

## Foreword

The clinical articles in this issue of the Bulletin have been contributed by the members of the Department of Obstetrics and Gynaecology, Dalhousie University, Halifax, N. S.

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# Week In Obstetrics, Gynaecology and Paediatrics

November 26th-30th, 1956

<b>Monday, November 26th, 1956.</b>		<b>Grace Maternity Hospital</b>
8.45	Assemble in Front Hall of Grace Maternity Hospital on University Avenue. Accommodation arrangements and facilities explained.	
9.00-10.00	The First Ten Minutes.—Dr. H. B. Atlee.	
10.00-11.30	X-Ray Pelvimetry.—Dr. I. A. Perlin.	
11.30- 1.00	Symposium: Anti-partum Haemorrhage. Moderator—Dr. W. G. Colwell. Staff.	
2.00- 3.30	Gynaecological Office Procedures.—Dr. M. G. Tompkins.	
3.30- 5.00	Current Trends in Toxaemias.—Dr. K. M. Grant.	
<b>Tuesday, November 27th, 1956.</b>		
9.00-10.00	Celiac Disease — Modern Trends and Concepts.	Dr. H. B. Ross, Dr. M. Roberts.
10.00-12.00	Symposium: "Respiratory Infections."	
	(a) Upper Respiratory — Diff. Diagnosis and Treatment.	Dr. N. B. Coward.
	(b) Laryngeal Conditions— " " " "	Dr. R. S. Grant.
	(c) Lower Respiratory— " " " "	Dr. R. M. Ritchie.
12.00- 1.00	Discussion period.	
2.00- 4.00	Preparation for Childbirth.	Dr. W. R. C. Tupper.
4.00- 5.00	"Menopause" Its Significance and Management (Film).	
5.00- 6.00	Pathological Conference.	
<b>Wednesday, November 28th, 1956.</b>		<b>5th Fl. Clinic Rm. V. G. Hospital</b>
9.00-10.00	Ward Walk — 5th Floor West — V.G.H.	Dr. H. B. Atlee.
10.00-12.00	Operating Room Demonstrations.—Staff.	
12.00- 1.00	Round Table: Vomiting of Pregnancy Puritis Vulvae Dysmenorrhea Frigidity	Gyn. Staff with Dr. Hirsch and Dr. Weil
2.00- 3.00	X-Ray in Paediatrics.	Dr. R. L. Smith.
3.00- 4.00	The Retarded Child — Diagnosis and Management.	Dr. F. A. Dunsworth.
4.00- 5.00	Common E.E.N.T. Problems.	Dr. A. G. Shane.
<b>Thursday, November 29th, 1956.</b>		
9.00- 9.50	Ward Walk — Post-Partum complications.	Dr. W. R. C. Tupper
10.00-11.00	Anaemia of Pregnancy.	Dr. M. G. Tompkins
11.00- 1.00	Symposium: (a) Care of Labouring Woman. (b) Rh Complications. (c) The Pregnant Diabetic. (d) Common Surgical Emergencies.	Dr. K. M. Grant. Dr. W. R. C. Tupper Dr. I. A. Perlin. Dr. J. H. Charman.
2.00- 4.00	Diagnosis and Treatment of Common Neonatal Emergencies.—Paediatric Staff, Grace Maternity Hospital.	
4.00- 5.00	A Review of Neonatal Management Procedures of the Grace Maternity Hospital.—Paediatric Staff, Grace Maternity Hospital.	
<b>Friday, November 30th, 1956.</b>		<b>Children's Hospital</b>
9.00-10.00	Common Paediatric Skin Conditions.	Dr. Howell.
10.00-12.00	Case Presentations.	Dr. Wiswell and Medical Staff
12.00- 1.00	Common Surgical Paediatric Conditions.	Dr. W. E. Pollett.
2.00- 3.00	Hormone Therapy in Gynaecology.	Dr. I. A. Perlin.
3.00- 5.00	Symposium.	
5.00- 6.00	Staff Meeting. V.G.H. Program by Dept. of Gynaecology.	

Dr. Pierre Hubinont, an outstanding Belgian Obstetrician and Gynaecologist is being invited to participate in this program. Schedule will be re-arranged accordingly if he is able to be in Halifax at that time.

Thirty-seven hours formal study credit will be allowed by the College of General Practice for attendance at all sessions of this course. Registration Fee is at the rate of \$5.00 per day.

## COLLEGE OF GENERAL PRACTICE

The second annual meeting of the Nova Scotia Chapter of the College of General Practice was held in Halifax, October 16th, in conjunction with the Dalhousie Refresher Course. In his address the retiring President, Doctor F. Murray Fraser, discussed some of the problems of preparing medical students for general practice and the necessity of having general practitioners take some part in their teaching while at medical school. He also stated that the Nova Scotia Chapter was started in June, 1956, with a membership of 13, and this has now increased to 80 members.

The meeting welcomed Doctor Charles L. Gass of Tatamagouche, President of the College of General Practice of Canada, who made a short speech outlining some of the aims of the College.

The meeting also heard annual reports from Doctor H. Ian MacGregor, Chairman of the Education Committee; Doctor J. R. Macneil, Chairman of the Hospitals Committee, and Doctor A. G. MacLeod, Provincial representative to the Board of Representatives.

The following officers were elected to the Nova Scotia Chapter for the year 1956-57:

President, Doctor H. B. Whitman, Westville.

Vice-President, Doctor J. R. MacLean, Halifax.

Secretary, Doctor M. F. Fitzgerald, New Glasgow.

Treasurer, Doctor C. G. Harries, New Glasgow.

Provincial Representative to the Board of Representatives, Doctor F. Murray Fraser, Halifax.

Chairman, Education Committee, Doctor H. I. MacGregor, Halifax.

Chairman, Hospital Committee, Doctor D. I. Rice, Halifax.

The meeting approved the appointment of Doctor D. I. Rice of Halifax to be Chairman of the Residency Training Committee of the Nova Scotia Chapter of the College of General Practice.

The meeting also approved the appointment of Doctor Hereford Still of Halifax to be Chairman of the Education Committee of the College of General Practice of Canada, and a nucleus committee has been formed, the members of which are — Doctors F. Murray Fraser, A. W. Titus, H. I. MacGregor and D. I. Rice, all of Halifax.

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### Society Meetings

#### Cape Breton Medical Society

A meeting of the Cape Breton Branch of The Medical Society of Nova Scotia was held at Sydney September 27th, 1956. Doctor A. L. Sutherland, the President, was in the chair. Twenty members were in attendance. The following motion was made by Doctor Eric Maedonald, seconded and unanimously carried — "That this Society appoint five members to study the new Constitution of The Medical Society of Nova Scotia with a view to giving notice of motion to that Society of amendments that this Committee deems advisable."

The Executive was directed to appoint five members with the nucleus of the Committee in Sydney. It is intended that this Committee will function for two years.

# Medical Education\*

Duncan A. Graham, M.D.\*\*  
Toronto, Ontario

It is for me a high honour to be invited by the Refresher Course Committee of Dalhousie University to deliver the John Stewart Memorial Lecture for this year, and I desire to express my deep appreciation for the distinction you have been pleased to confer upon me. The topic for my address, suggested by your Committee, is Medical Education. It would seem to be a fitting theme for a lecture in commemoration of the life of John Stewart who served with distinction for many years as Professor of Surgery and later also as Dean of the Medical Faculty of Dalhousie University.

I propose to talk about the evolution of a university standard of medical education and its influence in raising the standards of medical education and the practice of medicine and on the advancement of medical knowledge. In conclusion, I would like to comment on certain present day trends and problems in medical education and the practice of medicine.

The advances in our knowledge of the science of medicine and the application of this knowledge to the study of disease and its prevention and to the preservation of health have been greater in the past one hundred years than in the preceding two thousand years, and greatest in the past fifty years. This progress may be attributed chiefly to contributions to our knowledge of nature and man by the sciences of anatomy, physiology, biochemistry, pathology, bacteriology and immunology. Until the present century, advances in medical science came chiefly from Germany and Austria. Early in the nineteenth century in these countries both the basic and preclinical sciences were considered essential to medical education and were taught in the university by scholars and scientists, masters of their subjects who were not engaged in the practice of medicine but devoted their time to teaching and research. Staff appointments and instruction were under the control of the university. It was possible, therefore, to develop a suitable curriculum of coördinated studies in these sciences for the undergraduate in medicine, the university providing the necessary laboratory facilities for teaching and research. Through the control of admission requirements, only students suitably prepared to make use of the course of instruction were admitted to the universities.

In Great Britain, the United States of America and Canada, it was not until the last quarter of the nineteenth century that graduates in medicine began to devote their full time to teaching and research in the preclinical sciences and departments of these sciences were established in a medical faculty of the university and functioned on the same plane as departments of humane learning and the basic sciences of physics, chemistry and biology. In this university environment the departments of the preclinical sciences became centres of teaching and research and exercised a wide influence in raising the standard of instruction in the preclinical sciences and in extending the boundaries of knowledge in the science of medicine. Referring to the growth of scientific

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\*Eighth John Stewart Memorial Lecture read before the Dalhousie University Faculty of Medicine Annual Refresher Course, October 17, 1956.

\*\*Professor Emeritus, Medicine, University of Toronto.

medicine in the nineteenth century, Osler, in 1901, said that the study of physiology and pathology in the last half of the century had done more to emancipate medicine from routine and the thralldom of authority than all the work of all the physicians from the days of Hippocrates to Jenner.

In the last quarter of the nineteenth century, universities in Germany exercised the same control over appointments of their clinical teachers as over those of the preclinical sciences, and the teaching hospitals functioned as part of the medical faculty. The university selected clinical teachers who had had graduate training not only in the practice of medicine but also in one or more of the preclinical sciences; they were able, therefore, to apply the knowledge thus gained, in their clinical teaching and in the study of disease. Clinics in the teaching hospitals were equipped with the necessary laboratory facilities and, like the preclinical science departments, became centres of teaching and research.

At this time, in Great Britain and on this continent, clinical teachers, with few exceptions, had little or no graduate training in the preclinical sciences and were unfamiliar with laboratory methods in diagnosis. Examinations requiring the application of these techniques in diagnosis were performed by the staff in the laboratories of the preclinical sciences, chiefly pathology and bacteriology, and reports of the results were sent to the clinicians. Such an arrangement improved the accuracy of diagnosis made on patients in the hospital and rationalized treatment to some extent, but it effected little change in the nature and character of the clinical instruction given to the undergraduate student. However it gradually became evident that, if the instruction given the student in the preclinical sciences was to be coördinated with that given in the clinical departments and knowledge and methods gained in the study of the preclinical sciences were to be applied intelligently to the investigation of patients and the study of disease in the teaching hospitals, those appointed as clinical teachers would have to have graduate training in one or more of these sciences. Also, that the necessary laboratory facilities and equipment would have to be made available in the teaching hospitals.

