

# THE NOVA SCOTIA MEDICAL BULLETIN

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## Needed: An Active Section

If these few words had been written about one hundred and fifty years ago, rather than today, a much smaller number of interested people, say about forty-five percent would have been present to read them. We hope that fifty percent of all concerned people will be interested enough to take time to read the Journal this month, and, particularly this month.

There has been an attempt to get a General Practitioner's issue for June. It has been a difficult task. Why? One can only get the answer to this by serving a term on the Editorial Staff. It is worthwhile and enlightening. And **Frustrating!** Why the lack of interest of the General Practitioners in particular is a mystery.

One hundred years ago infants and children died from whooping cough, diphtheria, scarlet fever, measles, nutritional deficiencies, tetanus or a number of infections. The odds may be one in ten or one in twelve. These figures are not of extreme importance at this time.

The important thing is that medicine, with great aid from pharmacology has brought about a great change.

Within the past one hundred years health preservation was as great a revolution as the Industrial Revolution; women's suffrage and many other upheavals.

It was Hippocrates who said that the ultimate of medicine is the best possible health. Of course

this can only be obtained when there are sufficient workers. There is urgent need for recruits, education and continuing education.

The need for more doctors to provide for health service for Canadians is at this time very pressing. This, of course, presents a problem of widespread concern.

It takes, as you all know, a minimum of seven years for a physician's educational preparation. It can't be rushed. But there are other important factors which should be considered. These are best brought about by General Practitioners themselves. Many students under the steady guiding hand of specialists are also so inclined to be specialists. In recent years the faculty has been stressing the role of a General Practitioner more adequately. The General Practitioners have been engaged in a Preceptor - Preceptee relationship with a more general trend toward general practice. The results can be seen in the latest graduating class. These results are heartening. Can they be kept interested so that the ranks are not always being depleted? One of the ways shown to be quite successful is the College of General Practice. This organization can be most powerful along these lines. But there tends to be a certain amount of "let the other fellow do it".

Sir William Osler, one of the great Canadian physicians of the century, said, "The Master word in medicine is work". He probably referred to

medicine itself, but with the present day expansion of services it could be applied to other endeavours.

While the doctor is the most important part of a health team he is not alone in providing the services. The care of the population's health is essentially a team endeavour. An example of this is seen in control of typhoid fever. Immunization gives protection to individuals; filtration and chlorination of water by engineers removes disease producing pollution; and pasteurization purifies milk. But though the General Practitioner may call upon these outside services and colleagues for help and advice, the ultimate responsibility for the patient is his.

What he may lack in depth he certainly makes up in breadth. He deals with everything from children's ailments to geriatric problems. He sees his patients as living under certain conditions and not merely case numbers. He judges the cause; gives the correct treatment or refers him to the appropriate specialist.

Medical science had become so diversified that medical practice had to develop necessary specialists. Advances in knowledge and various techniques demand wider and deeper knowledge every year.

The physician has three important functions: to provide medical care to ailing people, to teach, and to carry out further medical research.

The Canadian Medical Association says these are a trinity: unique, interdependent and indivisible.

It goes without saying that the Physician's first obligation is to his patient but there is a tradition in medicine that whenever possible he should devote part of his time in teaching.

This traditional obligation can be met in part with the physician acting as a preceptor. This is a

body associated with medical faculty and instituted by the combined efforts of Dalhousie and the College of General Practice. The details need not be discussed here. It is this body, earlier referred to, that may share with the faculty the more recent and greater trend of graduating students going into general practice. At least it is generally felt that even a few years in general practice before going into a specialty will produce an even better and well rounded knowledgeable specialist.

Now we know how important the General Practitioners are in the scheme of things. With the loss of the General Practitioner and overloading of work isn't it even more important to have a strong voice before the situation approaches the "vanishing indian" stage? May we have a short digression right now? The General Practitioners have always had a "Section" with a representative in the Nova Scotia Medical Association. Any information required concerning General Practice, however, is always directed to the College of General Practice, which up to recent times has only been an educational body. It is now established and recognized as being representative of General Practice on the national level.

