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What is Psychotherapy?

R. J. Weil, and F. A. Dunsworth, M. D.*

AS psychiatrists we are very often faced with the question, "What is psychotherapy?" not only by referring physicians and our patients but also by the sophisticated laymen at meetings at which we have spoken expounding psychiatric theories and mental hygiene principles. Because of this interest it was felt that a brief non technical article would be of value.

Everyone talks about psychiatry these days and the laymen is exposed to and confused by psychiatric terminology. In films he sees various forms of psychiatric treatment applied, he reads about it in the newspapers and popular magazines, and many novels are written around psychiatric themes. A great deal of confusion has arisen about this subject and while physical methods of treatment in psychiatry, such as electroshock and insulin treatment are more readily acceptable and comparable with other medical treatment procedures, few can grasp that by "just talking" feelings can be modified, symptoms eradicated, and personalities changed. How is it done? By what method? What goes on behind the closed door of the psychiatrist's office? Very many questions arise regarding the real crux of psychotherapy, for example, is it psychoanalysis, is it hypnosis, is it administration of "truth serum?" The patients ask after psychotherapy had been suggested, "What do I do?" "Do you ask me questions?" "Do you guide me in my everyday living?" "Will psychotherapy be likely to change my feelings about my family, my marriage, or my religion?" These and many other questions indicate the patients' and thus the public's confusion.

In addition to this confusion there is the general resistance towards psychiatry. Its enquiring nature into repressed human conflicts and problems is a threat to people, and in addition, it differs radically from well established medical methods.

These questions and resistances are justified and require careful consideration. They indicate fears and ignorance and antagonism and they cannot and should not be brushed aside with impatience but dealt with as carefully as possibe. We cannot hope to answer all of them. There are no fixed answers for any patients in any branch of medicine and the approach must be individualized. We hope in the following to give a general outline of our concept of psychotherapy, the full details of which will vary with each patient.

The first difficulty in discussing this topic is the fact that psychic disorders and their treatment cannot be directly compared to the usual forms of treatment in general medicine. In the usual medical practice a patient comes to a doctor for relief of symptoms. He expects something *given to him*, for example, medicine or advice or a diet sheet, or have something *done to him*, for example an operation or manipulation on some part of his body. With this attitude, the patient shifts all the responsibility onto the physician. An immediate clarification of this point must be given when the patient comes to psychotherapy, for in psychotherapy the patient has to take the greatest share of

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responsibility for bringing about changes in himself which will help him to live more happily with himself and others. *He has to want treatment*, that is, he cannot be treated against his will, and he must have a genuine desire to carry out his part of the treatment procedure. In many cases this means changing certain patterns of behaviour which have led him into internal or external maladjustment and it also means complete honesty with himself and the therapist with a frank and unreserved discussion of his past and present feelings, warm as well as hostile. Lastly, it means sacrifice of time and money since this form of treatment is relatively prolonged and relatively expensive. In other words, the cornerstone of psychotherapy is the patient's *motivation*. If this is strong, treatment results are very encouraging and gratifying and the change they exert in the patient very remarkable.

At this point it may be asked: "What is the function of the therapist?" Psychotherapy is an art as well as a science and the therapist must have certain personality assets as well as technical skills and he must constantly attempt by acceptance, by understanding and by confrontation and interpretation to relieve the patient from intolerable tension. If successful, therapy will give to the patient increased ability to cope with his problems and adjust in a mature manner.

Usually the patient has seen many other doctors. He may have had some symptoms which after a negative physical examination and investigation plus evaluation of psychic factors have proven to be psychogenic. Often these patients are people who never have been able to establish any firm and secure relationship with anybody and it is therefore little wonder that they approach a psychiatrist with the same apprehension, distrust and bewilderment as they have done in the past with other medical men and other human beings in general. Again, most patients who come to a psychiatrist have the feeling that they never have been understood and often feel that they don't even understand themselves. Obviously then it is difficult for them to hope that this new person in their life will be able to grasp their problem, still less able to do something about it. Therefore the first function of the psychotherapist is to establish *rapport*; i.e., a relationship of communication and understanding. This working relationship must be established from the first contact and the more secure the doctor the more comfortable the patient will feel in his presence. Without establishment of rapport, without some trust on the part of the patient toward the therapist, psychotherapy cannot be continued. This trust early in treatment is usually fragile and tenuous. Therefore it is understandable why the psychotherapist has to tread very carefully at first and not antagonize, irritate or embarrass the patient by too much probing, inquisitiveness, or too many questions concerning intimate problems. Very often it takes many hours before rapport is established and the patient and therapist well enough acquainted with each other so that the patient can feel comfortable in his relationship to disclose the problems he never discussed before; i.e., his most intimate conflicts. The patient will test the therapist for a long time before he will disclose intimate information. The degree of his intimacy is a measure of his rapport.

The therapist knows a great deal about the patient by the time the latter has seemingly exhausted his autobiography, his family history, his working history, his concepts of sexual adjustment, etc., but still, he will be suffering

from the symptomatology which brought him to the psychiatrist. What now? Up to this point the patient could understand that the psychiatrist wanted to know as much about him as he could to understand his problem, but gradually the patient comes to the realization that the psychiatrist's understanding of him and an intimate knowledge of his life's history really do not help him to get better. The patient certainly is not interested in giving information to satisfy the therapist's inquisitiveness and curiosity and he will rightly ask what will happen from now on. Here the specific skill of the psychoherapist will determine the further course of the therapeutic contact. The history that the patient has given is of course a very superficial one. The patient has revealed facts which are readily available to him consciously and very rarely contain those conflicts, ideas, and feelings which he had to repress all his life because he was unable to face them. From the patient's history, from some slip of the tongue the patient may have made, from his behaviour, attitudes, from his dreams, from his everyday activities, the therapist has formed for himself a picture of this patient's personality and his basic difficulties, and on the basis of this rather involuntary information, the therapist can reflect back to the patient those feelings, ideas, and attitudes which the patient himself has never been able to see in their real light. Very often, by interpretation of his behaviour and statements the patient may be able to understand the importance of his personality difficulties which have so far caused him to manouvre himself into trying situations. The psychotherapist can also help the patient to bring out repressed ideas and conflicts of which the patient may never have been aware and as the patient begins to see himself as others see him he will, with the help of the therapist, go about *doing something* about those feelings, conflicts and problems which caused his symptomatology in the first place.