All this was, and in some university medical schools still is, difficult of attainment. In the first place, appointments to the attending staff of the hospital in which clinical instruction had to be given were not under the control of the university and the selection of clinical teachers was limited to the staff appointed by the governors of the hospital. Further, there was a belief—still evident in some centres—that every successful practising clinician, irrespective of his training, was qualified to serve as a clinical teacher and that the doctor with a busy practice and enviable local reputation was best qualified to hold a senior post both in the hospital and in the medical school. Secondly, laboratory facilities within the hospital were then non-existent. It became evident that, if the educational standards of the clinical departments were to be brought up to those accepted for the preclinical sciences, it was essential that the university have control over the appointment of its clinical teachers either by having its own teaching hospital, as in Germany, or by a working agreement with the governing board of its affiliated teaching hospital through which the university could exercise control over appointments to the attending staff of the hospital.

When the Johns Hopkins Medical School was organized as a University Medical Faculty, the university erected its own teaching hospital with adequate facilities for the care of the sick and for the teaching of scientific medicine and research. In 1889 Sir William Osler was appointed Professor of Medicine in the Johns Hopkins University and Physician-in-Chief to the John Hopkins Hospital. He selected a staff trained abroad in the latest developments in the science of medicine, and instituted methods of clinical teaching which embodied the best features of British and Continental medical education. He introduced a system of graduate interne training in the hospital which is now generally recognized as an important and essential feature in our programme of graduate medical education. The improvement in the standard of medical care of patients and of clinical instruction for medical students and the stimulus to research which followed the organization of this modern university medical school soon attracted the attention of other medical schools and their teaching hospitals and exercised a wide influence on medical education on this continent. Owing to the cost of construction and operation of a university hospital, universities with established medical schools entered into agreements with their affiliated teaching hospitals by which the university was given control in the selection of their teachers on the attending staff of the hospital. The adoption of these agreements between university medical schools and their teaching hospitals has proved to be mutually helpful and marked an important forward step in medical education by making possible the development of a university standard of education in the clinical departments.

In the beginning of this development, professors appointed as heads of clinical departments in the hospital and their assistants were paid a nominal salary or honorarium by the university but were forced to earn their main livelihood from the practice of medicine. A few with scholarly tastes and a deep interest in teaching and the advancement of scientific medicine gave liberally of their time and energy, but not without hardship to themselves and their families. Others with growing private and consultation practices and the attendant social and financial commitments were finding it increasingly difficult to devote the necessary time to the care of patients in hospital, to teaching and research and, at the same time, to earn their main livelihood in the practice of medicine. Leaders in the advancement of medical science became convinced that, if the clinical departments were to become centres of teaching and research in the hospital like the preclinical science departments in the medical faculty of the university, the heads of the major clinical departments should be appointed full-time professors in the university and be paid a salary which would permit them to devote their whole time to the care of patients in the hospital, to the training of students, undergraduate and graduate, and to clinical research. Again the Johns Hopkins Medical School, supported by funds from the Rockefeller Foundation, led the way in this movement. In 1914 the heads of the medical, surgical and paediatric services of the Johns Hopkins Hospital became full-time professors in their respective departments in the Medical School, with each having a certain number of full-time assistants. Members of each department already engaged in limited private practice were retained as part-time members of the staff and continued to care for patients and teach in the hospital. The full-time scheme for clinical professors, in a modified and

less restricted form, was gradually adopted by other university medical schools. Since 1914 nearly all the chairs in medicine and an increasing number of the chairs in surgery, obstetrics and gynaecology, paediatrics and psychiatry in university medical schools on this continent and in Great Britain have been filled, as vacancies occurred, with professors on a full-time basis. Through agreements entered into between the university and the trustees of the affiliated hospital, the full-time professor became head of the corresponding service in the hospital and responsible for the care of patients in the wards and out-patient department of the hospital. Today the full-time scheme is no longer in the experimental stage but is a firmly established principle of medical education in leading medical schools and their teaching hospitals. The unparalleled advances in medical knowledge that have been made in the English-speaking world in the present century, with the accompanying improvement in the standards of medical education and practice, have resulted from the efforts made by medical educators to establish the preclinical and clinical departments in the medical school on a university basis with university ideals.

The rapid accumulation and expansion of medical knowledge, especially in the past three decades, has made increasing specialization inevitable in all branches of medical science and has created new problems in medical education. Fifty years ago a few students, after graduation, spent a year in hospital gaining further experience and assuming responsibility under supervision in the care of the sick, but the majority went directly into the practice of medicine. The medical curriculum was planned to train the student for general practice and to qualify him to meet the statutory requirements for the practice of medicine. At present a year as an interne in hospital, before or after graduation, is considered a requirement before entering into independent medical practice. Those who wish to specialize in the practice of medicine must spend at least four more years in education and training and pass an examination before being certified as specialists. Further, those engaged solely in the practice of medicine who wish to keep abreast of new developments in diagnosis, treatment, prevention of disease and the promotion of health find it necessary to supplement their reading and thinking by attendance at local, provincial and national medical meetings, and at refresher courses of instruction such as the one now being conducted by Dalhousie University. The large attendance at the present refresher course is evidence of the fact that education and training in medicine are continuing processes throughout the career of the efficient practitioner of medicine.

The chief aim of undergraduate medical education is no longer to prepare the student for the general practice of medicine. The primary objective of the undergraduate curriculum is to provide a basic education for the doctor who, with further education and training after graduation, may become a general practitioner, a practitioner in a special branch of medicine or surgery, or a teacher and investigator in one of the clinical or preclinical departments of the medical school. With the rapid development of knowledge and techniques in each branch of medical science, it is impossible to give the undergraduate student a comprehensive knowledge of modern scientific medicine. In each branch of science, beginning with physics, chemistry and biology, courses of instruction must be limited to acquainting the student with the fundamental principles,

facts and methods upon which each branch of science is based and the application of this knowledge to the understanding of other branches of science subsequently studied in the undergraduate course, with special emphasis on their application to the investigation and treatment of the sick. As an example of a recent application from the field of physics, one might mention the use of radioactive chemicals—radioisotopes—in the solving of fundamental physiological and biochemical problems and in the investigation, diagnosis and treatment of certain diseases in man. Early in his course the student should be introduced, through appropriate demonstrations and practical work in the laboratory, to the methods of science in making controlled observations, the planning of experiments and the recording of findings for interpretation in the light of existing knowledge in the science under study. By the repetition of such demonstrations and practical work in each laboratory department, and later in hospital, the intelligent and earnest student learns the methods by which sound knowledge in each branch of science has been gained and how the making of a new observation and its wise interpretation advances sound knowledge. The student's interest is aroused; he acquires a desire to know and understand, and develops an enquiring mind. In the same manner the student is helped to appreciate that the acquisition of basic knowledge and techniques in the basic sciences is essential to the study and understanding of the preclinical sciences and, in turn, of the clinical branches of medicine, and that the accumulation of factual knowledge in each subject from lectures and textbooks to pass examinations before proceeding to other subjects in his course of study is of little value for his best development.

An ever-present problem in undergraduate medical education is the co-ordination of the courses of instruction in the scientific and technical aspects of medicine given by the different laboratory and clinical departments, and the correlation and integration of the basic knowledge of each science. The weakest link in the effective coördination and correlation has been, and still is, the teaching in the clinical departments. As has been pointed out, advances in knowledge in the basic and preclinical sciences and the teaching of these sciences as scientific disciplines made little change in the traditional methods of teaching and training in the clinical departments in the leading medical schools of this continent until they were placed on a university basis. Fortunately, recent graduates interested in a career of learning, teaching and research have been attracted by the opportunities in clinical departments organized on a restricted or modified full-time basis. In addition to their graduate clinical training, they are willing to spend a year or more in one of the basic or preclinical science departments learning the methods of research and acquiring a grounding in the discipline of science and a detailed systematic knowledge of the science studied as a preparation for a full-time appointment in teaching and clinical investigation.

The appointment in clinical departments of clinicians trained in the discipline of science and interested in a career of teaching and research made possible the teaching and practice of the scientific and technical aspects of clinical medicine as a scientific discipline and a more effective coördination of preclinical and clinical courses of instruction. In the wards and out-patient departments of the teaching hospitals they use the methods of science in solving the problems



presented by the sick patient, and instruct the undergraduate student accordingly. Data gathered from the clinical history, the traditional methods of physical examination and the simpler routine laboratory tests are interpreted in the light of existing knowledge of the functions of the body and mind in health and disease and of underlying mechanisms causing signs and symptoms of disturbances of function in different organs and systems of the body. After a critical assessment of such data, a provisional diagnosis is made and immediate treatment prescribed. If data from the initial clinical examination are considered inadequate for the making of a final diagnosis upon which to base a definitive plan of treatment, special methods of examination or investigations likely to provide the desired information are carried out. Similarly, in treatment the procedures selected are those which accurate knowledge and controlled clinical trials have shown to have a favourable influence on the disturbances of function present. They are not selected on the basis of clinical impressions or on the recommendation of exponents of "cures" for incurable conditions or on the extravagant claims of certain manufacturers of foods, pharmaceuticals, etc.

Working in this manner under the guidance of a clinical teacher trained in the discipline of science who is able to provide a correlation between preclinical and clinical work, the undergraduate student continues to use the methods of science in his clinical studies and to apply the knowledge acquired in the basic and preclinical sciences.

As the efficient practice of internal medicine demands the clinical examination of the whole patient—body and mind, and treatment embraces all measures of therapy except surgery, it is natural that teachers of internal medicine should introduce the undergraduate student to his studies in the hospital. In a course of lectures and demonstrations on selected patients the routine methods of clinical examination are described and the student is shown how the findings elicited by examination can be correlated with alterations in normal function or structure of different organs or systems of the body. Paralleling the lectures and demonstrations, teachers both in medicine and surgery continue the instruction with small groups of students in the techniques and applications of routine methods of examination on medical and surgical patients respectively. Having obtained a grounding in methods of examination, the student continues his study in internal medicine and general surgery and, at an appropriate time, begins his studies in the departments of obstetrics and gynaecology, paediatrics, psychiatry, ophthalmology, otolaryngology and radiology. His work in paediatrics is in the main a continuation of his training in internal medicine and general surgery but includes instruction in the care of the new-born and in the application of the knowledge and understanding of nutrition and development of the normal child. In the course of hygiene and preventive medicine the student is made aware of the physical, social, environmental and economic factors affecting the health of communities and of the general measures adopted for their control. The teaching of paediatrics probably affords the best opportunity for arousing the student's interest in measures for the prevention of disease and the maintenance of health of body and mind.

