

THE NOVA SCOTIA MEDICAL BULLETIN

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The Price of Progress

In this, our Centennial year, many Canadians are becoming aware for the first time, of the immensity of their country and the diversity of its peoples. And yet, there is slowly emerging an appreciation of an essential unity, a distinctive Canadian entity, characterised by attitudes to social economic and political problems which differ from those of other countries, defined by some as a healthy scepticism.

This scepticism was applied in full measure to the idea of Expo during its evolution, and to the idea of celebrating the Centennial year in a gigantic birthday blow-out. In the preceding years there was apathy and disinterest and even outright criticism of the waste and uselessness of such a celebration, but as time passed, and the Centennial Commission persuaded and cajoled and showed the way, and as the Expo buildings grew, a tide of enthusiasm began to rise, mounting steadily to reach the flood. Canadian visitors to Expo have returned with their scepticism shattered, having obtained a new view of themselves as Canadians and as members of the brotherhood of mankind, and of the tremendous creative capacity of the country. Welded wisely with our rich heritage of natural resources, such a capacity seems to give us a limitless future. A future, however with increasing responsibilities towards our own underprivileged citizens, and to those of other countries, for all progress brings its problems.

Viewed in the glow of the present celebrations,

the act of Confederation of July 1st, 1967 seems to have been an unbounded act of faith inspired by the wisdom of our founding fathers. In fact, it was an act of desperation, born of necessity, and only undertaken after many false starts, and with grave misgivings. As with so many mergers, those who had gained bemoaned their losses, and those who had lost refused to count their gains. In its execution it was incomplete, since only the provinces of Canada, (formed by the union of Quebec and Ontario in 1864), Nova Scotia and New Brunswick were partners in the July 1st Confederation. Wisdom there was, however, and the founding fathers are rightly honoured for their ability to see the political and economic necessity of Confederation through the mist of apathy, resentment and provincial parochialism that prevailed at that time.

One hundred years has given us the wisdom to see the essential rightness of that first step, and to view the progress that has inevitably followed once the structural framework was laid down. Thus in this sense, everyone may build better than he knows, since every organization of human endeavour has potentialities far beyond the narrow limits of its design, generating change in other organisations, and itself responding to these changes. All human organisations are dynamic rather than static, and must either decay or grow. Like Alice and the Red Queen in Lewis Carroll's 'Alice through the Looking Glass' it is only by running as hard as you can that you can maintain the same position.

In this issue of the Bulletin we report the Special Convocation and opening ceremonies by Her Majesty the Queen Mother of the Sir Charles Tupper Medical Building, honouring both the vision of one of our founding fathers, and of the University of Dalhousie. Yet this, too, was an act of necessity, born of the desperate need to progress in order to maintain our standards of medicine, which has culminated in the provision of a structural framework for an organisation of human endeavour in this field. Here, too, we are sure that the University cannot envisage all the enormous potentialities to be generated by this structural framework, just as we are equally sure that there will be misgivings and resentments among some of those working within this framework which will form the essential prod for self generating progress towards these unknown potentialities.

Even without the tremendous tide of change sweeping through the medical faculties of all universities, the very existence of the building itself will generate change, provided that the reins of progress are not held in check.

University authority must be such as to stimulate, and facilitate rather than to hold in check, and the stream of financial aid, from public and private sources must grow steadily to enable any progress to be made at all.

We are very conscious of the great generosity of the Provincial and Federal Governments, the many private foundations, agencies and individuals who have made this building possible, but let them be warned: our appetites have been whetted, and like Oliver Twist, we shall be back, asking for more.

I.E.P. □

THE HEALTH RESOURCES FUND, AND THE RELATION OF THE FEDERAL GOVERNMENT TO DOCTORS FEES

Text of two official statements issued by

THE RT. HON. ALLAN J. MACEachEN

Minister for National Health and Welfare

Two statements issued by National Health and Welfare Minister Allan J. MacEachen follow recent comments by presidents of the Canadian Medical Association and the Ontario Medical Association in regards to the Health Resources Fund and physicians' fees under Medical Care Insurance.

In an address to the Ontario Medical Association, Dr. R. K. C. Thomson, President of the Canadian Medical Association, is reported to have described the amount of money available through the Health Resources Fund as "a mere pittance of what is needed for Canada".

Mr. MacEachen has issued the following statement in connection with Dr. Thomson's comments:

"The Health Resources Fund, in an amount of \$500 million, is designed to provide capital assistance up to 50 per cent for the building, acquisition, renovation and equipment of health training facilities such as medical schools and teaching hospitals and for research institutions.

In addition to the substantial support thus being provided, the program will create a major stimulation to the building of necessary training and research facilities since the effect will be that at least \$1,000 million will be made available for these purposes.

To support the operating costs of institutions of higher learning including medical schools, the post-secondary educational assistance program which the government established with effect from April 1, 1967, will be making available 50 per cent of the operating costs of such institutions in an amount estimated to run at some \$350 million annually.

It is not likely that many taxpayers in Canada would describe these sums of public monies as 'a mere pittance'."

Mr. MacEachen further commented on the reported statement by Dr. R. M. Matthews, President of the Ontario Medical Association, in a press conference in Toronto on May 9, wherein Dr. Matthews stated that plans being prepared by the Association for a withdrawal of physicians' services might be used in the event of a federal freeze on doctor's fees.

Mr. MacEachen replied:

"There is nothing in the federal Medical Care Act which would give any basis for the eventuality of federal interference in arrangements made by provincial governments with medical associations or others, with regard to fees. The federal Medical Care Act is a statute to empower the federal government to contribute to the provinces one-half of the per capita cost incurred by participating provinces of medical care services.

There is no statutory power whatsoever in the legislation limiting provincial autonomy in this regard and, in fact, there is no way in which the federal government could intervene in any way in provincial arrangements. Medical Care programmes will be provincial programmes, operated by the provinces in accordance with provincial law. This principle is one with which the medical profession must be well aware.

It is expected that the basis for payment for doctors services will be a matter for each provincial plan to negotiate and arrange with the appropriate medical body." □

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Report

Medical Advisory Committee on Driver Licensing

1966

General

The Medical Advisory Committee on Driver Licensing completed its fifth year of operation in December 1966.

Membership

The Committee consisted of the following:

Mr. J. C. Douglas - Chairman

Dr. H. Kenneth Hall - nominated by The Medical Society of Nova Scotia

Dr. Alan J. MacLeod - nominated by The Medical Society of Nova Scotia

Lieut. Hugh Vincent - nominated by the Association of Psychologists of Nova Scotia

Mr. D. J. Tully - Registrar of Motor Vehicles

Mr. C. E. Pass - Secretary

In July of 1966, Lieut. Hugh Vincent ceased to be a member and Dr. H. D. Beach was appointed.

Regional Representatives

The following were Regional Representatives of the Medical Advisory Committee during 1966:

Dr. R. Sers, Antigonish - Antigonish-Guysborough Medical Society

Dr. P. R. Little, Truro - Colchester-East Hants Medical Society

Dr. H. C. Still, Halifax - Halifax Medical Society

Dr. R. G. A. Wood, Lunenburg - Lunenburg-Queens Medical Society

Dr. J. N. Park, New Glasgow - Pictou County Medical Society

Dr. F. W. Morse, Lawrence town - Valley Medical Society

Dr. B. C. Trask, Sydney - Cape Breton Medical Society

Meetings

Regular monthly meetings of the Committee were held during 1966.

Proceedings

During the year, 58 individual cases were studied by the Committee. On some of these, further information was required, with the result that some cases were referred back to the Committee on more than one occasion. The total number of referrals to the Committee, as the result of this, was 72.

The following actions were taken as the result of recommendations made by the Committee:

Seven persons had their licenses suspended for reasons of medical unfitness.

Two unlicensed persons were refused licenses on the grounds of medical unfitness.

Three persons were required to submit medical reports before renewal of license.