Before the College was even established there was a Section of General Practice in the Medical Association. This section has been so quiet as to be non-existent. The "Section" is section in name only. It is too inactive to be effective. Lip service is not enough. General Practice in Nova Scotia is not organized. Steps to become strong will be taken at this year's meeting at Digby, Nova Scotia. Now is the time for all "General Practice" to unite.

In unity - there is strength and a strong voice.  
Make your "section" valuable.

W.A.C.

## Clinical Staff Conferences

### PATHOLOGY INSTITUTE 5800 UNIVERSITY AVENUE

Surgical Pathology	Monday 4:00 p.m.	Lecture Room 327	Weekly
Orthopedic Pathology	Monday	Lecture Room 327	Periodically
Gynecological Pathology	Tuesday 5:00 p.m. (first of month)	Lecture Room 327	Monthly
Seminars in Pathology and Bacteriology	Tuesday 4:00 p.m.	Lecture Room 327	Weekly
Neuropathology	Wednesday 9:00 a.m. (first of month)	Room 332	Monthly
Brain Sectioning	Wednesday 2:00 p.m.	Autopsy Room	Weekly
Surgical Death	Thursday 5:00 p.m. (last of month)	Lecture Room 327	Monthly
Autopsy Conference (Gross)	Friday 2:30 p.m.	Autopsy Room & Room 327	Weekly
Autopsy Conference (Micro)	Friday 4:00 p.m.	Autopsy Room & Room 327	Weekly

# Summer Meeting, The Pines, Digby, N. S. July 4th, 5th, & 6th, 1966

You are invited to complete and return the Housing application form on this page.

Dr. A. J. M. Griffiths and his Committee Chairmen are developing the program which starts on Sunday evening July 3. The detailed program is outlined on page 145 of this Issue.

You can be assured of an interesting program which will include time for relaxation to enjoy the surroundings and pleasures associated with The Pines at Digby.

## HOUSING APPLICATION FORM The Medical Society of Nova Scotia The Pines Hotel, Digby, N. S. July 4, 5, 6, 1966

Executive Secretary  
The Medical Society of Nova Scotia  
Dalhousie Public Health Clinic  
Halifax, N. S.

Please have reserved for me the following: -

Please check  
IN HOTEL

1. ( ) Double room with bath - twin beds - including meals \$14.00 per person per day. (accommodates 2 persons)

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2. ( ) Cottage with sitting-room and two twin bedded bedrooms - including meals \$14.00 per person per day. (accommodates 4 persons)

3. ( ) Cottage with sitting-room and three twin bedded bedrooms - including meals \$14.00 per person per day. (accommodates 6 persons)

4. ( ) Single occupancy: If attending alone please indicate with whom you wish to share accommodation.

5. ( ) CHILDREN under 14: Rate \$8.50 per day per child. Please give ages of children accompanying you.

Date for arrival JULY..... AM..... PM.....

Date for departure .....

Name of persons who will occupy above accommodations:

NAMES

ADDRESS

In view of the attendance expected, single occupancy of rooms cannot be guaranteed. If coming alone, and you are willing to share a room in the hotel, please check here.....

N.B.—Space will definitely be available at "The Pines" for applications received up to June 10, 1966. Accommodations at the Pines or a motel can be provided for applications received after June 10.

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NOVA SCOTIA DIVISION

OF

THE CANADIAN MEDICAL ASSOCIATION

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# Summer Meeting, The Pines, Digby, N. S. July 4th, 5th & 6th

## - - P R O G R A M M E - -

SUNDAY, JULY 3rd.	Accommodation available late afternoon and evening.
	Evening only: - 8.00 p.m. Meeting of Branch Societies, Presidents and Secretaries.
	- 9.30 p.m. CEILIDH - Welcome Party.
MONDAY, JULY 4th.	MORNING: - Medico-Legal Panel; Report on C.M.A. General Council 1966.
	AFTERNOON: - Golf, Boat Tours, Swimming and games.
	EVENING: - Meetings, Movies and Entertainment.
TUESDAY, JULY 5th.	MORNING: - Clinical Panel. Section for General Practice. Executive Committee. M.M.C. Board of Directors.
	AFTERNOON: - Repeat of Monday.
	EVENING: - Shore Party followed by presentation of prizes. Dancing and Movies.
WEDNESDAY, JULY 6th.	MORNING: - Executive Committee. Other Meetings to be arranged.
	AFTERNOON: - Free and vacate.