By constant practice under supervision on in-patients of the hospital, the industrious student acquires proficiency in the techniques of physical examin-

ation and routine laboratory tests. He is able to detect, at first, the definite and, later, the minor deviations from the normal produced by alterations in function and alterations in structure. And he gains experience in the art of clinical history-taking—**the most important single method in the clinical investigation of a patient.** When the student has examined a number of patients with different diseases and has become familiar with the common signs and symptoms of alterations of function or structure in different organs and systems of the body, and with the history of the illness causing them, he is assigned patients for complete routine clinical examination and asked to record his findings indicating the salient points in each method of examination upon which he has based his provisional diagnosis and suggestions for treatment. These are checked by the resident doctor on the ward and an assessment is made of the student's industry and proficiency in methods of examination and of his judgment in the evaluation of data. At a bedside clinic the student presents his case before his clinical teacher and is asked to discuss his findings, their interpretation and his evaluation. If the student satisfies his teacher that he has made a careful examination of his patient but that data from his examination are inadequate for the making of a provisional or final diagnosis, he is asked to suggest other methods of examination likely to provide the desired information. If he can justify their use, such data are supplied from the hospital record. The teacher then reviews the results of the clinical investigation of the patient with the student and discusses pertinent points in the clinical history: the factors causing the patient's illness, the signs and symptoms and the disturbed mechanisms producing them, the patient's reaction to his illness and its importance in diagnosis, prognosis and treatment.

From the continued examination of patients and bedside discussions, the student learns that many different factors: physical, psychological, social, environmental and economic, contribute in varying degrees to the impairment of health and to illness of body and mind and that all require assessment in diagnosis and prognosis and due consideration in the immediate treatment and in the after-care of the patient. Through bedside clinics and his study of patients with different types of illness, the student learns that emotional disturbances alone may produce signs and symptoms closely simulating those of structural disease and that they always modify, to a greater or lesser degree, the course of an illness from physical or other causes. He learns too that patients react differently to illness from the same aetiological factors and that their reaction plays an important role in prognosis and treatment.

At this stage of his clinical education and training, the clinical investigation of out-patients in the hospital is of the greatest educational value to the student. Here he gains an insight into some of the problems of general practice. He examines patients coming from home or work outside the home with the same complaints and presenting the same problems in diagnosis and immediate treatment as patients coming to the doctor's office. In the out-patient department it is necessary for the student to make a complete routine clinical examination of the patient, record and evaluate the data obtained, and make a provisional diagnosis in a much shorter period of time than in the wards of the hospital, and he is faced with the immediate problem of the treatment of the patient either in hospital or in the home. In solving these problems with his

clinical teacher the student is made aware of the social, environmental and economic factors involved, not only in the causation of the patient's illness but in the planning of treatment in hospital or at home, for a mother or for the wage-earner of the family. In the out-patient department more than in the wards of the hospital, the student learns of the use made by his clinical teacher of information obtained from the public health nurse and the social worker about conditions and problems in the patient's home or place of work in his consideration and assessment of factors affecting diagnosis and treatment. The student becomes aware of the functions of agencies within and without the hospital which are active in the health and welfare of the community in which the patient lives.

If the undergraduate in medicine is to acquire a sound foundation of education and training in the clinical branches of medical science he must be led and directed in all clinical departments by teachers trained in the discipline of science who, in addition to their clinical training, have a systematic knowledge of the preclinical sciences and the techniques pertinent to their specialty. Even with clinical teachers so trained—at present too few in number—the correlation of work between clinical departments is more difficult than in the preclinical sciences where all teachers devote their whole time to teaching and research and each science is taught as a scientific discipline. The head of each science department can plan the teaching programme of his subject and select his teachers. He can arrange, if he will, the sequence of presentation and the coordination of his course of instruction with the heads of other preclinical science departments. In the teaching hospital, on the other hand, courses of instruction in the same subject—the care of the sick—are given in eight established clinical departments: internal medicine, surgery, obstetrics and gynaecology, paediatrics, psychiatry, ophthalmology, otolaryngology and radiology, each functioning as an independent unit. It is, therefore, more difficult to provide a cohesive course of instruction in the clinical investigation of patients and their treatment. The presentation of different viewpoints, more particularly on therapy, by teachers in medicine and surgery is confusing to the mind of the student, but he should hear of them providing they deal with principles and not details and are based on available knowledge and not on dogmatism. There is also a greater degree of overlapping in the courses of instruction. This is inevitable in clinical training if the student is to become acquainted with the routine methods of clinical examination, the common diseases encountered and the simpler methods of treatment in each medical or surgical specialty, and with indications for the need of special methods of diagnosis and treatment in the general practice of medicine.

For many years clinicians have studied and practised additional branches of medicine and surgery: in medicine, neurology and dermatology; in surgery, orthopaedics, urology and, more recently, neurosurgery. In some medical schools and teaching hospitals these specialties function as independent departments or, more often, as sub-departments of internal medicine and general surgery respectively. In an earlier Memorial Lecture my colleague, Dr. Gallie, discussed the effect of specialism in surgery in presenting his views on undergraduate and graduate training in surgery. From a fairly long experience as Professor of Medicine and Physician-in-Chief of the parent teaching hospital

of my Alma Mater your present Lecturer is convinced that internal medicine, including its special branches, now recognized in practice, must be taught as a single discipline if the undergraduate student is to acquire a broad view of medicine and a firm foundation for his future work. The head of a department of medicine must be able to select teachers who have had a discipline in science, whose graduate training equips them to apply the knowledge and techniques of the preclinical sciences and provide an effective correlation between pre-clinical and clinical work; teachers whose education and training inculcate in the student an enquiring attitude of mind and a scientific method of thought. The head must be responsible for the care of all medical patients in the teaching beds of the hospital and in attendance at the medical out-patient department. This is necessary in order that he may plan an orderly sequence in courses of instruction and be able to assign teachers with general or special interest in internal medicine at an appropriate time to assist in the bedside or out-patient instruction of students and supervise their work.

For the instruction of students in the general medical clinic of the out-patient department it is essential that teachers be trained in and practise the broad field of internal medicine rather than one of the special branches. Dermatology is the only special branch of medicine that should be taught in the out-patient department.

After the introductory course of instruction on the techniques of routine clinical examination has been completed two weaknesses are prone to develop in the more advanced instruction at the bedside. The first is lack of attention by teachers to the importance to the student of acquiring early in his clinical training proficiency in the techniques of routine clinical examination. A growing knowledge of the principles of medicine in diagnosis and treatment before he has acquired skill in the techniques of routine examination is a serious handicap to the student in his future work. The second weakness is a common failing among clinicians, in their care of patients on the wards, of requesting X-ray, biochemical and other special methods of examination before they have made a critical assessment of the findings from a complete routine examination of the whole patient and arrived at a provisional diagnosis. There are emergencies in the practice of all branches of medicine and surgery, requiring quick action, in which the clinician must rely on information obtained from a skilled and complete routine clinical examination. The skilled and experienced clinician can take certain short cuts in his examination of patients in practice, but it is incumbent upon him as a teacher to lead and guide the student in acquiring skill and orderly habits of examination. Unless the student is gaining confidence in the accuracy of his findings from constant practice of the techniques of routine clinical examination he feels insecure and loses interest in acquiring a masterly skill in the examination of a patient. This insecurity marks the beginning of the habit of resorting too early to requests for information from special methods of examination. It is a function of the head of a department to see that all teachers cultivate the habit at bedside case presentations by the student of first testing his skill in the techniques of clinical examination before proceeding with a discussion of the patient's illness and its treatment. In this manner the student learns of his mistakes in technique, is stimulated to practise their correction and thereby to gain confidence in the accuracy of his find-

ings. As his skill in the techniques of routine examination improves along with his growth in knowledge of internal medicine, he becomes more self-reliant and learns of the place and purposes of special methods of examination in the diagnosis and treatment of disease. In some instances special methods are necessary to discover the cause of an illness; in others, to confirm or support the provisional diagnosis; and, in still others, to shed light on an unusual phenomenon that may be present. Detailed knowledge and skill in the use of these special techniques is part of the graduate training of practising specialists and clinical investigators, but the undergraduate must know of their purposes and when to avail himself of their use.

The content of courses of instruction in all subjects of the curriculum needs revision each year for the incorporation of new knowledge and new techniques which clarify earlier conceptions and widen understanding of the functions of the body and mind in health and disease and provide more effective methods of treatment. As stated by Sir Henry Cohen, "the growth of knowledge in both medicine and educational methods means that a curriculum can never be final; it is always moving to that end but never arrives." Wise planning of the curriculum is necessary and important for maintaining a high standard of medical education but of even greater importance is the selection of teachers interested in teaching and research and the selection of students with character, intelligence and good general education for admission to the study of medicine.

As future teachers are recruited from among the students of today, one might consider first the selection of students. Teachers in university medical schools are aware that an appreciable percentage of students admitted to the university and even graduated in medicine are unsuited for the exacting profession of medicine for one reason or another: character, personality, intelligence, lack of fitness in body or mind or both, general education or motives not in accord with our heritage, the Hippocratic ideal in medicine. The selection of suitable applicants for admission to the university and the study of medicine is a problem with many facets constantly under study and review. While a satisfactory solution has not been found, progress is being made. Apart from efforts to exclude unsuitable applicants, there is another related problem of vital interest to the people of Canada as a whole: an urgent and growing need for trained scientists and technologists and a scarcity of teachers to train them. One of the means for meeting this crisis in university education is to make funds available for secondary school students of character, integrity and exceptional ability who are interested in science but who, for financial reasons, are unable to proceed with a university education. It would be more profitable to the country as a whole if monies were spent in this manner rather than on scholarships and bursaries awarded during the students' course of studies at the university.

In Canadian medical schools students of recent years spend two or more years after matriculation from secondary schools in a premedical course of study of the humanities and basic sciences in the Faculty of Arts before beginning their professional course in medicine. The aim of the course of study in the humanities is to awaken in the student a continuing interest in the English language, literature, history and philosophy, that he may acquire greater facility

in expression, greater clarity in thinking and a growing knowledge of human nature and the real values in life. And the course in the basic sciences of physics, chemistry and biology gives him a discipline in the methods of science and the fundamental knowledge of these sciences essential for his vocational training in medicine. Students in a premedical course, associated with teachers and other students primarily interested in humane learning, acquire a broader understanding of human beings and start the professional course in medicine with a more mature outlook.

Universities regard the advancement of knowledge and teaching as equally important functions of a university. In appointments to the staff consideration is given to the capabilities of potential candidates in both teaching and research. When preclinical science departments were established within the university towards the end of the last century, teachers were selected on the same basis of qualification as teachers in the basic sciences of the Faculty of Arts. As has been pointed out, it is only within the past two or three decades that significant progress has been made to establish one or more of the major clinical departments in medical schools on a university basis.