To bring repressed material to the surface is not the only function of the psychotherapist. The interpretation of repressed ideas, the pointing out of some behaviour pattern which may have been detrimental in the patient's adjustment and even the repeated disclosure of the patient's unconscious associations will not help him to change his pattern of behaviour. The patient is not exposed to psychotherapy all day long. He may see the therapist once to three times weekly for an hour but the rest of the week he lives with his family, he goes to work, he participates in church activities and other communal functions and that means he is continually exposed to *the reality of inter personal relationships*". Even if he is in a hospital he has to contacts with human beings and it is his behaviour, his attitudes, the reality outside of the therapeutic hour which very often is so important in therapy. The patient usually brings into the therapeutic hour discussions of his daily activities, of his relationship with his family, with his employer with friends, with colleagues, etc., and on the basis of these relationships the therapist is able to evaluate progress. It is important that the patient is led to realize that some of his behaviour, statements, and attitudes toward himself and people around him interfere with his adjustment. For instance, if a husband does not dare to express his opinion at home and harbours a great deal of deep resentment, he will become more and more tense, irritable and hostile against his family and occasional aimless outbursts of temper will be the result. Of course, his wife and children will react to these outbursts of anger and will

behave accordingly. All those facts have to be pointed out to him and he has to see that it is primarily his behaviour which forces others into acquiring certain attitudes towards him.

At this point we would stress two additional facts. *It is not the therapist's role to give advice*; once advice-giving starts, psychotherapy stops. Our aim of the patient grasping, facing and doing something about his problems will be lost and rather than independence, a fostering of his pernicious dependency will destroy any hope of true maturity.

The other point is that the therapist must realize that his most important tool is the *doctor-patient relationship.* The warmth and strength of the rapport will lead the patient to attempt actions that previously panicked him. He also finds perhaps for the first time in his life, that there are consistent secure persons who can accept him and permit him to express his feelings without moralizing or censure. This same relationship also may be a liability. The physician who practices psychotherapy must quickly learn that his patients may misidentify him and feel about him as they felt about their parents, siblings or even cast the therapist in an aggressive or seductive role. These misidentifications will test the security of the therapist but must be anticipated and dealt with, not by withdrawal or anxiety but by pointing out the possible connections of the patient's present feelings with significant people in their range of experience. Very often clarification of these feelings bring about the turning point in therapy.

The third function of the therapist is to *emphasize the positive features* of the patient's character. Every human being has some positive aspects of his personality but few are able to utilize those assets to the utmost and if the therapist is able to support the patient and push him into using them he can carry on in his daily activities with greater assurance and with improved self esteem.

So, to sum up our answer to "What is Psychotherapy?", we feel that first it consists of the establishment of rapport, i.e., a working relationship between patient and doctor. Secondly, the patient has to be helped to face those feelings, conflicts and associations which he has never been able to work through and which he avoided facing or expressing. Thirdly, the therapist has to represent reality. He has to point out the pateint's responsibility to change his function in his family, his job, and in his community. Lastly, the patient has to be supported and the positive apsects of his personality and his assets emphasized. The results are greatest when all points are fully utilized and no one approach used to the neglect of the rest.

COMMITTEE ON TRAUMA
AMERICAN COLLEGE OF SURGEONS

The Care Of Hand Injuries*

V

Fractures and Dislocations

I. **Protection of the Hand** (Abstract of Article I)

The first-aid care of wounds of the hand is directed fundamentally at protection. It should provide protection from infection, from added injury, and from future disability and deformity. The best first-aid management consists in the application of a sterile protective dressing, a firm compression bandage and immobilization by splinting in the position of function.† No attempt should be made to examine, cleanse or treat the wound until operating room facilities are available.

II. **Requirements of Early Definitive Treatment** (Abstract of Article II)

Early definitive care requires thorough evaluation of the injury with respect to its cause, time of occurrence, status as regards infection, nature of first-aid treatment and appraisal of structural damage. For undertaking definitive treatment, the conditions required are a well-equipped operating room, good lighting, adequate instruments, sufficient assistance, complete anesthesia and a bloodless field. Treatment itself consists of aseptic cleansing of the wound, removal of devitalized tissue and foreign material (exercising strict conservation of all viable tissue), complete hemostasis, the repair of injured structures, protecting nerves, bones and tendons and providing maximum skin coverage and the application of firm protective dressing to maintain the optimum position. After-treatment consists of protection, rest and elevation during dealing, and early restoration of function by directed active motion.

III. **Surface Injuries** (Previously circulated)

IV. **Lacerated Wounds** (Previously circulated)

V. **Fractures and Dislocations**

The purpose of treatment of closed fractures and dislocations of the bones of the hand are:

*Note: This is the fifth of a series of articles on "The Care of Hand Injuries". This material is prepared by the American Society for Surgery of the Hand and is distributed by the Committee on Trauma, American College of Surgeons, through its Regional Committees.

† Pisition of function or position of grasp: wrist hyperextended in cock-up position, fingers in mid-flexion and separated, thumb abducted, slightly forward from hand and slightly flexed.

1. Protection of the injured bony structures from further displacement and avoidance of added damage to soft parts.
2. Restoration of normal relations of the bony structures.
3. Maintenance of the corrected relation of the bones to permit healing, at the same time avoiding stiffening in position of nonfunction.
4. Restoration of function.

These objectives are sought in the various stages of treatment.

1. First-aid treatment.

   A. Avoid manipulation or attempts at reduction until skilled attention is available and accurate diagnosis has been made.

   B. Prompt protection of the hand by complete immobilization in the position of function pending definitive treatment.

2. Definitive treatment.

   When proper skill and facilities are available, this consists of:

   A. Diagnosis by means of

      1. Inspection to determine swelling, ecchymosis, deformity, loss of function.

      2. Palpation, gently employed, to discover bony irregularity, point of maximum tenderness, referred pain. This sign is of importance in discovering fractures of the long bones, particularly where deformity may not exist or is concealed by swelling. Gentle pressure in the line of axis of the long bone will result in pain at the fracture site.

      3. X-ray examination. Obligatory where fracture or dislocation is suspected. Injuries in the region of the carpus require not only antero-posterior and lateral views but two or more oblique views in addition. Fractures of the carpal bones frequently fail to show in antero-posterior and lateral views.

   B. Reduction. Restoration of normal position of bony structures should be secured at the earliest possible time by:

      1. Manipulation.
      Whether reducing a fracture or a dislocation, full relaxation, preferably under general anaesthesia, is desirable. Manual traction, pressure and moulding should be gentle and deliberate to avoid further soft-part injury.

      When attempts at reduction by manipulation are not promptly successful under these conditions, they should be abandoned in favor of open (operative) replacement. Dislocation at the metacarpophalangeal joint of the thumb will almost invariably require open reduction.