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The Annual Nova Scotia Medical Golf Tournament will take place.

The Section for General Practice and the Section for Salaried Physicians will hold meetings during the three days.

The Section for Pathology is hosting the Atlantic Society of Pathologists.

The Nominating Committee of the Society will meet on Monday evening.

Maritime Medical Care will have a meeting of the Board of Directors.

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For the Ladies: - Coffee and Sherry Party 10:00 a.m. each day, Golf Tournament, etc.

For the Children: - Playground, Games and Swimming.

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Social Registration \$10.00

# Halifax Civic Hospital

The Halifax Civic Hospital, formerly called the Convalescent Hospital, has now been recognized by the Hospital Insurance Commission, as an "active treatment" hospital.

Its new status thus entitles it to the benefits of Insurance and Prepaid Medical Care Plans, hospital contracts.

Its 53 beds, about equally divided between male and female, are proving a useful adjunct to hospital facilities in this area.

It will receive most types of illness which do not require the special investigative and nursing services available only in the V.G. and Infirmary.

Its own facilities include X-ray, laboratory, E.C.G., Physiotherapy, and minor surgical procedures.

Any physician practising in the Halifax-Dartmouth area may become a member of its Active or Consultant Staffs by completing an application form obtained from the Administrator of the hospital.

Patients may be admitted directly from their homes or referred from other hospitals. The only criteria for admission being suitability and the agreement of a member of the Active Staff to be responsible for their treatment while in hospital.

Children, under 15 years of age, are admitted only under special circumstances.

It is hoped that the hospital will become accredited after a year's service in its new status. □

## General Practice Opening

Excellent future for energetic young general practitioner as associate in rapidly expanding general practice. Share overhead in newly equipped office. Equal time off to enjoy nearby accessible beauty, fishing, skiing and other recreational opportunities.

Apply to Box 105, The Nova Scotia Medical Bulletin.

## General Practitioner Wanted

"General Practitioner wanted in the Town of Port Hawkesbury, Cape Breton, N. S. A good opening for a third G.P. in a growing town and large surrounding area. Interested party may write c/o P.O. Box 339 or 399 Port Hawkesbury, N. S."

## FORTY YEARS AGO

The Nova Scotia Medical Bulletin June 1926

### Prohibition and the Profession

We were the goat. When the people of this province, at the behest of the temperance reformers, placed the Prohibition Law on the statutes there had to be a loophole somewhere. The politicians, mostly lawyers, looking around for that loophole-a tongue in each cheek - cast their eyes upon us and chuckled ironically. "Look you!" they cried. "The people want this prohibition so we can't side-step it. We must give the people what they want - but we'll fix it so the boys can get what they want from the doctors." It was a splendid gesture. The noble medical profession in their great work of healing the sick must needs have alcohol. They *must* have it. Suffering humanity, lying at death's door, needs such stimulus. The splendid doctors shall provide for them.

And then what did the government do? Did they ask us to confer with them and take us into their confidence? Did they seek information from us as to the quantity of liquor that might be required for purely medical purposes before buying a supply? They certainly didn't take us into their confidence, and if they had asked us about quantities we could have told them that about a thousand bottles of brandy and a few hundred gallons of Port Wine would have been sufficient. Instead, they established a Commission, hired a lot of helpers, bought a large warehouse, and stocked it with sufficient hard liquor to fulfill the medical needs of the whole world for at least a year. Did that mean that the government was going to be tied up with medical supplies of an alcoholic nature until our grandchildren grew beards? Oh, no, the doctors would see to that! □

### How Do Practising Physicians . . . . .

continued from page 157.