If the clinical departments in the hospital are to function on a university basis, they must be centres for teaching and research. Clinicians selected to care for the sick and to teach medical students must have had a grounding in the discipline of science, experience in research, and have demonstrated by their work a capacity to conduct research. They must be able to test, under scientifically controlled conditions, the validity of new discoveries and new inventions applicable to the investigation or treatment of disease in man. This can only be done by clinicians trained in the discipline of science, who are masters of their subject and have at their disposal in the hospital and university the necessary facilities and equipment. Advances in knowledge and the development of new techniques in the preclinical science departments may be of the greatest value for the elucidation of clinical problems but the application of this new knowledge and new techniques for the benefit of mankind must be tested by clinicians using the same scientific methods under the conditions of the ward and the bedside. Research on problems of disease in man and methods of treatment should be carried out by clinical teachers trained in the discipline of science, in the hospital wards and laboratories and not in preclinical science departments or departments organized solely for research. At no time has it been more important, not only for students and practitioners of medicine but for the welfare of mankind, that clinical departments become centres of teaching and research and foster sound learning and scholarship.

The discovery of hormones, of vitamins which gave to the clinician the key to his understanding of "deficiency states," and of penicillin rank among the great discoveries of medical science now being utilized for the benefit of mankind. Valuable as the intelligent use of these agents has proved to be in the cure and prevention of disease, the informed clinician knows of the needless consumption by patients of expensive vitamins, of the danger from the indiscriminate use of hormones and from the too free and indiscriminate use of antibiotics. In recent years the lay public has shown an increasing interest in announcements of new agents and new methods in treatment. Publication of these, often taken from reports at medical meetings, appear with increasing

frequency in the daily press and in popular magazines. In fact, the desire and even the demand of some patients for a particular treatment is presenting a new problem for the clinician in his handling of patients. There is also a tendency among practitioners to recommend or prescribe new treatments for related conditions not recommended by the original observer or to prescribe agents strongly recommended by a salesman of pharmaceutical products. It is, therefore, important that clinical departments be staffed and equipped to determine by controlled clinical trials the possible risks from new methods of treatment and their value in relation to existing methods of therapy. It is only in this way that sound information on new developments can be made available in a comparatively short time to students and colleagues in practice.

At present all the clinical teachers in our Canadian medical schools and their teaching hospitals, and in an increasing number of our larger non-teaching hospitals, hold a higher qualification: either certification by the Royal College of Physicians and Surgeons of Canada or Fellowship in the College. The course of training laid down by the Royal College for Fellowship provides for a broad and sound clinical training and requires a knowledge of the basic sciences necessary to the proper understanding of the specialty studied. The primary object of the course was to provide a sound training for the practice of a specialty but it has tended to become a pattern for the training of clinical teachers. The Royal College accepts as one of the required years of graduate training a year or more spent in full-time research and teaching in one of the preclinical science departments but few heads of clinical departments advise potential teachers among their students to spend a year or more acquiring a discipline in science and experience in research. Knowledge of the basic sciences is usually acquired through organized courses of instructions and at times practical work in the sciences applicable to the specialty studied. As the majority of graduates taking the course of training are primarily interested in practice rather than teaching and research and there is a stiff examination to be passed before qualification for Fellowship, it is almost inevitable that many become interested more in acquiring skill in the techniques required in the practice of their specialty and in the accumulation of factual knowledge for the purpose of examination than in building a solid foundation based on principles underlying their specialty. The appointment of specialists so trained on the attending staff of the larger hospitals, especially the non-teaching hospitals, has certainly raised the general standard of medical care of patients and improved the training of internes but the same beneficial influence is not so evident in our teaching hospitals in the education and training of undergraduate students and of graduates interested in a career of clinical teaching and research. The lack of a scientific discipline and experience in research in their graduate education and training causes them to emphasize in their teaching of students the importance of special techniques and details of their specialty rather than the principles involved. Science rather than technique should permeate the education of the student.

The head of a clinical department should be constantly on the lookout for potential teachers among his students. If the student selected is interested in a career of teaching and research, the head should lead and guide him early in his graduate years along a path which will best prepare him for an academic career and at the same time minimize the untoward effects of a necessarily

stiff examination on his graduate education and training. Such guidance also helps to avoid the dangers both in teaching and practice from too early specialist training in branches of medicine and surgery. Eventually it should raise the standard of undergraduate and graduate education and promote the advancement of sound knowledge in clinical science.

In his seeking for potential teachers for further education and training in clinical science, the head should select students with character, integrity, intelligence and a liberal education; students who in their daily work display a curiosity to know and understand and, above all, have a love of mankind. None can exhibit these qualities of mind and heart in full measure but the clinical teacher must possess them in an appreciable degree, for students learn much by example and precept from their teachers. Medicine is an Art as well as a Science, and its graduates are members of a learned profession which has been given a code of ethics by Hippocrates, the Father of Medicine, a code to shape their conduct as helpers of mankind.

Education and training in the science of medicine—training for the vocation of medicine—has been discussed, but the practice of medicine is concerned with all spheres of human endeavour. If the doctor is to exercise wisdom in dealing with the many different problems of living presented by his patients and their families, he should know and sense how to live well. In one of his fine addresses on education, Sir Richard Livingstone has suggested a philosophy of life that steadies its purpose and gives it direction, which he calls the Philosophy of the First-rate. This, he points out, gives standards of value and judgment that apply to all spheres and activities of human life. People learn what is first-rate by contact with it. You learn what is great music by hearing it, what is great architecture by seeing it. You come to know the first-rate in ideals and conduct from the teachings and study of the great religions, moral philosophy, literature and history.

By the inauguration of this Lectureship, its sponsors would pay homage to the memory and achievement of John Stewart. Your Lecturer tonight was privileged to know John Stewart. He had the Philosophy of the First-rate. He attended a great medical school: Edinburgh University. He studied surgery under two great masters, James Syme and Lord Lister. He had a discipline in science and experience in research from his association with his revered master, Lord Lister, in his development of antiseptic surgery. He practised his profession in the spirit of the Oath of Hippocrates, associating his love of mankind with the love of his craft. He found joy in the beauty and wonders of nature. One has but to read his Listerian Oration to know that he was imbued with the first-rate in literature. He was a loyal citizen and served his country well. Nurtured in a Christian home, he believed and lived the teachings of the Master Physician. The concept of medical education I have attempted to present to you would seem to be exemplified in the man whose life we commemorate this evening.



# "A Challenge"

A. F. Weir, M.D.

Hebron, N. S.

ALL of us, no matter how modest may be our knowledge of Medicine, should have something to contribute to the pool of medical knowledge, and thus help each other to do better work. It is our duty to pass on the knowledge we have gained, by experience or otherwise, just as most of our knowledge was passed on to us. We cannot do much toward repaying our teachers, but we can repay society by helping those who come after us. Even the humblest of us should be able to contribute something. It has occurred to me that even I may have made some discoveries that have been overlooked by others. It is with that thought in mind that I write this.

For 26 years I served three fishing villages with a total population of about 2000. During that time I had only six patients, under the age of 70, who suffered a myocardial infarction. It has always seemed to me that, after the age of 70, one should expect degenerative diseases to take their toll, so I am not considering those over 70. As a matter of fact I always thought that I had lost a "round" if a patient died under 70. After 70 I did not feel badly about it, because we all have to die sometime. Degenerative diseases may show up in the 60's, but not so often. We have too many coronaries among people in their 30's and even in their 20's. Too many doctors die in their 40's. We should be doing something to save the young ones.

I will never forget the first coronary case that I was called to attend. At that time I did not know enough to make a correct diagnosis and put it down to angina pectoris. Looking back I am certain I was dealing with a coronary occlusion. The patient was a man aged about 60—one of those high-pressure fellows who was always off on business trips to Boston, Gloucester, or some other place. He had a family whose tastes were beyond his means. One day I was called to him in a hurry and, when I got out of my car, I could hear his moans and groans out in the street. In his bedroom I found his whole family and before I was properly in the house, they all began to shout at me to "do something." I was the youngest in the room and I bowed to all this superior authority. I did something, all right. I gave him  $\frac{1}{4}$  gr. morphine and they wanted me to give him more, because he was still moaning as loud as anyone could moan. The second one did not stop his pain, so I gave him a third one, and maybe a fourth. I stopped his pain, but permanently. That was 37 years ago, but I can still see his staring eyes and hear his groans. I know now that a veterinarian would have done a more merciful job for his patient. He would have shot him.

The next case I had turned out better. He was a taxi driver aged 62. He got practically no exercise and his wife was the best pastry cook in the area. This time I was all alone in the room with the patient and had a chance to think. I gave him  $\frac{1}{4}$  gr. morphine and waited. He kept moaning with pain and asking me to do something. I gave him another quarter and waited again. He couldn't even sit still nor lie down, but kept pacing the room and I expected him to drop any second. At last, after about fifteen minutes of this, he said, "For God's sakes, Doctor, can't you do something?" I told him that, if he

would lie down, I would do something. Before that I had found that, in treating biliary or renal colic, the most satisfactory way was to give morphine  $\frac{1}{4}$  gr. and hyoscine hydrobrom 1/100 gr. s.c. and follow that with light chloroform anaesthesia until the hypo had time to take effect. At that time I never even considered giving morphine intravenously. So I treated this man in much the same manner, only I gave him no hyoscine. After he lay down I gave him chloroform on a mask and his pain stopped almost at once. I kept the chloroform up for about ten minutes, maybe 20 drops a minute, until the morphine took over. I kept him in bed for six weeks. At the end of that time his blood pressure came up from 90 systolic to about 140. Then I started him on graduated exercises. He had absolutely no more pain. I know that if any cardiologist should read this he will throw up his hands in horror at the idea of giving such a patient chloroform, but those are the facts. I am not recommending the treatment, although it did work in this one case. The man returned to work and was active for 22 years after that, with no more pain. His weight had come down and I saw that he kept it there. Twenty years later this man, who was 82 at the time, was ready to go to church and was lying on a couch in the kitchen, waiting for his wife to get dressed. She heard him make a gurgling noise and, when she went to him, he was dead.

Of the other four patients, two were merchants and two were ferrymen. None of them ever had any vigorous exercise. Their ages ranged from 52 to 62.

During all that 26 years I never had one fisherman with coronary artery disease, nor, as far as I can find in my records, had they any other circulatory disorder.

Coronary artery disease has been blamed on the overindulgence in tobacco. Most of these fishermen smoked constantly. Some of them stopped long enough to have a chew or to eat.

It has been blamed on eating too much animal fat. The fishermen I have known fried much of their food. Their favorite dinner was fried pork scraps with salt cod, with liberal quantities of melted fat poured over their potatoes.

Coronary Disease has been blamed on nervous tension or stress. If a fisherman doesn't lead a worrisome life I would like to know who does. He may go out and lose all his trawl or lobster traps. He may go out day after day and not catch enough fish to pay for his gasoline. If he does start to get big catches the dealer lowers the price on him. When haddock are running well along come the dog-fish to ruin his trawl. If he does get enough money ahead to pay his back bills the Department of National Revenue lands on him and takes no account of all the poor years he has had. On top of all that fishing is a very hazardous occupation. Drownings are fairly frequent and much fishing gear and many boats are lost. In spite of all that the fisherman is, as a rule, very happy-go-lucky. He is always ready to help anyone who has a run of bad luck. Perhaps that is why Christ was so partial to fishermen.

