

MARCH 1962

The NOVA SCOTIA MEDICAL BULLETIN**EDITOR-IN-CHIEF**

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CORRESPONDING MEMBERS—SECRETARIES OF BRANCH SOCIETIESGUEST EDITORIAL**THE NEED FOR A TUMOUR REGISTRY**

Treatment of malignant disease is often inadequate. Nevertheless great strides have been made in recent years and cancer cure is no longer a myth. Good results are being achieved only by the application of the best techniques using the greatest possible care and by calling on the finest minds available to guide the various aspects of diagnosis and treatment. Early diagnosis insures the best outcome for the individual. Careful control and follow-up insures the best results in terms of tumour types.

A Tumour Registry is not just a list of names. It is a means to bring scientific quality control to bear on treatment methods and show the profession where we succeed and where we fall down. It helps the doctor to know how his patient is getting along individually and by comparison with others, and helps the patient to obtain continuing treatment and the benefit of the latest advances.

A Tumour Registry means work. It also means reporting our cases to an agency which we hope would be set up on the advice of the profession itself, and with our participation. In Nova Scotia, much information is stored by the Hospital Insurance Commission. Legislation to allow this information to be released for scientific purposes and ultimately for the patient's benefit is required. Suitable safeguards to preserve the individual's privacy can be worked out. We need a Tumour Registry in Nova Scotia now, and hope no petty considerations will stand in the way.

S. C. Robinson.

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* Deceased Sept. 19, 1961.



WILL UNCLE OTTAWA PAY THE STENOGRAPHERS?

EXECUTIVE

BRIEF to THE ROYAL COMMISSION ON HEALTH SERVICES 1961

INTRODUCTION

Mr. Chairman and members of the Royal Commission on Health Services,

The Medical Society of Nova Scotia, which is the Nova Scotia Division of the Canadian Medical Association, bids you a cordial welcome to Nova Scotia. It is of interest to note that the first provincial hearing of this Royal Commission takes place in this Province, since the Medical Society of Nova Scotia is the senior medical association in Canada, having been founded in 1854 and having held its 108th consecutive Annual Meeting in June, 1961.

Created in 1854, in the interests of protecting and improving standards of medical care, the membership has continually sought the ideal of providing a high quality of medical services under the varying circumstances identified with this Province. The Society, which now has 636 members, is fully conscious of its responsibilities in the realm of prevention of disease and the diagnosis, treatment and rehabilitation of the patient with disease.

The members, all of whom join the Society and maintain membership on a purely voluntary basis, are also voluntarily active in the encouragement of and assistance to the many fields of endeavour, public and private, which provide services ancillary to those provided by the physician for the benefit of the patient.

As the Nova Scotia Division of the Canadian Medical Association, the Medical Society of Nova Scotia has had close association with the national scene involving medical and allied health services. The beliefs and principles as expressed by the Canadian Medical Association (1960) are supported by this Division as a basis for the development of medical services insurance in Canada. (Appendix I, Page 97)

We in this Province have participated in the modern development of scientific medicine, we have co-operated with official and voluntary agencies to bring the advances to our people, we have improved the quality of medical care and we have established under our own auspices a successful plan of pre-paid medical insurance. The objects of our Society and the Committees by which we attempt to attain them, are outlined in Appendix II, Page 100. We recognize that health services of high quality are regarded as essential in our society, as is attested by the following resolution passed in 1960 at our 107th Annual Meeting:

"that the Medical Society of Nova Scotia at this general meeting (1960) goes on record and is in accord with a plan for medical services insurance in Nova Scotia so that the highest possible quality of medical services will be available irrespective of income; and furthermore, the Medical Society of Nova Scotia believes that this can be brought about by the united efforts and co-operation of existing agencies interested in and responsible for the health of the people of Nova Scotia".

In the autumn of 1960 we established a Special Research Committee to implement our belief and we have outlined in Appendix III, Page 102 the terms of reference of that committee of five members. It will be observed that our field of study bears a close resemblance to that assigned to the Royal Commission. We have advised the leaders of all political parties in the Legislature of Nova Scotia of our undertaking because we recognize that the co-operation of legislators and the medical profession will be required to attain the level of health service which will be needed.

The gratifying announcement by the Prime Minister of Canada in December 1960 that a Royal Commission on Health Services would be appointed, resulted in our Executive Committee delegating to the Special Research Committee the responsibility to prepare a submission for the Royal Commission for the approval of the Medical Society. Studies had been initiated under the terms of reference of the Special Research Committee, but since the announcement of the terms of reference of the Royal Commission on June 20th, 1961, we have framed our investigations with your requirements in mind.

The necessity and desirability of having health services available to all residents of Nova Scotia creates no issue; we are entirely in agreement. The point for examination and decision is how the objective is to be achieved. This, we submit, requires the closest examination. Medical "needs" in contrast to medical "wants" will have to be determined. Within Nova Scotia there are varying regional problems, in some instances strikingly similar to variations across Canada.

There are many services developing and contemplated which must be considered as **necessary** for a solid foundation in order to assure the full implementation of the potential of health services to residents.

The highest possible quality of medical services cannot be purchased as a piece of merchandise. Nothing is as personal as the service which a physician provides to his patient. Such service, projected by the physician in whatever field of endeavor he may choose, results from a combination of medical training and medical research which is initiated in student days and continued throughout his lifetime. The utilization of this knowledge assimilated by the physician in the fields of prevention, diagnosis, treatment and rehabilitation is a personal responsibility proudly assumed by the great majority of physicians.

From time to time continued progress in scientific and social affairs requires a pause to examine the numerous factors involved and an attempt to orient them to take full advantage of their potential. Health services are essential. We welcome this opportunity, along with other interested groups, to make an objective review of these matters following your extensive terms of reference. We are of the belief that we have a mutual objective in such a study which is to assure the residents of Canada, and, from our viewpoint particularly Nova Scotia, that the highest possible quality of health services are available to all to maintain health, to prevent disease and when disease does occur, early diagnosis, adequate treatment and rehabilitation. We submit that the central factor in this area is the medical service provided to patients by physicians.

The preceding recommendations are based on the information included in the accompanying submission. In it we have dealt with each term of reference based on information available to us. Unfortunately, the interval between the announcement of the terms of reference (June 20th, 1961) and the date it was necessary to finalize the brief (October 15th, 1961) is such that we do not have available all the detailed information we would wish to present to you. Our comments will relate to each of your specific terms of reference.

(To be continued)

Come to Halifax!

109th ANNUAL MEETING

THE MEDICAL SOCIETY OF NOVA SCOTIA

Nova Scotian Hotel, Halifax, May 21st, 22nd & 23rd.

PROGRESS REPORT

Dr. R. F. Ross, President of the Society and general chairman for the Annual Meeting 1962 reported to the Executive Committee on February 24th when he outlined a preliminary programme for the Annual Meeting. While certain details remain to be finalized, the programme is attractive in all respects. Your attendance will make the meeting a real success.

A summary of the programme follows:—

Guests: Dr. G. W. Halpenny, President of the Canadian Medical Association and Mrs. Halpenny.
Dr. A. F. W. Peart, Deputy General Secretary of the Canadian Medical Association and Mrs. Peart.

Clinical Speakers: Dr. David A. Howell, Neurologist, will speak on two subjects—

- (a) The Treatment of Strokes and Strokelets caused by Arterial Ischaemia by Anticoagulant Drugs.
- (b) Observations on the Diagnosis of Strokes caused by Arterial Infarction, Intracranial Haemorrhage and Cerebral Tumours.

Dr. Kenneth T. MacFarlane, Obs. & Gyn., will speak on—The Modern Management of Toxaemia of Pregnancy.

Both these physicians are from the staff of the Montreal General Hospital.