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3. *Attitudes of US Physicians toward Pharmaceutical Industry*, Chicago: Ben Gaffin & Associates, Inc., 1959, p C-13.
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5. Committee on Professional Education of American Heart Association, New York: American Heart Association, 1961, p. 10.
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# General Practitioners Become More Active

D. C. BROWN, M.D.<sup>1</sup>

Amherst, N. S.

General Practitioners are becoming more active across Canada in the last few years. Evidence of this has been shown in the Maritimes in the successful conclusion of the First Conjoint Scientific Assembly of the Maritime Chapters of the College of General Practice held in Charlottetown in October 1965. This was a very successful meeting and showed a different trend in that approximately half of the people presenting papers to the gathering were General Practitioners. General Practitioners are becoming increasingly more active and one phase of this is through the College of General Practice, more details of which are presented by the President of the Nova Scotia Chapter in this issue.

The College of General Practice of Canada looks after the educational needs of General Practitioners and I need not go into details of the tremendous amount it has accomplished for the General Practitioner in its few short years of existence. It has been felt that the future of General Practice in this country depends, in a large measure, on the ability of the General Practitioner to keep up to date through education and thereby retain his rightful place in the field of medicine. The College, at its inception, was charged with this responsibility, and has I believe in its enthusiasm, been divorced from economics and politics. This policy of the College was reaffirmed at the last annual assembly on the Caribbean Cruise. At this gathering some very good points were put forward upholding this policy of not becoming involved in medical economics and politics.

It was recognized from the beginning that in addition to his educational needs, the General Practitioner had very real economic and political needs that must be recognized. It was felt, that this could best be done at the divisional levels of the Canadian Medical Association through Sections of General Practice. The views of the General Practitioner in this area would then be made known to the Provincial Divisions through their Committee on economics, fees, or whatever,

and through these Committees to the National level of the Canadian Medical Association through their Committee on Medical Economics. This in some areas has worked well and one thinks particularly of Alberta, British Columbia and Ontario.

Further evidence of the increasing activity of General Practitioners was their Conference of Sections of General Practice held in Banff, Alberta on January 29 and 30th, 1966. The intent of this Conference can best be summed up in a resolution which was passed and I quote, "Be it resolved that it be announced that the purpose of this Conference is to perfect methods of communicating the opinions of General Practice to political or executive bodies within the profession and without". The feasibility of having a national organization of Sections of General Practice was discussed at this meeting. It is hoped that this will take form within the framework of the C.M.A. and that such a national organization of Sections of General Practice have representation on General Council. I do not think it desirable to have a national organization of Sections of General Practice outside the C.M.A. as this just leads to fragmentation and weakening of the parent body.

However, this matter will require much more study and many meetings before it becomes satisfactorily resolved.

Dr. Cudmore, in his article in this issue, can be helped greatly by assistance from General Practitioners in the proposed new program of continuing medical education. Indeed without the assistance of the General Practitioner this program would not work in the smaller community hospitals.

At a meeting of the Executive of the Section of General Practice held in Truro on March 6, 1966 a committee was appointed to report to the Digby Pines meeting in July on the aims and functions of the Section of General Practice. Any General Practitioner who has strong views on this subject should express them at this meeting. A

<sup>1</sup>Chairman, Section of General Practice, Medical Society of Nova Scotia.

Committee was also appointed to review and update the rules and regulations of the Section of General Practice and report to the same meeting. This is a summer meeting at Digby Pines and the various Sections from The Nova Scotia Medical Society will be having their meetings to discuss matters of interest to their Section. This is a very important meeting for the Section of General Practice as there are a lot of matters of concern to us all which should be clarified, and an efficient means of representation should be organized. A strong Section of General Practice in our division will give the General Practitioners a much better opportunity to express themselves and make their views heard to better advantage in The Nova Scotia Medical Society and subsequently in the C.M.A. So bring your families along and come to Digby Pines in July.