One person was denied a Public Vehicle Chauffeur's license as the result of recommendation made by the Committee.

Nine persons were found to be medically fit but were required to be re-examined as a driver before license was issued.

Twenty-eight persons had their licenses recommended as medically fit.

Five cases were discussed but a medical report was not felt to be necessary.

Two cases are awaiting further information
One person was recommended his licence to be restricted with visual correction and hand controlled vehicle.

The above report re the activities of the Medical Advisory Committee on Driver Licensing during 1966 is respectfully submitted.

J. C. Douglas,

Chairman -

Medical Advisory Committee
on Driver Licensing. □

ERRATUM

In the June issue of this journal a discrepancy appeared in the NORLESTRIN advertisement with respect to the progestogen content of NORLESTRIN 2.5 mg. and NORLESTRIN® 1 mg. The correct content of these products is:

NORLESTRIN 2.5 mg.

each tablet contains: norethindrone acetate 2.5 mg.; ethinyl estradiol 0.05 mg.

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Dalhousie Notes

II THE OPENING OF THE SIR CHARLES TUPPER MEDICAL BUILDING

C.B. STEWART MD., DEAN

Halifax, N. S.



PHOTOGRAPH BY WAMBOLT - WATERFIELD

The Sir Charles Tupper Medical Building, Nova Scotia's chief memorial to the Centennial of Confederation, was officially opened on July 14th, by Her Majesty Queen Elizabeth The Queen Mother.

Threatening skies and occasional showers forced a last minute change in plans. Instead of an outdoor Convocation held in the forecourt of the Tupper Building, where there would also have been ample room for a large public audience on the lawn of the Forrest Building, the ceremony had to be moved to the Memorial Rink on the Studley Campus. The unveiling of the Commemoration Stone and Centennial Plaque also had to precede the Convocation with only the official party present instead of two hundred invited guests, who would otherwise have moved from the Convocation to the Memorial Room of the Tupper Building for these events.

Nevertheless, a large and enthusiastic audience attended the colourful and impressive ceremonies and judged them to be an unqualified success.

Following an official luncheon given by the Government of Nova Scotia, Her Majesty Queen Elizabeth The Queen Mother arrived at the College Street entrance of the imposing new Sir Charles Tupper Medical Building. She was met by President Henry D. Hicks, Mr. Donald McInnes, Q.C., Chairman of the Board of Governors and Dean C. B. Stewart, with their wives. Arriving with The Queen Mother were Lieutenant Governor and Mrs. H. P. MacKeen, Prime Minister and Mrs. L. B. Pearson, Premier and Mrs. R. L. Stanfield, Mayor and Mrs. Allan O'Brien, the Earl of Dalhousie, Viscountess Hambleden, Lord Adam Gordon, Sir Martin Gilliat, General H. D. Graham and Captain Peter Norman.

Her Majesty first unveiled a stone to the right of the main entrance commemorating the opening of the Sir Charles Tupper Medical Building. She then entered the building, going to an office in the Medical Library to don the LL.D. gown of Dalhousie University. Lord Dalhousie, who already holds an LL.D. from the University named for his illustrious forebear, and Prime Minister Pearson, later in the day to receive the same degree, also dressed in the scarlet Dalhousie robes.

A small audience was assembled in the Memorial Room just inside the main entrance of the Tupper Building, including Dr. M. R. Kinde of the W. K. Kellogg Foundation and Dr. Normand Belliveau, President of the Canadian Medical Association; Dr. Arthur D. Kelly and Dr. Arthur Peart also of the C.M.A. and Mr. John Fisher, Director of the Centennial Commission. Among the guests also were several members of the Tupper family, including Miss Katherine Tupper of Winnipeg, a granddaughter of a younger brother of Sir Charles Tupper; her niece, Mrs. Margaret Tupper Prie of Montreal, and Dr. and Mrs. W. J. Couldwell of Vancouver, she being the sister of the present baronet. When this group was joined by Her Majesty and the other members of the royal party, the Centennial Plaque was unveiled.

President Hicks invited Prime Minister Pearson and Premier Stanfield each to draw a cord on either side of the Centennial Plaque to unveil it, signifying the joint participation of the two governments in this project. With a light touch, Prime Minister Pearson commented, as he took his position, that he was on the "right" side. Premier Stanfield countered that he would read only the first (English) half of the inscription on the plaque since Mr. Pearson had volunteered to read the French. After Premier Stanfield had read the English inscription, the Prime Minister deftly reduced his share of this ceremony with the words "La même chose en français".

A presentation was made by Dr. Normand Belliveau, President of the Canadian Medical Association of a handsome bust of Sir Charles Tupper, which stands on a pedestal at the east end of the

marble-walled Memorial Room. He and Madame Belliveau were then presented to Her Majesty followed by Dr. and Mrs. Kinde and a few of the senior University officials. The change in program unfortunately made it impossible to include in this reception many of the department heads who had been involved with the planning of the building.

The party then proceeded to the Halifax Memorial Rink where the academic procession and an audience of more than a thousand were already assembled. The President extended a welcome and commented on the support received from many sources for the Sir Charles Tupper Medical Building.

Her Majesty Queen Elizabeth The Queen Mother then addressed Convocation. She referred to her happy memories of the last visit to Halifax in 1939 and noted that many changes had taken place in the city. The handsome new Sir Charles Tupper Medical Building, she said, is a singularly appropriate memorial to the leader of the Nova Scotia delegation to the historic conferences at Charlottetown and Quebec. This building will not only serve the youth of the Atlantic Provinces, but will fulfill a function that touches very closely on the lives and health of all of the people of this region and indeed of Canada as a whole. Her Majesty ended by extending best wishes to the young men and women who study here, and to the teachers and research scientists who will train future generations in medicine.

The honorary degree of Doctor of Laws was then conferred by President Hicks on The Queen Mother, Prime Minister Pearson, Dr. Matthew R. Kinde and Dr. Normand J. Belliveau. The citations were read by Dean Stewart and the recipients received their hoods from Dr. L. C. Steeves and Dr. L. B. Macpherson.

Convocation was then addressed by Prime Minister Lester B. Pearson, who directed his remarks primarily to the youth who face many problems today, including the obvious inconsistencies between what is taught or preached and what is practised both by governments and individuals.

After the singing of "O Canada" and the benediction by President Emeritus A. E. Kerr, the Convocation procession withdrew. The royal party proceeded on their tour to Camp Hill Hospital and other appointments for Her Majesty The Queen Mother. The guests of Dalhousie attended the "Open House" at the Sir Charles Tupper Medical Building.

The building is in fact only partially completed, but guests were able to obtain a fairly clear picture of how it will appear. All of the two storey arcade with lecture rooms, seminar rooms, and student study facilities was open as was also the Library on the first and second floors of the tower. The Department of Physiology on the third and fourth floors showed the layout of a typical teaching floor and a research floor. Most of the work was also

completed on the fifteenth floor where guests had an opportunity to see the Faculty lounge, the Faculty Council room and the administrative offices. There was much favourable comment on the interesting use of modern materials and colour combinations in the building, which is on the whole a strikingly handsome edifice both outside and inside, although also extremely functional in its whole design.

The gala day for Dalhousie Medical School ended with a dinner at which Dean Stewart and

Mr. McInnes were co-hosts to one hundred guests including all of the department heads of the Faculty of Medicine, the Deans of other Dalhousie Faculties, guests from other medical schools, representatives of the Department of National Health, the Canadian Medical Association, the Association of Canadian Medical Colleges, the Provincial Medical Board and Medical Society of Nova Scotia, the Governments of the Atlantic Provinces, Dalhousie Medical Alumni and several other groups.