2. Skeletal control.

To maintain reduction, particularly of oblique or comminuted fractures of phalanges or metacarpals or fractures into joints, control by skeletal fixation may be required. This may be applied by means of a length of thin Kirschner wire inserted transversely through the distal end of the fractured bone or through the terminal phalanx of the finger. The hand and injured finger or fingers should be supported in the position of function on a palmar moulded curved form or ball splint. This alone will ordinarily suffice to maintain proper position after reduction by manipulation. When control by skeletal fixation is required for maintenance of reduction, the transfixing wire may be connected to this splint on its palmar aspect or to a projecting frame, at or above wrist level, by elastic bands. Fixation or traction by means of a hole in the finger nail, or by adhesive applied to the finger, or by woven constricting device is not satisfactory. Continued straight traction on the fingers in the extended position is to be avoided.

3. Open reduction.

When manipulation fails to produce satisfactory reduction, open operative reduction is to be employed. This requires careful preliminary skin preparation and should be carried out under optimum operating conditions as described in II (Requirements of Early Definitive Treatment.)

3. Maintenance of reduction.

Immobilization of bony injury following reduction should:

(a) Be secured with firm, even pressure bandaging, permitting no motion at site of injury.

(b) Be nonconstricting, not interfering with circulation.

(c) Be comfortable, causing no excess pressure.

(d) Preserve, as far as possible, the position of function, taking into account the normal concavities of the palmar surface of the skeletal structures (arches of the hand) and flexor surface curves of the phalanges. (Wrist in 30° dorsiflexion, metacarpophalangeal and distal interphalangeal joints in 45° flexion and middle interphalangeal joint in 90° flexion). Flat splinting is to be condemned.

(e) Leave free to move all joints whose motion will not jeopardize position and healing. During immobilization, active motion of all joints not necessarily confined is to be encouraged.

Immobilization may be accomplished by:

(1) Splinting or plaster casting, applied as described in 2B Reduction.

(2) Internal fixation. Kirschner wires may be employed, following either open or closed reduction, as axial intramedullary splints for

individual long bones (not to protrude into a joint); as transversely introduced fixation pins passing through adjacent bones to secure the fragments of metacarpal fractures; as penetrating fixation for fragments of carpal fractures.

Wiring or plating of fractures of the bones of the hand is generally unsatisfactory.

During the early period of immobilization, elevation of the hand is desirable. Immobilization of the injury should be consistent and continuous until healing and firm union have been established.

Healing of ligamentous injuries accompanying dislocations requires two weeks of immobilization following reduction.

Healing of fractures of the long bones requires immobilization for three to five weeks.

Healing of carpal bone fractures requires twelve to fourteen weeks' immobilization. Fractures of the navicular may require four months to unite. If immobilized consistently forthis length of time, most of these fractures will not require surgical intervention.

4. Restoration of function.

During the healing process, all joints not necessarily immobilized should be freely moved to activate their controlling muscles and their use by the patient encouraged.

Following establishment of healing or firm union, restoration of function is secured by directed active motion, particularly through the means of exercise and occupational therapy.

Society Meetings

The Nova Scotia Society of Ophthalmology and Otolaryngology

A joint meeting of the New Brunswick and Nova Scotia Societies of Eye, Ear, Nose and Throat Specialists was held Wednesday, November 21st' 1951 at Halifax, N. S.

The clinical portion of the programme opened with presentation of cases at the Victoria General Hospital.

Dr. H. W. Schwartz presented the following cases:
Repair of an ora-antral fistula—Steel in the vitreous (first thought to be non-magnetic)—Kamel operation for pterygia.
Epithelioma of the auricle—Glaucoma (non-congestive) extreme degree of cupping—total blindness.—Nasal reticulo sarcoma with widespread metastases.
Dr. A. E. Doull, Jr. presented the following cases:
Interstitial Keratitis—Congenital Glaucoma.
Dr. E. I. Glenister presented the following cases:
Glaucoma simplex—Esotropia (post-operative)—Choriditis (with loss of vision) and esotropia—following measles.
Dr. R. F. Hand presented the following cases:
Loss of vision secondary to the infestion of methyl alcohol—treated (in part) with cortisone.—Cervical fistula following a radical mastoid operation.—External operation for chronic infection of the frontal sinus and ethmoid labyrinth drainage maintained by tantalum foil.—Correction of nasal deformity by bone graft.
Dr. L. G. Holland presented the following cases:
Case of retinal disturbance for diagnosis.—Late complication of cataract extraction.
Dr. D. M. MacRae presented the following cases:
Unilateral exophthalmus due to fibrous displasia—Boek's sarcoid (several cases with eye, chest and glandular involvement)—Oseophageal stricture—two cases—secondary to ulcer of the oesophagus—Carcinoma of the larynx—Recurrence in traecheal stoma following the laryngectomy.
Dr. R. H. Stoddard presented a series of X-ray films illustrating bronchogenic carcinoma and bronchiectasis, and displayed some of the newer types of instruments used for the examination and treatment of these cases.

A short business meeting was held at the Lord Nelson Hotel preceding the luncheon, the President, Dr. Fuller, opened the meeting and welcomed all present to the first official joint meeting of the two Societies. Dr. F. L. Ramsay of Yarmouth was proposed for membership, this was moved by Dr. Schwartz and seconded by Dr. Stoddard.

It was the opinion of the meeting that the next joint meeting would be held in Moncton or Saint John, N. B. in the early part of May, 1952, the time and place to be decided by the New Brunswick Executive. There being no further business the meeting adjourned for luncheon.

The afternoon session opened with presentation of papers at the Halifax Infirmary. Dr. Desmond of Moncton presided.

Dr. W. Ross Wright, of Fredericton, N. B. presented a paper—Indications for Enucleation.

The discussion was opened by Dr. Schwartz, Dr. D. M. MacRae, Dr. Desmond and Dr. Chipman, Dr. Fuller also joined in the discussion. Dr. Schwartz asked that Dr. Wright might allow his paper to be reprinted in the Bulletin.

Dr. H. J. Davidson presented a paper "Comments on Peroral Endoscopy." In the paper Dr. Davidson made reference to the various instruments and techniques commonly used.

Dr. J. P. McGrath opened the discussion and made some comment with regard to plenty of local anaesthesia and the importance of X-ray before any instrumentation.

Dr. C. H. Smith gave an interesting paper, "Some aspects of Ophthalmology in West Africa." Dr. Smith briefly mentioned some of the eye conditions commonly seen there and how the General Doctor had to treat them and the results.

Mr. F. H. Flinn then gave a short talk on C.N.I.B. problems with regard to their relation to the Eye Specialists. There was considerable discussion by the members, and it was moved by Dr. Wright, seconded by Dr. Phinney that the President name a committee of three for the Nova Scotia Society and one for the New Brunswick Society to hold a meeting with Mr. Flinn and bring a report in at the next joint meeting.