One important aspect of this is whether or not membership in the Section of General Practice should be automatic for doctors who have paid their Provincial Medical Society fees and elect to belong to that Section, as is the policy in Ontario. The Sections of the Ontario Medical Association

are not entitled to charge their membership fees although they may by voluntary agreement pass the hat. On the other hand Alberta membership in the Section of General Practice is limited to those Practitioners who have paid dues. Money required to carry out the various functions of the Sections is obtained solely from membership dues. From these two extremes you can see it is very important for full discussion on this subject and all General Practitioners interested, and this should include all General Practitioners, should voice their opinions to the meeting at Digby Pines. All branches of the Nova Scotia Medical Society have been asked to appoint a corresponding member to the Section of General Practice. It is important that any General Practitioners who have views on these important matters should make them known to this meeting either directly or indirectly through the corresponding member of their Branch Society.

This is the first ever all General Practitioners issue of the Nova Scotia Medical Bulletin. We hope that this is just a start on more things to come in the future. □

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## The College of General Practice

JOHN M. WILLISTON, M.D.<sup>1</sup>

*New Glasgow, N. S.*

As President of the Nova Scotia Chapter of the College of General Practice for the year 1966, I strongly urge that every General Practitioner in the Province join this organization without delay.

The College can help you keep abreast with the practice of modern medicine and stimulate you to keep up on the latest developments in all phases of your work.

The success of the College calls for all out support from the practicing doctors in the Province, and with a greater number of members the College can become a stronger voice to speak out for recognition of the General Practitioner.

The Conjoint Scientific meeting held in Charlottetown last fall was very successful and it is hoped that the next Conjoint Scientific meeting in October 1966 will meet with even greater success.

Don't be satisfied to keep up on post graduate training by sitting home in a comfortable armchair in the living room, and watching your favourite doctor perform on the T.V. set. Come alive and join an active study group like the College of General Practice and obtain a new outlook at your medical programme. □

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<sup>1</sup>President, Nova Scotia Chapter, College of General Practice.



## An Interesting Diagnostic Problem

E. B. SKINNER, M.D.

*New Glasgow, N. S.*

Following is presented, with follow up, a report on an eighteen year old white male who was an interesting diagnostic problem on entrance into hospital on September 8, 1965.

### Past History:

At age eleven, August 1958, he had a tonsillectomy and adenoidectomy with uneventful recovery. On November 25, 1964 he was admitted to hospital with complaint of weight loss, backache, chronic fatigue and anorexia. An intravenous pyelogram was done as an outpatient. The patient was treated for low grade pyelonephritis and was discharged on December 16. At this time he was afebrile, had gained weight and enjoyed general good health.

In February, 1965 he was once again admitted to hospital with diagnosis of Pyelonephritis and secondary Anemia. The symptoms at that time were abdominal pain, frequency, urgency, a mild weight loss, and supra pubic tenderness. The investigations at this time included barium enema, upper gastrointestinal and cystoscopic procedures. These all proved negative. He also responded to urinary antiseptics. His weight on discharge was one hundred and twenty-eight pounds. The patient was seen regularly at the office, and he was looking good, felt good, and gained weight up to one hundred and fifty-four pounds. At this time he felt well enough to perform with a singing group which required considerable time and effort.

His last admission to hospital was on September 8, 1965.

Prior to admission he again developed abdominal pain, had some weight loss. An intravenous pyelogram done at the Out-patient Department revealed the kidneys to be normal in size, shape and position. There is a slight delay in excretion on the right. The collecting system in the ureter on the left, appear normal in all respects. There is some calycectasis on the right which seems little changed from the examination of November 1964. There seems to be a little displacement at the upper end of the right ureter which may or may not be significant. The right pelvis itself does not appear to be unduly dilated and there is no dilation of the ureter. The bladder outline seems unremarkable.

### Opinion:

There is again seen a slight degree of calycectasis on the right, but no irregularity of calyces. The appearance is essentially unchanged since the last examination and findings may be due to Chronic Pyelonephritis.

On admission this young man appeared chronically ill, was pale and had a temperature of one hundred and one point eight.

