable and frustrating social and economic settings. The minister, the lawyer, the school teacher, or the employer may all be utilized in a highly successful manner in rendering the setting as easily adjustable as is possible under the circumstances. It is well to remember that we cannot treat a sick person in a vacuum, but within the setting of the community in which he lives.

(4) *Emancipation.* Treatment of this type, as was stated above, involves a special relationship that must be established between the physician and the patient. As the patient is encouraged to discuss some of his innermost problems and bring up early childhood experiences, he cannot help but develop a great deal of dependency upon the physician himself and the therapeutic situation. It is a well known fact that under such conditions the patient may become so dependent upon the physician that in the course of time, even though he may have succeeded in getting rid of his symptoms, he may not be able to emancipate himself from the physician in order to lead an independent existence. This may turn into one of the most trying developments in the course

of such treatment if the physician, from the very beginning of the treatment, does not have in his program as one of the important goals the eventual emancipation of the patient. It is important, therefore, for the physician, from the outset, to prepare the ground gradually for the patient to be able to break away from that dependence and adjust himself on his own resources.

These, then, are the goals of such psychotherapy. It is obvious that the degree of achievement of these goals will vary. Perhaps under no circumstances, even with the most complex methods of therapy are these goals attained to perfection. Sometimes we have to be satisfied with part goals, and in the course of psychotherapy, just as in any other process of treatment, we must remember that even the most desirable results may still leave the patient with some degree of defect, just as no operations can be performed without leaving some scar.

For the purpose of achieving these goals, we have available a certain set of techniques, and these are as follows:

PSYCHOTHERAPEUTIC TECHNIQUES

(1) *Exploration.* By this we mean techniques whereby the material is obtained both from the patient and those about him. So far as the physician is concerned, his most important source for such material is the patient himself, and this is done on the basis of appropriate *interview* technique. From what was said above, it must be clear that the manner in which the material is obtained from the patient is important not only for the purpose of getting information, but also for the attainment of the other goals. It is while the patient and the physician discuss the patient's problems that emotional contact is established, that the plans for removing causes are made, and the first steps towards eventual emancipation are being taken. Interviewing technique, therefore, becomes one of the most important practical measures in psychotherapy, and it should be strongly emphasized in the teaching of students or physicians. It is impossible here to give even a brief sketch of the technique of interview, but we might emphasize a few important features. The most obvious of these is the fact that the material obtained in the interview must come from the patient and not from the physician's conjecture. This means that the patient should be allowed to express himself without unnecessary interruption, and direct questions should be reduced to a minimum. Suggestions should be avoided, and interpretations made only very rarely. This may take more time and may place more stress on the physician's patience, but in the end it will pay dividends. It is true that the physician must have a certain amount of necessary information which he can only get by direct questioning. He must have a clear view of the onset of the illness, the attending circumstances, and the exact chronology. This is best obtained at the beginning of the treatment; and even in the early interviews, he should allow the patient to set the pace inasmuch as possible. The physician must be on the lookout for the cropping up of relevant relationships and should make mental notes concerning these points. Taking notes while the patient is talking may be considered by some as good practice, but it certainly has its

disadvantages, because it renders the interview somewhat artificial and legalistic. At the same time, it also reduces the possibility of a proper emotional setting.

Quite frequently the experiences which have led to the development of the symptoms may be partly or wholly repressed by the patient, and certain techniques will have to be utilized to help the patient get at the hidden material. This is not an easy thing to do in the course of brief psychotherapy, but some of the techniques utilized by the more complex methods can also be used here. One can take advantage of slips of the tongue or accidental acts, memory lapses in regard to important events which should be remembered clearly, repeated cropping up of some experience or special persons throughout the interview, fretting at the interview being too prolonged while the patient has been talking about some special problem, failure of the patient to come to the interview on time, following a previous discussion of what may appear an unimportant event and similar hints can be utilized as indications of the material that the patient tends to repress. Dream material is of great value in pointing at such underlying factors. Although deep analysis of dreams may present some difficulties to the uninitiated, nevertheless, some of the dreams may point so clearly and obviously to a repressed conflict that even the patient sometimes after he has related the dream will offer a more or less suitable interpretation of it. Under certain conditions and with some degree of experience, chemical agents may be used to facilitate the bringing up of repressed material. Sodium-amytal in appropriate doses renders the recounting of unpleasant or painful experiences more easy and, at the same time, has the added advantage of improving the emotional contact with patients who tend to withdraw from such a relationship.

(2) *Emotional Participation.* This leads up then to the consideration of the technique that may be employed to secure emotional participation. The most important item to consider here is that of the development of a setting in which the patient has the greatest possible confidence in the physician. This requires a good deal of self-discipline and control on the part of the physician. He must follow strict rules of honesty as far as the patient is concerned. He should not reveal confidences that the patient has expressed, other than by permission of the patient himself. In order to feel free to bring up personal material, the patient must have complete assurance that it will remain between him and the physician. The physician must also be sympathetic, by which is not meant that he must "spoil" the patient or express pity for him, but he must be earnest and sincere in dealing with the problems that the patient brings up. He must also refrain from either ridiculing the patient or sermonizing to him. At the same time, however, he must be objective in urging the patient to work hard in an effort to understand how his problems have developed and what issues he must meet if he is to act like a grown-up person. This will be of great help in the subsequent process of emancipating the patient from his dependence upon the physician. It is not advisable for the physician to inject himself as a person in to the therapeutic procedure and, therefore, he should not present his own problems to the patient or set himself up as a paragon of good adjustment. One has to be very careful

in dealing with questions that the patient may continuously bring up. If it is a matter of making decisions and the patient seeks advice, it is best to lead the patient along kindly but firmly to seek his own solutions, helping him with the understanding of relationships, but not with actually making a decision. Counseling is indicated only in situations where technical knowledge is required, but where the personal interests of the patient are concerned, he should be urged to take stock of relationships within the situation and come to a conclusion that is most suited to his own way of living. Throughout the treatment, the patient should be taught to apply what he has learned to everyday problems. At the same time, it is advisable to secure the help of others in the patient's setting, to help the patient make that setting more tolerable to him. This brings us to the next technique in the therapeutic procedure:

(3) *Utilization of Outside Resources.* We have already stated above that the patient cannot be successfully treated in a vacuum. The physician must make himself thoroughly cognizant of the variety of conditions that exist in the patient's life and may have a bearing upon his problem. Frequently, it is impossible for the physician himself to achieve this without outside help. Recent developments in medical education have stressed the need for utilizing inasmuch as possible social workers and agencies, relatives, neighbours, friends, spiritual advisors, etc. The patient lives in close relationship to his community setting, and his ultimate adjustment will have to be to that setting. Anything that can be done by the physician, or those who are willing to help him, to facilitate that, will go a long way in rendering the therapeutic procedure successful. It is also important to remember that while the physician is working with the patient, the emotional relationship that is established is a two-way proposition, and eventually the physician, to a large extent, sees the patient's world through the patient's eyes. It is true that information obtained from the outside may not be altogether unprejudiced, and in some instances it may even introduce distortions, but at least one gets a broader view of it. At the same time, helping the patient to appreciate the other people's point of view will materially help in the process of emotional maturation, which the patient should achieve if he is to reach the stage of independent adjustment.

(4) This then brings us to the consideration of the methods that can be used in attaining the last of the goals described above, namely that of *emancipation*. To a large extent this was anticipated in our previous discussion. As we proceed with the treatment and encourage the patient to make his own decisions, to face his problems frankly, to answer his own questions and to adjust himself to the persons with whom he deals in his everyday life, we actually help him to grow up. An important factor in this process is to act judiciously in determining the time and manner of concluding the treatment. It is not advisable to break it off abruptly. If the patient is being seen twice or three times a week, for instance, the termination must proceed by a gradual cutting down of the frequency of the visits. At times the patient himself may urge the physician to stop the treatment abruptly, but if it is felt that the patient is not ready for such a step, he should be strongly advised against it. In most cases, however,

we find that the patient has difficulty in facing the responsibilities of independent adjustment and he will try in one way or another to induce the physician to continue to see him more frequently. Under such conditions, the physician must assume a more positive role in urging the patient to take on more responsibilities, reassure him of his ability to do so, and help him to recognize the evidence of his improvement. If in the process of therapy the physician has availed himself of the assistance of some outside persons such as relatives, social workers or others in the community, it is well at this time to attempt to substitute closer contacts with these persons in place of the interviews with the physician. In this way, the close personal relationship that the patient has developed towards his physician can be transferred to those persons who play an important role in the setting in which he lives and thus render the patient capable of adjusting himself to that setting.

BIBLIOGRAPHY:

- WITMER, H. L., Editor: Teaching Psychotherapeutic Medicine. New York, Commonwealth Fund, 1947.
- LEVINE, MAURICE: Psychotherapy in Medical Practice. New York, The MacMillan Company, 1942.
- MALAMUD, WILLIAM: Brief Psychotherapy in Medical Practice. The Medical Clinics of North America, Philadelphia, W. B. Saunders, September, 1948.
- MALAMUD, WILLIAM and RUSSELL, D. H.: Psychotherapy in the Medical Care of Children. The Medical Clinics of North America, Philadelphia, W. B. Saunders, September, 1951.
- MALAMUD, WILLIAM; BANDLER, BERNARD; RUSSELL, D. H. and VAUGHAN, W. T.: Teaching of Brief Psychotherapy in a Medical School. Diseases of the Nervous System, Vol. IX, No. 4, April, 1948.

Infectious Hepatitis With Atypical Laboratory Findings

WITH A REPORT OF A CASE

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CONSISTENTLY negative flocculation tests for liver function are unusual in infectious hepatitis. In the case to be reported this factor contributed to an already difficult diagnostic problem.