Group Clinical Discussions will be held when members will have the choice of attending any one of the following discussions:—(a) Fractures (b) Congenital Heart Disease (c) Antibiotics (d) Enccephalitis and Virus Diseases of the Nervous System and (e) Cardiovascular Disease after age 50.

Luncheon speakers: Dr. G. W. Halpenny will speak on the Monday; the Hon. G. I. Smith on Tuesday and Mr. Justice Patterson on Wednesday.

Social Functions: On Sunday evening, May 20th, a Ceilidh to be held in the Commonwealth Room from 9 - 11 p.m., will create an opportunity to renew acquaintances. Dr. Carl Giffin of Truro is in charge for the evening and is expecting a good turnout

Each morning the ladies will be invited to foregather for coffee or sherry at 10 a.m. Dr. Harland Lavers of Truro is in charge of the Ladies' Programme.

The Annual Ball will take place on Monday evening starting at 9 p.m. in the Commonwealth Room with Don Warner's Orchestra in attendance.

Tuesday afternoon is "free"; the Golf Tournament will be held under the Chairmanship of Dr. B. D. Karrel. The possibility of a cruise on the harbour or a fashion show is being explored; Tuesday afternoon may also be used by the groups who wish to organize meetings for any particular purpose.

Tuesday evening is set aside for entertainment by the Colchester-East Hants Society which may take the form of a Lobster Supper on the south shore. The hosts will be Dr. and Mrs. T. C. C. Sodero of Truro.

The President's Reception and the Annual Banquet take place on Wednesday evening. The programme for the Annual Banquet will include the presentation to the Society of Presidential Insignia. The incoming President for the 110th year of the Society's history will be inducted to office with suitable ceremony.

It is apparent from the foregoing that the Committee for the Annual Meeting 1962 is making every effort to have a programme which will appeal to all. The social events will be enjoyable and the clinical sessions instructive.

BUSINESS SESSIONS:

However, the primary purpose of the Annual Meeting is to deal with the business of the Society which is of increasing importance to all members and Medicine as a whole. The Executive will report on its activities in the interval since the last meeting. There will be reports from the twenty Standing Committees and ten Special Committees of the Society as well as its representatives to eight organizations. There will be reports on the three projects sponsored by the Society under Federal-Provincial Health Grants.

These Annual Reports are organized in a volume which will be available prior to the Annual Meeting and will be forwarded to those who complete housing application forms. It is to be noted, however that any member is welcome to a copy of these Annual Reports by writing to the Executive Secretary. The reports will also be available at the time of registration, but to have the best results they should be studied prior to the meeting itself.

The registration desk for the Annual Meeting will be open at 8.30 a.m. on Monday, Tuesday and Wednesday. The social registration fee is \$10.00.

The success of an Annual Meeting is dependent on the attendance of members. Make **your** plans now to attend.

FOR SALE

My wife no longer requires stairway elevator—a completely automatic safe and economical alternative to costly remodeling or moving. Ideal for cardiac patient or one with severe physical handicap. May be seen in operation by phoning for appointment—Halifax 455-1030, or any information desired may be obtained by writing Dr. Walter M. Little, 58 Edward Arab Avenue, Halifax.

109th ANNUAL MEETING
The Medical Society of Nova Scotia
(Nova Scotia Division of the Canadian Medical Association)

HOUSING APPLICATION FORM

Dates of Meeting: May 21st, 22nd, 23rd, 1962 - Nova Scotian Hotel, Halifax.

Please Note: Re reservations at Nova Scotian Hotel —

Single room rate from \$8.50 to \$12.00 per day —

Single room rates in the old section of the hotel from \$8.50 - \$10.50;
in the new section \$11.50 - \$12.00.

Double room rate (twin beds or double bed) from \$12.00 to \$14.50 per day —

Double room rates in the old section from \$12.50 - \$14.50 per day;
in the new section \$15.00 - \$16.00 per day.

Please indicate on the application form the rate you wish to pay.

Dr. C. J. W. Beckwith,
The Medical Society of Nova Scotia,
Dalhousie Public Health Clinic,
University Avenue,
Halifax, N. S.

Please arrange a reservation at the Nova Scotian Hotel for the undersigned as follows:—

Single roomat.....per day

Double room: twin beds at.....per day

double bed at.....per day

I expect to arrive on May..... a.m. p.m.

I expect to depart on May..... a.m. p.m.

Names of persons who will occupy the above accommodation:

Name:

Address:

Signed: Date.....

Applications for reservations at the Nova Scotian Hotel will be passed on to the hotel management for action and confirmation.

MARITIME MEDICAL CARE TO ADOPT MEDICAL SERVICE AUDIT FORM

From time to time concern has been expressed by Maritime Medical Care subscribers and by Participating Physicians concerning the lack of verification of submitted Maritime Medical Care accounts. The subscriber complains that he does not know what the Plan is paying on his behalf, while some physicians feel that false accounts may be submitted with very little fear of detection. It has frequently been suggested that all accounts should require the signature of the patient, as well as the doctor. Although this procedure might prove an effective answer to such criticism, it is felt that it would prove very unwieldy in practice, as compared to the convenience of the present system for doctor and patient.

However, in response to the expressed need, it is the intention of the Corporation to introduce shortly a "Medical Service Audit Form", a copy of which appears below. Because of the large number of claims being processed, it would prove too costly to advise every subscriber every month of the claims paid on his behalf. A system of selective preparation will accordingly be used, by which audit statements will be sent each month to one-sixth of Maritime Medical Care subscribers, on a pre-arranged schedule. This will not mean that each Maritime Medical Care subscriber will receive two audit statements per year, but rather that each subscriber's case history will be checked twice a year, and if claims have been paid for him during the month when his history is reviewed, the subscriber will receive an audit form, stating the services received. If no claims were paid, no audit form would be sent.

It is felt that the adoption of such a system will not pose the administrative problems which would be attendant on requiring the patient to sign submitted accounts, yet will be sufficient to achieve the primary object of informing the subscriber of the cost to the Plan of the medical service he is receiving. Regular distribution of the Medical Service Audit Form will also make the profession aware that the subscriber is informed of the charges made to the plan for services rendered.

It is the sincere hope of Maritime Medical Care that the adoption of the Medical Service Audit Form will prove to be the answer, in large measure, to the criticisms in regard to our present system.

G. B. SHAW, M.D.,
Medical Director.



MARITIME MEDICAL CARE INCORPORATED

P. O. BOX 428

HALIFAX, N. S.

.....
(Agreement No.)

.....
(Group No.)

-
-
-

MEDICAL SERVICE AUDIT FORM

This form is not a bill but indicates accounts submitted to us on behalf of your agreement and is issued for audit purposes. Return this form only if the services listed below **do not** agree with your records. Please use the reverse side to explain any differences you may find.

NAME OF PATIENT	SERVICES RENDERED BY	DATE OF SERVICE	TYPE OF SERVICE RENDERED	APPROVED AMOUNT

THIS STATEMENT CANNOT BE USED FOR INCOME TAX PURPOSES

THE MEDICAL USE OF RADIOISOTOPES

F. J. FILBEE, M.B., B.S., D.M.R.T.
HALIFAX, N.S.

The production of artificial radioactive elements just prior to World War II was quickly followed by attempts to apply them clinically. However, the quantities available at first were minute and the cost high. This was because they were made in a cyclotron which is inefficient for this purpose. Radioactive iodine was, however, used to investigate the thyroid.

Soon after the war Nuclear Reactors became available for peaceful purposes and gradually, starting in 1946, artificial isotopes of many types were developed. The Medical uses were among the first investigated, especially iodine for investigation and treatment of thyroid conditions and phosphorus for the treatment of blood diseases.