On the motion of Dr. J. P. McGrath., seconded by Dr. Ross the meeting adjourned.

E. I. Glenister, M.D.
Secretary-Treasurer

VALLEY MEDICAL SOCIETY

The regular monthly meeting of the Valley Medical Society was held at the Nova Scotia Sanatorium, Kentville, on December 14th. Following a short business session Doctor H. B. Atlee of Halifax spoke on "Natural Childbirth." After dinner a symposium ws held on "Newborn Mortality", when Doctor Atlee spoke on Prenatal and case-room aspects, and Doctor Henry B. Ross of Halifax on "Handling of Problems of Newborn."

A Day of Preventive Medicine

ON Monday, January 7th, the Post-Graduate Committee of the Dalhousie Medical School put on an intensive day of clinical preventive medicine. It was very well attended as many of the Health Officers from Nova Scotia and quite a number from New Brunswick were present.

The morning began with a consideration of Infant and Maternal Mortality, and Doctor A. R. Morton, Commissioner of Health for the City of Halifax presided. Doctor H. B. Atlee took up The Care of the Mother and Child during the Pre-natal Period, and there followed a consideration of the Effect of Nutrition on the Infant and Mother by Miss Juanita Archibald, Director of Nutrition, Department of Public Health, Province of Nova Scotia. Doctor C. L. Gosse, Assistant Professor of Urology, continued with the consideration of Congenital Syphilis; Doctor H. C. Read spoke briefly on the Rh Factor; Doctor Henry Ross on Prematurity and Doctor C. J. W. Beckwith on Tuberculosis. This was followed by a discussion of the Post-natal Care of the Mother by Doctor W. R. C. Tupper and Doctor J. McD. Corston, both of the Department of Obstetrics and Gynaecology.

The afternoon session was presided over by Doctor J. L. Sutherland, Superintendent of the Children's Hospital. The Care of the Child during the First Year of Life was taken up by Doctor Henry Ross, Assistant Professor of Paediatrics at Dalhousie Medical School; Infant Feeding by Doctor G. B. Wiswell, Professor of Paediatrics; Diarrhoea and Enteritis, by Doctor N. B. Coward, Associate Professor of Paediatrics; Congenital Abnormalities by Doctor B. F. Miller, Assistant Professor of Surgery and Orthopaedics and Tuberculous Meningitis by Doctor C. J. W. Beckwith, Assistant Professor of Medicine.

Mr. C. R. Ross, the Director of Industrial Hygiene of the Department of Health, Province of Nova Scotia, gave a most interesting discussion on Silicosis. This was discussed from the radiological angle by Doctor P. G. Loder, Instructor in Radiological Anatomy and Doctor D. M. Grant of the Workmen's Compensation Board took up the topic from the angle of compensation.

The afternoon was completed by a most interesting paper on Laboratory Aids to Diagnosis by Doctor D. J. Mackenzie, Director of Laboratories, Department of Public Health.

The programme was completed by Doctor C. E. van Rooyen, Professor of Virus Diseases at the University of Toronto. Doctor E. F. Ross, Chairman of the Dalhousie Post-Graduate Committee, presided, and Dean H. G. Grant introduced the speaker. Doctor Van Rooyen who gives his whole time to research and study on virus diseases, covered the whole field of virus diseases and took up specifically the questions of Infantile Paralysis, Infectious Hepatitis and Virus Pneumonias. His talk was given in the Auditorium of the Victoria General Hospital and the room was filled to capacity. The students of the third and fourth years of the Medical School were present by invitation and in addition there was an excellent representation from the

Province and also quite a number from the Province of New Brunswick. Following Doctor van Rooyen's talk Doctor C. E. Kinley, Associate Professor of Surgery, discussed the paper taking up several points in connection with infantile paralysis. Doctor R. M. MacDonald, Assistant Professor of Medicine, made a few remarks dealing chiefly with Infectious Hepatitis, and Doctor C. W. Holland, Professor of Medicine, spoke about his clinical experience with virus pneumonias.

It was generally agreed that the lecture by Doctor van Rooyen was a complete success. Following the lecture light refreshments were served through the courtesy of the Victoria General Hospital.

On Call

Published in the interest of community medical service

THE STATE OF THE NATION

A. D. KELLY
Deputy General Secretary

The vitality of the Association's provincial divisions continues to gain strength. There is a growing local interest in both technical and non-technical affairs of the divisions.

There is active co-operation by doctors in the development of prepaid medical plans, and support for Trans-Canada Medical Services.

Through the sustained efforts of the profession, hospital and other medical facilities are expanding as doctors set their sights on the highest standards of medical service.

These are the conclusions which may be drawn as a result of the divisional meetings recently held across the country. One of the responsibilities, and privileges, which the Canadian Medical Association imposes or confers, on its president, is an official visit to each of the 10 divisional annual meetings, accompanied by a member of the Secretarial staff.

Dr. Harcourt B. Church, accompanied by the writer, has attended in quick succession eight divisional meetings from August 28 to October 12. Truly our president has been "on call" in the interest of the medical profession and the people whom we serve.

One would be dull indeed if such an experience did not convey a better appreciation of the Canadian scene and the part which our profession is playing in the building of the nation. Canada is literally bursting at the seams in an era of rapid growth and development. Economically and sociologically this expansion is evident from the Atlantic to the Pacific and, like all growth phenomena, it is accompanied by necessary changes and adjustments.

In the field of medicine one sees new and energetic attacks on the age-old problems of cancer, arthritis and tuberculosis. It is encouraging to observe the partnership between the official health agencies and practitioners of medicine in meeting these menaces to the health of our people. The bricks and mortar of recent additions to hospital facilities of the nation are evidence of expansion. New medical schools will shortly be graduating additional recruits to the ranks of the profession and in their development there is abundant proof of the sound planning which is so essential to these fundamentally important institutions.

In the business sessions of the divisional meetings there was much discussion on methods of distributing medical services. Our plans of prepaid medical care are gaining widespread public acceptance and their growth in most instances is as rapid as administrative practices will permit. The formation of Trans-Canada Medical Services is regarded as a forward step. But the inherent promise of this new organization must shortly be justified by its performance in spreading the benefits of prepaid medical care coverage. Any tendency to complacency at the growth of our plans is tempered by an awareness on the part of the profession that they have to date made little progress in covering rural subscribers and providing contracts for individuals. The medical care of the large new group of recipients of old age pensioners was thoroughly discussed and the policy of the Association was everywhere

reaffirmed—that these pensioners are not automatically entitled to government-sponsored medical care.