Infectious Hepatitis is caused by a virus very similar to that causing serum hepatitis. The two diseases are clinically similar, the only noteworthy differences being in the different modes of transmission and incubation periods. Serum hepatitis is transmitted by injection only. Infectious hepatitis can be transmitted by injection but is usually transmitted by the fecal-oral route or by direct contact. (1).

The clinical course of infectious hepatitis has been adequately described by many investigators (2) (3) (4) and need merely be summarized here.

The clinical onset of the disease is typically acute and febrile, described as "influenza-like picture" (5). This initial period is typically brief, lasting but a few days and is followed by a short latent and asymptomatic period. Usually epigastric distress, pain, nausea, vomiting, fever and the appearance of jaundice ensue. The jaundice typically increases for a period of two to ten days and then abates. While this describes in brief the main feature of the typical clinical picture, it should be realized that Infectious hepatitis is capable of the utmost variation. It seems apparent that numerous subclinical anicteric infections occur which are passed over as merely mild attacks of gastro-enteritis. Rarely, the infection may be fulminating with rapid and complete destruction of the liver ("Hepatic Coma") and death.

Physical findings are sparse. There is often a slight general lymphadenopathy, particularly of the cervical glands, enlargement and tenderness of the liver, jaundice and, less commonly, splenomegaly.

The pathological picture is essentially one of generalized degeneration with inflammation of the parenchymal cells of the liver in varying degrees. The supporting elements are typically maintained. With recovery there is usually a return to histological normality. The disease has been implicated as a precursor of cirrhosis. In those cases where extensive liver damage occur there is considerable evidence that cirrhosis ensues in a percentage of cases.

Laboratory Diagnosis:

The value of the laboratory in establishing or confirming the diagnosis of jaundice is definitely established. The differential diagnosis of haemolytic or familial non-haemolytic jaundice from so called parenchymatous or "re-

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gurgitation" variety, and from obstructive jaundice is also easily attained by laboratory methods. Unfortunately, however, the more common problem of differentiating between "intra-hepatic" jaundice of infectious hepatitis (regurgitation or parenchymatous jaundice) and extra-hepatic jaundice (obstructive jaundice) cannot always be handled by the laboratory with the same ease, as exemplified by the present report.

A large number of laboratory procedures are available for the purpose of differentiating "surgical" and "medical jaundice" and, as commonly is found in such instances, no single one or all combined are invariably reliable, especially when one is confronted with an established case. Generally speaking, the most reliable battery of tests is composed of the cephalin cholesterol flocculation procedure, thymol turbidity evaluation, alkaline phosphatase determinations, total serum cholesterol and cholesterol-ester determinations.

In the typical case of infectious hepatitis (regurgitation jaundice) the flocculation and turbidity values are elevated and the cholesterol-esters are lowered, indicating parenchymatous damage; while the alkaline phosphatase and total cholesterol remain significantly unaltered. In jaundice due to extra-hepatic obstruction, the flocculation tests and cholesterol-esters remain unaltered while the values for alkaline phosphatase and total cholesterol are significantly evaluated. The proper interpretation of the pattern of results obtained, however, requires a knowledge of certain conditions pertaining to the behaviour of these estimations in jaundice, without which erroneous conclusions may be drawn.

The value of thymol turbidity reaction and the cephalin cholesterol flocculation tests in the diagnosis of infectious hepatitis has not been seriously questioned. The values in these tests are generally very definitely raised in established cases of infectious hepatitis (17). Neefe, et al: (12), however, have reported in an excellent paper on these two tests an epidemic of hepatitis in which 15.7% of the 108 cases had negative responses to both the thymol turbidity and cephalin cholesterol estimations throughout the course of the disease. The fallibility of these tests in a proportion of cases must be acknowledged, although the two tests used in conjunction would appear to be the most valuable laboratory means at our disposal for the diagnosis of this disease.

The behaviour of serum cholesterol in cases of infectious hepatitis is much more liable to inconstancy. In the first instance the normal level of the serum cholesterol of the particular patient is usually not available. Although the normal range of 150-250 mgs.% is usually given for the Bloor procedure, these figures do not include the occasional normal person with a serum cholesterol of as high as 320 mgs.% (6). The fact that the level of the total cholesterol is usually unaltered in infectious hepatitis is therefore not as useful for the clinician, unless his patient happens to have a low normal serum cholesterol value. In such a case the determination is of value in ruling out extra-hepatic obstruction. It is also noteworthy that rarely the serum cholesterol may be raised in undoubted cases of infectious hepatitis (7).

Perhaps a more valuable determination is the estimation of the proportion of total cholesterol to cholesterol esters which unfortunately was only performed once in the case to be described. In infectious hepatitis the amount

of estrified cholesterol decreases and since the total cholesterol remains at a normal level, the proportion of free cholesterol rises. This change is particularly prominent in the first two weeks of the disease and tends to become less prominent thereafter (13).

It is unfortunate that a general impression is current in many quarters that the alkaline phosphatase is not raised in infectious hepatitis. The serum alkaline phosphatase is usually increased in infectious hepatitis (8) (9) (10) (17). The point that should be understood is that the rise is less in infectious hepatitis than in extra-hepatic biliary obstruction. Gutman (11) using the Bodansky method, studied 69 patients with "Catarrhal Jaundice" and found 88% with alkaline phosphatase levels above normal. However, only 19% of the values were higher than 9.1 units. On the other hand, in extra-hepatic obstruction he found 92% of the values for alkaline phosphatase above 9.1 units. The work of Gardner, et al (13) has substantiated these findings. Popper & Schaffner (17) on the basis of their observations have adopted a base level of 15 Bodansky units for this purpose. The estimation of alkaline phosphatase, therefore, is of considerable value in the differential diagnosis of jaundice due to infectious hepatitis or extra-hepatic obstruction when a figure in the vicinity of 10-15 units is used as a base line.

An elevated prothrombin time associated with its resistance to correction by the administration of Vitamin K is of course, a well recognized test of liver function. Generally speaking, this test has not been given the prominence that has been awarded to the flocculation tests in the differential diagnosis of jaundice. It would appear in this particular recorded case that the results of this procedure should have received more weight.

An additional estimation that has considerable diagnostic value in the problem is the determination of serum proteins. In hepatitis the serum albumin is usually decreased while the serum globulin is increased, resulting in a reversal of the albumin globulin ratio. This change is, however, not specific for the condition under discussion, although it constitutes contributory evidence.

Other liver function tests such as the Van Den Berg estimation, and bromsulphalein tests, etc., contribute very little to the solution of the differential diagnostic problem. Much the same can be said for the estimation of urinary urobilinogen, although it might be added that the urinary urobilinogen is usually increased in diffuse hepatic disease particularly in its early stages. Of course, the problem is resolved when a total absence of bile in the stools is discovered, but in total extra-hepatic biliary obstruction the clinical picture is such that the differential diagnosis is not usually difficult.

It is therefore apparent that, in the absence of needle biopsy of the liver, the laboratory can only supply ancillary information in the differential diagnosis of an established case of jaundice possibly due to infectious hepatitis or partial extra-hepatic biliary obstruction, and the final decision must, as in most conditions, depend largely on the clinical acumen of the attending physician.

Case History:

The patient, a fifty-five year old male, was admitted to hospital on February 24th., 1953. He had been, in the months prior to admission, a frequent visitor in areas in which infectious hepatitis was endemic. There was no previous history of infection or of serum injection. On admission there was a history of general malaise of several weeks' duration with fatigue and moderate anorexia. The stools had been loose, occurring three to four times a day for one week. He described his subjective sensations as those of "flu" and had in the two days prior to admission noted gray stools and dark urine. Yellowness of the skin was noted by a friend on the day prior to admission. Other symptoms included a sensation of dryness in the mouth for several days with occasional dry cough. In his work the patient used a microscope and had noted some cloudiness of vision in this respect for one week. Complete functional enquiry was otherwise negative and in particular there was no previous history of gastro-intestinal or gall bladder disease, jaundice, or any chronic digestive disturbance.

On physical examination the skin and sclera were definitely jaundiced, the tongue coated and wrinkled transversely. Palpable lymph nodes were not noted.

Examination of the chest, apart from the finding of occasional expiratory rhonchi, was entirely negative. The pulse rate was 80, the blood pressure 140/80. The heart sounds were regular and rather distant. The abdomen was entirely negative to examination and in particular the liver and spleen were not palpable. An accentuation of the capillary network about the cheeks was noted and there was marked reddening of the thenar and hypothenar areas of the hands.

From the day of admission until March 9th. jaundice deepened rapidly and became most profound. During this period the patient's only complaints were a looseness of the stools and occasional very slight flatulence. Anorexia was moderate. However, on March 3rd. the liver became palpable, and progressively enlarged over the next few days to five cm's below the right costal margin. It was rather soft in texture and moderately tender. On March 8th. the spleen was felt. The jaundice reached its peak on March 9th. and thereafter abated rapidly. The stools, which had been gray from the time of admission, returned to their normal colour on March 9th. The liver, however, remained palpable. Fever was not noted at any time during the illness.

Roentgenological examination of the stomach and duodenum and of the chest were normal during the illness. Normal gall bladder visualization was noted on June 27th. It was not done during the period of acute illness because of the certainty of non-visualization. Liver biopsy was not performed because of the risk involved in our inexperienced hands.

Laboratory Findings:

The laboratory findings as noted on Table 1 formed an unusual pattern in many respects. The serum bilirubin varied, as might be anticipated, showing a gradual rise to a maximum value of a total bilirubin of 27 mg.% and then gradually decreasing until normal values were reached during convalescence. The thymol turbidity test value remained, during the disease, slightly above

the high limit of normal (4 units) but did not show any definite constant increase in value as might be anticipated. The cephalin cholesterol flocculation test (normal neg. to 1 plus) acted in a similar manner. The alkaline phosphatase estimation (normal 0-4 units) quite frequently showed values slightly above the upper limits of normal; however, it is significant that at no time did the value obtained exceed 9 units. The total cholesterol showed unusually high values during the period of most intense jaundice; it decreased slightly but remained around the high limits of normal during the entire course of the disease. The prothrombin time initially was normal but was abruptly elevated during the period of most intense jaundice. During this period the elevation proved refractory to the administration of Vitamin K. After being elevated for approximately one week it abruptly returned to normal and remained at that level during the remainder of the patient's illness.