Since that time there have been more and more different isotopes available, and more and more centres have been using them. This has followed increases in the quantities available and great reduction in price. It is of interest that the first high activity Cobalt⁶⁰ sources suitable for radiation therapy were made in Canada—we having the first high intensity reactor suitable for making them. The first unit was installed in Saskatoon in 1951 and Canada for long has led the world in the production of these sources, and in the design of therapy equipment.

In this Province we first began the clinical use of radioisotopes in 1956 and the facilities offered have grown steadily. At present all clinical isotope work is centered in the Victoria General Hospital, but other laboratories are a-building.

THE PHYSICS BACKGROUND:**

Atoms are composed of a central nucleus, and a system of planetary electrons. The positive charge in the nucleus, due to Protons exactly balances the number of electrons and is the Atomic Number. Each proton has a mass of 1. and any balance is made of uncharged Neutrons also of unit mass. Thus:

Hydrogen	At. Wt. - 1	At. No. - 1	Protons - 1	Neutrons - 0
Carbon	At. Wt. - 12	At. No. - 6	Protons - 6	Neutrons - 6
Iodine	At. Wt. - 127	At. No. - 53	Protons - 53	Neutrons - 74
RadioIodine	At. Wt. - 131	At. No. - 53	Protons - 53	Neutrons - 78

You will see that the last two lines both refer to Iodine, but the last (I^{131}) has four extra neutrons in the nucleus, which make the atom unstable. Every element up to Lead has at least one form when the nucleus is stable, but other forms may exist with too many or too few neutrons, which are unstable. Each form is an Isotope of the element, the unstable ones being Radioisotopes.

Radioactive atoms decay with the emission of a beta particle (electron) or a gamma ray (X-ray) or both, to become stable. This happens at a rate which is constant for any one isotope.

The decay is "Exponential", meaning that the fraction of the total number of atoms disintegrating in a period of time is constant. This gives rise to the term "Half Life" which is the time for half the atoms to decay. After a second "Half Life" the number is again halved and so on.

**We have kept Math out of this as far as possible, but the reader may skip this section if he wishes.

After 1 half life	—	$\frac{1}{2}$ remains
2 half lives	—	$\frac{1}{4}$ remains
3 " "	—	$\frac{1}{8}$ remains
4 " "	—	$\frac{1}{16}$ remains and so on

Amounts of radioisotopes are measured in Millicuries, each millicurie being equivalent in activity to one milligram of radium. The mass of one millicurie of radioactive material is of the order of a fraction of a microgram. They are thus used as "tracers"—behaving chemically as the stable isotope of the element they can be traced by their radioactivity. Tracer doses are usually measured in microcuries, i.e. in thousandths of a millicurie.

They are measured by counting the number of rays reaching either a Geiger tube or a Scintillation crystal. Each ray produces an electric pulse which can be amplified and counted.

In practice all isotope techniques are counting methods, with allowances for radioactive decay, natural radiations in the laboratory (background) etc.

CLINICAL RADIOISOTOPES AS USED IN NOVA SCOTIA

Facilities are available here for a wide range of investigations from thyroid function to Pernicious Anaemia.

All are insured services under the Nova Scotia Hospitalisation Insurance Act.

Follows an outline of the main tests available:

THE THYROID GLAND

Radio-Iodine is absorbed in the gut and remains in the blood until either trapped by the Thyroid or excreted by the kidneys. In the Thyroid it is incorporated into thyroid hormone. It is stored for a time, and then returned to the circulation bound to protein — the P.B.I. Following metabolism the iodine split off the protein becomes available for competition again between the Thyroid and kidney.

In hyperthyroidism the trapping rate is raised and in Myxoedema it falls, so that of an oral dose of iodide the percentage picked up by the thyroid mirrors the thyroid state—the remainder being excreted.

This is the basis of the 24 hour R.A.I. uptake:

The patient is given a tracer dose of labelled iodide and the percentage in the thyroid estimated at 24 hours. Results will be in the following ranges:

Hypothyroid	0 - 15%
Euthyroid	12 - 43%
Hyperthyroid	35 - 100%

Most results will be well within these ranges, but where there is overlap a further sorting can be made. In suspected hypothyroidism, the uptake is repeated after Thyroid Stimulating Hormone. It rises in the normal patient. Possible hyperthyroidism can be excluded by repeating after a short course of thyroid hormone or Triiodothyronine. This suppresses normal T.S.H. and uptake falls in the normal.

Unfortunately there is another source of error, as dietary intake of milligram quantities of iodine will saturate the thyroid and give a falsely low reading. Uptakes equally cannot be done shortly after medical use of iodides—Lugol's Solution, or dye contrast radiology, e.g. I.V. Pyelogram, Cholecystogram, etc.

Nor should they be relied on in the presence of a blocking agent such as perchlorate or tapazole.

We can get further information from both the percentage and the pattern of the urinary excretion.

The spatial arrangement of the radio-iodine in the thyroid will often demonstrate, as well as the size of the gland, the presence of areas of excessive or of low uptake (Hot or cold nodules). A "hot" nodule normally is benign and is found in toxic goiter. Cold nodules, especially if single, are suspicious of cancer. This is shown in a "scintiscan" in which a counter scans the neck, while a printing device makes a series of dots on paper. The more counts there are, the closer the dots so that a picture of the gland is built up.

In Hashimoto's disease the trapping mechanism is faulty so that a dose of perchlorate given following R.A.I. will flush a proportion of the activity out of the gland.

Other tests such as the $\frac{1}{2}$ hour I.V. Uptake and P.B.I.¹³¹ conversion ratio are not routinely done here.

Efforts are being made to measure thyroid function by radiochemical reaction with red cells or plasma. These tests, if accurate over a large series of controls, will enable young children and pregnant women to be tested without the ingestion of any radioisotope.

Some other Isotope studies:

RADIOIODINATED HUMAN SERUM ALBUMIN (RISA)

This is purified albumin labeled with Radio iodine.

Typical uses are:

1. Blood and plasma volume determinations. This is a dilution method and is rapid and reliable.
2. Brain tumour localisation by scanning the cranium after giving RISA which is more heavily absorbed in some tumours than in normal brain tissue.

RADIO CHROMIUM Cr⁵¹

This isotope is widely used in Red cell mass and survival studies. Patient's red cells can be "tagged" with Cr⁵¹ and their fate after reinjection studied. We are at present doing studies with Cr⁵¹ on:

- (a) Red cell mass — by dilution technique.
- (b) Red cell survival — by following the loss of activity from the blood.
- (c) Splenic activity — by observing count rates over the spleen. A delayed rise indicates pooling of blood in splenic sinuoids. Persistently high counts suggest hypersplenism.

RADIOCOBALT Co⁶⁰

Aside from its use in place of Radium, Co⁶⁰ is used to label vitamin B₁₂ for diagnosis of Pernicious Anaemia. In a patient who has had B₁₂ therapy this may be the only method of arriving at a diagnosis, as it is independent of the state of the bone marrow.

FAT STUDIES — I¹³¹

Both neutral fat (triolein) and split fat (oleic acid) can be labeled with I¹³¹ and their absorption checked by studies of blood activity and fecal excretion. This enables us to differentiate pancreatic insufficiency from other malabsorption states.

The above account leaves out several other tests we are doing and makes no mention of radioisotope therapy for a number of conditions from thyrotoxicosis to breast cancer. Perhaps a further article might discuss these.

ARTICLE

WHAT'S ALL THE TALK ABOUT A PROVINCIAL CANCER REGISTRY?

NORMAN H. GOSSE, M.D.

Halifax, N. S.

The answers as we hear them are as varied as those that were given in the case of the six blind men and the elephant. It is a fact however, that, while there may be some variations in the operation of Central Tumour Registries, experience and the desire to extend efforts in Cancer Control are causing the answers to converge upon uniformity as far as the essential purposes of a registry are concerned.