The following is the inscription on the stone unveiled by Her Majesty Queen Elizabeth The Queen Mother:

Sir Charles Tupper Medical Building

The Province of Nova Scotia Commemoration
of the Centennial of Confederation in Canada
Opened by

Her Majesty Queen Elizabeth
The Queen Mother

On Friday, the 14th day of July, A.D., 1967
In attendance were

The Right Honourable Lester B. Pearson,
Prime Minister of Canada

The Honourable Robert L. Stanfield,
Premier of Nova Scotia

and representing Dalhousie University,

Donald McInnes, Chairman of the Board of
Governors

Henry D. Hicks, President

Chester B. Stewart, Dean of the Faculty of Medicine

The wording of the brass inscription on the wall behind the bust of Sir Charles Tupper in the Memorial Room is:

This building, erected by Dalhousie University, the Province of Nova Scotia and the Government of Canada to commemorate the Centennial of Confederation in Canada, is also dedicated to the memory of

The Right Honourable Sir Charles Tupper,
Baronet, G.C.M.G., C.B., LL.D., M.D.

A Father of Confederation and a dedicated Physician 1821-1915. He was Premier of the Province of Nova Scotia 1864 to 1867, Prime Minister of the Dominion of Canada in 1896, the first President of the Canadian Medical Association in 1867, and a member of the Board of Governors which established the Faculty of Medicine of Dalhousie University in 1868.

Architect J. Philip Dumaresq & Associates,
Halifax, N. S.

Contractor Kenney Construction Co. Ltd.,
Halifax, N. S. □

1967 Schedule of Fees

OF

THE MEDICAL SOCIETY OF NOVA SCOTIA

The revised and up-dated Schedule of Fees for 1967 has been approved by the Executive Committee. At the 5th Regular Meeting of the Executive (July /67) the following resolution was moved, seconded and carried: -

Moved by Dr. H. C. Still

Seconded by Dr. H. D. Lavers

"THAT the 1967 Fee Schedule of the Medical Society of Nova Scotia be effective July 1st, 1967." CARRIED.

The Schedules are expected to be in the mail not later than August 1, 1967.

C. J. W. Beckwith, MD, D.P.H.
Executive Secretary

- Notice -

PROPOSED AMENDMENT TO THE BY-LAWS

OF THE MEDICAL SOCIETY OF

NOVA SCOTIA

The 5th Meeting of the Executive Committee 1967 agreed that Chapter II "Objects" be amended by adding No. 6: -

"The preservation of the economic welfare of its members by negotiation and agreement on behalf of its members with whatever persons groups or bodies, governmental or otherwise, that the Society may deem necessary or advantageous."

C. J. W. Beckwith MD., D.P.H.
Executive Secretary

Medical-Legal Enquiries

HOSPITAL PRIVILEGES

Q. Whereas hospital privileges are granted to practitioners with the intent of preserving quality patient care, what is the legal position of the hospital in suspending such privileges?

A. The governing body of the hospital has assumed an obligation to the community to insure the best possible service in all the hospital departments, clinical and otherwise. In it, therefore, is vested the legal authority to appoint the members of the Medical Staff and to suspend their privileges.

This is clearly laid down by a State Court decision in the U.S.A. where it was ruled.

"The power of managing the affairs of the corporation includes the power to exclude physicians of practicing therein".¹

Furthermore this authority may not lawfully be delegated to an Executive Committee of the Medical Staff.²

Lay Hospital Boards will not usually take it upon themselves to judge the medical competence of doctors and normally they set up a local committee of senior physicians to advise the Board, and insofar as professional activities are concerned, normally they will be guided in their decisions by the Committee.

I.D.M.

References

1. State et rel. Wolfe vs laCrosse Lutheran Hospital (quoted in Bull. Am. Hosp. Assoc., Oct. 1929.
2. Houton vs Hurley Hospital, Flint, Mich. (quoted in in Ponton T.R. "The Medical Staff in the Hospital" (Chicago) Physicians' Record Company, 1939 : Page 34.

NOVA SCOTIA MEDICAL BULLETIN Editorial Office

You are invited to contribute questions to our **Medical Legal Enquiries**.

Q.....
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Please send completed form to: - Ian Maxwell, M.D.
Medical-Legal Liaison Committee
Department of Pathology
Halifax Infirmary
Queen Street
HALIFAX, Nova Scotia
Halifax, N. S.



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A Country Doctor's Life, 1859-1888

FRANK W. MORSE, MD

Lawrencetown, N. S.

These notes are written on the life of my grandfather, Leonard R. Morse, M.D., who lived from 1833 to 1903. Born near Bridgetown, N. S., on a farm owned by his grandfather, Abner Morse, a New England Planter who came to Nova Scotia in 1760, he practised medicine in Nova Scotia between 1861-1888. His earlier days, from 1853 to 1858, were spent in teaching school in Annapolis County - at West Dalhousie, Lawrencetown, Melvern Square, and Middleton - in order to finance his education. After an apprenticeship in Bridgetown, he completed his medical education at Harvard, and set up practice in Lawrencetown in 1861. He was the first of a family which has supplied physicians to this Nova Scotian village continuously for over 100 years, up to the present day.

* * * * *

The earliest story of my grandfather that I recall was about "Malcolm", the family skeleton; this was not the real name, but it will do, the real name being used as a proper name as well as a surname. Malcolm was a murderer who was hung about the middle of the 1800's. This hanging took place one midnight at Annapolis Royal. Attending this were about six doctors, anxious to get his body for dissection. Somehow my grandfather succeeded in getting the body, whereupon he slung Malcolm's body over his saddle and rode off into the night. He must have made the twenty-four miles before dawn, otherwise every one would have known the story: fortunately there were no street lights!

My grandfather dissected Malcolm's body thoroughly and then prepared the skeleton. He was always very proud of the skeleton and valued it highly: it was a great help to him in those days before X-rays. Four of his children studied medicine and they took some of Malcolm's bones with them; they also took them to their various places of practice, to British Columbia, to Detroit, and to China. My father was left with the skull, and this was how I learned the story. If the name Malcolm was ever mentioned, immediate and intense interest was always shown, for

this was a name about which all were sensitive, it being almost taboo.

An interesting sequel occurred in 1942, when my wife and I had decided to go to the vicinity of Crescent Beach on Nova Scotia's South Shore. We arrived at a hotel near the beach; as I was registering I noticed an old lady looking over my shoulder. On entering the living room after tea, we met the old lady. She said, "How glad I am to meet you, Dr. Morse". I was not surprised she knew my name for I knew she had seen me register. Then she said, "I know a great deal about you".

I thought that some of my patients might have told this woman something about me. So I said, "I hope what you know about me is good". She replied, "I suppose it is more peculiar than good. You see, I know about Malcolm." With the word Malcolm I was really surprised, even shocked, to "run into" the skeleton. I asked, "How do you know about Malcolm?" Her answer was still more surprising: "You see, Doctor my father was a schoolteacher in Lawrencetown and he helped your grandfather get Malcolm from Annapolis one dark night!"

* * * * *



"...he slung Malcolm's body over his saddle and rode off into the night."

Premedical Training

Following his period of teaching, my grandfather had an agreement with a Bridgetown doctor, J. E. Forsythe, M.D., for three years' training. A fee was paid, the amount of which is unknown. It seems from his diary that this training consisted mainly in the use of Dr. Forsythe's books, and he recorded studying *Materia Medica*, and Burn's "Midwifery and Inflammation" in the vacation between his first and second (final) years at Harvard. Although he was not too impressed with the knowledge gained in this way, for these three years of study he was given two years' credit at Harvard and Dr. Forsythe issued a certificate to Harvard for this period of instruction.

Sailing trip to Boston

In 1859 there was no railroad in the Annapolis Valley so my grandfather had to sail to Boston. He recorded that there were three schooners which frequently sailed from Bridgetown to Boston. These were packet schooners used mainly for carrying freight along the Nova Scotia coast; they were small two-masted vessels, each with one small cabin for crew and passengers. His diary tells that he made his bed "on top of trunks and boxes" and that he was made uncomfortable by a sailor building a hot fire in the middle of the night and by several of the crew smoking their pipes.