The urine bilirubin followed the serum bilirubin closely; however, the urine urobilinogen though slightly elevated during the entire course of the disease became markedly elevated for a short period shortly after the urine and serum bilirubin values dropped. Stool urobilinogen was decreased during the initial stages of the disease but anticipated the drop in urine and serum bilirubin values by appearing in normal quantities.

Occult blood was initially absent from the stool but appeared during the period of most intense jaundice and was present in specimens taken for approximately one week. Thereafter it disappeared to remain absent during the remainder of the patient's illness.

During the whole period of illness the patient remained remarkably well and at no time was there any acute discomfort. It was decided that the clinical impression of infectious hepatitis, based particularly on the rather typical history and physical findings, should be accepted and that the laboratory results, since they did not form a definite pattern, should not form the basis of justification for surgical exploration.

Discussion:

The problem, from a clinical point of view, was one of differential diagnosis between parenchymal liver disease (infectious hepatitis) and extra-hepatic biliary obstruction. While the history and the clinical picture pointed toward a diagnosis of infectious hepatitis, the indefinite function tests were disturbing. In addition, the age of the patient, the severity of the jaundice and the occult blood in the stool all suggested the possibility of stone or malignancy.

Popper (17) suggests that in viral hepatitis the most prominent feature is liver cell degeneration with its accompanying functional derangements indicated by elevated flocculation values (i.e., cephalin cholesterol and thymol turbidity) and a lowered cholesterol ester ratio. The same author however, indicates that cholestatic features are present in every case and that in the rare case the cholestatic features (interference with the bile flow after its formation), may predominate. Cholestasis whether intra-hepatic or extra-hepatic, results in the elevation of the serum cholesterol and alkaline phosphatase values. It is interesting to note that the same process, cholestasis, due to regurgitation

of biliary substances, is said to inhibit flocculation as it occurs in the thymol turbidity and cephalin cholesterol tests (18).

It would appear, then, that the case described was the unusual one where the cholestatic features of the disease predominated and that this feature would explain the action of the flocculation tests, the serum cholesterol and cholesterol esters.

The increased levels of serum bilirubin, occurring with a decrease in stool urobilinogen and a moderate increase in urine urobilinogen, suggested that whatever small amount of bilirubin was reaching the gastro-intestinal tract and being converted to urobilinogen was being excreted by the liver with difficulty. This feeling was reinforced by the appearance of a marked rise in urine urobilinogen during the period of rapid subsidence of jaundice and at a point when the stool urobilinogen was normal. It appeared to us that, while bilirubin was being excreted in the intestinal tract in increasing amounts, there was again a lag in the excretion by the liver of the increased amounts of urobilinogen formed in the intestine.

The presence of occult blood in the stool led us to consider very seriously the possibility of malignancy and in particular the possibility of carcinoma of the head of the pancreas or of the Ampulla of Vater. No explanation for this finding has been forthcoming although it is interesting to speculate as to whether it might not in some way have been connected with the elevated prothrombin time. The return of the stool to normal in this respect, the negative radiological investigation and the clinical recovery continuing for one year after the attack, we feel, satisfactorily rules out the possibility of carcinoma.

Summary:

The case is presented as one of infectious hepatitis with profound jaundice and hepatomegaly but without any significant alteration in the more common flocculation tests of liver function. In this particular case the value of the prothrombin time estimation coupled with the administration of Vitamin K as a test of liver function is demonstrated, as this test suggested liver impairment when the flocculation tests were consistently negative.

It is suggested that the unusual nature of the findings could be explained by the assumption that the cholestatic (intra-hepatic obstructive) features of viral hepatitis predominated and obscured the laboratory findings resulting from the diffuse liver cell degeneration.

The necessity of adopting a base value in the vicinity of 10 rather than the normal value for the alkaline phosphatase determination as a basis of appraisal in the differential diagnosis of established jaundice is demonstrated. The factors contributing to the unreliability of the estimation of total cholesterol as a diagnostic aid in such cases are pointed out.

The case is presented as an example of the infinite variety which this particular infection may exhibit and as a demonstration of the great difficulty which is often encountered in the differential diagnosis of established jaundice, particularly as between parenchymal liver disease and extra-hepatic obstructive jaundice.

TABLE I
LABORATORY FINDINGS*

| | Bilirubin Direct | Total | Thymol Turb. | Alk. Phos. | Ceph. Flocc. | Proth. Time | Cholesterol | Urine Urob. | Urine Bilir. | Stool Urob. | Stool Blood |
|---------|--|-------|-----------------|---------------|-----------------|----------------|-------------|----------------|-----------------|----------------|----------------|
| Feb. 25 | 6.8 | 9.2 | 5.0 | 7.35 | | | | 1/10 | | Deer. | |
| Feb. 26 | | | | | + | 100% | 310 | | | | Neg. |
| Feb. 27 | 8.8 | 11.1 | 7.4 | 7.4 | ++ | | 314 | 1/20 | | Deer. | |
| Mar. 2 | 13.8 | 17.9 | 5.0 | 9.0 | | | 216 | 1/20 | | | |
| Mar. 3 | 15.6 | 22.7 | 5.0 | 7.2 | + | | 248 | 1/20 | ++++ | Deer. | Ps.? |
| Mar. 4 | | | | | + | | | 1/10 | | Deer. | |
| Mar. 5 | 18.1 | 24.1 | 5.0 | 7.8 | + | 100% | 220 | 1/20 | ++++ | | Pos. |
| Mar. 6 | 21.6 | 26.4 | 5.2 | 8.0 | | 69% | 232 | | | Deer. | Pos. |
| Mar. 7 | 21.8 | 27.2 | | | | 69% | | | | | |
| Mar. 8 | 20.0 | 26.0 | 5.2 | 7.4 | + | 69% | 260 | 1/20 | | Deer. | |
| Mar. 9 | 21.6 | 26.2 | 5.0 | 5.7 | | 69% | | 1/20 | ++++ | Pres. | Pos.? |
| Mar. 11 | 18.0 | 24.8 | 5.0 | 3.6 | + | 69% | 280 | 1/20 | ++++ | | Pos.? |
| Mar. 13 | 17.0 | 21.0 | 5.0 | 7.0 | + | 100% | 260 | 1/20 | +++ | Pres. | Pos. |
| Mar. 16 | 9.0 | 14.2 | 7.0 | 6.1 | + | 100% | 290 | | +++ | | |
| Mar. 18 | | | | | | | | 1/160 | + | | Neg. |
| Mar. 22 | 6.3 | 9.1 | 7.0 | 5.4 | + | 100% | 270 | | | | Neg. |
| Mar. 23 | 5.0 | 7.0 | 3.0 | 4.7 | + | 100% | 260 | 1/40 | + | Pres. | |
| Mar. 26 | 3.6 | 5.7 | 4.8 | 4.6 | + | 100% | 280 | 1/20 | + | | Neg. |
| Apr. 4 | 2.7 | 3.9 | 4.5 | 3.2 | Neg. | | | 1/20 | Neg. | | Neg. |
| June 27 | 0.4 | 1.05 | | | Neg. | | | | | | |
| Apr. 4 | Bromosulphalein 35% of dye retained at 15 minutes—11.2% at 45 minutes. | | | | | | | | | | |

A lack of response to Vitamin K injection was noted on March 7th. and on April 4th.

Additional tests with results within normal limits included serial complete urinalysis, serial complete blood counts (including sedimentation rates) blood kahn, serum protein (with A/G ratio) serum amylase, fasting blood sugar.

***METHODS:**—Bilirubin-Malloy & Evelyn (Direct 1 hr. bilirubin). Thymol Turbidity-McLagen Buffer Ph. 7.8.

Alkaline Phosphatase-Bodansky. Cephalin Cholesterol Flocculation-Hanger (Normal for this laboratory neg.—one plus.)

Prothrombin Time—Quick: one stage (100% 12 seconds) Cholesterol-Bloor, Peleken & Allen.

Occult Blood (Gregerson Benzidine Barium Peroxide Smear) Urinary bilirubin. Barium Strip (Modification of Harrisons Test).

REFERENCES

- 1.—W. H. D. Techn. Rep. Ser. 62 (1953).
- 2.—Barker, M. H., Caps. R. B. and Allen, F. W.: J.A.M.A. 128:997 (1945).
- 3.—Linsey, A. A. Proc. Royal Soc. Med. 37:165 (1944).
- 4.—Swift, W. E., Gardner, H. T., Moor, D. J., Streitfield, F. H. Havens, J. R.: Am. Journ. of Med. 8:614 (1950).
- 5.—Sborov, V. M. and Keller, T. C., "Gastroenterology" 19, (1951).
- 6.—Peters, J. P.: VanSlyke, D. D. "Quantitative Clinical Chemistry", Vol. 1, Page 496. The Williams & Wilkins' Co.
- 7.—Neufeld, A. H. Can. Med. Assoc. Journ. 68:384 (1953).
- 8.—Roberts, W. M. Brit. Med. Journ. 1:734 (1938).
- 9.—Canterow, A.: Nelson, J. Arch. Int. Med. 59:1045 (1939).
- 10.—Hoagland, C. L. and Shank, R. E., J.A.M.A. 130:615 (1946).
- 11.—Gutman, A. B., Olson, K. B., Gutman, E. B., Flood, C. A. Journ. Clin. Investigation. 19:129:(1940).
- 12.—Neefe, J. R., Gabescia, J. M., Gardney, H. T. and Knowlton, M. Am. J. of Med. 8:600 (1950).
- 13.—Gardner, H. T., Swift, W. E., Modica, M. & Levintow, L. Am. J. of Med. 8:584: (1950).
- 14.—Harrison, R. R., "Principles of Internal Medicine." The Blakeston, Co. (1951).
- 15.—Readinger, H. M., Swift, W. E.: Gardner, H. T., and Sheedy, J. A. Am. J. of Med. 8:611 (1950).
- 16.—MacIntosh, O. C., Can. Journ. of Med. Technol. 10:13 (1948).
- 17.—Popper, H., Schaffner, F. Jour. Am. Med. Assoc.: 150:1367 (1952).
- 18.—Popper, H. de la Huerga, J. S. Tergman F. & Slodki, M. Jour. Lab. and Clin. Med. 35:391 (1950).