On this continent, perhaps the first to realize the importance of a registry was the State of Connecticut. They have been pioneers in much in the Cancer field. Today, under their Department of Health, but fully backed by the State Medical Society, they operate as perfect a system of registration and follow-up of cancer cases as there is anywhere. It costs their state a good bit to operate it the way they do, but nobody doubts that it is money well spent.

Since the flowering of that registry, most other States of the Union have come into the picture, though with some variation as to sponsorship. For example, California organized its registry under the combined efforts of (1) The State Medical Society, (2) The American Cancer Society (which because of the great participation by medical men in that country, is a powerful organization) and (3) The State Department of Health. The understanding is that probably not more than three states now remain without such Registries, though they are not necessarily of equal calibre. Primarily, of course, it is a matter of Public Health concern.

The European countries, too, have long been in this field. One of the finest, yet one of the least pretentious, that I have seen is that of Norway, situated in Oslo. There again they have the backing of several organizations. Interestingly, most of the Cancer effort in that country—therapy, research, epidemiology, etc.—is carried on under the aegis of the Norwegian Cancer Society, but its budget is greatly augmented by directly contributed State funds. In some respects the Cancer Foundations of Ontario and British Columbia are similar, at least to the extent that State participation, which is large, is indirect.

In Canada we are seeing registries being set up in different provinces, some modest and partial, some concerned only with obtaining a knowledge of the true incidence of Cancer in their provinces, others, equally concerned as to that, are concerned also with the extent that they can be of value to the province in the realm of Cancer Control. The last province that we know to have joined the list of registries is the province of Quebec. This, it is understood, was instituted by its provincial Department of Health a few months ago.

In Nova Scotia, we, who have appreciated its potential and have been anxious to have its benefits accrue to our people, have been discussing the matter for several years, and representations have been made from time to time respecting it. In 1960 the Cancer Committee of the Medical Society of Nova Scotia, after looking into the feasibility of having it instituted here, presented a resolution to the Annual Meeting of the Society concerning it. That society indicated its interest, its progressive thinking, and, by implication, its desire to cooperate, by adopting a resolution which urged the setting up of such a registry by this province. Talk has continued since that time but recently the matter has had a revival with persistent questioning as to why

something has not been done. The answer is not part of this communication.

It is reasonable, of course, that with the revival of the question there should be men who would ask how such a registry would operate and what its impact would be upon the practicing doctor. In speaking to that, let it be understood that I do so with no authority to speak for anyone, and any suggestions of mine are made (a) upon the recognition of a need, and (b) out of the experience and knowledge which opportunity has afforded me. How the instituting authority would develop such an idea has not, to my knowledge, been indicated. Nevertheless it is reasonable to expect that in this province such authority would not go far from sound medical opinion (a) as to the type of measure that would justify the cost, and (b) as to how it should operate to contribute most in Cancer Control. I am fully satisfied that here we can have the best of both worlds and reasonably; hence, I am under some compulsion at this juncture to express some views concerning it.

Because it is so necessary to link clinical research with therapy, the Nova Scotia Tumour Clinic must continue — and indeed develop — its detailed registry and follow-up *beyond the requirements of a central registry*. It therefore will be able, quite readily, to provide to the central registry the requisite data on the patients that come to it. That will constitute the major part of the Central Registry's material. Again: As follow-up is an important part of the Clinic's work, that too must continue to be done by the Clinic. Thus also will it assist the registry in maintaining the *continuing* record of patients listed with it. *On the majority of patients then, there would be no change from current practice.* What is that practice?

Patients referred to the Clinic are seen and treated, and the follow-up is conducted as a continuation of that treatment. Necessity for this is indicated with every recurrence of cancer. At first such follow-up is direct, but with the progress of time, reports from one qualified source or another are accepted as adequate. On the other hand, patients who have been admitted privately and directly to the V.G. Hospital and are not referred to the clinic as such come only into the *registry section* of the Clinic. These are "followed" by the Clinic registry *through the referring doctor*, and are followed by other measures only when the referring doctor himself has lost contact and/or authorizes the registry to follow directly, or to utilize those other professional measures that, fortunately, are available. That has worked well. Cooperation has been so good that last year, at the time of printing the 5 year statistical report of the Clinic, one patient only was shown to be lost; and he was later traced. This year, the 5 year follow-up report is 100%. This is remarkable, but nothing short of it should be regarded as acceptable.

In most countries, if not all, the Central Registry has full *legal* authority to employ any or all methods in follow-up, requisite to getting results in all cancer cases. For the most part it represents "reserved authority", however, for the direction of the Registry by a knowledgeable medical man, and the continued interest on the part of medical men in general would seem to have proven that a successful operation is possible without the use — or with very little use — of such "reserved authority". At the same time it provides that no case should be lost because some one individual defaults.

Most, if not all cancer patients that are *not* in the registry of The N. S. Tumour Clinic sooner or later find themselves in a hospital and are discharged from it. The collecting of such "discharges" should prove to be simple in the circumstances that obtain in this province when there is legal authority for doing so. (This would seem to be one of the rocks on which we have been

grounded). The measures for the collection of the *additional data* essential to the making of the patient's initial record in a central (provincial) registry should also not be either difficult or extensive for the hospital which discharged the patient. The exception to this is perhaps the V. G. Hospital which, through the Tumour Registry, must report the additional data on so many patients.

The Registry so set up would provide important statistical information, concerning Cancer in Nova Scotia, which at this moment is not available. Accepted judgment is however that the value of that information would be minimal could it not complete the record from year to year of each and every patient registered *until the time when there is nothing left to record*. However, while tumour clinic follow-up must have a frequency anywhere from 1 month to 12, because it is responsible for treatment, the Central Registry would probably not require it more than once a year.

All this of course means work — a great deal of work — for the Registry. It means I.B.M. punch-cards and all that goes with it, and accessibility to a statistician; and if a high standard is to be attained by our Province it means here as elsewhere, the cooperation of the doctor concerned, when, as the cancer patient's physician he is asked to tick off an item or two regarding status, on a sheet or a card, to put it in a return-stamped envelope, and to drop it in the mail. That is being done with genuine cooperation today, in all but the most exceptional case that is being followed. One could safely predict therefore that in the event of our seeing a Provincial registry legally constituted, there would be similar cooperation; and so would be included those patients who are not now being included, and for a great part not now being "followed".

It has been suggested that patients might not want to be bothered once they get to feel well, and would be annoyed by such attention. Fortunately, some of us are in the happy position of being able to produce evidence to prove that the opposite is true. There is much appreciation and much gratitude expressed by patients for the interest shown in them. Such expressions, as we get them, are, for the most part, for an institution and for the doctors as a group. In the case of the provincial registry however, such appreciation could be only for the personal physician who might have to see or communicate with his patient from year to year to properly "tick" his follow-up form as he is asked to do now. How much additional work for the doctor concerned or for the Hospital, does this entail? It is not difficult to calculate the answer, on the basis of the number of cancer patients he or it sees in any month or in any year.

No apology is made for offering these impressions or suggestions at this time of revived interest. Having had pride in seeing this province achieve greatly improved service in the care of cancer patients over recent years, and having seen demand for that service expand to the point where the Clinic is now bursting at the seams, for lack of space, it is as natural as breathing that we should desire to see this and other needs met and other facilities developed to the place where all Nova Scotians may be happy to realize that their province is endeavouring to meet its obligations in Cancer Control and that, in all its several aspects we are endeavouring to keep well up among the progressive countries of the world. Just as in recent years it has attained much progress so must Medicine push on, in this and other ways, adopting from time to time such measures as offer value, in the long quest for Cancer Control: and we go forward or we slip back.