At 3:30 p.m. on October 17th 1859, he sailed from Bridgetown on the schooner "Sultan". By dark they had only gone four miles down the Annapolis River to Tuperville, where they anchored for the night. The following morning they sailed at 4:30 a.m. and cleared Annapolis Royal at 7:30 a.m. They sailed out of Digby Gut in a roaring gale and there lost their flying jib; continuing down Digby Neck they arrived at Westport, N. S., at 4:00 p.m. At Westport, where they stayed for two days because of headwinds, there were "Thirty-three sail vessels and fishing smacks". On the morning



"They sailed out of Digby Gut in a roaring gale and there lost their flying jib".

of the third day they tacked across the Bay of Fundy in rough weather, anchoring in Little River Harbour, Maine, that night. For the following two days they tacked down the New England coast against headwinds; it was cold as well as rough, for the salt water froze on the decks. Finally, they gained the mouth of Boston Harbour, where they had to anchor overnight due to headwinds and a falling tide. He wrote that this was his worst trip to Boston for it took ten days, and he was continually seasick, losing ten pounds as a result.

Harvard Medical School vs. Edinburgh Medical School, 1859

Just before this sailing trip Dr. Forsythe, a graduate of Edinburgh, had tried to persuade my grandfather to finish his medical course in Edinburgh. He was nearly persuaded to go to the "old country"; some of the points which were considered by him were:

- being a graduate of an English school would be a great help to beginning as a doctor in Nova Scotia or even the United States;
- if he went to Edinburgh, it would take him eighteen months more to finish; at Harvard he would finish in nine months;

— at Harvard he would have the opportunity to earn some money in the three months between finishing classes and the final exams;

— the costs for board and lodging were about the same;

— the Edinburgh Diploma would cost \$140.00 (£30) and the Surgeon's Diploma, \$20.00.

His conclusion was that his finances would not permit him to go to Edinburgh and that his age (26) was also against him. However, even after he graduated he was still tempted to go to Edinburgh.

Harvard Medical School and Boston.

In that era the medical course was four years long. However, he had received credit for the first two years, and he had attended the "winter" course in 1858 from November 1 to February 28, 1859. The best known member of the Harvard Medical Faculty was Oliver Wendell Holmes, better known today for his poetry than his medicine. Dr. Holmes made one important medical advance when he discovered the cause of Puerperal Septicemia, or Childbed Fever as it was then known. He was very popular with the students and often quoted his poetry to them; his examinations were not feared.

The Medical Faculty gave two banquets for the medical students at the Revere House, both of which were much appreciated because most of the medical students boarded themselves and needed these two good meals. Grandfather recorded that the entire body of medical students in 1859 was 185, while there were 36 in his class. Other Maritime students at Harvard taking medicine, 1859 to 1860 were: Flowers and Mercer from Halifax; J. S. Skinner, Saint John, N.B.; McDonald, New Brunswick; and Jacobs from Lunenburg. His greatest friend was Skinner, with whom he went to attend a play, to visit a large cemetery, and to inspect Charleston Navy Yard. These were the main diversions between November 1, 1859 and July 9, 1860, when they graduated. On Sundays they often attended two sermons, mainly at Tremont Temple. Much time was spent in going to the wharves in search of mail on the various schooners from Annapolis County. Unfortunately, these trips were usually unsuccessful and he was disappointed and felt abandoned by his friends and family. The rare letter or parcel was received with great joy. Most of these parcels contained home-made clothes. His money was sent as drafts by a Mr. McCormick, a merchant in Annapolis Royal, on Ladd and Hall, a firm of merchants in Boston. He usually had trouble getting the drafts cashed and then only after long waits.

He attended a political meeting in 1860, at Faneuil Hall, when the nomination of Abraham Lincoln for President was ratified. His impression of the meeting was not good, his main comment being about the disorderliness of the audience which made it difficult to hear the speeches. The worst offenders were street urchins who were perched in various high places throughout the hall, keeping up a continual chorus of yells for attention. He also noted the

many poor Irish children in Boston.

Notes on Harvard Medical Course, 1859-1860

November 2, 1859 - first lecture in medicine (winter course).

December 9, 1859 - Faculty entertained entire medical student body at the Revere House. The banquet was much enjoyed. This entertainment was repeated on February 10.

December 18, 1859 - Vaccinated by City Physician, Dr. McLean: "Three quills in left arm".

February 28, 1860 - End of winter course of lectures (four months).

March 1, 1860 - Final examinations of previous class (summer). Thirty-six candidates; one failed, a middle-aged man.

March 16, 1860 - Worked as an assistant to an apothecary for three weeks, paid \$6.00 per week. Did dressings and prescribed as well as dispensed.

April 4, 1860 - Angle and ramus of jaw removed from an old man suffering from metastatic cancer of jaw (from lip), Massachusetts General Hospital; patient died one week later.

Most surgical patients developed ulcers before healing. This was termed 'Hospital Gangrene'. It was noted that a cataract operation did well.

July 9, 1860 - Final examinations, winter course (medicine). Dr. Oliver Wendell Holmes examined him in Anatomy, Physiology and Surgery. All candidates passed.

The main hospital used for medical teaching was The Massachusetts General (and its Eye and Ear Infirmary).

Cost of Medical Course:

Room, \$1.00 per week

(private house);

Food, \$0.80 per week, average. He boarded himself.

He recorded that he ate no meat for five months, November to April;

Complete tickets for the course of lectures, \$85.00;

Oral examinations, preliminary to final examinations, \$10.00;

Diploma, \$20.00.

Practice in Lawrencetown, N. S.

My grandfather began practice in the village of Lawrencetown, Annapolis County, in 1861. Thus started a family tradition, for there has been a Doctor Morse in Lawrencetown continuously since that time. Four of his seven children became physicians, as did two of his grandsons. Leonard R. Morse was succeeded in the practice by his eldest son, the second L. R. Morse, whom I followed.

In 1860 there was another "family practice", for Dr. John Primrose was in Lawrencetown, with his son Samuel being apprenticed to him. When licences became requirements for practice, the Nova Scotia Legislature granted the younger Dr. Primrose a licence by "Act of Legislature", as it did to all other physicians in similar circumstances. The Doctors Primrose were skilled and were popular with the public: this is still evident from the number of people of the older generation whose given name is Primrose. My father told me that he had to be on his toes whenever he had a consultation with the younger Dr. Primrose, and he found it advisable to brush up on the probable diagnosis as Dr. Primrose often had some embarrassing and penetrating questions. Of such was the quality of this physician "by Act of Legislature". Physicians of this time were certainly not ignorant, but they lacked the drugs and hospitals with which we are blessed today. We should remember that these hard-working doctors laid the groundwork for the marvelous advances of today; without the work of these men many of us today would not be alive. Let us not forget that Beaumont, a pioneer of physiology, was a physician of this period. I often wonder if we would do as well if

we had to treat our serious infections as they did, with worthless drugs and only our own nursing to offer.

These physicians had to depend on the horse for transportation and this fact accounted for the small number of calls that they could do in a day. My grandfather always had three horses which usually were tired out; often he had to hire a horse from a friend. The next time you growl about going out to your car in a blizzard, think of these poor men who had to stay out in this weather for hours on end! My father told me that on several occasions he had to be lifted from his sleigh on arriving at a patient's house since his frozen clothes prevented him from moving. We are also too apt to forget the terrible problems they faced with mud, spring and fall. These muddy conditions lasted for weeks at a time until they were relieved by freezing or by the roads drying out in the spring. The only relief from mud was by deep snow on the unplowed roads in winter or by bad dust conditions in summer.

The vehicle usually used by my grandfather was a two-wheeled cart which was modified and refined to resemble the racing sulkeys of today's race tracks, his

professional bag being slung beneath the seat. He referred to this as his car; it was continually in need of repairs. On more formal occasions he drove a four-wheeled carriage. When the going was really bad, he rode horseback or walked.