The Place of Occupational Therapy in the Rehabilitation Program*

Margaret E. H. Markham**

OCCUPATIONAL Therapy, born as a profession out of World War I, has now reached early adulthood through World War II and is on the advance to maturity in the field of rehabilitation. In fact, it is the only profession completely confined to it. To get a clear picture of its war effort and its contribution to rehabilitation and the problems of peace is like trying to stop a movie film at any point saying, "There—that is the story." Developments are so rapid, and all on such a wide scale, that records can scarcely be made before succeeding events and methods outmode them.

During World War II occupational therapy fought on two fronts—the military, and the civilian. It was its work on the latter front—that of keeping workers on the production line—which ushered it into peace-time rehabilitation.

During the war, it was important to get every man or woman out of the hospital—orthopaedic, general, mental or sanatorium—back on the job. Every person who returned with greater function, every handicapped person who acquired new work habits and skills, aimed at restoring him to society as a contribution to the production effort, was an asset. So again, war has shaped the course of occupational therapy reminding man whether in war or peace, "Thou art thy brother's keeper."

The war man-power shortage gave the opportunity to prove that the worker who is handicapped, whether through disease or injury, can do as good or often a better job than his normal brother. It is necessary now to go further and give every man access to abundant and effective living because of reverence for life and not for war.

There is a story which well illustrates what Rehabilitation in peace-time expects from Occupational Therapy. It is told by Dr. Cranfield in his article. (1) "What Physical Medicine Expects From Occupational Therapy." Great expectations from both!

"Once upon a time, a traveller, who was also a philosopher, as he moved towards the outskirts of a mediaeval city, chanced upon a group of men. Along with them were piles of granite, stacks of oaken logs and here and there was the glow of a blacksmith's forge.

The ancient traveller engaged in separate conversation several of the workmen. The reply to his enquiry as to what they were doing came variously from the carpenter, "I am smoothing this timber," from the smith, "I am sharpening tools", from the mason, "I am squaring this block of granite." So our friend approached a deep ditch from which came the sound of a young

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man's voice uplifted in song. He peered over the edge and just avoided being struck by a shovelful of earth. He addressed the singer: "And what are you doing?" This young man stopped, leaned on his shovel and turned up his smiling countenance to reply, "I am building a cathedral."

Physical medicine and rehabilitation expect Occupational Therapists to be cathedral builders. Now Dr. Cranfield says, "You cannot build cathedrals without perspective. This means feet on the ground and the sky in your eyes. "To keep our feet on the ground" is a common expression implying the exercise of judgment and common sense. We must see the earthly, broken things as they are, before we can start building. It means an awareness of our particular job no matter what it may be, but it also means an awareness of what it may become. Our workmen are lame and maimed, blind and dumb, diseased and ailing, broken and sometimes raving. They are oft times proud and lonely in their misfortune, fearful about the outcome, rebellious at God and man, blighted in the prime of life. Some have only one string to play upon. It is the skill of the therapist to tune upon the right instrument stirring up the patient's will to recover, guiding his efforts until he, too, can produce music. This school of adversity is no easy school and there is no easy way out, but there can be a victorious one. We may plaster our patient with materials and jobs, even pensions, and find to our disappointment—a selfish, pampered, and demanding individual still turning to us for aid and more aid, casting blame and more blame for his unhappy state and lack of employment, for he is unemployable. Our patient has not been re-habilitated; he is de-habilitated.

What are the facets then which the Science of Occupational Therapy presents that our patients may be the more truly useful and happy members of society? Its general action may be likened in a hospital to that of leaven in the homely occupation of bread making. As yeast raises and coheres the particles in the whole loaf so does occupational therapy activate and unite the patients in a hospital, creating from the very beginning of hospitalization a product and purpose outside themselves. Without it hospitalization is flat and sodden and future rehabilitation hopeless. With it in increasing doses, morale rises, faculties awaken, vocational goals materialize, time flies, and the patient, once the passive recipient, often becomes the active donor.

Now, in particular, what are the "vitamins" set to work, if this comparison may be permitted. You are all familiar with them—the A B C D E S and V Therapy—Arts, Book (Library), Craft, Diversional, Educational, Social and Vocational given under the prescription of a doctor, orally or by correspondence, individually or in groups, not necessarily always palatable to be effective. When a doctor treats a patient, whether for a nerve injury or for tuberculosis, he treats the whole man. That is what occupational therapy does. When "vitamin D", diversional therapy, that much debated medicine, is administered, it is for the same purpose as the administration of "vitamin V", vocational therapy; that is, the fullest rehabilitation of the patient is being undertaken. Just as it is given to the ailing as medicine, occupational therapy is also given for a definite purpose and it must be controlled.

Now "vitamin D" has also been called the Directional or Preventive treatment. As vaccination can control smallpox and as B. C. G. vaccine provides partial but appreciable protection against tuberculosis, so "vitamin D", preventive therapy, will help to protect your patient against the development of psychoneurosis adding to his disability and presenting still another rehabilitation problem. There is a proper timing in the administration of these "vitamins." In some cases it would not be beneficial to pour "vitamin V-vocational" down a person's throat until he had first a dosage of "vitamin A-arts," "C-crafts", or "E-educative". The patient might not be prepared for so strong a medicine. But there are cases when no time need be lost in administering "vitamin V". In fact, one physician asks this forward-looking question in his first interview with a patient, "What are you going to do when you leave the hospital?"

Certainly a therapist must be so hopeful and rehabilitation-minded as to lose no time in administering "vitamin V-vocational" in the treatment of tuberculosis where the conservation of energy is so necessary and a change of job often indicated on discharge. She must ever be on the alert for the earliest chance to introduce opportunities for the patient to prepare himself for his return to employment. She must develop an almost uncanny sense in detecting vocational goals, as well as determining when to administer the other "vitamins" from her knowledge of craft and job analysis and personality types. In many instances it may mean that a patient will find greater pleasure in practising some normal skill through "vitamin V-vocational" therapy in the hospital than he might in any other therapy presented to him. He is being toughened physically in so doing. It may tax the ingenuity of the Therapist to devise some means of conservation of energy by applying some remedial aspect to the skill or trade or vocation familiar to the patient.

In administering any of the other "vitamins", Arts, Craft or Diversional, a therapist has the opportunity to observe and assess the patient's ability, work tolerance, behaviourism, and attitude to work. A man is not fully rehabilitated if he is trained for a job but goes to it asocial, with a chip of the effects of his illness still upon his shoulder, with a TB-leper complex and a warped mind. He may be readmitted to the hospital as soon as the man who has gone out without an established physical stability. In the first case "vitamin S-social" therapy must be administered along with the other "vitamins". It was surprising in England in visiting Clare Hall Sanatorium at South Mimms, Barnet—a little English village in the beautiful countryside—to find these signs printed outside various buildings: Educational Therapy, Physio-therapy, Occupational Therapy, Social Therapy. It was difficult to determine which door to enter being rehabilitation-minded, but it was soon found that Social Therapy played an important part in the hospital. Although the word "rehabilitation" was not used, all the "therapies" worked together towards this goal.

There, under Occupational Therapy of the craft type, was found a normal working situation with some fifteen women weaving, sewing and making rush-cane shopping bags, and baskets. The atmosphere was easy but it was evident these patients were about their business and the situation was obviously

controlled by the two therapists. There was no cajoling or coaxing of patients; they seemed prepared and glad to do anything proposed for them. In this hospital work in the Occupational Therapy Workshops is compulsory when the physical condition warrants it.

In the men's workshop, a male technician in wood work and cobbling kept fifty men employed. These men came to him for three to six weeks of craft therapy after which they were sent to a Convalescent Centre for further work. Here it was the therapist who provided the projects. Often he had to do the preparation of heavy work and intermediate steps and finishing of articles. The men were coming to him for a concentrated period of physical toughening, muscle toning, conditioning. While there they got along with their job, whether they had any particular liking for woodwork or not. They all seemed happy and busy. It was the craft the doctor ordered and the patient accepted his therapy as he did any other treatment directed to his recovery. He did not shop at this and that shelf helping himself to whatever "vitamin" he liked the taste of—nor did he jumble them altogether so that no one had a chance. He did not go on to the Convalescent Centre if he by-passed his therapy here.

Another step in this craft therapy in England is the Industrial therapy such as found at Preston Hall, British Legion Village, Settlement for Tuberculosis. It is situated among the charming hopfields, cherries and fruits of Kent, accommodating about two hundred and fifty patients, mostly men. There the usual Occupational Therapy set-up includes a workshop which serves the wards and ambulant cases. Little leather work is done here because it is too expensive a craft. Lamp shade making and reed work are popular. Ambulant cases either come to the workshop in their activity periods or take a walk.

After a certain time at the Occupational Therapy workshop a patient is sent to the Industrial Workshop. Needless to say, this activity is as compulsory as the rest periods which are so naturally accepted as treatment in England. The Industrial workshops had men instructors. The first shop visited was indeed a hive of industry with men and women working at factory speed, or so it seemed. Here they put on the market three articles—dolls, Anona Picture Toilet soap, and Christmas crackers—all marked with their patent number and trade mark, "Produced by British Legion Industries."