RESULTS OF THE TREATMENT OF TUBERCULOSIS BEFORE AND SINCE THE INTRODUCTION OF CHEMOTHERAPY *

The prognosis of many forms of tuberculosis is greatly improved when at least two drugs are administered for a period of eighteen months. Relapse is also less frequent than in the pre-chemotherapy era.

The proper administration of chemotherapy has led to a striking improvement in the outcome of the treatment of tuberculosis. If, however, patients with active disease have received inadequate chemotherapy, the cure rate will be lower and the relapse rate higher. All new cases of active tuberculosis, irrespective of the site, should receive combined continuous chemotherapy for about 18 months or longer. Bed rest is indicated during the early active phase and, in certain selected cases, surgical measures are also necessary.

Three antimicrobial agents have proved to be of great value, namely, isoniazid, streptomycin, and para-aminosalicylic acid (PAS). It is generally agreed that these drugs should not be prescribed alone, but should be given in a combination of at least two. If any one of them alone is prescribed to a patient with open cavity disease, the tubercle bacilli in the host rapidly develop resistance to the drug, so that it is no longer effective in combating the tuberculous infection. If, on the other hand, two or all three of the antimicrobial agents are given concurrently, the development of resistance by the tubercle bacilli to the drugs administered is markedly delayed, and the drugs continue to be effective in combating the infection for a much longer period.

ISONIAZID ESSENTIAL

Although there is not much difference in the effect of the different combinations, it is generally agreed that isoniazid should be one of the drugs given. It has established itself as the most powerful agent in the treatment of tuberculosis.

In assessing the results of the modern treatment of such a chronic disease as tuberculosis, we are handicapped by the fact that adequate chemotherapy, as we know it, has been in use for little more than seven years—insufficient time for an adequate long-term follow-up. However, since relapses usually occur within a period of five years, the results here reported should be a fair indication of the ultimate prognosis.

Before antimicrobial therapy was available, the mortality rate of active pulmonary tuberculosis was estimated to range from 5 per cent in minimal cases to 20 per cent in moderately advanced disease and to 70 per cent in far advanced. The majority of patients with persistent cavitation died within five years.

Modern treatment has resulted in a striking reduction in mortality and relapse rates. At the Toronto Hospital for Tuberculosis we have analyzed the results of treatment of all patients with active pulmonary tuberculosis who were admitted to that hospital in 1953, who had sputum positive for tubercle bacilli, who had not been given antimicrobial therapy before, and who were administered streptomycin, isoniazid, and PAS continuously for at least nine months. The average duration of triple-drug therapy given to the 140 patients in the series was 17 months.

At the end of five years, six patients had died, or 4 per cent of the total. All the deaths were in the far advanced group. With adequate chemotherapy, and resectional surgery where indicated, the mortality was strikingly reduced as compared with the prechemotherapy estimates of from 5 per cent (minimal) to 70 per cent (far advanced).

(*Abstracted by National Tuberculosis Association)

Of the 25 cases of minimal tuberculosis in the series, 100 per cent had attained inactive status by the end of two years, while 97 per cent of 61 moderately advanced cases had become inactive by the end of three years, and 81 per cent of 54 far advanced cases had become inactive by the end of three years. (Inactive, as defined by the National Tuberculosis Association, means that the following conditions had been met for at least six months; repeated examinations of the sputum or fasting gastric contents are negative for tubercle bacilli on culture: the chest radiographs have remained stable in appearance, and there is no evidence of cavitation.) It is evident that if cases of minimal or moderately advanced disease are adequately treated with drugs, one can be confident that the process will in almost all cases become inactive within two years. With far advanced disease, however, a favorable outcome is less certain.

RELAPSES

In an attempt to find out how many patients relapse after attaining an inactive status, 125 of the 140 cases were followed from two to five years. It was found that 4 per cent had relapsed in the period of follow-up. In a series of 900 cases treated without chemotherapy, or inadequate chemotherapy, reported by the Veterans Administration Hospital, Memphis, Tenn., 30 per cent had relapsed at the end of three years. The 4 per cent figure has also been reported by the Fitzimons Army Hospital, Denver, for 2,500 patients adequately treated with drugs and followed from one to five years.

It must be noted that the presence of a persistent cavity in the lung is always a great menace to the patient, whether he has had chemotherapy or not. The presence of a cavity in the lung that has failed to close after six to eight months of chemotherapy is the cardinal indication for surgical resection.

In the Toronto Hospital series, pulmonary resection was performed in 31 cases, or 22 per cent. The resection was segmental in 20 cases; a lobectomy was performed in 10 cases, and a pneumonectomy in one case. All these surgically treated cases became inactive; there were no deaths, but one relapse occurred.

Adequate chemotherapy in bone and joint tuberculosis has resulted in a marked reduction in mortality, more rapid subsidence of active disease, decrease in length of hospital stay, and marked reduction in relapse rate. Nearly half the cases are discharged with movable joints.

Four groups of cases of renal tuberculosis have been followed. In the first group of 82 patients who had neither chemotherapy nor nephrectomy, 58 per cent died of tuberculosis. In the next group of 347 cases treated by nephrectomy but without chemotherapy, 46 per cent died of tuberculosis. Inadequate chemotherapy in 175 cases led to a moderate reduction of mortality, but in the last group of 163 cases, adequate chemotherapy resulted in a striking reduction in the mortality to 1 per cent and a relapse occurred in only 1 per cent of this group.

SUMMARY

The outcome of modern treatment has been compared with that before the use of chemotherapy. Although the follow-up period is not long enough for final assessment, it is evident that combined continuous administration of isoniazid with PAS or with streptomycin, or all three drugs, for 18 months or longer, has resulted in a striking reduction in the mortality rate and improvement in the relapse rate.

COMMENT

“ . . . her roses on the bed . . . ”

Very often one sees the optimistic opinion expressed that such and such infections will in the course of time be completely eradicated as human reservoirs of infection dry up by means of widespread vaccination or the application of stringent sanitary laws. Lately this has often been written of poliomyelitis. But more especially, in the past fifty years, to those diseases that have their reservoirs in the dense populations of the East, notably smallpox. Before the continents were brought together by the speedy air bridges that exist today the sea frontiers of any nation when efficiently organized could and did provide effective barriers to the entry of smallpox. In Britain, for instance the only stimulus to vaccination was the occasional mild case that slipped through the net of the Port Health authorities and infected people in the upper age groups whose immunity had lapsed with time. Nevertheless, right up to 1946 when the legislation for the British Health Service was enacted, vaccination was compulsory unless a conscientious objection to it was sworn by a parent before a magistrate. In spite of this the regulation was never seriously enforced so that in the nineteen-thirties a considerable immunological hiatus existed in the general population that favoured the spread of smallpox. Ironically, when the provisions of the Health Service became law in 1948, vaccination became entirely a matter of choice, which meant, of course, to the average man in the street (from whence our Ministers of Health are drawn that it was no longer necessary. Naturally the upward trend toward non-protection continued. Many doctors protested at the time though without avail so that when death from smallpox swept in with the jets early this year Jenner's lesson had to be re-learned from the harsh realities of co-existence with life behind the viral curtain. Like the breathless horseman who brought the good news from Ghent to Aix, vaccine packages were rushed hither and thither as the presence of the virus disclosed itself and minor vaccination Dunkirks and even vaccination heroes were lauded by the press, as valiant medical Stakhovanites collapsed from sheer exhaustion carrying their scarifiers with them to the ground. And all because the lesson of modern Medicine has not yet entered the thick skull of demagoguery, namely that the proper application of scientific medicine is now the only yardstick by which the merits of any medical service, whether state or competitive, may be measured.

For some fresh advice on the matter one can do no better than refer to Jenner's proud announcement of his momentous discovery in a letter to a friend.