He breaks all the rules about regular hours, because he is ruled by the tides. So he may start work at 2 A.M. and finish at 4 P.M. Then he baits trawl so he may be ready to go fishing at about 2:45 A.M. the next morning.

From the supposed causes of coronary thrombosis the fisherman should be a victim early in life. As a matter of fact, at least in my experience, he es-

caples entirely. It is not at all unusual to see men far past 70 actively engaged in fishing. Why should they be different? Why is the coronary death rate three times as high in Ontario as in Newfoundland?

During that 26 years I examined many fishermen of all ages and types. There was one thing I found them all to have in common. They were all muscle. It is said that a man's heart is as big as his fist. These men had mighty fists and mighty hearts. It was common to find the apex beat  $4\frac{1}{2}$  inches from the midsternal line. They all learned to row a boat at an early age and most of them started fishing in their early teens. To get to their boats they generally had to plod long distances, wearing heavy rubber boots. Then they have to row out to where their boats are moored. In trawl fishing from small boats they have to haul in a line half a mile long and loaded with fish. No other man could begin to haul in the trawl. They do get inguinal hernias, lame backs and haemorrhoids, but no coronary occlusions.

It has been claimed that a person is born with a potential coronary occlusion, just as he is born with a potential hernia. If this is so, why were not some of these fishermen born with potential coronary occlusions?

It has been claimed that too rich a diet predisposes to coronary artery disease. Perhaps this is true, but it is also true that people who are able to afford rich food probably get very little exercise. So it may be the lack of exercise that is the real culprit. During World War II it was found that there were fewer coronaries than usual. It was reasoned that it was because there was less fat eaten. Perhaps it was because everyone was on his toes and working like mad. In an ordinary peacetime life one must carry a lot of unused adrenalin in his blood. We have adrenalin to open up our bronchioles, shorten the clotting of blood, give us more nervous energy, etc. Since we don't use it for any of these purposes because we never have the Fight or Flight choice handed to us, the only thing left for the adrenalin to do is to tighten our arteries. Our remote ancestors were built to live dangerous lives. Perhaps the fishermen live more like our ancestors than anyone else.

Doctors have a very high mortality rate from coronary thrombosis. One would think that, for their own protection, they would be trying harder to lower this rate. As far as I know not much new has been added to our knowledge in the last ten years. President Roosevelt's polio did a great deal to hasten the production of means of combating this disease and now we have Salk vaccine. President Eisenhower's heart attack has not produced any very noticeable results to date.

Here in Nova Scotia we do not seem to have been doing as much research work as we should. It has occurred to me that some of the other doctors in the Province might write in and tell of their experiences. Many of them might be chaff, such as this article, but there might be some wheat. I would like to suggest that this Bulletin would issue a special invitation to all the doctors to write in and tell their experiences and their pet theories. Perhaps we could learn something from each other.

Eventually this might lead to Dalhousie sending out a research team to get cardiograms, histories and physical examinations. There is a wealth of human material in the Province, waiting to be used.

Some doctors practise in farming communities and they could tell of their experiences. Others treat many well-to-do patients and they could comment on their findings. There are those who treat several classes of patients, e.g. farmers, fishermen and lumbermen. They might be able to give comparative statistics. There are cardiologists and internists who might be able to contribute the most of all.

I believe we should all try to do something about coronary artery disease in this Province, because very little progress seems to have been made elsewhere. Opiates and oxygen seem to be the only forms of treatment generally accepted as good.

I would like to hear some comments from other readers of the Bulletin. To me this looks like a chance for Nova Scotia to take a lead. We have as good brains here as they have anywhere, but we are not using them enough. We can concentrate through the Bulletin on coronary artery disease and, by pooling our knowledge, we may come up with something helpful. Let's see if we can't start something on our own, instead of following the lead of others.

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## OBITUARIES

Dr. Lewis Hoyes Fraser died recently at Saratoga Springs at the age of seventy-three. Dr. Fraser was born in Bermuda, received his early education at Truro and King's College, Windsor. He was graduated from Queens University, Toronto in 1907, and had internship in Lincoln, Bellevue and St. Luke's Hospital, New York. He was a competent surgeon and spent his professional life in Peru except for some years which he served in Royal Medical Corps in War I. Dr. Fraser frequently visited Nova Scotia where members of his family lived and attended our Refresher Course several times.

His sisters lived for many years in Halifax and his surviving sister Miss L. Flora Fraser, R.N., was for many years Registrar of Registered Nurses of Nova Scotia, now resides in Bermuda. He is survived by his wife, several children and grandchildren and by one brother who lives at 16 Vernon Street, Halifax.

Dr. John Angus MacIvor. Our attention has only recently been called to the death of Dr. MacIvor who died at Vancouver in 1953. Dr. MacIvor Dalhousie 1903, practised in Baddeck, C. B., until 1923 when he moved to Vancouver. He is survived by his widow who lives in Vancouver.

# "Talking of Diabetes"

Arnold Logan

Halifax, N. S.

YOU know, speaking as a layman diabetic, I'm beginning to regret I know so much about the disease! I keep wondering if my doctors are ever going to catch up with me in pure knowledge about my "trouble," and when they're going to be able to answer the questions I ply them with on my check-up visits!

Of course the doctors brought it all on themselves: shortly after I was admitted to the Victoria General Hospital in Halifax this year to be "standardized" ("brought under control" is another of their pet explanations) they told me it was most desirable to learn all I could about the disease.

"Now, starting tomorrow," one of them announced, "we want you to go to the lab and do your own specimens. We're also going to have a dietitian call on you now and then to explain about your diet. And don't be afraid to ask questions. Jot them down as they occur to you."

Well, I did that. And, looking back, the doctors and dietitians did very well with the answers too! I had just read a FEW books and articles on diabetes mellitus up 'til then, you see, and all a doctor had to do was be glib with a few words like "polydipsia" or "hypoglycaemia" and I thought I was getting my money's worth.

I should have stopped reading about diabetes right then and there. Instead I read everything I could borrow from the Halifax Memorial Library on the subject; I pored over doctor's text books; I arranged to have a book dealer set aside for my purchase every magazine that contained an article on diabetes; I began corresponding with the American Diabetic Association and the Canadian Diabetic Association.

I imagine I'm the biggest bore in Nova Scotia to-day when it comes to dietetic suggestions, and from the quantity of reagent tablets I buy for urine-sugar tests, my favorite druggist must think I'm operating a hospital on the sly. I have to catch myself from replying "two plus" when an acquaintance asks me "how things are going," but, worst of all, I find myself secretly pitying my doctors over the herculean task of answering my questions which are daily becoming so increasingly shrewd even I realize I'm nothing short of a **specialist in Diabetes**.

Any day now I'm expecting a call from my doctor seeking advice on how to treat a diabetic who is proving a little difficult to "bring under control;" I feel only his stubbornness accounts for his reluctance to "call me in" before this.

As an instance of this narrow-mindedness on the part of my particular doctor, here is how he reacted to my query as to why he wasn't getting me some of that orally effective substitute for insulin recently discovered in Germany, BZ-55.

"It's right here in Time magazine," I pointed out to him patiently.

My doctor hardly glanced at the article.

"Look, Logan," he sighed, "I'm getting all my medicine out of Reader's Digest these days!"

Any man can plainly see what I'm up against; any man, that is, who doesn't happen to be a doctor.

For instance **my** doctor claims I'm in pretty good control!

Once more I go over it for him:

"Now just listen, please, doctor," I beg. "Every morning I get up and shoot 35 units of P.Z. into me. About eleven o'clock in the morning I take a test and what do I usually find—a **trace, or even one plus**. The rest of the day it's negative."

Sometimes the good old medico even yawns right in my face.

"Hmmm," he says, "good! I like my diabetics to show a trace or one plus now and then."

And there he is, caught. Right off base!

"E.P. Joslin, the Boston doctor, the doctor who writes the bibles on diabetes for you doctors," I trumpet gloriously, "says **always keep the urine sugar free!**"

There are other authorities, I'm then told, who don't quite hold with this.

Yes, there certainly are. I've discovered them.

And I'm scared stiff!

Another famous United States doctor, Edward Tolstoi, has treated diabetics successfully for over thirty years. **And he**, Heaven help us, **says it's not very important to have either sugar-free urines or low blood sugars!**

You pays your money and you takes your choice!

When I pounce on my doctor with this, he merely smiles and pats me understandingly on the back.

"Hmmm," he intones, "kind of worries you, these two schools of thought, eh."

Filled with self-pity all I can do is stare at him. When even **doctors**, I shudder to myself, hold diametrically opposite views on basic diabetic regulatory problems, what is to become of US?

"We'll just chart a course **BETWEEN** these two views," chuckles my doctor.

But I'm still scared! There's Tolstoi who sneers openly at diabetics who are afraid to break their diets. (And one gathers from his writings he permits his diabetics to eat handsomely **so long as their little old Diabetic symptoms don't return**) and there's Joslin whose followers think the expression "Let them eat cake" was originated by Satan as special torment for diabetics unfortunate enough to be delivered unto him.

There would be no problem whatever if all Tolstoi's diabetics dropped like flies in their sweet, sticky tracks, and all Joslin's subjects trod the straight and narrow with head erect, cheeks rosy, bursting with good health.

The trouble is, diabetics live on and on under each master for the same number of years.

I just don't want to lie in the next bed to one of Tolstoi's diabetics oh, say, fifty years from now when we're both passing on, and have him turn to me and say something like this:

"Well, old top, I guess it's curtains for us. I lived these last fifty years with diabetes under Tolstoi and boy, oh boy, did those apple pies and thick fried steaks with mashed potatoes covered with gravy taste good! How did

you make out, you old diabetic you.”

I can hear myself now.

“Oh I stuck with Joslin throughout—two thousand calories a day; never had a bad test and my blood sugars were so normal Joslin presented me with TWO medals. The only thing I didn't relish was the nickname my friends gave me: 'Drooling Logan.' Yeah, I used to drool whenever I thought of pumpkin pie covered with whipped cream!”

Now just in case some of my readers are thinking I'm a pretty ungrateful cuss, and that I should have developed diabetes before doctors Banting and Best discovered insulin, I hasten to state I thank the good Lord nightly in my prayers for originating those two great Canadians in time for me.

Indeed, during my recent hospital stay, I addressed a piece of doggerel to the institution's dietitians that demonstrates fully, I suggest, not only my thankfulness for insulin, but my gratitude to the animals for donating it. I waxed bitterly in the verse, it's true, over the great regularity with which cottage cheese and skim milk found their way onto my tray, (“Both products of animals given to moo,” I recall I wrote) but then my better self asserted itself and I ended the effusion with these lines:

However a product I use from the beast  
Keeps you from calling me “Logan, deceased.”