It was very intriguing to watch a Christmas Cracker, (like those we have at the Sanatorium Christmas dinner) take shape—first: plain paper, then a sparker; the coloured wrapping all drawn over a cylinder and pulled tightly over notched ends with wire. A toy and a joke were inserted. Final touches of a coloured picture were added. Certainly light work, colourful and varied! Millions of these crack all over the world adding gaiety to the Christmas season.

Equally intriguing was the doll factory where thousands of heads and limbs were cast in moulds and wired together, dressed, and sent out pretty. The picture soap is delicately scented and carries beautiful pictures of flowers

vowed to last as long as the soap. Miss Mabel Lucy Attwell, well known English designer, puts out Kiddie Pictures for the soap too and these are very popular.

From this large workshop of comparatively light work one passed to the Carpentry Shop. This was run on a big scale and much of the work done in the open. There was also a Printer's Shop. Here were much noise, smell, and great machines. This is where Napt Bulletin is printed by the National Association for the Prevention of Tuberculosis.

After a period of time in these workshops, a patient was either discharged or had the privilege of becoming a Settler, under certain conditions, with a house and work at the hospital. Remuneration from the Industrial Workshop and for the settlers would seem to us very low. In fact, it was the most negligible factor involved in therapy at any stage.

It was obvious that vocational work was not undertaken by the sanatoria in England. Their system was to cure the tuberculosis and to toughen a man to the point of maximum physical, mental and social health and then the Social and Welfare, Education and Employment agencies outside the hospital dealt with his further rehabilitation problem. Occupational Therapy did a concentration job in toughening the patient physically and also psychologically before he passed through the doors to an Employment Bureau. This is the primary and major contribution of Occupational Therapy in the rehabilitation program. The program has lost its stamina and so has the patient if we exert no more direction than to allow a patient to lie in bed until the time of discharge doing, shall we say, a correspondence course.

It might be profitable here to enquire a little further regarding why handicrafts are so generally used in occupational therapy treatment and so find a place in the rehabilitation program. From a scientific point of view, the primary answer is found in the reaction of the motor centers of the brain to work stimuli, and the resultant improvement of the higher centers of the brain. Then, too, through the ages we find in crafts a primitive means of expression; an instinctive healthy outlet of individuality. In all sick persons the primitive instincts usually come to the fore. So, at this time especially, handicrafts have an appeal.

Crafts can be graded for all stages of tuberculosis. Their scope is well defined as follows: (2) "Crafts can be easily graded and selected to meet the mental capacity of either a mental defective or an intellectual; the interests of a day labourer and a genius. The crafts can supply all physical movements required in restoration of impaired function of joints and muscles, etc. To this may be added the less tangible but not least useful psychological value of that peculiar pleasure derived from work accomplished with one's own hands."

It is too long a matter here to discuss the realistic opportunity that crafts give to Habit Training—"re-education in substituting better habits (for bad habits) or the building of new habits to replace those which have been lost." Suffice it to say Occupational Therapy early supplies our patients with just

the right media in pleasing mode for changing his habits when the patient's whole attitude, way of living, and perhaps work, must be changed for his total rehabilitation. To quote further, (2) "There is no general habit, no general memory, that is common to all mankind. It is individual habit and memory. Everyone builds his or her own. "Habit psychology" is the only basis on which to re-educate and re-train."

It is not enough to admonish the patient or advise him, thus using theology rather than practical hospital work; he must be placed in a work-a-day experience with things to do, skills to learn and self-reliance to recover or win. His work habits must be brought to the point where good work habits are re-established and he is ready for any intensive vocational training that can be made available. The therapist's observations and assessments of aptitudes and attitudes in this process should be invaluable to the other team members in Rehabilitation.

What is the relationship of Educational Therapy to Diversional Craft or Art Therapy? Adult education and academic work are indeed wonderful avenues open to our patients. It is the teachers who know this and must marvel at the tool in their hands. Some learn to read and write for the first time, others take preliminary reviews for further courses. It is not always realized that for some patients it is the indicated therapy apart from any vocational goal. For some it acts as a mental stimulus; for others, a relief to their active restless minds. It is unreasonable, however, to expect the ill person, and the ill mind, to be subjected to periods of mental work exclusive of any physical occupation. Many patients have thought little in the abstract at all and perhaps not for years. It inflicts too much mental strain on them to be expected to apply themselves solely to mental work. Every well person needs a diversion to keep well—how much more the unwell to get well.

But there is another very important psychological law at work in "all work and no play makes Jack a dull boy." It has been proved that minds retain lessons longer with periods of occupational therapy. All therapists and teachers are concerned and distressed at the frequent plea, "I can't remember what I learn." To get to the root of this matter would involve a consideration of work and play mechanisms too involved for this paper.

An insight into this was seen in London at the Portland Clinic for delinquent children supervised by a psychiatrist. These children were released from Court and undergoing psychological treatment. They had a room which looked as if all the devils in the world had thrown pots of paint of hideous colours and dangerous weapons on the walls. This was their free expression room where they could raise Cain and do what they wanted. In another room a therapist was treating one child only, a girl of twelve, apparently normal but who was viciously throwing a rubber knife at the eyes of a picture she had drawn of the last visitor. She identified her with her grandmother at whom she held spite.

In more modified and milder forms we use Art Therapy and Craft Therapy for the same purpose. We have all had times when we wanted to hit out. Patients, too, have them, without normal outlets. Then they are in no con-

dition to talk of work or vocation. The application of Art and Music Therapy earlier on the wards tends to make patients more responsive to treatment and rehabilitation. Art and Music can get to places in the human organism beyond the reach of medicines, beyond x-ray. You are familiar with its curative value and emotional satisfaction. In the words of a prisoner in a penitentiary, (3) "As an antidote to frustration, painting has much in common with dancing, and a series of brush strokes are felt rhythmically as one feels a series of steps. Painting rhythmically is the result of looking at nature's rhythms and dancing to them with one's paint brush, rather than with one's feet. I always returned to the noisy reality of the hut as if from a journey through the fields, and I was lucky enough to keep what others sometimes lost—a regard for my fellows."

A prisoner is trying to keep a regard for his fellows! And so this paper comes to the end—"feet on the ground and the sky in your eyes." Occupational Therapy has much to give—this intermingling of science and art—specific treatment and yet the treatment of the whole man, flexible service and yet according to methods, old as David with his harp and yet new as the latest problem in human welfare. So too, it has much to learn and must be ever critical of itself as a science.

The horizon and the future both for occupational therapy and the patient are symbolized by the sky. Happy is the Therapist who through purposeful activity can transport his patient in imagination from the atmosphere of his hospital to that of future recovery and employment. With the sky in your eyes you will lend inspiration and strength too. Sincere interest and regard for the patient plus a belief in your work is the surest way to attain this. To quote: "Go quietly amid the noise and the haste and remember what peace there may be in silence. As far as possible, be on good terms with all persons. Speak your truth quietly and clearly and listen to others—they, too, have a story. Keep interested in your own career however humble. It is a real possession in the changing fortunes of time."

BIBLIOGRAPHY

- (1) What Physical Medicine Expects from Occupational Therapy. H. V. Cranfield, M.D.
- (2) Syllabus for Training of Nurses in Occupational Therapy. Eleanor Clarke Slagle, O.T.R., and Harriet A. Robeson, O.T.R.
- (3) Painting in Prison. Earl Haig.

Come To Cape Breton

When you come to Cape Breton in September, you can approach Sydney by two routes. One takes you through Margaree following the famed Cabot Trail and the other follows along the highway that skirts the Bras D'Or Lakes from St. Peter's to Sydney.

Why not plan now to make this your vacation? Bring your wife along and both of you will rhapsodize over our *SCE NIC WO NDERS*.

Driving leisurely and at a pace to enjoy the scenery and landscape, if you choose to go by way of Margaree, you will delight in the peaceful and gently beauty of the Margaree Valley. . . . Thrill to the dizzy height as you go over MacKenzie Mountain, rising ponderously into the air, while the sea swirls and foams at its rocky base. . . . Exclaim at the enchanting jewel-like setting of Pleasant Bay which one comes upon quickly on the downward descent from MacKenzie Mountain!!!

The Trail winds through the National Park which offers a countless variety of scenery—the wide blue expanse of the ocean rolling into the base of sheer craggy cliffs or lapping gently at the shoreline. . . . At times the road takes you over the top of these craggy cliffs and then drops back down to run parallel to the shore line——

Keltic Lodge which combines fun, relaxation, and scenic beauty, is set down in the National Park on the Trail and you can explore, ride, golf or sail amidst comfort and luxury if you choose to stop over on your way.

You are thrilled when you cross MacKenzie Mountain on the Inverness side but wait till you come down over Smoky and stop to look back up over the trail which carried you down! Majestically, its bulk towering over and dominating the landscape of Northern Cape Breton, Cape Smoky can be seen on clear days, for miles along the eastern coast line of the Island. Only the actual experience of coming over this road which seems to lie perilously near the edge of the cliff, can adequately describe the exhilarating and satisfying sensation one feels.

Baddeck. . . .with its famous Beinn Breagh, the burial place of Alexander Graham Bell, is always worthy of a visit.

As you go along the highway now, various stretches of water which make up the Bras D'Or Lakes are glimpsed through the trees but here and there the road is actually flush with the water-giving the travellers a many-faceted view along this same highway!

St. Ann's. . . .which conjures up the stories one has heard of Giant Mac-Askill, or perhaps, reminds one that here is the scene of the Annual *GAELIC MOD*.

Through Bras D'Or, Sydney Mines, North Sydney with a magnificent view of Sydney Harbour as it sweeps out past the headlands to merge with the ocean and on into Sydney through a pleasant and picturesquely landscaped suburb on its outskirts.