There were no telephones so each call was made after receiving a message from someone who called at the house or met him on the road. This messenger's name was always recorded in his day book along with the description of the service and the charge. Probably the fact that it was necessary to send a messenger eliminated many night calls. Dr. Primrose for some time kept a bear in his home as a pet; no doubt this eliminated many of his night calls!

As my grandfather was seldom home long enough to hold regular office hours, there are practically no office calls recorded, but an overnight stay with a patient was a relatively common occurrence. From 9 p.m. on December 26, 1863 to noon on December 29, my grandfather was in continuous attendance on a patient in an isolated community some eight miles from his home.

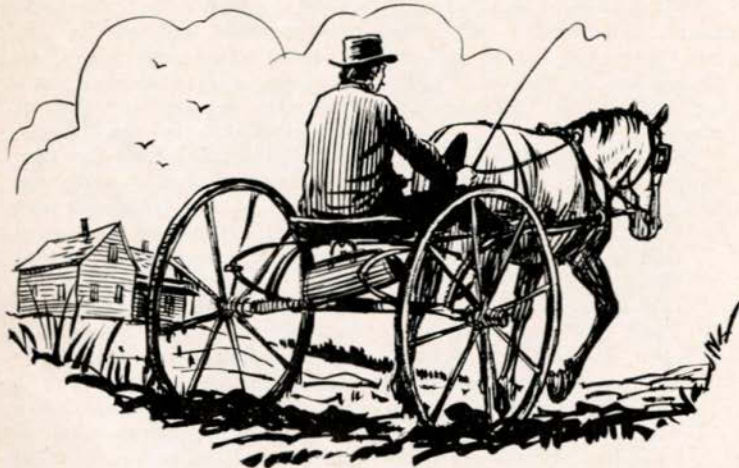
I was surprised to learn of the dentistry my grandfather did, especially the number of fillings:

about ten weekly were recorded for several years. In 1864 the first charge was made for filling a tooth with tin foil; gold and gutta percha were also used. Later he rented his office to a dentist who spent several days each week in the village, but even then people had him do their fillings, perhaps in the absence of the dentist. All these fillings were done with hand instruments such as files and excavators, since the mechanical foot drill did not come into use until 1900. Tooth extractions, or "drawing teeth", were often done from his wagon seat, evidently without the benefit of anaesthesia, since only one dental anaesthetic was recorded between 1863 and 1880.

Surgery was mainly minor: trauma, fractures, incisions of infections and the rare amputation. "Prostates" were catheterised daily and usually died within six weeks. Serious elective surgery went to Halifax and Boston. Most patients undergoing major emergency surgery died; rarely they survived due to good nursing care and good luck. From 1867 on, special trains, hired at a cost of about \$100.00, transported emergencies to Halifax. These trains continued in use until the 1920's, when surgery commenced in this area, at first in homes and later in hospitals which were built about this time.

Obstetrics was done in the homes by candlelight until 1875, when kerosene for lamps came into use. There were usually two midwives in attendance and their names were recorded. Forceps were used but there was no record of obstetric manipulations; they must have been used for there were no Caesarian Sections. It was usually noted that the placenta was delivered within ten or fifteen minutes, suggesting that many of these placentas were manually delivered. Few were puerperal infections recorded.

Bills were often paid in kind, for money was scarce. Many of the articles on the credit side of



"...physicians had to depend on the horse for transportation".



"Obstetrics was done in the homes by candlelight

the ledger are familiar to the country doctor of today: meat by the quarter, vegetables, firewood or labour, but other items were both interesting and surprising. One unusual item of credit was a loon skin, while one delivery was paid for by 66 pounds of bear's fat. Thought to have great powers of healing and soothing, bear's fat was used as a base for ointments as well as a salve for rheumatism. No doubt this practice was handed down from the Indians. The most unusual entry read as follows:

Jacob X.

Dr. 186 -: May and June, to Medicine.

Cr. 186-: Hanged at Annapolis Royal for poisoning of his wife. Attended it.

By present standards, my grandfather's earnings were pitifully meager. The charges during 1861 - 1888 varied from \$1000.00 to \$1500.00 yearly; some of these charges were certainly not collected. He supplemented his income by owning a drug store and two farms: some patients probably paid their bills in labour. The following charges are of interest:

1863: - Extract Tooth	.25
Bleeding	.50
Visit and advice	.50
Mileage, per mile	.25

1861: - Deliveries	\$ 4.00
1880: - Deliveries	\$ 8.00
Reduce Ulna	\$ 5.00
Reduce Femur	\$10.00

Of the *drugs* in use at that time, few were effective. Tincture of Digitalis first noted in 1864, was, surprisingly, very little used. Opium was used in various forms, mainly as Tinct. Camph. Co. (Paregoric), and as Pil. Opii, which was prescribed almost routinely in the post-partum period, as was fluid extract of ergot. Chloral hydrate was the only sedative, until Potassium bromide was noted in 1875. Pil. Asafoetida, Pil. Hydrarg., Pil. Rhei and Pil. Emmenagogue were in common use, as was Unguentum Hydrarg. Ammoniatum and Sulphur Ointment. This latter was particularly used in the spring, probably to relieve itching, while Tincture of Iodine was often used as a paint for the chest in pleurisy and pneumonia, as well as being used as an antiseptic. Chloroform was first noted in 1864 and first used in obstetrics in 1866. It was used for the only dental anaesthetic recorded up to 1888, and was much more commonly used than ether, whose use is first noted in 1875. This is surprising, since ether was in use at the Massachusetts General Hospital

while my grandfather was training there. I can only attribute this to the strong influence of the Edinburgh Medical School on Nova Scotia at this time.

Thus, if we exclude the anaesthetics, ointments and antiseptics, only four effective drugs were in common use before 1875. This limited armamentarium together with the poor transportation and the absence of major surgery and hospitals accounted for the many complications these old time physicians were compelled to deal with, often alone, and in isolated circumstances. Other means were called into use: poultices were used frequently, and in 1861 the use of sticking plaster was noted. Blood-letting or venesection was used at times: there were three in 1865 and two in 1866. In 1864 a retention catheter was used for 60 hours in a patient. Vaccinations were not recorded before 1888, perhaps due to the difficulty of procuring or keeping the vaccine, or lack of public demand, although one was performed by a neighbouring physician in 1884.

My grandfather purchased a stethoscope for sixty cents in 1865; it was his first, a monaural type, and made of hard wood. A thermometer was first mentioned in 1879.

Prominent in medical practice then were the infectious diseases, which comprised one of the main causes of death in this period, and indeed for long afterwards. Winston Churchill wrote at the turn of the century of his decision that three children were ideal for a family, but that he should have four, in case one died: there was a good chance that one would die from an infection or an infectious disease. *Diphtheria* (known as "putrid sore throat"), *Scarlet Fever*, and *Measles* were the main killers. There were no antitoxins no antibiotics or even good nursing, for nurses were rare before 1900. Florence Nightingale had not done her monumental work until 1854, and it was about 1900 before nursing spread to Nova Scotia. *Diphtheria* and *Scarlet*

Fever started the lonely little family cemeteries of perhaps ten graves, which used to be so common in rural Nova Scotia. One of my grandfather's worst experiences was the loss of four children due to Scarlet Fever in one family in ten days: what a terrible tragedy and how they all must have suffered and struggled in vain! The complications of infectious diseases - mastoiditis, otitis media, septicemia, nephritis and rheumatic fever - have either been banished or greatly lessened with modern drugs. It is rare to hear the term Toxic Carditis nowadays and yet this was a great killer until 1938 when "sulphas" were used.