The physical findings on admission were:

Tachycardia with rate of 108/M. Heart sounds were of good quality with no murmurs. Blood pressure was 120/82. No ankle edema detectable. All pulses were palpable bilaterally. Kidneys, liver and spleen were not palpable. Nervous system findings were essentially normal. Urinalysis had been done prior to admission on various occasions and reported negative. On admission urine showed one plus albumin and occasional white blood cell. There was a moderate positive acetone; specific gravity was 1.007. Culture and sensitivity were negative. Daily urinalysis from September 13 to 24th, showed continual one plus albumin with occasional bacteria.

Blood studies on admission was hemoglobin (Hb) 12.1%, packed cell volume 42; sedimentation rate (sed rate) 37mm/hour. On the 16th, hemoglobin was 11.5; sed rate was 40; on the 26th Hb was 11.4; sed rate 40 mm/hour; white blood count on the 9th was 4500; on September 16th the white count was 7950, 34 segmentals and 21 bands. He looked quite ill at this time.

Serum calcium was 10.2 Mgs. %

Urinary calcium was 21.2 Mgs. % / 24 hours.

Phosphorus was 92 Mgm % or 552 Mgm / 24 hours.

Blood cultures were negative. Purified Protein Derivative was negative.

Alkaline Phosphatase was 2.8 Armstrong Units.

Chest X-ray was normal.

A barium enema was repeated and reported as follows:

The barium passed easily through the colon with no delay or obstruction. No diverticula were seen. The caecum was filled fairly well and the appendix was visualized. The post evacuation film shows partial evacuation.

#### Opinion:

No definite abnormalities of the colon were demonstrated. It may be of value to carry out a small bowel series with particular reference to the distal ileum and the caecal area.

This examination was done September 21st and the report is as follows:

The small bowel appears normal as far as the terminal ileum. Here there is a segment showing finely irregular mucosa in some areas and a coarsely irregular mucosa in others. The segment in question appears to be normally expansile. There was no apparent delay in the passage of barium.

#### Opinion:

The ileum, in what appears to be its terminal portion, is abnormal. There appears to be some mucosal ulceration, but there is no narrowing as one usually sees in regional ileitis. The appearance is more suggestive of nonclerosing ileitis, except that the few cases described have been seen only on females. The exact nature of the lesion is not determined.

At this stage I would like to put the course in hospital up-to-date as far as the patient is concerned.

The patient was admitted with a temperature of 101.8 and ran a spiking temperature, from 101.8 down to 99. His weight on admission was 124 pounds; September 26th it was down to 116, and down to 113 on October 4th. Chief complaints were abdominal pain and intermittent nausea and mild diarrhoea. He spent the first couple of days doing fairly well. Then on the eleventh he was complaining of abdominal distress with cramps and on examination it was felt that there was a bit of tenderness in the right side, but certainly no masses were palpable and there was slight guarding in the right lower quadrant. His complaints of abdominal cramps and diarrhoea continued and he also complained of malaise. This was the chief feature and as the days went on this boy was still complaining of intermittent abdominal cramps, and was not improving on the medications. He was now complaining of night sweats - became listless and continued to lose weight. The last blood smear showed numerous bands (21) suggesting some toxic process. By this time the Upper G.I. report and follow through had been done and the patient was examined by a surgeon. It was felt that he should definitely have a Laparotomy. Whereupon the following report is pertinent to the history.

#### Operation; Laparotomy

##### Procedure:

Right upper paramedian incision was performed and there is a lesion in the last inch of the terminal ileum and the first two inches of the ascend-

ing colon, which is thickened and hard. It feels almost like an annular carcinoma. There are many large discrete glands in the mesentery of the ascending colon and terminal ileum. The lower nine inches of the ileum shows great distension but no evidence of any disease in the bowel wall. The appendix does not appear to be the site of the condition. The serosa of the whole area involved is red, hemorrhagic and edematous. The remainder of the small bowel and colon is normal. There is no evidence of polyps or Meckel's diverticulum. The stomach, gall bladder, liver and pelvis are normal. There are many discrete glands along the aorta. A right Hemicolectomy was done and an end to end anastomosis of the ileum and transverse colon, using chromic catgut for the inner layer and silk interrupted for the outer layer.