The City of Sydney has an important place in the *history* of Nova Scotia. It was built as a garrison city more than two hundred years ago and it contains

not a few reminders and historic landmarks of its early traditions. St. George's Church on North Charlotte Street still stands on its original site where it was built as a garrison chapel and treasures among its possessions a chair that is said to have belonged to Nelson.

To-day, Sydney is famous as a great steel-making centre and we promise that conducted tours of the Steel Plant for all interested, are being arranged.

For those who make the study of local history a hobby, good roads will take them in less than an hour from Sydney to the famous historic site of Louisburg. The Museum there will produce amazing and highly intriguing relics of the French settlement and its subsequent seige by the English. A reconstructed Model of Louisburg at the time of French ownership will prove vastly interesting we know. It will give insight into some wonderful military and civil engineering feats which were meant to make Louisburg impregnable as a fortress!

Perhaps you might prefer to come directly to Sydney along the main highway from St. Peter's and return home by making the overland trip on the Cabot Trail.

Whichever way you choose, we can assure you that you will be enthusiastic and greatly pleased with the beauty and grandeur Cape Breton offers. Not least of all will be the breath-taking and georgeous Sunsets which nature lavishly displays for our continual enjoyment and each one is unique and individual in its presentation. Truly—Cape Breton, the land of beautiful sunsets!

Then, we shall be expecting you and we intend to make your 1954 Convention, the *Most Enjoyable Yet*.

Minutes of the Semi-Annual Meeting

The Medical Society of Nova Scotia, 1954

The Semi-annual Meeting of the Executive of The Medical Society of Nova Scotia was held in the Board Room of the Dalhousie Public Health Clinic, Halifax, N. S., on Tuesday, January 12th, 1954, at 2.30 p.m.

Doctor M. G. Tompkins presided and those attending were Doctors H. F. McKay, D. M. Cochrane, R. O. Jones, H. G. Grant, A. G. MacLeod, J. A. MacCormick, J. A. McDonald, G. D. Donaldson, P. O. Hebb and E. F. Ross.

Doctor Tompkins called the meeting to order. In discussing plans for the next annual meeting he said that in order to fit in with the Plans of the Canadian Medical Association plans it would be necessary to start The Medical Society Meeting on Monday, September 6th.

The meeting will be held in the ball room of the Isle Royale Hotel in Sydney, with the exhibitors in the same room. Doctors will write directly to the Manager of the Hotel for accommodation.

It had first been planned to hold the meeting at the Xavier Junior College at Sydney, but the exhibitors objected to this.

Doctor H. F. McKay asked if the Hotel could handle all the members attending, and Doctor Tompkins advised it could, but they would have to register early.

Doctor Grant advised that he wanted to charge the exhibitors \$100 for booths (formerly it was \$75), and also that Mr. E. S. Murray of the Imperial Press had advised that they were going to raise the rates five per cent on April first.

It was moved by Doctor R. O. Jones and seconded by Doctor H. F. McKay that the Society charge \$100 for booths of the exhibitors, and as well to increase the advertising rates in the Nova Scotia Medical Bulletin by ten per cent. Carried.

(Note. Since this time we have been informed by our printers that they are not making any increase in our rates, consequently we are holding the same rates as hitherto.)

Doctor J. A. McDonald gave the following report.

"A meeting of the Committee to look into the matter of the establishment of a Chair in General Practice by The Medical Society of Nova Scotia was held in the Board Room of the Dalhousie Public Health Clinic, Halifax, N. S., at 10.30 a.m., Tuesday, December 15, 1953.

"The Chairman, Doctor J. A. McDonald, called the meeting to order. Present: Doctors J. J. Carroll, J. C. Wickwire, A. G. MacLeod, A. W. Titus, H. F. McKay, G. R. Forbes, D. M. Cochrane, M. G. Tompkins and H. G. Grant.

"Doctor McDonald read the resolution passed at the second business meeting of The Medical Society of Nova Scotia, October 9, 1953, as follows:—

'Doctor Eric W. Macdonald moved that The Medical Society of Nova Scotia recognizing the desirability of a Chair in General Practice being established at Dalhousie University appoint a committee to consider and investigate the possibility, keeping in mind that the cost must be contributed by our membership.'

"In answer to a question whether such a Professor would be full time or part time the reply was that the Chair would be under a full time Professor of General Practice, and that such a Chair would necessitate an endowment between \$250,000 and \$300,000.

"After a long and very frank discussion it was moved by Doctor H. F. McKay that this Committee go on record as being favourably inclined to the establishing of a Chair in General Practice, but that it is not feasible at the present time. This was seconded by Doctor G. R. Forbes and carried.

"After further discussion it was moved by Doctor A. W. Titus that the Committee appointed to study the question of the establishment of a General Practitioner's Chair of The Medical Society of Nova Scotia feel that establishing a Chair of General Practice at Dalhousie is not feasible at the present time, but that they recommend that a Committee be appointed by The Medical Society of Nova Scotia to investigate further ways and means of improving and establishing better General Practitioner's training at Dalhousie Medical School.

"It is further recommended that this Committee request the University to have its Faculty and its Committee on Studies meet with this Committee to discuss this problem in order to obtain a clearer picture of difficulties involved and ways and means of overcoming these to the advantage of the medical students and to the medical needs of the people. This was seconded by Doctor J. C. Wickwire. Motion carried."

Doctor J. A. McDonald moved the adoption of the report, which was seconded by Doctor D. M. Cochrane, and carried.

Doctor E. F. Ross: "I feel that this Committee should continue its work."

The President asked if it would be agreeable if he appointed three to meet the Committee from Dalhousie Medical Faculty at 8.30 in the evening.

It was moved by Doctor P. O. Hebb that the Chairman appoint a committee of four to consult with the Executive of Dalhousie Medical Faculty. This was seconded by Doctor E. F. Ross and carried.

The President appointed Doctors J. A. McDonald, H. F. McKay, A. G. MacLeod and D. M. Cochrane.

The Secretary said that he felt the Canadian Medical Association should pay The Medical Society of Nova Scotia for collecting its dues. He thought that there should be an annual charge of about \$250 against them for this service.

Doctor H. F. McKay asked if it would not be better to make the same thing Dominion wide. He thought the Executive should instruct the Secretary to find out what the other provinces did in this matter.

Doctor H. F. McKay moved that Doctor Grant, Secretary of the Nova Scotia Division, be instructed to bring this matter up at the meeting of the Divisional Secretaries next month, and to press the Canadian Medical Associa-

tion for some satisfactory solution in the matter. Failing such a solution, this Division to take the matter up directly with the Canadian Medical Association. This was seconded by Doctor R. O. Jones. Motion carried.

The Secretary read the following letter from Doctor A. W. Titus dated December 31/53.

"As Chairman of the committee on revised scale of fees of the Society, I wish to submit the following as a progress report on what we have done since the annual meeting in October. Our fee schedule has been revised and corrected into a single minimum schedule of fees as we were directed. It is now ready for the printers, and should you approve our action and the following expense we will go ahead with the printing and should have the new schedule ready for mailing within the next six weeks.

"I was instructed by the Executive at a previous meeting to publish this in loose leaf form. We have obtained four different jobbers prices for suitable binders and the prices range from \$1.60 each down to 20c. each, with an additional cost of about 6c each for lettering. I spoke privately to our Secretary, Doctor Grant, and our President, Doctor Tompkins, and they agreed that I should go ahead with the ordering of 800 binders at approximately 35c each. Printing of the loose leaf sheets will cost roughly \$250 to \$300, including cost of material. This cost cannot be determined accurately until the printers see our binders. These prices are exclusive of mailing costs.

"Maritime Medical Care Incorporated have already approved our schedule of fees and are using it at present and have expressed the desire to purchase 100 copies of the new schedule, preferably at cost, and I feel this is reasonable since they went to a great deal of trouble of mimeographing the preliminary reports. I wish the Executive would approve this expense and with this I respectfully submit this report."

As Doctor Titus had been asked to come to the Executive meeting to speak on this report, it was decided to delay any action until he arrived.

The Secretary read the following letter from Mr. C. E. Fader, Secretary-Registrar of the Nova Scotia Pharmaceutical Society, dated December 4th, 1953.

"Your letter of November 17th was most welcome. The suggestion that the Committee on Pharmacy of your Society meet with a committee from the Nova Scotia Pharmaceutical Society to talk over matters of common interest is indeed a splendid one.

"I presume that this month will be a busy one with all of us, but I shall contact the Chairman of your Committee, Doctor H. R. Peel, Truro, Nova Scotia, early in the New Year.

"A copy of this letter is being sent to Doctor Peel as a matter of record."

The Secretary read the following letter which he had written as Dean of the Medical Faculty to Doctor F. L. Whitehead, Secretary of The New Brunswick Medical Society, dated November 12, 1953.

"To date the expenses of the Post-Graduate activities of Dalhousie Medical School have been met by a grant from the W. K. Kellogg Foundation of Battle Creek, Michigan.

"We have been running on a budget of \$18,000 and the grant will expire the end of June, 1954.

"A couple of days ago President Keer called a meeting of an ad hoc committee, made up of members of the Faculty of Medicine and also members of the Board of Governors of Dalhousie University to consider what efforts should be made to continue this work and it was decided that The Medical Societies of Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland should be approached for an annual contribution and that also the Governments of the respective Atlantic Provinces should be, likewise, approached.

"A few weeks ago I talked with Doctor M. R. Kinde of the Kellogg Foundation and they have agreed to consider a new agreement with the Dalhousie Medical School on the following terms:

| | | |
|-----------|----------------------|----------|
| 1954-1955 | Dalhousie University | \$ 3,000 |
| | Kellogg Foundation | \$15,000 |
| 1955-1956 | Dalhousie University | \$ 6,000 |
| | Kellogg Foundation | \$12,000 |
| 1956-1957 | Dalhousie University | \$12,000 |
| | Kellogg Foundation | \$ 6,000 |

"The job was given to me to approach the various Medical Societies and I am writing you to see whether or not you would help in approaching The Medical Societies of New Brunswick and Prince Edward Island.