Typhoid Fever came as a scourge each fall and spring with many deaths. These were banished with the introduction of modern water supplies and sewage. "Inflammation of bowels" was the term applied to *Peritonitis*, often caused by *Appendicitis* which was usually fatal. *Pneumonia* was also a great killer, particularly of young children, young adults, and the elderly. It is hard to realize that it was not until 1938 that there was much change in the mortality from this disease, and difficult for young people to imagine what a horrible experience pneumonia was before the sulphas and the antibiotics became available. There was great prostration, pain and chills for ten days before the crisis, which was terrible to witness with its great collapse and sweating. Then came a long convalescence. After pneumonia a person was fortunate to be out of bed by the twenty-first day and was lucky to be back to work in three months. *Empyema* was a common complication, and most of the general practitioners were forced to drain empyemas in the home.

Tuberculosis of the lungs and bone was common and killed or crippled many in their late teens and twenties each year. These cases had to be treated in homes where many of the family contracted this dread disease. Many

were the hunchbacks, from tuberculous spines, throughout the province.

Osteomyelitis was another dread disease which accounted for many deaths and great disability, leading to amputation, particularly in the young and in older patients with compound fractures. Probably amputations and the drainage of empyemas were the commonest operations at this time.

* * * * *

With such a practice to keep him occupied, there are but few references to Confederation in my grandfathers' diary: in January 1865 a public meeting was held in Lawrencetown to discuss "Confederation of the British Provinces in America". This meeting was called by the sheriff who held another meeting the following week in a neighbouring town. The date of July 1st 1867 is headlined "Union of Canada, Nova Scotia and New Brunswick". This seems peculiar terminology, but it is factual since the name Canada had been given to the Province formed by the union of Ontario and Quebec in 1864.

* * * * *

The practical nurses, together with the midwives, gave yeoman service to the early practitioner. It is hard to believe that until about 1875 it was felt that these wonderful vocations were not acceptable except to the lower classes. I often have felt that the early doctors were the only skilled nurses available then and that the difference in results that different doctors achieved was mainly due to their skill in nursing or to the availability of good practical nurses.

It is also remarkable that hospitals were so late in coming to this area. The first hospital in the Annapolis Valley was the hospital in Berwick which was founded in 1922. This was closely followed by the other hospitals in present use.

The names of the early doctors in the western part of the Annapolis Valley should be recorded.

They laboured long with very little recompense. The following physicians are entered in the ledger of my grandfather; the dates given are the years that they purchased drugs from his drugstore or were known to have practiced:

1862 - Dr. Joshua de St. Croix, Bridgetown, N. S.

1861 - 1872 - Dr. John E. Forsythe, Bridgetown, N. S.

This physician practiced in Bridgetown for several years prior to 1855 and he was the doctor to whom my grandfather was apprenticed.

1861 - 1900 - Drs. John and Samuel C. Primrose, Lawrencetown, N. S.

Dr. Primrose, Jr., practiced for several years after 1897, and he was one of my father's competitors.

1871 - Dr. Barnaby, Granville.

1875 - Dr. T. W. Harding.

1860 - 1861 - Dr. J. W. Phelps.

1870 - Dr. Welton.

1867 - Dr. Bell, Kingston, N. S.

1867 - Dr. Jonathan Woodbury, Wilmot, N. S.

- Dr. Outhit, Kingston, N. S.

1877 - 1879 - Dr. L. Minard.

- Dr. Balcom, Aylesford, N. S.

1869 - 1881 - Dr. L. G. DeBlois, Bridgetown, N. S.

1872 - 1881 - Dr. Joseph Dennison, Bridgetown, N. S.

1871 - 1881 - Dr. George T. Bingay.

1867 - Dr. Shaw.

1867 - 1870 - Dr. Thomas Fullerton.

1880 - Dr. Fletcher.

1875 - 1920 - Dr. S. N. Miller, Middleton, N. S.

Dentists recorded in the same ledger were:

1877 - 1881 - S. F. Whitman.

1875 - 1891 - J. E. Mulloney.

Another professional man who did some practice in this area was Dr. Dorival Bruce, a homeopath, who had formerly practiced in Philadelphia. Dr. Abraham Gesner, who practiced medicine in Kentville for several years, was a

most interesting person for he published in 1842 a Geology of Nova Scotia which is still used, and was the founder of the New Brunswick Museum, and its curator for several years. His main claim to fame was the discovery of the process of manufacturing kerosene, for which there was a great need, for lamps; his process was later used by the Rockefellers and became the basis for their millions. Dr. Gesner was of Swiss origin but was born in Granville, N. S.

* * * * *

Such is an outline of the life of my grandfather. He served his day and his generation as well as he could. He struggled against terrible odds - medical, physical, and financial. He and his contemporaries kept alive the scientific approach and paved the way for the great medical advances of today. These were their greatest achievements. May they rest in peace and know the gratitude their patients bore them but probably did not express "in the heat of the struggle".

Sources of information:

- Diary of Dr. L. R. Morse, 1859 - 1860, his last year in Harvard Medical School
- Account books of Dr. L. R. Morse kept from 1853 to 1858 when he taught school.
- Day books and ledgers of Dr. L. R. Morse 1861 to 1888
- Stories told me by my father, L. R. Morse, M.D.

Public Health News

Revised Form of International Certificate of Vaccination Against Smallpox

The International Sanitary Regulations have been amended some time ago and a revised form of International Certificate of Vaccination against smallpox has been adopted. The use of this certificate became permissible January 1, 1966, and from January 1, 1967 it will be the only form on which certificates of vaccination or revaccination may be issued and be internationally recognized.

Certificates of vaccination or revaccination performed before January 1, 1967 and recorded on the old format of International Certificate of Vaccination against Smallpox remain valid for three years from date of issue.

The new certificate requires that the origin (manufacturer) and batch number of the vaccine used be recorded. It also includes in the text a statement that the vaccine is certified to fulfil the recommended requirements of the World Health Organization.

All smallpox vaccines licensed for distribution in Canada have now been certified to fulfil these requirements and all certificates of vaccination or revaccination issued in Canada in the future for international use should be the revised form.

Supplies of the new form may be obtained from the Health Unit Directors and from the Commissioner of Health in the City of Halifax. It may also be obtained from the Atlantic Zone Office, Medical Services, Department of National Health and Welfare, Immigration Annex, Terminal Road, Halifax P. O. Box 2410.

All physicians using these certificates should obtain a supply of the revised form and destroy any of the old forms they may have on hand.

Trichinosis in Nova Scotia

Trichinosis in Nova Scotia - Now. To date, a total of six confirmed cases of trichinosis and one suspect case have been reported in Lunenburg County. The date of onset of the first case was late August and the others occurred in September and October. Three of the confirmed cases were males aged 34, 47 and 54 years. The three female patients were aged 14, 30 and 51 years. All cases, including the suspect case, were hospitalized. All of the patients complained of malaise, muscle aches and pain and swollen eyes. Laboratory investigation showed marked eosinophilia in all cases and in four cases muscle biopsy revealed trichinella spiralis.

The public has been advised through the press, radio and television to cook thoroughly all pork and pork products before eating them. All sources of pork and pork products are being investigated with a view to obtaining information concerning the feeding of raw garbage to pigs. No offenders have yet been discovered.

One of the cases in this outbreak is of particular interest. This is the fourteen year old girl who was admitted to the local hospital September 28. Once a week her family would buy pork from the local store grocery truck and this girl would cook it. Each time she cooked pork she would eat pieces raw. She became so ill that she was admitted to the Victoria General Hospital in Halifax for treatment with a drug, thiabendazole, which has just recently been licensed for clinical trial in the treatment of this disease. On admission to the Victoria General she was showing early signs of heart failure. After one weeks treatment with the new drug the improvement was dramatic.

This is the second outbreak of trichinosis in Nova Scotia in recent years. The previous one was in a village on the outskirts of Dartmouth and took place in 1960. There were eleven cases and one death. The fatal case was a 41 year old woman who died of heart failure.

Poliomyelitis

There were no cases of poliomyelitis diagnosed in Nova Scotia in 1965.

The following is an "Annual Surveillance Summary, Paralytic Poliomyelitis - 1965".