Finally (I'm not one to be taking any chances) if my doctors read this, I just hope they don't decide to wash their hands of me. And speaking of washing of hands, why can't I wash my hands TWICE every morning, dip the needle into alcohol, then plunge, instead of boiling the things for ten full minutes and—  
Oops—Sorry!

I don't want to start another argument.

# Nova Scotian Physicians In Government

K. A. MacKenzie, M. D.

Halifax, N. S.

Physicians of Nova Scotia, nearly all members of our Medical Society, have always taken a reasonable share of responsibilities of Government. This year eight physicians have sought a place in our Provincial Parliament, and seven have been successful, namely:

James Arnold Langille	Dal. 1932	Cumberland East
Carleton Lamont MacMillan	Dal. 1928	Victoria.
Duncan MacMillan	Dal. 1928	Halifax East.
Pierre Elisee Belliveau	Dal. 1922	Clare.
William Arthur MacLeod	Dal. 1908	Pictou East.
William Cleveland O'Brien	Dal. 1919	Yarmouth
Charles Henry Reardon	Dal. 1945	Halifax West.

The Bulletin wishes to congratulate these successful candidates.

Charles Patrick Miller, Dal. 1947, was defeated in Inverness.

It is interesting at this time to publish a list of members of our Society who have been members of Parliament in the past.

## MEMBERS OF FEDERAL PARLIAMENT. 1867 to date.

Sir Charles Tupper, Bart, M.L.A.	Nova Scotia and Federal member.	
Sir Frederick W. Borden	Kings.	1896-1908. Minister Mili
Hugh Cameron	Inverness.	1867-1872 & 1882-1896
James Forbes	Queens.	1867-1878 & 1882-1886
Angus MacLennan	Inverness.	1896-1908
Wm. McK. MacLeod	Cape Breton.	1878-1882
Lewis W. Johnstone	Cape Breton.	1925-1938
Arthur S. Kendall	Cape Breton.	1900-1904
A. W. Chisholm	Inverness.	1921-1939. 18 year
M. E. McGarry	Inverness.	1940-1949. 10 year
J. B. Black	Hants	1904-1911
Edward Blackadder	Halifax	1911-1917
L. J. Lovitt	Digby.	1921-1925
John Bell	Pictou	
Dugald Stewart	Lunenburg.	1911-
John A. MacDonald. Senator	Richmond and C. B.	
D. J. Hartigan	Cape Breton.	1935-1940

Note—Half of these members represented Cape Breton.

## SENATORS from Nova Scotia.

William MacKay	Cape Breton
William J. Almon	Halifax
John A. MacDonald	Richmond and Cape Breton



**NOVA SCOTIA PHYSICIANS. Members of Provincial Parliament.**

E. L. Brown	Kings	1867-1871
George Murray	Pictou	1867-1871
Duncan Campbell	Inverness	1872-1881
Edward Farrell	Halifax	1874-1878
Angus MacLennan	Inverness	1883-1885
Chas. Henry Munro	Pictou	1882-1889
John L. Bethune	Victoria	1886-1896
William MacKay	Cape Breton	1886-1889
		1894-1897
Arthur S. Kendall	Cape Breton	1897-1900
		1904-1911
Chas. Peter Bissett	Richmond	1901-1916
James Fraser Ellis	Guysborough	1904-1920
C. E. MacMillan	Inverness	1906-1911
Henry Arthur March	Lunenburg	1906-1910
Archibald M. Covert	Kings	1911-1916
James W. Reid	Hants	1911-1925
Jordan W. Smith	Queens	1911-1925
John A. MacDonald	Richmond	1916-1926
Benjamin A. LeBlanc	Richmond	1916-1928
Amedee R. Melanson	Yarmouth	1920-1925
Wallace N. Reh fuss	Lunenburg	1925-1928
John L. MacIsaac	Antigonish	1925-1942
Moses E. McGarry	Inverness	1928 1940
Angus McD. Morton	Halifax	1928-1933
James A. Proudfoot	Inverness	1928-1933
George H. Murphy	Halifax	1930-1933
Frank R. Davis	Lunenburg	1933-1949
George Raymond Deveau	Richmond	1933-1937
Weldon W. Patten	Cape Breton	1933-1937
William Duff Forrest	Halifax	1937-1940
Robt. A. MacLellan	Hants	1945-1949
Carleton Lamont MacMillan	Victoria	1949-

One member of our Society became Lt-Governor of Nova Scotia. Dr. Henry Ernest Kendall, B.A., M.D., was Lt-Governor 1942-1946.

**PHYSICIANS IN GOVERNMENT BEFORE 1867****Members of Her Majesty's Council, organized in 1720.**

William Skene	Annapolis	1720-1749
Robert Grant	Halifax	1756-
William Brattle	Halifax	1787-
John Haliburton	Halifax	1787

**House of Assembly. (Elected) 1758. 22 members. Halifax**  
**Halifax, 4. Lunenburg, 2. At large, 16.**

John Steele	Annapolis	1761-1764
Sam Willoughby	Cornwallis	1761-1776
Charles Head	Colchester	
John Harris	Colchester	1779-1785
John Boleman	Lunenburg	
Gurden Dennison	Horton	1785-1791
William Baxter	Cornwallis	
Wm. B. Webster	Cornwallis	1855-1860

**Legislative Council. 1838-**

William Bruce Almon	Halifax	-1840
D. McN. Parker	Halifax	1871-1901
William Grigor	Halifax	1851-1857
William Smith	Sydney	1785-
Under DesBarres		
Hugh Cameron	Cape Breton	1878-1882
C. C. Hamilton	Kings County	

It would be difficult to report the activities of these members but several deserve special mention.

The most distinguished member of the group was Sir Charles Tupper, Bart., who practised for twelve years in Cumberland County and for a few years in Halifax after which he devoted all his time to politics. His career was a stormy one at a stormy period in our political history. He was an M.L.A. for many years from 1855 onwards. He defeated the great Joseph Howe and became Premier of Nova Scotia. He also occupied several important Government posts including Provincial Secretary. In 1873 he entered Federal politics serving in turn Minister of Internal Revenue, of Customs, of Railways, and of Finance. For four years he was Canada's High Commissioner in England. In 1891 he became Prime Minister of Canada and gave to his native province and our Society the honor of having the only physician to occupy this high post. He was also the first President of the Canadian Medical Association and played an important part in its organization. He played an important role in improving educational methods in our Province and was active in bringing into being the Medical School of Halifax in 1868. We have good reason to be proud that he was a member of our Society.

Sir Frederick Bordon had a long and distinguished career in Politics. He was Minister of Militia and Defence 1896 and had a long service in Parliament. He shares with Tupper the honor of receiving a Knighthood.

Dr. J. B. Black was active in framing the Roddick Bill.

Dr. W. B. Webster was largely responsible for framing and passing the Anatomy Act in Nova Scotia in 1867.

It is difficult to obtain information about Nova Scotian Physicians who were active in politics outside of the Province. Three may be mentioned as a matter of interest.

Lt-Col. Alfred Thompson, a native of Hants County and a graduate of Dalhousie (1898) was elected to the Yukon Council in 1902 and to the House of Commons, Ottawa, in 1904 and 1911.

Dr. A. MacGillivray Young, a native of Pictou Co. was a Federal member for many years and was very helpful in framing legislation for the Royal College of Physicians and Surgeons.

Dr. Thomas Robert McInnes, a native of Cape Breton was elected M.P. for New Westminster 1878-1881, called to the Senate in 1881 and served as Lt-Governor of British Columbia from 1897 to 1900.

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### U. K. DOCTORS REJECT "MIRACLE" CURES\*

The British medical profession after a study of faith healing claims to have thrown cold water on the possibility of "miracle" cures.

A team of prominent doctors appointed by the British Medical Association reported that "as far as our observation and investigation have gone we have seen no evidence that there is any special type of illness cured solely by spiritual healing which cannot be cured by medical methods which do not involve such claims."

"The cases claimed as cures of a miraculous nature present no features of a unique and unexpected character outside the knowledge of any experienced physician or psychiatrist."

The result of their investigation—requested as evidence by a Church of England commission on divine healing—is published in a book form.

The report said that many illnesses said to be "cured" by non-medical methods of treatment are in reality the result of psychological or emotional disturbances. Such disorders can be cured by many methods of treatment involving suggestion. Alleviation of symptoms such as abolition of the pain in organic illness may be mistaken for cure. A toothache may be alleviated by plugging the socket with an analgesic by Christian science, by hypnotic suggestion or even by diverting the attention. **Statesman**, May 13, 1956.

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\*Reprinted from Calcutta Medical Journal, July, 1956.

# Dalhousie Expansion Appeal

## Interim Report

A year has gone by since the Dalhousie Medical School began its appeal for funds for expansion purposes. Medical doctors throughout Nova Scotia and elsewhere responded generously to this appeal. Your committee felt you would like to know the exact extent of the donations, the use to which your money has been put and what further expansion is envisaged.

The plan of your committee is to cover the four Atlantic Provinces and New York. To date this has been only partially completed but the campaign is continuing. The results have shown a continued warm feeling towards Dalhousie and a desire on the part of us as medical graduates to repay in some tangible way the thousands of dollars expended in our behalf during our undergraduate years. It also has shown that doctors today have a very definite interest in a medical school just as our forefathers did when they contributed to Dalhousie so that we as practising physicians might fall heir to the best standard of medical education.

To date the appeal has resulted in a total of \$144,356.00 in both receipts and pledges. A detailed break down is as follows:

Nova Scotia.....	\$131,771.00
Counties:	
Antigonish.....	\$ 1,300.00
Pictou.....	450.00
Yarmouth.....	1,000.00
Annapolis.....	111.00
Kings.....	100.00
Queens.....	1,000.00
Lunenburg.....	4,435.00
Cumberland.....	1,300.00
Colchester.....	11,400.00
Hants.....	2,300.00
Cape Breton.....	18,650.00
Halifax.....	89,725.00
Newfoundland.....	2,250.00
P. E. I.....	3,550.00
U. S. A.....	6,785.00
<b>Total.....</b>	<b>\$144,356.00</b>
Number of doctors contributing — 205.	

The campaign in Newfoundland and New Brunswick is just getting underway and we shall be reporting on those provinces later. Some counties in Nova Scotia have not yet reported but it is our feeling that they will do equally as well as those who have already come forward.

**What has been done with the funds subscribed and what is planned for the future?**

As indicated by the nature of the appeal, the program is one of "Expansion." Already the Medical Science building has been renovated, additional

rooms made and new equipment provided so that by virtue of the campaign funds it can now accommodate 96 students, an increase from a previous maximum of 70 students. Similar changes are planned in the Anatomy and Histology Laboratories when the new Dental School is completed and more space is given to medicine in the Forrest Building.