Much interest was displayed in the operation of the National Health Service in Great Britain and in the Canadian evidences of the trend to government intervention in medical care. Critical as we are of the shortcomings of the British scheme, and convinced that it is quite unsuitable for Canada, we must lose no time in demonstrating that our own voluntary approach to the problem of budgeting for the cost of medical and hospital services is a better alternative. Although the large majority of our profession is convinced that we can do so our position is weakened by two attitudes displayed by some of our members. The first and most dangerous viewpoint is represented by the doctor who ignores the signs and who assumes that the comfortable ways of private practice will persist unchanged. To him "socialized medicine" is unthinkable and he belittles the efforts of the profession to promote plans of voluntary prepaid medical care. He is a menace to endeavour because he believes that "It can't happen here". At the other end of the scale, a few of our people assume that despite our best efforts, eventual domination of the practice of medicine by government is inevitable. This defeatist attitude leads them to stop struggling to promote and improve our voluntary plans and they have already thrown in the sponge.

Fortunately, the profession as a whole adopts neither of these attitudes. Attuned to the times and playing its full part in Canada's growth and development, it recognizes the need for promoting a distinctively Canadian approach to the health problems of our restless people. The progession does not deny the place of the state in the promotion of health services and it believes that it has demonstrated its ability to work in harmony with governments to the great advantage of all Canadians.

The presidential tour provided an excellent opportunity to assess the vitality of our organization and its constituent Divisions. Beginning at the meeting of the infant Newfoundland Division at St. John's, it was immediately evident that the doctors of our newest province have been stimulated and aided by their contact with the national Association. In this area with its unique medical problems, Confederation has had the effect of initiating such public services as Workmen's Compensation. The profession is considering its relationship to this and other matters, familiar to the profession elsewhere.

The New Brunswick Division met in the delightful surroundings of the Algonquin Hotel, at St. Andrews, at its seventy-first annual meeting. The smoothness and efficiency with which the sessions were conducted testify to the experience gained in contributing to the medical life of the province and the country as a whole over a long period.

The real veteran of organized medicine in Canada, our Nova Scotia Division assembled for its Ninety-eighth annual meeting at Antigonish. The facilities of St. Francis Xavier University were placed at our disposal and a diversified program of business, scientific and social events was presented.

The vigour of the Island Division was never better displayed than at this year's meeting at Charlottetown. Panel discussions on cancer control and on the Mental Health Program were convincing demonstrations of the

integration of the division with the immediate problems of its province. The business sessions showed that the doctors of P. E. I. are well informed on the issues of the day.

At these four Maritime meetings a single team of speakers accompanied the president and made most effective presentations to the scientific sessions. The Canadian Medical Association and its divisions are grateful to these busy practitioners and teachers who contributed so much to the educational activities which are fundamental to the purposes of our organization. It is encouraging, however, to note that our divisions are not now depending solely on guest speakers to provide the educational program. Presentations by local contributors are finding an increasingly important place.

The scene quickly changed to the west where the first of four meetings was convened by the Sackatchewan Division at Moose Jaw. Despite the coincidence that the duck shooting season opened the same day, a large attendance of Sackatchewan doctors and their wives was registered. Business, scientific and social activities were pursued with the enthusiasm characteristic of our Saskatchewan colleagues and here the contribution made by local speakers to the scientific program was outstanding.

Next, the forty-sixth annual meeting of the Alberta Division was held at Edmonton. Here the stimulating atmosphere of Canada's oil capital and the stabilizing influene of the University of Alberta were evident. Although actively engaged in many important intra-provincial medical projects, our Alberta friends found time to discuss plans for the Eighty-third annual meeting of the C.M.A. which will be held at Banff and Lake Louise during the week of June 9, 1952. Dr. Harold Orr, president-elect and his local committees are making preparations for a memorable gathering.

The British Columbia Division assembled at Vancouver for a week of diversified activity including the official opening of the new home of the Vancouver Academy of Medicine. This modern building provides ample accommodation for the medical library as well as office and committee rooms for all provincial medical organizations. Its facilities created a feeling of envy among the visitors who inspected it. A momentous decision was reached at this meeting and the B. C. Division will undertake to finance its own activities by levying an annual fee among its members on a voluntary basis.

The final meeting on the presidential tour was that of the Manitoba Division at Winnipeg. Well documented and well arranged, it provided a fitting climax to a highly informative survey of Canadian medicine from coast to coast.

Although it is fallacious to draw conclusions relative to the state of an organism as complex as the Canadian medical profession, it is possible to report the impression that the subject is alive and vigorous, even lusty, and that in this respect its condition parallels that of the nation.

CORRESPONDENCE

DEPARTMENT OF VETERANS AFFAIRS
Camp Hill Hospital,
Halifax, N. S.
December 18th, 1951

H. G. Grant, M.D.,
Secretary,
Nova Scotia Medical Society,
Dalhousie Public Health Clinic,
Halifax, N. S.

Dear Mr. Grant:

With reference to our recent telephone conversation concerning the matter of the prescribing of new and expensive drugs for entitled veterans under the Doctor-of-Choice Plan by members of the Medical Profession in the province, attached herewith please find the communication covering our Regulations and we would request that it be submitted for publication in the next issue of the Nova Scotia Medical Bulletin.

Yours very truly,
C. J. Macdonald, M. D.
Assistant Hospital Superintendent

DEPARTMENT OF VETERANS AFFAIRS
Camp Hill Hospital,
Halifax, N. S.
December 18th, 1951

H. G. Grant, M. D.,
Secretary,
Nova Scotia Medical Society,
Dalhousie Public Health Clinic,
Halifax, N. S.

Dear Dr. Grant:

Recently it has become apparent that with the passage of time and the increasing number of young practitioners in the Province, the regulations of the Department of Veteran's Affairs in regard to the prescribing of new or expensive drugs for entitled veterans under the Doctor-of-Choice Plan, is not known sufficiently well and it is thought advisable to review the regulations for the information of the Profession generally.

The original instructions issued when the Doctor-of-Choice Plan was inaugurated, stated clearly that new or expensive drugs were not to be prescribed for entitled veterans without prior authority from the Department.

This was for two reasons: first, to prevent prescribing of insufficiently proven drugs, and secondly, to cut down expenditure of Public Funds, since such drugs if approved for use, could be supplied from Departmental sources at considerably less cost. Particular reference is now made to such preparations as Cortisone, ACTH, Chloromycetin, Terramycin, Aureomycin, etc., which are coming into more general use and are still very expensive.

In an acute emeregncy, authority to obtain such drugs locally may be obtained from the Senior Treatment Medical Officer, or his Assistant, by phone or if this proves impossible, the physician has authorization to proceed on his own and report the circumstances to the Senior Treatment Medical Officer immediately.