*The final total of paralytic poliomyelitis cases reported to the Poliomyelitis Surveillance Unit of CDC during 1965 is 61 cases. This total is based on the "best available paralytic case count," the criteria being cases with residual paralysis at 60 days and cases reported initially as paralytic polio but which were not followed up. The national total for 1965 is the lowest yet recorded and is approximately two-thirds the total in 1964. Forty-three of the 61 cases occurred from May through August. Although a summer seasonal peak was not evident in 1964, the summer incidence is again discernible but in a slight degree, in 1965. Texas reported the highest incidence of 18 cases, the majority of which were located near the Mexican-United States border.

The paralytic cases are presented by age group and sex in Table 1. Consistent with the trend noted since 1960, approximately one-half of these cases were in children under 5 years of age, eight of whom

were infants under one year of age. Five deaths occurred, two in adult males and three in female children. Fifty-one of the 61 cases were in white persons, 5 in Negroes; in 5 cases the race was not reported.

TABLE 1
Paralytic Poliomyelitis by Age and Sex
United States, 1965

Age Group	Male	Female	Total	Percent	Deaths
0-4	17	14	31	50.8	1
5-9	2	8	10	16.4	1
10-14	4	3	7	11.5	1
15-19	2	0	2	3.3	0
20-29	2	2	4	6.6	1
30-39	2	1	3	4.9	1
40+	3	1	4	6.6	0
Total	32	29	61	100	5

As in previous years, poliomyelitis tended to occur in unimmunized young children. More than 70 percent of the cases had received neither oral nor inactivated poliovaccine; only 8 of the 61 cases (13.1 percent) had received oral vaccine and only 16 of the 61 cases (24.2 percent) had received inactivated vaccine. □

*Morbidity and Mortality, Volume 15, Number 27. Weekly Report, Week Ending July 9, 1966. U.S. Department of Health, Education and Welfare. Communicable Disease Center.

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—reprints of complete article and full Jectofer disclosure available on request.

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Hoarseness

ROBERT S. MURPHY

Halifax, N. S.

Hoarseness by definition is a rough quality of voice. It is often the initial and most important symptom of laryngeal pathology. It is caused by any condition that will interfere with the normal physiology of the larynx. In laryngeal disease the true cords fail to perform properly and hoarseness results. There are more than 50 causes of hoarseness. Primarily, it is due to improper approximation of the true cords whereby they cannot vibrate.

CAUSES OF HOARSENESS

A. Children:

- (a) Inflammation
 1. Acute laryngitis
 2. Acute laryngotracheo-bronchitis (Croup)
 3. Acute epiglottitis
 4. Chronic laryngitis
- (b) Pseudo Tumors
 1. Singer's nodule
 2. Papillomata
- (c) Congenital Lesions
 1. Laryngomalacia
 2. Congenital web
 3. Laryngeal cyst, etc.

B. Adults:

- (a) Inflammatory
 1. Acute laryngitis
 2. Acute epiglottitis
 3. Chronic laryngitis
- (b) Pseudo-tumors of Larynx
 1. Vocal polyp
 2. Vocal nodule
 3. Contact ulcer
 4. Hematoma Ulcer
 5. Intubation granuloma
- (c) Tumors
 1. Benign
 1. Papilloma
 2. Fibroma
 3. Lipoma etc.
 2. Malignant Tumors
 1. Squamous cell carcinoma
 2. Adenocarcinoma
 3. Metastases
- (d) Miscellaneous

The most common cause of hoarseness is acute laryngitis. This is more serious in the child than in the adult. The relatively small size of the child's larynx and its loosely attached mucosa and increased vascularity makes it more liable to partial or complete respiratory obstruction. Acute laryngitis may be bacterial or viral. It may affect the epiglottic, supraglottic or subglottic areas or even extend into the bronchi, to become known as acute tracheo-bronchitis or croup. The treatment of these conditions requires humidification of air, antibiotics and expectorants. In severe cases of croup I have not been impressed with use of steroids. Periodically, when the airway becomes impaired a tracheotomy becomes necessary. However, in the next five to

ten years this procedure may be replaced by the insertion of a plastic endotracheal tube for the first twenty-four to forty-eight hours.

Acute epiglottitis is the most severe and most formidable of all laryngeal inflammations. It is differentiated from croup by dysphagia and inability to swallow. Saliva may be seen collecting at the corners of the child's mouth. Hoarseness is not as early a symptom as one sees in croup. These children are very sick and most of them will die unless they have a tracheotomy.

Chronic laryngitis in children is primarily due to vocal abuse. Most of these cases will respond to an improvement in their speech habits and periodically they may require prolonged speech therapy.

Another common cause of hoarseness in children is the so-called Singer's nodule. This is an organized hematoma caused by profuse shouting while playing. The patient and his parents should be counseled about vocal abuse; occasionally the nodule is large enough to require surgical removal. This nodule will re-occur if he continues to abuse his voice. Many of these children would benefit by speech therapy.

Laryngeal papillomata should be considered in all children whose hoarseness persists beyond two or three weeks. These are viral conditions which may progress to completely occlude the glottis. They look like warts and are generally confined to the true cords but may be seen anywhere from the ary-epiglottic folds down to the main stem bronchi. They should be suspected in any child whose hoarseness is not improved by voice rest, whose hoarseness is getting worse or if dyspnea becomes evident. These papillomata multiply rapidly and can block the glottis sufficiently to necessitate a tracheotomy. Treatment requires meticulous removal by repeated biopsies via direct laryngoscopy. They generally disappear by puberty; in a small percentage of cases they remain until adulthood. Approximately five percent may become malignant.

Acute laryngitis is the most common cause of hoarseness in adults. It is frequently seen following an upper respiratory tract infection. The course is generally self limiting except in people who have a superimposed infection, vocal abuse or tobacco irritation, whereby the symptomatology will be prolonged. Ordinarily, the inflammation and symptoms are gone by one week. On examination, the cords are hyperemic. The cough is often a bother-

some symptom because of the concomitant tracheitis which may accompany the laryngitis. The treatment in these cases is: Voice rest, elimination of smoking, humidification and increased fluid intake and output. Antibiotics should be given only if there is a suspected sinusitis. If the laryngitis recurs then X-rays of the sinuses should be done.

Chronic laryngitis is due to some form of vocal abuse. Poor speech habits and excessive smoking and coughing are factors. People with chronic sinusitis often have chronic laryngitis. Hoarseness is the primary symptom. It is more pronounced in the a.m. and gradually disappears as the day progresses. Treatment in these cases requires: elimination of cause, proper examination and speech therapy, X-rays of sinuses and chest should be a routine.

Benign pseudo tumors of the larynx causing hoarseness are quite common and are generally due to vocal abuse, trauma, chronic irritation and infection.

A vocal polyp is the most common non-inflammatory lesion of the larynx. It is chiefly seen in adults who shout a great deal especially in noisy places. Cigarette smoking is a factor. Pathologically, the polyp is edematous granulation tissue on the anterior surface of one of the true cords. It prevents approximation or adduction of the true cords and thus results in hoarseness. A disagreeable voice may result as the false cords attempt to usurp the action of the true cords. These vocal polyps require surgical removal.

Vocal nodule is another frequent cause of persistent hoarseness in adults. It is seen in professional singers and adults who use their voice profusely. They are unable to reach the higher tones which are produced by the anterior 1/3 of the true cord. Clinical diagnosis is easily made by the history of hoarseness during a bout of singing or attendance at a hockey game. There seems to be a breakdown of the voice or the voice does not last any length of time. These people are unable to shout. The treatment for these people is: complete voice rest with no whispering or smoking. If there is no relief of the symptomatology after one or two weeks then the patient warrants an indirect laryngoscopy. Most vocal nodules will disappear with proper voice rest and speech therapy. Periodically, they may require surgical removal.