"Since the Kellogg Foundation has offered to continue in diminishing amounts I feel that we should ask each Society if they will, say, assess an educational levy of \$2.00 for the first year, i.e. 1954-55; \$3.00 for 1955-56 and \$5.00 for 1956-57 with the understanding that the \$5.00 will be a permanent contribution.

"There will be a meeting of the Deputy Ministers and the members of the Health Planning Committee of the Maritime Provinces and Newfoundland about January 15th and at that time Doctor C. B. Stewart will present a brief to the group asking for an annual grant from each Province. It would be most helpful to him if he were in a position to say that the respective Medical Societies were prepared to contribute so much, or, if we cannot advance that far, at least be able to say that he is of the opinion that this matter has the backing of the Medical Societies. Consequently, without rushing matters, I would like to have your advice just as soon as convenient. Also, if you think anything would be gained, I would be very pleased to come to Saint John to talk the matter over with you and also interview any of the key men that you felt I should."

Doctor Grant stated that since writing that letter the Newfoundland Medical Society had written they would be very pleased to assess their members Two Dollars, and the Provincial Medical Board of Nova Scotia has offered to grant \$250, with the promise that next year they will give \$500, provided Legislation can be secured to give them authority to do so.

Dr. E. F. Ross stated that the Kellogg contribution would run out this summer, and the Post-graduate Committee needed funds if they were going to continue this activity. He asked what the contribution of Newfoundland would amount to, and Dr. Grant replied approximately \$300.

The estimates as worked out for the four Medical Societies for 1954 are as follows: Nova Scotia, \$900; New Brunswick, \$550; Newfoundland, \$150; Prince Edward Island, \$100. From the Provincial Governments, Nova Scotia, \$488; New Brunswick, \$112; Newfoundland, \$112; Prince Edward Island, \$38; plus \$250 from the Provincial Medical Board.

Doctor E. F. Ross stated that the programme was an overall post-graduate programme for the four Atlantic Provinces, and consists of the courses that are put on at various times during the year.

Doctor Grant stated that in Colorado several of the hospitals had taken up post-graduate instruction entitling it "A day at the hospital." The instruction was given by members of the hospital staff and they invited outside members to contribute as they saw fit. This method of post-graduate instruction has been well received by the doctors of Colorado. District Medical Libraries would be of great value to the practising physician at strategic points, such as Yarmouth, Sydney, Moncton, St. John's and other places.

Doctor M. G. Tompkins: "There is no doubt of the value of the post-graduate course put on each year. Two dollars from every member would guarantee our quota. We have another possibility as we are fairly well off financially having something like \$10,000 surplus at present."

Doctor H. F. McKay stated that the average charge for post-graduate courses at most medical schools was \$10.00 a day.

Doctor H. G. Grant asked if \$10.00 a day would affect the attendance.

Doctor D. M. Cochrane did not think the doctors would object very much.

Miss Joan Hudson, the Executive Officer of the Post-Graduate Committee, who had been asked to attend for this discussion, stated the response to the short courses was not good.

Doctor P. O. Hebb: "The higher the fee, the smaller the attendance."

Doctor D. M. Cochrane: "It is not a question of cost, it is a question of time."

The Secretary thought that the members might be approached asking them if they wanted to make contributions. He said he would be pleased to canvas if he had support locally.

Doctor J. A. McDonald moved that The Medical Society of Nova Scotia contribute \$900 at this time to Dalhousie University for the Post-graduate Programme to cover the estimated levy for 1954, and that the Executive of The Medical Society of Nova Scotia recommend to the Annual Meeting that a levy of \$3.00 be made on the membership in 1955 for the 1955-56 programme, and a levy of \$5.00 yearly for this purpose beginning in 1956. This was seconded by Doctor A. G. MacLeod.

Doctor H. F. McKay did not think the Societies would vouch for it.

Doctor E. F. Ross thought that probably by the Fall the Secretary would have more information. He asked whether it would be possible to have some information when the Society met in the Fall as far as the Governments were concerned.

Doctor H. F. McKay thought that a brief should be presented on this matter at the annual meeting in very concrete form.

Doctor J. A. McDonald reread his resolution, and it was carried.

Doctor M. G. Tompkins stated that Doctor Grant was prepared to go out to the Branch Societies to collect money. There was no doubt that the Society had advanced very much in the last ten years. He thought that the thought should be kept in mind for the annual meeting whether the Society would continue to have a part-time secretary or a full-time secretary.

The Secretary said the Society would not know exactly what money was needed until they had the meeting with the Medical School.

Doctor A. W. Titus gave his report and stated that he had ordered 800 copies of the fee schedule, and they should be here the end of January; it will cost \$300 for binding and \$300 for printing.

It was moved by Doctor E. F. Ross that the Executive heartily endorsed Doctor Titus' work to date and gave him approval to continue on and complete his job. This was seconded by Doctor R. O. Jones. Carried.

Doctor H. F. McKay read his letter to Doctor M. G. Tompkins, dated December 7th, 1953, in which the difficulties of the Doctors of Pictou County with the Zurich Insurance Company were outlined.

After some discussion it was moved by the Secretary that the report of Doctor H. F. McKay be referred to the Committee on Economics and that the status of the Zurich Insurance Company and other sickness and insurance companies be studied and that a report be given to Executive within one month. This was seconded by Doctor H. F. McKay and carried.

The Secretary stated that he had received a letter from Mr. J. A. Walker regarding the formation of a Council, and if a Council were wanted a notice of motion would have to be given in proper time before our next annual meeting. He then read the following letter from Mr. J. A. Walker, dated November 27, 1953.

"In regard to the power of the Halifax Branch of the Nova Scotia Division of the Canadian Medical Association to amend its By-Laws so as to make membership in that Branch contingent upon the applicant for such membership being a member of the Nova Scotia Medical Society and Canadian Medical Association, I am of opinion that the Branch has power to amend its By-Laws so as to make this change, provided they obtain the concurrence of the N. S. Division.

"You will notice that Article XII deals with the amendment of the By-Laws and that one of the conditions for making the By-Law valid is "(b) concurrence of the Nova Scotia Division of the Canadian Medical Association."

"Whether the N. S. Division wishes to give its concurrence is entirely a matter for the members of the Division. If they do concur it implies that they agree in principle that no person should be admitted to membership of the Halifax Branch unless he is a member of the two other organizations.

"If the amendment to the By-Law should be passed than Article III regarding membership should read as follows:—

"1. The members of this Branch shall consist of all members of the medical profession in the City and County of Halifax and the Town of Dartmouth in the Province of Nova Scotia, whose names shall appear in the Medical Register and who are members of both the Canadian Medical Association and The Medical Society of Nova Scotia, and who shall have been elected as hereinafter provided.

"If it is decided to proceed with this amendment I would advise that the proceedings laid down in Article XII be strictly followed."

It was decided that a copy of this letter should be sent to the Secretary of the Halifax Medical Society.

Doctor H. F. McKay did not think that the Society should insist that members should be members of the Canadian Medical Association.

It was moved by Doctor P. O. Hebb that the Executive of The Medical Society of Nova Scotia should approve the change in the By-Laws of the Halifax Medical Society regarding membership in the Halifax Medical Society being continent on membership in The Medical Society of Nova Scotia and the Canadian Medical Association. This was seconded by Doctor R. O. Jones. Motion defeated.

It was moved by Doctor D. M. Cochrane that the matter of changing the By-Laws of the Halifax Medical Society be referred to the next general meeting of The Medical Society of Nova Scotia. This was seconded by Doctor E. F. Ross. Carried.

The following new regulations regarding enabling certificates of The Medical Council of New Brunswick were read by the Secretary.

"1. The applicant for an enabling certificate must have passed at least two years in Science or pre-medical studies in a University approved by this Council.

"2. He must have been graduated by a University approved by this Council.

"3. He must be of Canadian birth, or

"4. His birthplace must have been within the British Isles, or

"5. He must have acquired Canadian citizenship.

"N.B. The Council may, in their discretion, grant an enabling certificate to a legally practising physician in good standing in the State of Maine."

Doctor H. F. McKay moved that the regulations be received and referred to the Legislative Committee. This was seconded by Doctor J. A. McDonald. Carried.

Doctor H. G. Grant read the following letter from Doctor D. M. MacRae, dated October 7, 1953.

"As one of your representatives appointed to the Board of Directors of the Maritime Hospital Service Association, I was invited to attend a meeting of the Medical Advisory Committee at Moncton on January 10th and 11th.

"The Director, Doctor J. A. MacMillan, briefly reviewed the main problems dealt with during the past year in order to provide a background for the new members. The change made in the new contracts, as explained in the "Briefs", were necessary to enable the plan to remain solvent. The financial picture, after five months, has improved considerably and it was hoped that some increase in benefits could soon be considered. The director expressed the wish that closer contact could be made between the plan and each Maritime Provincial Medical Society. He thought that an advisory committee, representative of the province, would be of great value in enabling the directors to formulate medical policy—such as revision of indemnity schedule, increasing benefits, etc., when the directors felt the financial situation would permit

such changes. Also, such a committee would be very helpful in advising on problem cases involving payment of fees to doctors of that province. It was agreed that a memorandum would be sent by the Medical Director to the Executive Committee of the four medical societies for their consideration. The Executive and Board of Directors hope the medical societies will be willing to take a more active part in moulding and improving the medical aspects of the plan.

"On March 7th the annual meeting of the association was held in Moncton. Your representative sat in on this meeting only as an observer until the new board of directors were received and a meeting called by the new president, Mr. John N. Flood.

"The chairman of the Board announced that this year would be the tenth anniversary of the Blue Cross Hospital plan and the fifth anniversary of the Blue Shield Plan. At the end of 1952 there were 287,000 members in the Blue Cross and 152,000 members in the Blue Shield.