Dear Gardiner — As I promised to let you know how I proceeded in my inquiry into the nature of that singular disease the Cow Pox, and being fully satisfied how much you feel interested in its success, you will be gratified in hearing that I have at length accomplished what I have been so long waiting for, the passing of the Vaccine Virus from one human being to another by the ordinary mode of inoculation. A boy of the name of James Phipps was inoculated in the arm from a pustule on the hand of a young woman who was infected by her master's cows. Having never seen the disease but in its casual way before; that is when communicated from the cow to the hand of the milker, I was astonished at the close resemblance of the pustules, in some of their stages, to the variolus (smallpox) pustules. But now listen to the most de-

lightful part of my story. The boy has since been inoculated for the small-pox which, as I ventured to predict, produced no effect. I shall now pursue my experiments with redoubled ardour.

Believe me yours very sincerely,

Edward Jenner.

Berkley, July 19, 1796.

That these experiments were necessary may be judged by another quotation fresh and clear from the pages of history.

"Many a sweet face hath left its roses on the bed on which this dreadful and withering blight has laid them. In my early days, this pestilence would enter a village and destroy half its inhabitants; at its approach it may well be imagined not only the beautiful but the strongest were alarmed, and those fled who could." *

Thackeray's hero knew this only too well since along with his grog he stole not a few kisses from the comely barmaid of the village inn, who, when she laid her roses on the bed, infected the youthful Henry as well.

The moral of all this is not to forgo the pleasures of kissing pretty barmaids but to secure the protection afforded by vaccination before these youthful ardours manifest themselves in such dangerous inoculatory exercises. The fourth month of life would not be a moment too early in these froward times.

* Henry Esmond by W. M. Thackeray.

E.H.E.

CASE REPORTS

Many members have expressed the view that case reports of a single case (or a series of cases related by a common factor) will be a welcome addition to the clinical material of the Bulletin.

A letter to all Branch Secretaries has been sent conveying this suggestion. We would be most happy to publish such interesting material from all parts of the Province.



(Conclusion)

Address to the Saint John Medical Society

May 24/61

The less valid and perhaps most publicised sources of irritation are often entirely individual, for example Personality. The doctor should be kind, gentle, warm, interested. He should be slow to move when the patient is disposed to talk, but swift as a Jet when the patient wants relief. He should be run off his feet when the patient has no need of him, but always free and waiting anxiously for the call when the patient is in trouble. He should be NEVER GRUFF: NEVER ANGRY: NEVER TIRED! Men are not made of the stuff that meets these specifications today, but thousands of doctors are making a brave try at it.

Consider Apartheid: We are accused of being clannish, cold, uncommunicative, secretive, somehow irritatingly different from other men! And how very different we are! How can we be anything else but different? Who could train in Medicine and spend his lifetime at the bedside of the sick, the suffering and the dying and be as other men? Why are there a hundred young men striving to be engineers, architects, lawyers, astronauts or artists for every one who chooses to become a doctor? The 'Template For Youth' pictures the development of a child to manhood through the hopes of his ambitious mother. We see him first standing with his parent at the top of a hill, kite in hand, on a quiet summer evening:

"Look", shrills the child

"To that farthest star I'll fly my kite".

"Blow me some wind, God,

It's too still tonight."

(My son will be a famous astronaut, mused the loving mother)

We see him next several years later, gazing intently at a map of the world and dreaming dreams:

"I'll build a bridge", cries the boy

"From the Alps to the Andes".

"Look at them spans,

"Jeeze, aint they dandies"!

(My son will be a famous engineer, thinks the doting mother)
At this point we realize that his grammar is not quite up to medical standards.

A few years later we see him again, a husky teenager, bursting with energy and ambition as he looks up at the great peaks of the Rockies and shouts:

"I'll knock those big tops into the sea,
Grind up the rock all powdery,
Lay her out smooth, - yeah man,
Like a silken ribbon straight to Japan".
"She'll be the longest, the smoothest, the most,
The fastest speedway on the Coast".

(My son will be a famous builder, dreamed the fond mother)

Many hard and weary years later the scene has changed to an operating theater, where a young surgeon has just failed in his attempt to save the life of a man dying from internal haemorrhage. The patient has just expired on the table. The surgeon, still gowned and masked, slumps on a stool; the students stand immobile and awestruck in the gallery; the anaesthetist, assistants and nurses stand in awkward silence. The surgeon laments:

"How came I here"?
"Whose is this sticky blood upon my hands,
This nauseous belly stench"?
"These gaping fools who stare from yonder bench,
"A silent damning babel"?
"This still warm corpse in shrouds upon the table"?
Warm urine dribbles to his thighs,
And he, all mummy wrapped, is smothered, choking,—
"God ! Oh God!" he cries.
(My son is a great surgeon, brags the proud mother)

This is the fellow whom the public expects to be as other men. He cannot be. Doctors are people apart. Our science, our art, our skill, our pride, our joys and our tragedies cannot be comprehended by others, or shared with them. It behooves us therefore to wear our uncomfortable difference humbly, unobtrusively and with dignity.

Opulence: It is in this realm that the clay feet of the public relations idol becomes apparent and shows itself for what it really is,—advertising. Fashions in this kind of public relations have undergone many changes through the years. Until Psychiatry in these later days re-defined both insanity and immodesty, it was considered unethical for members of the medical profession to advertise, though to be sure, in all times, doctors, like love, have always found a way.

Fifty years or more ago, doctors advertised themselves through good works. Wherever there gathered a group of social uplifters, there you would find the doctors trying to do better and lift higher than anybody else. This was accompanied by advertising 'ex-ostentatio'. This consisted at first in driving the fastest horse and flashiest buggy in town and leaving it hitched in front of the most fashionable mansions while the doctor walked to the nearest pool room to shoot a game. This worked so well that we soon found ourselves living in the mansion and leaving our buggy hitched in front of the biggest bank, while we sneaked around to the loan company to stall off the next payment!

This was followed by the automobile age, during which period the doctor worked largely for the motor companies,—trading for a larger and flashier car every six months or so if practise seemed to slack off a little. This ceased to have advertising value when the charwoman's husband drove her to work in a better car than yours, and could change it every time he got behind in his payments,—with no loss of face.

Then followed the present era of advertising 'ex morbida'. This is done by choosing some dreadful and incurable disease, associating yourself closely with it, and then advertising the hell out of it. This works especially well, and is particularly appealing to the Press if the initial letters of the Society spell out a short and catchy word for headline use. The Canadian Arthritis and Rheumatism Society is a good exmple of this. Consider the following newspaper headlines:

- 'Premier presides at annual meeting of CARS'
- 'Dr. Jonathen Braker deplores slow progress of CARS'
- 'Dr. J. N. T. Oyler facilitates CARS movement'
- 'Rev. Muchmore Gass urges development of more powerful CARS'

You can see from these clippings that there are political and religious as well as medical opportunities for free advertising in this method.

Consider these clippings from the public relations file of the American Rehabilitation Society:

'Dr. E. Felter Buttoch, re-elected President, sees ARS getting bigger year by year.'

'Miss Ophelia Derrier, prominent socialite and president of the ladies auxiliary reports a very active year with ARS'.

Or this item from the Canadian Diabetic Society:

'Dr. U. Pasmore Sweetwater, national President, urges the nation, "Test it or taste it".'

Or this item:

'Dr. Burnham N. Shrinkem, prominent Toronto proctologist, appointed medical director of the National Haemorrhoidal Society.'

'Mr. A. Enos Itchum, prominent sand and gravel contractor, makes generous donation to local Haemorrhoidal Society'.

'Gen. Hamish Holesworthy presents long service Rosettes to prominent members of the Halifax Haemorrhoidal Soc. at annual'.