A new addition to the Pathological Institute is being built by the Government of Nova Scotia. However, some of the furnishings and much of the student laboratory equipment as well as research facilities will have to be provided by the University if 96 students are to graduate each year.

These are but a few of the plans in the minds of those charged with the duty of providing for these provinces and elsewhere the physical facilities to produce the finest medical graduates.

The thanks of the University and specifically the Medical School is extended to all who have so generously donated. The thanks of the committee is sincerely given to those who have campaigned in the various counties and provinces. Practically all who were asked to work accepted and did so cheerfully. Such a job I am sure no one relishes, but the task of the central committee was made considerably easier because of these doctors. May we continue to support our Medical School in the interest of all.

Clarence L. Gosse, M.D.,  
Chairman,  
Medical Campaign Committee.

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## Dalhousie Clinical Research Meetings

The bi-monthly meetings for presentation of progress reports on research problems currently being investigated at Dalhousie and associated teaching hospitals have recently come under the direction of the Dalhousie Medical Research Committee. They are enjoying a measure of success judging from the interest shown in the papers and the vigorous discussion which has followed each.

All physicians are cordially invited to attend these meetings and to participate in the discussion. They are held in the outpatient department conference room of the Victoria General Hospital at five o'clock on the second and fourth Wednesdays of each month during the academic year. Watch the **Bulletin** for notice of subjects to be presented in the near future.

The **Bulletin** will also carry abstracts of papers that have been read before the bi-monthly meetings. Several abstracts of papers that have recently been presented are included in this issue. Comment on the subject matter abstracted is invited.

The following are two abstracts of clinical research at the Dalhousie Medical School.

# Studies on the Urine of Mental Patients

F. Moya, Joan Dewar, Margaret MacIntosh, S. Hirsh, R. Townsend  
Division of Biochemistry Laboratories, Halifax and Nova Scotia  
Hospital, Dartmouth, N. S.

It has been reported in the literature that urinary extracts prepared by kaolin absorption from the urine of normal subjects (NM) and acute schizophrenic patients (SM) are hyperglycemic when injected into rabbits, the normal extracts being less potent than those derived from the patients' urine. The experiments presented show that both these types of extract are hypotensive and, following a short period of preincubation with serum, induce contractions of the guinea pig gut *in vitro*. This latter effect is not inhibited by atropine or anti-histamine compounds. The hypotensive effect can be inhibited by prolonged incubation in the presence of serum, or in the presence of kallikrein inhibitor obtained from cattle spleen. Consistently SM preparations were found to be less hypotensive and less active as smooth muscle stimulants than NM extracts, when compared on a weight basis. It is concluded that the hypotensive agent present in NM and SM is probably kallikrein, and since hyperglycemia following NM had previously been found to be inhibited by adrenergic drugs, the kallikrein present could account for its hyperglycemic effect. In view of the lower hypotensive action of the patient's extracts and the reported greater hyperglycemic action the presence, in SM, of a hyperglycemic factor other than kallikrein was postulated, and the action of both NM and SM on blood glucose concentration has been reinvestigated.

Our findings confirm the greater hyperglycemic action of extracts derived from acute schizophrenic patients. Under the conditions of these experiments maximal hyperglycemia in the rabbit was reached 3 hours after injecting patients' extracts and in less than 1 hour following the normal preparations (NM). Approximately 2/3 of the rabbits receiving SM died, whereas fewer than 1/10 of those receiving NM met a similar fate. The results rule out the possibility that the difference observed could be due to: sex, the manner of collecting the specimens in two different institutions or the sleeping draught received by some of the patients.

The results do not establish whether the peculiar behaviour of the extracts prepared from the urine of acute schizophrenics is characteristic of schizophrenia, or of mental disease, or of disease in general. Preliminary studies on mental patients, other than acute schizophrenics, indicate that extracts from their urine behave in a manner similar to normal extracts both in toxicity and hyperglycemic action.

# Possible Correlation Between Hormone Levels And Emotional Status In The Pregnant Woman

R. J. Weil and Lucille Stewart

Department of Psychiatry and Division of Biochemistry Laboratories,  
Provincial Department of Health

During the course of observing, over an extended period of time, a number of women threatening to abort, it was felt that the fluctuations in the levels of excreted hormone might have some correlation with the emotional state of the woman. Consequently, an attempt was made to study as many pregnant women as possible, regardless of the obstetrical history. The study was conducted in the following manner. As soon as the patient came to the attention of the group, she was seen weekly by the psychiatrist until the termination of the pregnancy. Forty-eight hour specimens of urine, collected during the two days preceding the psychiatric interviews were analyzed for the following: creatinine, 17 keto-steroids, 17 hydroxy corticoids, chorionic gonadotrophins, estrogens, and pregnanediol. At the end of the study the psychiatric interviews were evaluated as to the emotional state of the patient at that time, and not until this had been done were comparisons made between the interviews and the levels of hormone excretion.

The charts of one patient were discussed in considerable detail, and those of four others were mentioned briefly. It was felt by the authors that they could indeed show that periods of well-being coincided with improved levels of hormone excretion, especially in the chorionic gonadotrophins and that emotional disturbances were associated with lowered levels. It seemed that these fluctuations in hormone excretion occurred in women with good, and those with poor obstetrical histories, with the exception of one patient who acted out her difficulties and who showed a remarkably steady level of excretion of the gonadotrophins. It should be noted that these women were derived from the practice of the psychiatrist, or from the group of women presenting themselves because of obstetrical difficulties.

The only conclusions one can draw at the present are tentative. There are indications that some of the wider fluctuations in the level of gonadotrophin excretion in the pregnant woman may possibly be correlated with variations in her emotional status. This picture appears both in women with normal and those with poor obstetrical histories.

## Secretary's Page

**T**HE Editorial Board of the Bulletin has endorsed the principle of a "Secretary's Page." The members think that there is sufficient material each month, having to do with the affairs of The Society and other matters, to draw to the attention of readers in the form of notes which will appear on this "Page."

The Executive Secretary, who is also Managing Editor of the Bulletin, undertook his full-time duties on October 1, 1956. The offices of The Society consist of two rooms (209, 211) in the Dalhousie Public Health Clinic provided through the courtesy of the Dean of Medicine and the University. The office of the Post-Graduate Committee has since been moved to the same section.

### Re: Life Assurance and Disability Insurance

I have ascertained that 190 members of The Society are covered by the Group Life Assurance. The total value of the insurance is \$1,241,500.

At the last report from Mr. McKenna of the Group Disability Plan there had been 139 applications for Group Disability Insurance—of these 111 contracts have been issued, 9 are pending and 19 deferred. Two members of the staff of this plan have been in the area since November 5, 1956, and reports indicate an increasing number of applications, indeed, that the 50 per cent of the membership required to make the plan completely effective is in sight. These plans for Group Life Assurance and Group Disability are both sponsored by The Medical Society of Nova Scotia, and is a service offered to any member.

### Re: Group Health Insurance Plans

As of September 30, 1956 (latest figures available) the total of subscribers and dependents enrolled under Trans Canada Medical Plans is 2,616,235—being an increase of 21,551 over the previous month. Maritime Medical Care Incorporated had a total of 71,449, or an increase of 1,018, and Maritime Hospital Service Association had a total of 169,668, or an increase of 464.

### Re: Committees — Medical Society

The Society has sixteen standing committees. The completed list is published elsewhere in this issue, including chairmen and members. While each committee has definite responsibilities, the Committee on Fees and the Committee on Economics have a great responsibility during the ensuing year. The resolution creating the standing Committee on Fees reads as follows—"A Standing Committee on Fees be appointed to establish an equitable schedule of fees, to review this schedule annually, to receive representation from groups or individuals at any time and with power to set a schedule of fees and alter it according to the cost of living index or other circumstances." The wording of this motion has been slightly changed from that submitted at the annual meeting. This change was at the request of the mover, Doctor F. M. Fraser, and agreed to by the seconder, Doctor A. M. Marshall, and approved by the Executive Committee in session November 19, 1956. The work of this Committee is of extreme importance to The Society. I have already received four requests



for "Schedule of Fees," and have been instructed by the Executive Committee to state that our schedule of fees is presently under review and when completed will be forwarded. It is of vital importance to The Society that "representation from groups or individuals" be submitted to the Chairman, Doctor F. M. Fraser, 8 Prince Arthur Street, as soon as possible. This is an area of interest to all and might well be a centre for attention of the Branch Societies.

### **Re: Health Insurance**

The brief from The Medical Society approved at the annual meeting was given a final editing and submitted to the Chairman of the Planning Committee on October 30, 1956. This brief will appear in the next issue of the Bulletin. There has been one meeting of the Planning Committee in October, at which further information for study was submitted. The Secretary is representative of The Society on the Planning Committee.

### **In General**

It is the desire of the Executive Committee and The Society in general, that expressions of opinion and policies should reflect the thought and study of The Society as a whole. Committees are set up with specific terms of reference to make reports for guidance and action. Representatives to Advisory Committees on Federal-Provincial grants and particular organizations are appointed so that The Society may be kept informed of what is taking place, but also that The Society may have a voice in the deliberations of these Committees. The work and effectiveness of each will be much improved when they are guided by expressions of opinion as a result of study and debate in the Branch Societies, culminating in resolutions or memoranda to be brought to their attention.

It is one of the duties of the Executive Secretary to inform the Branch Societies on matters relative to the business of The Society and a sincere invitation is extended to make such inquiries which will be given prompt attention. Likewise, any communication, resolution or memorandum addressed to the Secretary will be forwarded to the appropriate committee for consideration.

I would take this opportunity to express to each of you, on behalf of Mrs. Currie and myself, Best Wishes for a Happy Christmas and a Healthy and Prosperous New Year.

C. J. W. B.

## AMERICAN COLLEGE OF SURGEONS

# Committee on Trauma

Meeting April 1957, Chicago

An intensive course on fractures and other trauma will be offered to all interested members of the medical profession by the Chicago Regional Committee on Trauma of the American College of Surgeons. The course will be held for three and one-half days, from April 10 to 13, 1957, at the John B. Murphy Auditorium, 50 East Erie Street, Chicago.

Lectures and demonstrations will be conducted by distinguished surgeon-teachers of the Chicago area, all recognized as authorities in their fields. Clinical cases will be presented, and discussion and questions from the floor are invited.

Subjects to be covered include bony trauma . . . soft tissue trauma . . . vascular injuries . . . bone grafting . . . traction technic . . . industrial casualties . . . farm injuries . . . auto crash injuries . . . burns . . . amputations . . . head injuries . . . and others.

The course is being given under the direction of Dr. Sam Banks.

Further information about the meeting will appear shortly.

## STANDING COMMITTEES

### THE MEDICAL SOCIETY OF NOVA SCOTIA

**Committee on Programme**—Doctor D. E. Lewis, Chairman, Digby.

**Committee on Public Health** (including Industrial Medicine and Pharmaceuticals): Doctor R. A. Moreash, Chairman, Berwick; Doctor A. A. Giffin, Kentville; Doctor H. E. Kelley, Middleton.