In the particular cases of Cortisone and ACTH, the use of these drugs under Departmental auspices is still under very strict supervision of a Special Committee on Research and Education at the Department's Head Office, and it is laid down by that Committee that Cortisone and ACTH can only be prescribed under the Doctor-of-Choice Plan after the patient's case has been thoroughly reviewed in a Departmental institution by the Special Hospital Committee on Cortisone and ACTH. Reports must be submitted at least every three months and following a re-assessment of each individual case in hospital. This procedure is essential if the Research Program is to have any value. In addition, the risk of unfavorable reactions is brought to a minimum and treatment is terminated immediately if no improvement results. Naturally in an emergency the procedure outlined in the preceding paragraph is applicable.

It is emphasized that the Department is very anxious to ensure that the best possible treatment is made available to veterans who are entitled to such. However, due to the present large expenditure for drugs under the Doctor-of-Choice programme, it is essential that certain supervision must be maintained. In the past our Department has had excellent co-operation from members of the Medical Profession in this area in respect to the Doctor-of-Choice programme. It is earnestly hoped that re-emphasis of the above policy will assist in the continuation of such co-operation.

T. E. Kirk, M. D.
Senior Treatment Medical Officer

THE CANADIAN MEDICAL ASSOCIATION
Toronto 5, Ontario
December 10th, 1951

TO THE SECRETARIES OF DIVISIONS

Dear Doctor Grant:

As a consequence of recent conversations with officials of the Department of National Revenue, it is now possible to announce a change in the

requirements of income tax returns by members of medical partnerships. The essentials of the new conditions are contained in the following notice which will be published in the January issue of the Canadian Medical Association Journal:

IMPORTANT INCOME TAX INFORMATION

Many physicians who practise in partnership, have been affected by rulings of the Income Tax Appeal Board, which had the effect of requiring them to claim deductions for the legitimate expenses of practice from the partnership income rather than in their personal income tax returns. The application of this ruling to the taxation years 1949 and 1950 has resulted in the disallowance of practice expenses claimed in personal returns for those years and in assessment for additional tax.

"A recent directive from the Department of National Revenue to District Income Tax Offices cancels this ruling and taxpayers who are partners may continue to claim as deductions in their personal returns the allowable expenses of earning their income. The situation therefore reverts to that which applied before the ruling of the Appeal Board in the case of 'Mr. I.'

"Doctors who have paid additional tax for 1949 and 1950 as a consequence of the disallowance of expenses charged in their personal income tax returns, SHOULD MAKE WRITTEN APPLICATION FOR REFUND WITHOUT DELAY.

"Section 52 (i) of the Income Tax Act, quoted hereunder, applies:

"The Minister may, upon mailing the notice of assessment, refund, without application therefor, any overpayment made on account of the tax, and he shall make such a refund after mailing the notice of assessment if application in writing is made therefor by the taxpayer within 12 months from the day the overpayment was made or the day on which notice of assessment was sent.'

"If you have made overpayment under these circumstances and have not made an appeal or have not already made application for adjustment, you are strongly advised to apply in writing to your District Income Tax Office for a refund before the expiry of twelve months from the overpayment."

You will observe that partners may continue to claim as deductions in their personal income tax returns, their share of the total allowable expenses of the partnership. This constitutes a re-establishment of the conditions which applied prior to the recent controversial rulings of the Income Tax Appeal Board.

It is particularly important that taxpayers who have been assessed additional tax for 1949 or 1950 in respect of disallowed practice expenses, claim a refund of any overpayment prior to the lapse of twelve months. May I

suggest that this information be transmitted to these doctors who may be affected, by any means at your disposal.

Yours faithfully,

A. D. Kelly,

Deputy General Secretary

CANADIAN MEDICAL ASSOCIATION

Toronto 5. Ontario

January 4th, 1952

TO THE SECRETARIES OF DIVISIONS

Dear Doctor Grant:

Attached please find the amended statement relative to Income Tax returns by members of the medical profession. The terms of this announcement have been checked by officials of the Department of National Revenue and we believe that it is as authoritative as we can obtain for the current year. At the request of the Department, we have supplied sufficient copies for distribution to all District Income Tax offices and you may be assured that the terms of our announcement will be familiar to local officials.

The main changes relate to permissible deductions by doctors employed on salary or contract and a clarification of the partnership issue.

The statement on Income Tax will appear in the February issue of the Canadian Medical Association Journal and in the meantime you may utilize this information as you see fit.

With all good wishes for 1952, I am,

Yours faithfully,

A. D. Kelly,

Deputy General Secretary

INCOME TAX INFORMATION

Individuals whose income—(a) is derived from carrying on a business or profession (other than farming); (b) is derived from investments; or (c) is more than 25% derived from sources other than salary or wages, are required to pay their estimated tax by quarterly installments during such year. Each payment must be sent in with Installment Remittance Form T.7-B Individuals. Any balance of tax is payable with interest with the T-1 General return which is due to be filed on or before April 30 of the succeeding year.

The following time-table indicates the returns required:

A. Doctors NOT receiving salaries amounting to $\frac{3}{4}$ of income:

Date Due	Forms to be Used
March 31	T.7-B Individuals
April 30	T.1- General (Note: Only doctors deriving their full professional income from salaries may use Form T.1 Short).
June 20	T.7-B Individuals
September 30	T.7-B Individuals
December 31	T.7-B Individuals

B. Doctors receiving salaries amounting to ¾ or more of income:

Date Due	Forms to be Used
April 30	T.1-General (Note: Doctors deriving their full professional income from salaries may use Form T.1 Short.)

Whenever Status is changed* T.D.-1.

Doctors who pay salaries to their own employees are required to send in Form T.-4 by the end of February each year.

DOMINION INCOME TAX RETURNS BY MEMBERS OF THE MEDICAL PROFESSION

As a matter of guidance to the medical profession and to bring about a greater uniformity in the data to be furnished to the Taxation Division of the Department of National Revenue in the annual Income Tax Returns to be filed, the following matters are set out:

INCOME

1. There should be maintained by the doctor an accurate record of income received, both as fees from his profession and by way of investment income. The record should be clear and capable of being readily checked against the return filed. It may be maintained on cards or in books kept for the purpose.

EXPENSES

2. Under the heading of expenses the following accounts should be maintained and records supported by vouchers kept available for checking purposes:

(a) Medical, surgical and like supplies;

(b) Office help, nurse, maid and bookkeeper; laundry and malpractice insurance premiums. (It is to be noted that the Income Tax Act

*With respect to new employer, marital status, dependents

does not allow as a deduction a salary paid by a husband to a wife or vice versa. Such amount, if paid, is to be added back to the income);

(c) Telephone expenses;

(d) Assistants' fees;

The names and addresses of the assistants to whom fees are paid should be furnished. This information is to be given each year on Income Tax form known as Form T.4, obtainable from your District Income Tax Office;

(e) Rentals paid;

The name and address of the owner (preferably) or agent of the rented premises should be furnished (see (1);

(f) Postage and stationery;

(g) Depreciation;

A description of the treatment of depreciation may be found on page four of the Income Tax Return form T.1 General under the Part XI Method.