'Mr. Irving Layton mentioned as Poet Laureate of the National Haemorrhoidal Society in appreciation of his poem 'Imperial' which appears as No. 64 in his recent collection of poems under the title 'A Red Carpet For The Sun', and which touches with such tender feeling on one of the great problems of our Society.

Thus it is obvious that in the field of modern medical advertising, no up and coming doctor need be left 'holding the bag', - - - oh - oh, that reminds me, I haven't paid my dues to the Halifax Hydrocele Society!

There are many people who appear to believe that newspapers are published solely for the protection of the 'little man' and to champion the victory of Good over Evil. Perhaps some are. Perhaps all sometimes are, but the fact remains that newspapers are published as a business to make a profit, and to do so they must sell not only advertising, but papers. This necessitates

the printing of interesting material, and nothing interests the paper buying majority as much as the discomfiture of the few, particularly if that minority be comfortable and complacent. That makes us mighty good copy! Surely, however we are sensible enough to admit that it is the duty of the Press to be watchful and critical of any service which touches the lives of the people as closely as does medicine.

In our effort to find a way of tempering the bite of the newspaper's wind when it blew in our direction, we came to realize that favorable publicity could be obtained by:

1. Purchasing advertising.
2. Maintaining a running stream of ennobling charitable activities.
3. Providing interesting copy.

The first was discarded for lack of sufficient funds. The second because sustained nobility is difficult, not to say boring, particularly to newsmen. This left the provision of interesting copy, and an effort was made to this end through the medium of newspaper sponsored public meetings, panels and forums. The result of this endeavour is in question, but the fact became apparent that newspapers must go out every day and forums can be held so infrequently that the very best intentioned editor is apt to find his indebtedness to Medicine worn quite threadbare when the chance for a bit of professional bear-baiting comes along!

We are getting altogether too thin skinned about our public image. It seems to me that we are being more than vain, if, in this day of disregard for learning, disrespect for authority and disdain for religion, we should expect to be singled out by the public for favourable notice. Who are we to be acclaimed before the Judiciary, the Clergy, or the University?

Medicine does not need a glamorous press. We seek only a free and honest Press, for where it is honest and free, honest men are also free; where it is purchased or in chains neither Medicine or men can keep their freedom long secure!

In our public relations let us make it plain that we are not clowns or actors seeking the good will of the people through entertainment on stage or screen, but professional people with a responsibility to an immense trust, accepting humbly the just criticism of the Press for our faults and inadequacies. At the same time, let us in the words of the ancient prophet admonish Editors, as they serve out the daily ration of news, that they do so, 'not with the old leaven, nor with the leaven of malice and wickedness, but with the unleavened bread of sincerity and truth.'

J. W. REID

PERSONAL INTEREST NOTES

HALIFAX MEDICAL SOCIETY

February 14, 1962—Monthly meeting at the Maritime Warfare School of H.M.C.S. Stadacona, under auspices of the Canadian Forces Hospital. The Clinical program included "Fractures of the Ankle" by Surgeon Lieutenant T. B. Hall, discussed by Surgeon Commander D. A. Maciver, and "A Case of Arrested Hydrocephalus" that presented as a psychiatric problem by Surgeon Lieutenant Commander J. H. Gerlitz.

Dr. Crossman H. Young, Dartmouth has been appointed as the 1962 Chairman of the Heart Fund for Nova Scotia, it was announced by C. M. Haley, President of the Atlantic Provinces Division of the Canadian Heart Foundation. Dr. Young announced a campaign objective of \$30,000 for the Province, this amount to be raised during the month of February and to be used throughout the year to support scientists devoting their time to Heart Research.

February 6, 1962—Frank Rowe, Q.C., has been appointed as a one man commission to compare medical services provided for patients at the Victoria General Hospital, Halifax with that provided by other hospitals of similar size in Canada, it was announced by Health Minister Donahoe. It was reported that Mr. Rowe is to enquire into the basis on which medical services are presently being provided ward patients and out-patients; the basis and conditions on which appointments are made to the medical staff; and the remuneration, if any, received by the medical staff for services to patients or to the University. It is the intention also that the Commissioner will compare the basis on which appointments are made to medical staffs of other hospitals; the basis of remuneration; other terms and conditions of medical staff employment; and the relationship of the medical staff to patients in private, semi-private, and public ward accommodation as well as out-patient departments.

Dr. Nicholas J. E. Nemethy, recently opened an office at 5853 (formerly 301) Spring Garden Road, Halifax for the practice of Dermatology. Phone 422-5801.

WESTERN NOVA SCOTIA MEDICAL SOCIETY

Dr. F. J. Melanson attended the meeting of the Royal College of Physicians and Surgeons of Canada held in Toronto during the week of January 21.

Dr. and Mrs. D. F. Macdonald have spent two weeks holidaying in Mexico recently. (Yes, they went to a bull fight.)

Dr. S. W. Williamson has just celebrated his 93rd birthday; he still does some practice.

NOVA SCOTIA CHAPTER OF THE COLLEGE OF GENERAL PRACTICE

Dr. H. I. MacGregor, Halifax has recently been elevated from Vice-President to Acting President due to the death of Dr. F. J. Granville, Stellarton. Dr. Charles Harries, New Glasgow, is the Secretary. The Annual Meeting of the local Society is scheduled for May, 1962.

DEFENSE MEDICAL ASSOCIATION OF CANADA

At a rather poorly attended Annual Meeting on January 29, 1962, it was decided to raise the Annual Dues to \$5.00, which will provide also for a copy of the Canadian Forces Medical Journal to those who wish it.

The Annual Mess Dinner is scheduled for March 29, 1962 at Maritime Air Command's Officers' Mess, Anderson Square, Halifax. The guest speaker will be Dr. J. B. Hardie of Pine Hill. (Tickets at \$7.00 per member or guest may be obtained from the members of the executive.)

The executive consists of President:—Lt. Col. J. L. Fairweather; First Vice-President:—Squadron Leader C. A. Gordon; 2nd Vice-President:—Surg. Lt. Commander C. D. Vair; Past President:—Surg. Lt. F. G. Mack; Secretary-Treasurer:—Col. J. E. H. Miller.

UNIVERSITY

March 7, 1962—"A Day in Research in the Faculty of Medicine" is to be held in the Auditorium of the Nurses Residence of the Victoria General Hospital. Dr. W. A. Cochrane, Chairman of the Faculty Research Committee has emphasized that it is for all faculty members, not just those whose major interest is Research at the present time. There will be a short introductory session on research in general and medical research in the Faculty in particular, to be followed by short papers on their own investigations by faculty members. These will be followed by a discussion group on the organization, prosecution, and needs of medical research at Dalhousie now and in the future. A social gathering is planned to end the day.

BIRTHS

To Dr. and Mrs. R. N. Anderson, a son, John Frank, at the Grace Maternity Hospital, Halifax, on January 25, 1962.

To Dr. and Mrs. M. A. MacCulloch (nee Ann Rainnie), a daughter, at Oakville Trafalgar Memorial Hospital, Oakville, Ontario, on February 18, 1962.

To Dr. and Mrs. Clive Macdonald (nee Shirley Eagles), a son, Clive Stephen, at the Eastern Kings Memorial Hospital, Wolfville, on January 23, 1962.

To Dr. and Mrs. Michael MacSween, a daughter, at the Halifax Infirmary on October 23, 1961.

To Dr. and Mrs. B. C. Trask (nee Maxine Porter), a daughter Carolyn Margaret, at City of Sydney Hospital, Sydney, on January 30, 1962. A sister for Peter.

To Dr. and Mrs. Kenneth Tulle (nee Edith Lippsett), a son, David Kenneth, at St. Joseph's Hospital, Dalhousie, N. B. on October 16, 1961. A brother for George and Mary.