**Committee on Rehabilitation**: Doctors W. D. Stevenson, Chairman; F. J. L. Woodbury, G. J. H. Colwell, A. H. Shears and A. W. Titus (representative of Society on Rehabilitation Grant), all of Halifax.

**Committee on Medical Economics**: Doctor A. L. Sutherland, Chairman, Sydney; Doctors G. C. Macdonald and H. J. Devereux, Sydney; Doctor D. M. MacRae, Halifax; Doctor W. A. Hewat, Lunenburg.

**Committee on Fees**: Doctors F. Murray Fraser, Chairman; J. W. Reid, D. R. S. Howell, A. M. Marshall, all of Halifax.

**Committee on Cancer**: Doctor G. W. Bethune, Chairman, Halifax; Doctor W. M. Grant, Amherst; Doctor B. R. Wilson, Middleton; Doctor G. C. Macdonald, Sydney.

**Editorial Board, Nova Scotia Medical Bulletin**: Doctor H. C. Still, Editor-in-chief, Halifax; Doctor W. K. House, Halifax; Doctor J. L. Fairweather, Dartmouth; Doctor C. J. W. Beckwith, Managing Editor, Halifax.

**Committee on Post-Graduate Education**: Doctor J. A. McDonald, Chairman, Glace Bay; Doctor L. C. Steeves and Doctor H. I. MacGregor, of Halifax; Doctor J. A. MacCormick, Antigonish.

- Committee on Legislation:** Doctor J. McD. Corston, Chairman, Halifax; Doctor D. F. Macdonald, Yarmouth; Doctor G. R. Douglas, New Glasgow; Doctor J. A. Vaughan, Windsor; Doctor A. L. Sutherland, Sydney; Doctors D. F. Smith, N. H. Gosse, Halifax.
- Committee on Traffic Accidents:** Doctor A. L. Murphy, Chairman, Halifax; Doctor J. R. Kerr, Annapolis Royal; Doctor J. A. McDonald, Glace Bay; Doctor T. B. Murphy, Antigonish; Doctor T. C. C. Sodero, Truro; Doctor R. G. A. Wood, Lunenburg.
- Committee on Child and Maternal Health:** Doctor M. G. Tompkins, Jr., Chairman, Halifax; Doctor R. M. Ritchie, Halifax; Doctor G. W. Sodero, Sydney; Doctor J. A. MacCormick, Antigonish; Doctor Samuel Marcus, Bridgewater.
- Medical Advisory Committee on Health Insurance:** Doctor D. M. MacRae, Chairman, Halifax; Doctor H. F. McKay, New Glasgow; Doctor H. J. Devereux, Sydney; Doctor H. E. Christie, Amherst; Doctor F. J. Barton, Dartmouth; Doctor C. B. Stewart, Halifax.
- Finance Committee:** Doctor M. R. Macdonald, Chairman, Halifax; Doctor A. G. MacLeod, ex officio, Dartmouth; Doctor C. H. Young, ex officio, Dartmouth; Doctor A. L. Murphy, Doctor R. O. Jones, Halifax.
- Committee on Bye-Laws:** Doctor W. A. Hewat, Chairman, Lunenburg; Doctor N. H. Gosse, Halifax; Doctor J. C. Wickwire, Liverpool; Doctor J. A. McDonald, Glace Bay.
- Committee on Public Relations:** Doctor F. J. Barton, Chairman, Dartmouth; Doctor L. C. Steeves, Doctor H. C. Still, Halifax, Nucleus Committee; Doctor A. W. Ormiston, Sydney; Doctor J. A. MacCormick, Antigonish; Doctor J. H. Fraser, Westville; Doctor L. A. MacLeod, Liverpool; Doctor B. J. D'Eon, Yarmouth; Doctor J. R. Kerr, Annapolis Royal; Doctor J. B. Reid, Truro; Doctor G. M. Saunders, Amherst.
- Committee on Civil Disaster:** Doctor A. R. Morton, Chairman, Halifax; Doctor G. R. Forbes, Kentville; Doctor A. W. Ormiston, Sydney; Doctor H. F. McKay, New Glasgow; Doctor D. F. Macdonald, Yarmouth; Doctor H. A. Creighton, Lunenburg.

# Erratum – Minutes of Annual Meeting, 1956

As a result of enquiry at the Executive Committee meeting November 19, 1956, it was discovered that a motion had been inadvertently omitted from the published minutes. This had to do with the report of the Committee on Tariffs.

Item 10 Report of the Committee on Tariffs as on page 348 of the October issue of the Bulletin is herewith republished with the omitted motion in heavy lettering in its proper place.

C. J. W. B.

## 10. Report of the Committee on Tariffs.

The Report of the Committee on Tariffs, as circulated to the membership was presented by Doctor E. F. Ross. Doctor Ross discussed the activities of the Committee in compiling this report and explained various portions of it.

Doctor A. G. MacLeod moved "That the word 'Minimum' be dropped from the title and that it be called simply a Scale of Fees." Doctor J. S. Manchester seconded. Carried.

Doctor H. J. Martin moved "That a specialist be defined as a doctor who practises a specialty particularly and does not engage in general practice." Doctor J. F. Cantwell seconded. Carried.

Doctor H. C. Still moved "That the motion of Doctor H. J. Martin be reconsidered." Doctor D. R. S. Howell seconded. Carried.

On reconsideration Doctor Martin agreed to change his motion to read: "That a specialist be defined as a doctor who practises a specialty exclusively, being qualified either by certification or its equivalent."

This motion was seconded by Doctor C. H. Reardon. Carried.

Doctor H. J. Devereux moved "That this motion be referred to the Executive Committee for further study." Doctor W. A. Murray seconded. Carried.

Doctor A. L. Sutherland moved "That this schedule of fees be adopted and be used for one year and then be reconsidered." Doctor R. A. Moreash seconded. Carried.

After citing various fees for general practitioner services as compared with fees for specialists Doctor C. H. Reardon moved "That the scale of fees as proposed under the specialist schedule for medicine, surgery, gynaecology, obstetrics, etc., be the scale of fees for The Medical Society of Nova Scotia to embrace all practitioners." Doctor K. P. Hayes seconded. Carried.

Doctor A. M. Marshall moved "That a committee be formed to study and formulate a schedule of fees satisfactory to The Medical Society of Nova Scotia and Maritime Medical Care Incorporated." Doctor C. L. Gosse seconded. Motion defeated.

Doctor F. Murray Fraser moved "That a Standing Committee on Fees representing all branches of the medical profession be appointed to establish an equitable schedule of fees, to review this schedule annually, to receive representation from groups or individuals at that time, with power to set a schedule and alter it according to the cost of living index or other circumstances." Doctor A. M. Marshall seconded. Carried.

# Appointment of Full Time Professor of Surgery Dalhousie Medical School

Dalhousie University and the Victoria General Hospital have jointly announced the appointment of Doctor Ian MacKenzie as the first full time Professor and Head of the Department of Surgery.

Dr. MacKenzie was born on the Island of St. Kilda in the Outer Hebrides and was educated at Edinburgh University. He graduated with the M.B., Ch.B. in 1933. He continued his training in Surgery, Pathology and Bacteriology and was awarded the F.R.C.S. (Edinburgh) in 1938. His training in Surgery was at the Royal Infirmary, Edinburgh, the Cumberland Infirmary, Carlisle and St. Giles Hospital, London. He spent one year at the Rockefeller Institute in New York, working under Dr. Peyton Rous on the aetiology of malignant disease.

Dr. MacKenzie then served for six years with the R.A.M.C., first in the Mediterranean Theatre and later with the special Airborne Forces working with the Resistance Movements in Yugoslavia and France. He attained the rank of Lieutenant-Colonel and was awarded the M.B.E. (Mil.) and the Croix de Guerre with Gold Star.

After the war Dr. MacKenzie returned to Edinburgh as the Beit Memorial Research Fellow and later served at the University of Durham in Newcastle-on-Tyne where he was first Assistant in the Department of Surgery. He has recently been Consultant General Surgeon to a group of West Cumberland hospitals under the National Health Service.

Dr. MacKenzie's special clinical interests are in the surgery of peptic ulcer, in malignant disease of the colon, and obliterative vascular disease. His special interests in research are in carcinogenesis and obliterative vascular disease. He is co-author with Dr. E. C. Mekie of the "Handbook of Surgery," a student textbook.

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## NOTICE

West Vancouver, B. C. General Practitioner, age 40, wishes to exchange practices with Nova Scotia general practitioner, preferably Halifax or Atlantic coast town. Reply c/o D. Brister, 285 17th Street, West Vancouver, with details re gross income, overhead, character of practice, description of office and of locality.

## NOTICE

### Hospitals and Doctors

Will any hospital or doctor who is discarding any medical instruments or equipment which would be useful to Christian medical mission, and who is willing either to donate or sell cheaply the equipment for missionary purposes communicate with Clarence Mosher, Newport, R.R. No. 1, Hants County, N. S., Canada.

# Springhill Mine Disaster

The Secretary, on behalf of The Medical Society, acknowledges with sincere appreciation the following letter from H. C. M. Gordon, Vice-President and General Manager of the Dominion Coal Company.

The letter arrived just as the Bulletin was going to press and is published herewith.

The Medical Society of Nova Scotia is justifiably proud of the service provided by those of its members who went to the scene of disaster to assist the local physicians in the emergency. It is pleasing indeed to receive a letter which expresses the sentiments of one who was so personally and intimately involved as Mr. Gordon.

C. J. W. B.

DOMINION COAL COMPANY, LIMITED  
Cable Address "Domincoal"  
Sydney, Nova Scotia

November 27th, 1956.

Dr. Chas. Beckwith,  
Secretary, The Medical Society of Nova Scotia,  
Halifax, N. S.

Dear Doctor Beckwith:

You will, I am sure, understand how it is that I have not been able to find an earlier opportunity to write to express my personal thanks and those of the Cumberland Railway and Coal Company for the very real assistance given by various members of The Medical Society of Nova Scotia on the occasion of the explosion at No. 4 Colliery, Springhill.

The generosity of so many of your members who voluntarily supplied medical services and their untiring effort in providing such essential assistance are greatly to be admired.

Much appreciation was expressed on all sides at the time and now that the strain of the fateful happening is receding somewhat, it is being realized that the kindly thought which prompted your help as well as the spontaneity and willingness with which that help was forthcoming does much to strengthen faith in one's fellow man.

The individuals who participated are unknown to me personally but I should much appreciate it if you could find it possible to express to each, as I now do to you, our very sincere thanks. I am sure that memories of their unselfish kindness and goodwill will long remain with the townspeople of Springhill.

Very sincerely yours,

(Sgd.) H. C. M. Gordon,  
Vice-President and General Manager.

# NOVA SCOTIA MEDICAL BULLETIN

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