The method of computing depreciation for tax purposes is the same as that used last year and you should have no difficulty if you have a copy of last year's return available.

Simply carry forward the balance remaining in each class after deducting last year's allowance. Add to this figure the cost of any new equipment purchased and deduct the proceeds from any disposal of property in each class. The rate you wish to use not exceeding the maximum rate (see below) is applied to this new balance for each class to obtain the depreciation you may claim this year.

The schedule on page four of the Income Tax Return is reproduced below for your information. Column (6) does not apply to doctors, the other columns are self-explanatory.

The maximum rates for the classes of equipment most used by doctors follow:

Capital Item	Class	Annual Maximum Depreciation
Medical Equipment		
(a) Instruments Costing Over $50 Each and Medical Apparatus of Every Type	8	20%
(b) Instruments Under $50 each	12	100%
Office Furniture and Equipment	8	20%
Motor Car	10	30%
Building (Residence Used Both as Dwelling and Office)	3	5%

Instruments costing less than $50.00 each belong in class 12 and have a maximum allowance rate of 100%. They should not be included in expenses but should be recorded as additions in column 3 of the schedule.

When a doctor practises from a house which he owns and resides in, the allowance may be claimed as above on a portion of the cost of the residence, exluding land. For example if the residence were a brick building costing $12,000. and one-third of the space were used for the office, the doctor would use $4,000.00 as the business portion of the cost and apply the building rate of 5% to determine the maximum depreciation allowable in the first year.

For further information on the subject you may refer to the Regulations or you may consult your District Income Tax Office.

SCHEDULE

(1) Class Number	(2) Undepreciated Capital Cost at Beginning of 1951 (Col. 10 of 1950 return)	(3) Cost of Additions During 1951	(4) Proceeds from Disposals During 1951	(5) Undepreciated Capital Cost before 1951 Allowance (Col. 2 plus 3, less 4)
(6) Net Deferred Assets	(7) Amount on which 1951 Allowance is Calculated (Col. 5 less Col. (6)	(8) Rate %	(9) Capital Cost Allowance For 1951	(10) Undepreciated Capital Cost Less Deferred Assets (Col. 7 less Col. 9)

(h) Automobile expense; (One Car)

This account will include cost of license, oil, gasoline, grease, insurance, garage charges and repairs;

The capital cost allowance is restricted to the car used in professional practice and does not apply to cars for personal use.

Only that portion of the total automobile expense incurred in earning the income from the practice may be claimed as an expense and therefore the total expense must be reduced by the portion applicable to your personal use.

The mileage rate permitted in years prior to 1950 may no longer be used to estimate the authombile expneses.

(i) Proportional expenses of doctors practising from their residence:

(a) Owned by the doctor.

Where a doctor practises from a house which he owns and as well resides in, a proportionate allowance of house expenses will be given for the study, laboratory, office and waiting room space, on the basis that this space bears to the total space of the residence. The charges cover taxes, light, heat, insurance, repairs, capital cost allowance, and interest on mortgage (name and address of mortgagee to be stated.)

(b) Rented by the doctor

Only the rent and other expenses borne by the doctor such as heat and light will be apportioned in as much as the owner takes care of the other expenses.

The above allowance will not exceed one-third of the total house expenses or rental unless it can be shown that a greater allowance should be made for professional purposes.

(j) Sundry expenses (not otherwise classified)—The expenses charged to this account should be capable of analyses and supported by records.

Claims for donations paid to charitable organizations will be allowed up to 10% of the net income upon submission of receipts to your Income Tax Office. This is provided for in the Act.

The annual dues paid to governing bodies under which authority to practise is issued and membership association fees, to be recorded on the return, will be admitted as a charge. Initiation fees and the cost of attending post-graduate courses will not be allowed.

(k) Carrying charges;

The charges for interest paid on money borrowed against securities pledged as collateral security may only be charged against the income from investments and not against professional income.

(l) Business tax will be allowed as an expense, but Dominion, Provincial or Municipal income tax will not be allowed.

CONVENTION EXPENSES

"Effective January 1, 1948, the reasonable expenses incurred by members of the medical profession in attending the following Medical Conventions will be admitted for Income Tax purposes against income from professional fees:

1. One Convention per year of the Canadian Medical Association.

2. One Convention per year of either a Provincial Medical Association or a Provincial Division of the Canadian Medical Association.

3. One Convention per year of a Medical Society or Association of Specialists in Canada or the United States of America.

The expenses to be allowed must be reasonable and must be properly substantiated; e.g., the taxpayer should show (1) dates of the Convention; (2) the number of days present, with proof of claim supported by a certificate of attendance issued by the organization sponsoring the meetings; (3) the expenses incurred, segrating between (a) transportation expenses, (b) meals and (c) hotel expenses, for which vouchers should be obtained and kept available for inspection.

None of the above expenses will be allowed against income received by way of salary since such deductions are expressly disallowed by statute."

PROFESSIONAL MEN UNDER SALARY CONTRACT

The employees' annual contribution to an approved Pension Plan and alimony payments may be deducted from salary income.

Amendments to the Income Tax Act, introduced in 1951 and made retroactive to the beginning of the calendar year 1951, provide for the deduction of certain expenses from salary income.

The allowable expenses include travelling expenses, annual professional membership dues, office rent, salary to an assistant or substitute and supplies consumed directly in the performance of the duties of employment.

The annual registration fee of the Provincial medical licensing authority would be allowable if paid by the Doctor himself.

Certain conditions are attached to the allowance of the expenses and without trying to recite the exact provisions of the law the main points are:

(a) That the expenses must have been incurred in the performance of the duties of the office or employment.

(b) That the employee is required, under the contract of employment, to pay the expenses.

(c) To claim travelling expenses the employee must be ordinarily required to carry on the duties of his employment away from his employer's place of business. Travelling between the doctor's home and his office is not included.

Where the travelling expenses are allowable under these provisions, depreciation may be claimed on the automobile used for this purpose but no other claim for depreciation may be made.

INCOME FROM A PARTNERSHIP

Additional expenses incurred by a partner, but not charged to the partnership, may be claimed as a deduction from the partner's share of income. However, the partner must be in a position to substantiate these expenses, to show why they were not charged directly to the partnership and that they were necessarily laid out to earn the partnership income.