COMING EVENTS

May 21-23, 1962—109th Annual Meeting of the Medical Society of Nova Scotia, Nova Scotian Hotel, Halifax.

May 28-31, 1962—Annual Meeting of Canadian Public Health Association. King Edward Hotel, Toronto.

June 18-22, 1962—95th Annual Meeting of the Canadian Medical Association, Winnipeg, Manitoba.

September 18-21, 1962—5th Canadian Conference on Mental Retardation, Nova Scotian Hotel, Halifax. This conference, sponsored by the Canadian Association for Retarded Children, will have as its theme: "The Community—A Necessary Member of the Team." Slogan: "Help Them to Help Themselves." For further information: Mrs. L. J. Stewart, C.A.R.C. National Conference Chairman, 610 Kenaston Ave. Town of Mount Royal, Quebec.

June 10-14, 1963—96th Annual Meeting of the Canadian Medical Association, Toronto.

September 23-26, 1963—6th Canadian Conference on Mental Retardation, Marlborough Hotel, Winnipeg, Manitoba.

OBITUARY

Dr. Edgar Marshall Curtis, 57, Truro, Chief Radiologist at the Colchester County Hospital for the past 15 years, died suddenly at the Hospital, Thursday, February 8, 1962 following a heart seizure. He was born in Princeport, Colchester County, attended Colchester County Academy, and graduated in Medicine from Dalhousie. He carried on a private medical practice in Truro, for 10 years before going on the staff of the Colchester County Hospital, having taken post-graduate studies at the Royal Victoria and Montreal General Hospitals in Montreal and Victoria General Hospital in Halifax. He was a member of St. Andrew's United Church, Truro Golf and Curling Clubs, and a member of Truro Lodge No. 43, AF & AM, the Victoria Lodge of Perfection and Keith Chapter Rose Croix. He is survived by his wife, three sons, one a medical student, five brothers, one a doctor, and three sisters.

Dr. George Leslie Covert, 53, Halifax, died suddenly at his home, Friday, February 9, 1962. He was born in Sydney, being the son of a former Lieutenant Governor of Nova Scotia, the Hon. W. H. Covert. Graduating in Medicine from Dalhousie in 1934, he took post-graduate work at Oxford and Edinburgh Universities before opening practice in Halifax in 1937. He was on the staff of the Halifax Visiting Dispensary. He was a member of the Cathedral Church of All Saints and of the Royal Nova Scotia Yacht Squadron. He is survived by his wife, four sons, one a medical student, one brother, and two sisters.

Dr. Hugh Artworth Fraser, 57, Bridgewater, passed away at the Victoria General Hospital Halifax, Tuesday, February 13, 1962. He was born at Brooklyn, Hants Co., graduated in Medicine from Dalhousie University in 1929, and did post-graduate work in surgery at the Charity Hospital, Cleveland, Ohio from 1929 to 1932. He practiced one year in Halifax before going to Bridgewater in 1933 in partnership with Dr. F. R. Davis, later Minister of Health. He was a Fellow of the American College of Surgeons and was Certified in Surgery by the Royal College of Physicians and Surgeons, (Canada). He served with the R.C.A.F. from September, 1942 to 1945 as a Squadron Leader at Moncton, Labrador, and Dartmouth. From 1946 to 1961, he served as Chairman of the Bridgewater School Board and was Medical Health Officer for Bridgewater until his death. In 1949 he was President of the Medical Society of Nova Scotia and was at the time of his death, on the Board of Maritime Medical Care Inc. He was Chairman of the Board of Trustees of the Bridgewater United Church, an active member of the Bridgewater Curling Club, Golf Club, and member of Acadia Lodge AF & AM, Canadian Legion, and a former Kiwanian. He is survived by his wife, two daughters, and four sisters.

SYMPATHY

The Editors of the Nova Scotia Medical Bulletin extend their sympathy to Dr. B. K. Coady, Halifax, on the death of his mother, January 24, 1962.

(Editor's Note: There follows a list of successful Fellowship and certification candidates for 1961 examinations of the Royal College of Physicians and Surgeons of Canada, recently completed. Since the total number for Canada includes 179 successful Fellowship candidates and 555 successful certification candidates, we have included only those who are local graduates, local residents, or who are known to have taken some local training.)

CERTIFICATION

SPECIALTY	NAME	UNIVERSITY GRADUATION	ADDRESS
Anaesthesia	ARCHIBALD, Willis Moore	Dalhousie 1953	Kitchener, Ont.
	DONIGIEWICZ, Stanislaw Bronislaw	London 1950	Antigonish, N. S.
	ISHII, Masatatsu	Keio, Japan, 1954	Calgary, Alberta
	JOHNSTON, Albert Ernest	Dalhousie 1956	Toronto, Ont.
	MCGILLIVRAY, Joseph Irving	Dalhousie 1948	Kingston, Ont.
Dermatology	NEMETHY, Nicholas Istvan Elemer	Hungary 1939	Halifax, N. S.
	MACLEOD, Alan John	Dalhousie 1950	Halifax, N. S.
Internal Medicine	MACLEOD, Alan John	Dalhousie 1950	Halifax, N. S.
Pathology	WALDORF, Verne Ross	Dalhousie 1953	Toronto, Ont.
Psychiatry	BODDIE, Charles Alexander	Queen's, Ireland 1952	Halifax, N. S.
	GOLDBERG, Benjamin	Dalhousie 1955	London, Ont.
	LESSER, Arthur Leonard	Dalhousie 1956	Halifax, N. S.
	VINCENT, Merville Oulton	Dalhousie 1955	Guelph, Ont.
	POWER, George Robert Irvin	Dalhousie 1953	Westbrook, Ont.
Diagnostic Radiology	REID, Neil Douglas	Dalhousie 1951	Belleville, Ont.
	RICHARDS, William Henry Allen	Dalhousie 1954	Cobourg, Ont.
	STEWART, William Brenton	Dalhousie 1952	Moncton, N. B.
	WOODS, Desmond Gerard	National U., Ireland 1948	Halifax, N. S.
	BATE, George Warburton	Dalhousie 1951	St. John, N. B.
	FEENER, Melvin Glenwood	Dalhousie 1952	Kingston, N. S.
	O'DRISCOLL, Robert Francis	Dalhousie 1950	Grand Falls, Nfld.
General Surgery	SPROULL, Donald McDougall	Glasgow 1950	Glace Bay, N. S.
	STEELE, Bernard Joseph	Ottawa 1952	Halifax, N. S.
	STILES, Gerald Bruce	Dalhousie 1953	North Bay, Ont.
	TAYLOR, Cyril Raymond	Dalhousie 1953	Sackville, N. B.
	VAUGHAN, Eric Garth	Dalhousie 1955	Windsor, N. S.
	MACLEOD, David Everett	Dalhousie 1954	Ottawa, Ont.
	Orthopaedic Surgery	SANGHI, Jodh K.	Agra, India 1949

FELLOWSHIP

Internal Medicine	ANDERSON, Robert Norman	Dalhousie 1954	Halifax, N. S.
	LANGLEY, George Ross	Dalhousie 1957	Halifax, N. S.
	SIDOROV, Joseph	Zagreb, Yugoslavia, 1951	Halifax, N. S.
Pathology	SPURRELL, Pierce Augustus	Dalhousie 1953	St. John's, Nfld.
	COADY, Campbell Joseph	McGill 1949	South Burnaby, B. C.
General Surgery	GILLIS, Daniel Alexander	Dalhousie 1953	Rockingham, N. S.
	KINLEY, Cecil Edwin (Jr.)	Dalhousie 1956	Halifax, N. S.
	MYRDEN, James Allan	Dalhousie 1950	Halifax, N. S.
	MURRAY, Donald Osborne	Dalhousie 1955	Don Mills, Ont.