Contact ulcers are not uncommon in the larynx and occur primarily in males who tend to speak with a deep voice. If the larynx is used profusely, particularly if the patient smokes or drinks heavily, the vocal processes rub together to form an ulcer which may be accompanied with pain referred to the ear with speaking. Treatment for these cases is: Voice rest, no smoking or drinking and surgical removal of the excessive granulation tissue.

A laryngeal hematoma will periodically cause hoarseness. A person who has been shouting pro-

fusely may sometimes rupture a blood vessel in the laryngeal mucosa with resulting hematoma. This hematoma will not allow proper approximation of the true cords, with resultant hoarseness. These people may spit up a small amount of blood at the time of the ruptured blood vessel. Treatment for this is: Complete voice rest for one to two weeks and removal of the hematoma if the hoarseness persists.

Recently, we have been noticing an increased incidence of intubation granulomas after administration of general anaesthesia. These granulomas may result either from trauma with intubation or from irritation due to long intubation. There seems to be a relationship between the movement of the patient during anesthesia and incidence. We see them more frequently in neurosurgical cases in which there is much posturing and movement of the patient. We have seen it in such minor procedures as pneumoencephalograms. There may be a relationship of the insufficient use of muscle relaxants so that the cords are moving on the indwelling tube. Frequently, there is a resulting hematoma with post-operative hoarseness which eventually clears. In other cases there is an ulceration of the laryngeal mucosa with resulting granulation tissue and persistent hoarseness. These people require excision biopsy of this granulation tissue.

Any person who has arthritis and hoarseness should have an indirect laryngoscopy to rule out any arthritic involvement of the crico-arytenoid joint.

Another rather common cause of hoarseness is functional dysphonia. This is due to incorrect phonatory mechanism and is merely a symptom of the psychiatric makeup. This can be suspected in people who can cough and whistle normally, yet claim they cannot speak properly. They warrant an indirect laryngoscopy and psychiatric consultation.

Three percent of all malignant lesions occur in the larynx. Ninety percent of these are in males. Tobacco and alcohol and chronic irritation seem to be factors. A person whose hoarseness persists beyond six weeks despite vocal rest and stoppage of smoking should have a proper laryngeal examination, that is indirect laryngoscopy. This is especially important in a heavy smoker and drinker. However, only too frequently do we see a terminal case of carcinoma of the larynx who has been treated for several months or years by antibiotics etc. for his hoarseness. If indirect laryngoscopy is unsuccessful then a direct laryngoscopy and biopsy should be done.

Early carcinoma of the larynx with mobile cords can be cured by radiation in 93 percent of cases. Once the carcinoma has spread beyond the true cords then the cure rate with radiation falls to 30 percent. The ideal treatment in these cases is preoperative radiation followed by radical surgery.

The overall curative rate in laryngeal Carcinoma is 65 to 70 percent. This will improve with earlier diagnosis and proper treatment.

Hoarseness may also arise on a neurogenic basis as a true cord paralysis due to a lesion of the recurrent laryngeal nerve such as post thyroidectomy, in which the nerve has been incised or a chest condition causing pressure or invasion into the recurrent laryngeal nerve or as a central paralysis resulting from any cerebral lesion which encroaches on the vagus nerve nuclei.

In summary, one can say that hoarseness is merely a symptom of laryngeal pathology. It is a common symptom in patients who have an upper respiratory tract infection and is best treated with the various oral decongestants and home remedies, rather than the use of antibiotics. If hoarseness persists in any patient longer than six weeks then this patient warrants an indirect laryngoscopy examination. This examination should be mandatory in any child with hoarseness in which there is no history of vocal abuse or inflammation. □

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FORTY YEARS AGO

From The Nova Scotia Medical *Bulletin*, August 1926

Rheumatic fever has, as a disease, a more unpleasant past, a more troubled present and a more gloomy future than any other malady of which we know anything. And altho' it appears but seldom on certificates of death under its own name, it peoples the graveyards of the country in an appalling fashion under a legion of other names.

It took generations for the doctrine of the unity of Tuberculosis to be established in Medicine, but now all of us think in terms of the Tubercle Bacillus when Lupus, Hip Joint disease, Pleurisy with effusion, Meningitis or Phthisis is mentioned. We do not look upon any of them as sequels of Tuberculosis. We think of them as Tuberculosis. And so when we think of Mitral Stenosis, Chorea, of Adherent Pericardium, of Auricular fibrillation, of Subcutaneous nodules, of forms of continued fever, or of migratory arthritis, we should look upon them not as results of Rheumatism but as *Rheumatism* itself.

By such an attitude we cease to look upon the

disease as a short lived nuisance, which in some instances in the distant future may cause trouble in the valves of the heart, and regard it instead, as an invader which once established digs itself in, working under ground month after month with perhaps occasional ruffling of the surface, bringing about eventually a damaged heart muscle, a narrowed valve, damaged arteries and damaged kidneys which all the king's horses and all the king's men cannot set to rights any more.

In the inexorable march towards physical breakdown which the rheumatic infection sets going, one cannot help being reminded that

"The Moving Finger writes; and having writ,
Moves on: Not all your Piety nor wit
Shall lure it back to cancel half a Line,
Nor all your Tears wash out a Word of it."

This, then, in some sense, is the sort of thing we think about when we talk of Rheumatic fever. □

The Role of Maritime Medical Care as a Fiscal Agent in The Provincial Medical Insurance Plan*

Health Minister R. A. Donahoe said today it appears that Maritime Medical Care Incorporated can play a major role in the administration of the Province's proposed Medical Care Insurance Plan.

The Health Minister said, in a statement, formal agreement to this effect between the Province and Maritime Medical Care will likely be reached in the next few weeks. He noted that agreement between MMC and the Province on a number of broad principles had already been reached, while some details remain to be discussed.

Mr. Donahoe said he was satisfied that MMC could well perform a role in a provincial plan.

Under the sponsorship of The Medical Society of Nova Scotia, MMC was incorporated by a special act of the Nova Scotia legislature in 1948. Since that time it has successfully administered a non-profit program of prepaid medical care insurance similar to doctor-sponsored plans being operated in other provinces. MMC's subscribers have steadily increased from 34,000 in 1950 to some 200,000 today, the majority of whom are residents of Nova Scotia.

The health minister said that since its incorporation MMC has acquired equipment, trained personnel, and experience in assessing and processing claims, and "has a high measure of public acceptance and the support of The Medical Society of Nova Scotia."

Mr. Donahoe said MMC "is eminently suited to participate in the Province's plan with efficiency and economy."

The minister referred to the Federal-Provincial Conference in July, 1965, when Prime Minister Pearson announced his Government's program of

Medicare, which stipulated four principal conditions for provincial participation in the federal plan; universality, comprehensiveness, public administration and portability.

Mr. Donahoe said MMC made a submission to him in January of 1966 offering its services as a vehicle in the administration of a medical care insurance plan for the Province. The submission was subsequently referred to the Medical Care Insurance Advisory Commission, appointed in June, 1966.

The Commission, chaired by R. MacD. Black, QC, of Halifax, was empowered to investigate all aspects of a medical insurance plan for Nova Scotia, and held a series of discussions with board members of MMC, Mr. Donahoe said.

He noted that when the Federal Medical Care Bill was introduced in the House of Commons in July of 1966, it was not clear whether a doctor-sponsored plan could have a role in the administration of a provincial plan.

Mr. Donahoe said the advisory commission subsequently entered into active discussions and negotiations in Halifax and Ottawa with federal authorities in respect to the use of MMC in the proposed plan. In March of this year, he said, the matter was finally clarified with federal health and welfare minister, Allan J. MacEachen, who advised him that the federal legislation would permit the Province's use of MMC in substantially the manner in which he and the Commission had sought.

The health minister added that officials of the Province and MMC are continuing negotiations in an effort to reach agreement on minor details. □

*A Nova Scotia information service press release of June 24th, 1967 published in full for the information of members of The Medical Society of Nova Scotia.

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