Personal Interest Notes

The medical students of Dalhousie University honoured Doctor S. W. Williamson of Yarmouth, at a banquet on November 29th, their first in five years. Doctor Williamson was born at Loganville, Pictou County, and graduated from the old Halifax Medical College in 1896. After a year's study in surgery at the old Victoria General Hospital Doctor Williamson started practice in Hebron, and moved to Yarmouth in 1903, where he is still practising, being the oldest practising physician in Nova Scotia.

Doctor Thomas W. Gorman, a native of Sydney, is now surgical specialist on the staff of St. Martha's Hospital, Antigonish. Doctor Gorman graduated from McGill University in 1944 and then spent seven years in the study of general surgery at the McGill Post-Graduate School of Studies.

Doctor S. J. Shane, Medical Superintendent of the Point Edward Hospital at Sydney, has been elected Fellow of the American College of Physicians and also Fellow of the American College of Chest Physicians. Doctor Shane has been a Fellow of the Royal College of Physicians of Canada sinced 1947.

Doctor and Mrs. L. M. Morton of Yarmouth spent the Christmas season at West Somerville, Massachesetts and are now at West Palm Beach, Florida, for the winter months.

Doctors D. J. Tonning, R. M. MacDonald and L. C. Steeves, all of Halifax were recently appointed Associate Physicians of the Department of Medicine of the Victoria General Hospital.

The Bulletin extends congratulations to Doctor and Mrs. F. R. Townsend of Halifax on the birth of a son, on January 4th, Arthur Martel and to Doctor and Mrs. F. A. Dunsworth of Halifax on the birth of a daughter on January 6th.

Doctor and Mrs. O. R. Stone of Bridgetown spent the Christmas season at Yarmouth and are now in Florida for the winter.

Doctor J. W. Merritt of Halifax was recently elected President of the Medical Staff of the Children's Hospital, Doctor E. F. Ross is the Vice-President and Doctor W. E. Pollett the Secretary-Tresaurer. Doctor A. Ernest Doull, the immediate past President, is the remaining member of the Executive.

A surprise party was held the end of December at the residence of Doctor and Mrs. A. J. MacLeod of Moser River, Halifax County to do honour to them and to thank the doctor for his efficient service to the community since going there some seventeen months ago as resident physician.

The doctor was especially thanked for his unremitting attention and medical skill at all times and in all weather during the 'flu epidemic.

NSMA 1952; 31: 25-6

Along with expressions of good will a tangible token in currency, collected within the zone—Port Dufferin east to and including Marie Joseph in Guysborough County.

Refreshments were served and a pleasant evening was enjoyed by all.

Doctor H. I. Goldberg of Halifax gave an address on "Cancer of the Skin" at the semi-annual meeting of the Halifax Women's Auxiliary, Canadian Cancer Society, held at St. Matthew's Hall, Halifax, on October 26th.

Doctor J. A. S. Wilson of Berwick who graduated from Dalhousie in 1948, returned from his studies in the Old Country and is now continuing his studies at the Royal Victoria Hospital, Montreal.

Obituaries

DR. NELSON PRATT

Dr. Nelson Pratt was born at Selma, Hants County, and received his early education there. After teaching some years he entered Dalhousie Medical School from which he received his M.D. in 1900. He built a house in Stewiacke and began to practise. After a short period in his chosen work failing health compelled him to temporarily seek a less rigorous climate. He journeyed to Montana where his health improved so greatly he decided to return to his native province and resume the practice of medicine.

Dr. Pratt had two hobbies, building and horse raising. On his return to Nova Scotia he acquired a farm at Alton a short distance from Stewiacke. Here he renovated the house and built barns to his liking. At Alton he was able to indulge his hobby of horse-raising and had several very fine horses in his stables. The outdoors appealed to him and he could be frequently seen riding over his farm on a disk harrow. He was happiest, perhaps, when driving one of his spirited steeds along the quiet country roads.

Though of a retiring nature, Dr. Pratt made many warm friends and was always a willing and helpful colleague and consultant. His early interest in schools continued and he was instrumental in organizing the school at Alton.

A few years ago Dr. Pratt retired from active practice and spent the time quietly in the country until his death on December 6th. He is survived by one daughter Mrs. Burton Lockhart of Toronto. His wife predeceased him a number of years ago.

In politics Dr. Pratt was a staunch Conservative.

H. B. Havey

The death occured at the Victoria General Hospital, Halifax, on November 14th, of Doctor William Busby Coulter, after he had come from his home at Aguathuna, Newfoundland, to accompany a patient to hospital.

Doctor Coulter was born in 1886 at Wallace, Nova Scotia. He completed four years of medical studies at Dalhousie University before going overseas with the 25th Batallion of the Canadian Expeditionary Force in 1914.

He was mentioned in dispatches by General Haig in 1916 and at the end of the war he was repatriated at the rank of major.

He returned to Dalhousie and finished his studies graduating in 1921. He served on the staff of Camp Hill Hospital for a year before going to the British West Indies. In 1928 he went to St. George's, Newfoundland, where he stayed for twenty years before going to Aguathuna as a physician with the Dominion Steel and Coal Company there.

Surviving are his widow, the former Avis Reeves of Devizes, England; one daughter, Marie (Mrs. Donald Savage) in the United States; one son, Claude, Aguathuna, one brother, Doctor Frank Coulter, Burbank, California; one sister, Mrs. A. P. Bonter, Fenwood, Saskatchewan, and two grandchildren.

Doctor Charles Stewart Cavanagh of Yarmouth died on November 14th from injuries sustained when he fell on the pavement. Doctor Cavanagh was born in 1903, and after graduating from Dalhousie in 1929 practised at Mulgrave, Cape North, Caledonia, Port Maintland and Wood's Harbour before going to Yarmouth ten years ago.

He is survived by his father, Thomas Cavanagh, two brothers, Neil and William, and a sister, all of Cambridge, Massachusetts.

The death occurred at his home at French Village on November 9th, of Doctor George Murray Lewis Hatfield. Doctor Hatfield was born in Yarmouth in 1902, and graduated from Dalhousie in 1927 and took post-graduate work in Montreal and Chicago. He did general practice work in Yarmouth before moving to Halifax some years ago where he practised until ill health forced him to retire. His wife was the former Vivian Webster, daughter of the late Mr. and Mrs. George Webster of Halifax.

The Bulletin extends sympathy to Doctor H. K. MacDonald of Halifax on the death of his sister, Miss Katherine MacDonald on November 17th; to Doctor Florence Murray of Korea and Doctor A. E. Murray of Halifax on the death of their mother, Mrs. Isabel Jessie Murray, wife of Rev. Robert Murray, of Middle Sackville, on November 1st; and Doctor C. E. Kinley of Halifax on the death of his mother, Mrs. James F. Kinley, of Lunenburg, on December 26th.