"This year will see for the first time a full representation on the Board of Directors with six members from the four medical societies, six members from the Maritime Hospital Service Association and six members representing the subscribers. There are eight medical men on the Board, since a doctor was appointed as one of their representatives by both the subscribers and the Hospital Association.

"The executive of the Maritime Hospital Association was welcomed to the meeting for an hour's general discussion of Hospital Relation and problems. Following this the following reports were received and discussed: Auditor's report, Chairman's report, Report of Medical Director, Public Relations report, Report of Hospital Relations and Claims Office, Report of Secretary-Treasurer, Report of Executive Director, Report of Association Director (Enrolment), Report of Associate Director (Internal Administration).

"It was announced that New Brunswick and Prince Edward Island Medical Societies had re-approved Maritime Blue Cross—Blue Shield for the year 1953.

"The resignation of Doctor MacMillan as Chairman of the Board of Directors was accepted. Later he was appointed Executive Medical Director of the Plan on a part time basis.

"A meeting of the new Board of Directors was then called and election of the officers took place. Doctor Harold Devereux, your two year appointee was elected to the executive and I was elected to the Medical Advisory Board.

"A second meeting of the new Board of Directors which I was unable to attend was held in Moncton in July. At that meeting plans were finalized for the erection of a quarter-million dollar office building for the Association in Moncton.

"In conclusion I will call attention to my term of office being limited to one year and respectfully request that I not be considered for re-appointment."

It was moved by Doctor D. M. Cochrane that this letter be received and sent along to the Committee on Economics. This was seconded by Doctor J. A. McDonald. Carried.

The Secretary read the notes which had been received from Doctor H. J. Devereux of Sydney just as the meeting was starting.

Doctor R. O. Jones stated that he had been advised by the auditor, Mr. M. L. Bellew, to transfer about \$5,000 from the current account to the savings account. It was moved by Doctor H. F. McKay that the Treasurer buy Five One Thousand Province of Nova Scotia Bonds. This was seconded by Doctor D. M. Cochrane. Carried.

It was moved that the meeting adjourn at 5.30 p.m.

The College of General Practice in Canada

Many General Practitioners are becoming Foundation Benefactors by the payment of \$100 or more to the Fund for the inception of the College. It is hoped that as many more as possible will do so quickly.

The Doctors of British Columbia are taking donations of \$100 to this Fund as including the donor's first year's dues, providing it is accompanied by his signed application form, which will be processed in the usual manner. They will be asking the Board of Representatives at its first meeting in June to make this arrangement effective.

Post-Graduate Committee of the Faculty of Medicine

The above Committee, the first week of March, presented a course in Metabolic and Endocrine Disorders emphasizing Thyroid and Diabetic Diseases.

I attended this course along with eighteen other general practitioners from Nova Scotia and New Brunswick, and therefore speak from personal experience.

Doctor Martin Hoffman was the guest speaker and many members of the staff of the Department of Medicine ably assisted him.

This was a course of the greatest practical value to the general practitioner, all of us who attended feeling that we had derived considerable pleasure and great profit by the manner in which these subjects had been presented.

Bearing in mind the requirements of the College of General Practice with regard to post-graduate study, general practitioners will find these short courses a source of current information, vividly presented and well worth making an effort to attend when subjects which interest them are on the agenda.

Progress on the Closed Shop

The following revised regulations recently appeared on the board at the Victoria General Hospital. Is this a policy of progress in accordance with the trend of specialization or a gentle closing of the door to some of our ambitious colleagues? Your comments will be welcome.

Re: Surgical Procedures: Operating Room Victoria General Hospital

The following recommendations of the Committee, have been approved on 5 Feb./54 by the Honourable Minister of Health:

1. Endoscopic procedures, except rectal examination, may be done only by those certified in the specialty concerned, except as hereinafter specified.

2. Tonsillectomies may be done only by certified (or higher) Otorhinolaryngologists, except as hereinafter specified.

3. Surgical procedures may be done only by certified (or higher) surgeons or surgical specialists with the following exceptions:

(a) . A certified surgeon who has been graduated prior to 1940, and who has been doing certain surgical procedures in a competent manner may, with the approval of the Credentials Committee, be permitted to carry out certain specified surgical procedures in the Victoria General Hospital.

(b) A doctor who has completed an approved course of graduate training in a specialty, and who is awaiting the examinations of The Royal College of Physicians and Surgeons of Canada may, with the approval of the Credentials Committee, be permitted to do surgical procedures of his specialty. This permission will not extend beyond the time of the announcement of the results of the examinations of The Royal College of Physicians and Surgeons of Canada immediately following the completion of his course.

(c) General practitioners may, with the approval of the Credentials Committee, be permitted to have limited surgical privileges and to the surgical procedures named in the list most recently revised by the Department of Surgery and approved by the Governing Body of the Victoria General Hospital.

Post-Graduate or Under-Graduate Teaching

During the course in Endocrinology early in March, the Executive Committee of the Nova Scotia and Halifax Branches of the General Practitioners' Society took the opportunity at a social evening, to get together with their out-of-town colleagues. Among the visitors were Doctors P. J. Dowd, Sussex, N. B., W. A. Hewat, Lunenburg, J. A. MacCormick, Antigonish, A. M. MacPherson, Kentville, J. L. Thompson, Saint John, N. B. and J. C. Wickwire, Liverpool.

Many problems in general practice in rural and urban areas were compared and discussed. The most animated discussion evolved about the function of the Dalhousie Medical School. It was felt that its primary duty was to turn out well trained general practitioners for the Maritime Provinces, and that, within recent years, this function was being more and more superceded by emphasis being put upon post-graduate teaching and specialization. It was recalled that a few years ago the unwritten rule was that no man would graduate unless he had done one appendectomy, one herniotomy, one tonsillectomy and one circumcision. These being the most common surgical conditions with which one should feel competent to deal with in the early months of practice. Now, interns seldom, if ever, have such an opportunity, and when practising in rural areas and faced with these conditions, can feel very ill-at-ease.

Medicine is now being taught by specialists in every field. This is excellent for the student's theoretical knowledge, but is he being taught how to apply it to the every day problems met with in general practice?

It was recognized that the type of patient now being admitted to the wards of a teaching hospital, e.g. the Victoria General Hospital, is such as to stimulate the advance in specialization; in other words, they are mostly cases with which the general practitioner feels unable to cope without all the aids to diagnosis and treatment found within such an institution, and without, perhaps, the help and advice of his specialist colleagues.

But is there not a very definite need for the teaching of the problems of general practice by general practitioners, appointed by the University to the teaching staff and holding equal status with their specialist colleagues?

Should not the amount of time spent in Psychiatry be reduced and general practice clinics be introduced? Should there not be a ward in the Victoria General Hospital set aside for general cases, where, without spending a fortune on diagnostic investigations, patients might be admitted and treated by general practitioners to the benefit of patient and student?

All these and many other suggestions were advanced and discussed, and are worthy of serious consideration by all general practitioners.

It was felt that such an exchange of views was most helpful and led to a better understanding of our common problems, and it was hoped that further opportunities would arise when similar informal discussions could be arranged to our mutual benefit.

F. Murray Fraser,
Secretary, General Practitioners' Branch.

A Message to the Doctor Regarding Mental Health Week

This year Mental Health Week is from May 2 to May 8. The purpose of Mental Health Week is to inform the public about Mental Health in Nova Scotia: about the available facilities and the need for more facilities, and to encourage support of all activities designed for improvement of Mental Health. Before such support can be forthcoming there must be public understanding and acceptance of the problems of Mental Health.

The family doctor is a potent force in helping people to accept and to understand mental illness. We would like to have your support during mental Health Week and request that you provide information for the many people who will ask questions about mental illness during this period.

Further information about Mental Health Week may be obtained by writing to the Nova Scotia Medical Bulletin.

Solomon Hirsch, M.D.

Chairman, Mental Health Week Committee

A Note From Yarmouth

The Medical Doctors of South-Western Nova Scotia held a short course in Children's Diseases on Thursday and Friday, April 1 and 2. Speakers were supplied by the Dalhousie Post-Graduate Committee and were Doctors Norman Coward and Robert Grant, both on the staff of the Children's Hospital, Halifax. Following an enjoyable dinner at Wagners Restaurant and a short business meeting under the chairmanship of Dr. D. R. Sutherland, the visiting Doctors gave an illustrated lecture on the subject, "The Child Who Fails To Thrive".

The following morning a round table discussion was held at the Yarmouth Hospital and several subjects related to children's diseases were discussed and problem cases presented.

The following Doctors were present:

Dr. G. V. Burton

Dr. R. M. Caldwell

Dr. C. K. Fuller

Dr. W. C. O'Brien

Dr. D. R. Sutherland

Dr. P. LeBlanc of Little Brook

Dr. E. Melanson of Eel Brook

Dr. George Burton

Dr. B. J. d'Eon

Dr. D. F. Macdonald

Dr. S. W. Williamson

Dr. P. LeBlanc of Little Brook

Dr. J. E. LeBlanc of West Pubnico

Dr. A. F. Weir of Hebron

D. F. Macdonald, M.D.,

Secretary, Western Nova Scotia Medical Society

Bursaries for Training in Public Health, Pathology and Radiology

Applications are invited from physicians wishing to train in the above. Bursaries to successful applicants—\$200.00 per month if single, \$250.00 per month with dependents, plus tuition, books and travel expenses.

Applicants must agree to return to salaries position in the Province for a stated period depending on the length of training.

Apply to:

J. S. Robertson, M.D., D.P.H.,
Deputy Minister,
Department of Public Health,
Provincial Building,
Halifax, Nova Scotia.

Locums Tenens Wanted

Doctor, graduating in May from Dalhousie Medical School, would like a locums from May 13th to the end of June. Apply to the Secretary.

To Rent

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