#### Operation; Right Hemicolectomy

##### Summary of the Path. Report:

Specimen consisted of twenty centimeters of small bowel, toward one end is a cauliflower heaping up of the mucosa, which on section shows thickening of the muscle, and it looks like chronic ileitis. The underlying glands are enlarged and distal to this pseudo - carcinomatous area the mucosa shows an alligator skin appearance, which extends to two centimeters from the end. Fat extends over the first area, typical of a regional ileitis. The appendix extends up into the base of this, which is probably acccum. The largest involved gland is two centimeters in width.

Microscopic examination of this shows evidence of regional ileitis. The mucosa shows similar irregularity, but there was no evidence of malignancy and lymphnodes are extensively lymphoid hyperplasia with dilation of the lymphatic sinuses and infiltration by many large macrophages, some of which are bi-nucleates forming pseudo-mirror image cells, akin to those Hodgkin's granuloma.

#### Diagnosis: Regional Ileitis

The post-operation course of this young man was progressive and favourable without incident. His temperature subsided and he was allowed to be up and around.

There was steady weight gain and the patient was discharged on October 18th, 1965. He has been seen regularly at the office since his operation. His Hb. on discharge was 9.4 gms %. It is now 13 gms% and his weight is now 146 pounds. His energy is exceptionally good. His sleep pattern is very good; appetite excellent and bowel habits normal. He is asymptomatic as far as his urinary tract is concerned.

This young man is presented as an interesting diagnostic problem. □

# Salmonella Thompson Infection in a Food Handler

JOHN B. WILLISTON, M.D.

*New Glasgow, N. S.*

It all started from a house call to see a 48 years white married female who had had diarrhea and vomiting for 48 hours.

On examination in her home she showed signs of moderate dehydration, slight generalized abdominal tenderness to palpation, and she complained of weakness, headache, aching bones and abdominal crampy pain. She had an elevated temperature - 101.6°F orally.

She was admitted to hospital with a diagnosis of Gastro Enteritis plus dehydration.

That night she was given intra venous fluids and allowed sips of liquids.

She had several stools during the night which were sent for Culture and Sensitivity.

Blood Chemistry in the morning was normal. White blood count was 5,460, Differential: Lymph 48, Seg. 45, Eosinophils 4, Monocytes 2.

The day following admission she was much improved, could take oral feedings and her diarrhea and vomiting ceased. Her temperature was normal.

She was discharged on the fourth day feeling well and anxious to return to her work as waitress in a local restaurant. I felt she should take another week off work and she agreed to do so. Then all the fun began.

The day following her hospital discharge, the Laboratory called to say that two out of three stool samples were positive for Salmonella Thompson. These were sent to Halifax for confirmation and were reported positive.

The Public Health Department get a copy of these reports and I was soon contacted to see how I was going to dispose of the case.

I contacted the patient to tell her of the Laboratory reports and that she could not resume her work as a waitress until the infection was cleared.

Four family members submitted stools for examination and all were positive. These family members were: (1) Father - Age 51 (2) One son - age 19 (3) One son - age 15 (4) one daughter - age 17.

A search of the literature for articles dealing with treatment for Salmonella Thompson disclosed

an excellent article in the B.M.J. where Penbritin had been used with good to excellent results.

They suggested three grams daily for three weeks as an initial course of treatment. For five people this could be 1260 capsules.

The manufacturers were asked if they would supply the capsules for this family and they promptly sent an adequate supply to begin treatment.

Following the three week course of treatment the father, two sons and one daughter all remained negative for Salmonella Thompson for a six month follow up.

The mother was negative for two weeks and then reverted to positive.

The next dose schedule suggested for difficult cures was four grams daily for three weeks. She was placed on this dosage and after two weeks she developed a mild proctitis and generalized urticaria. Both these side effects subsided when the patient was given Benadryl 50 miligrams q.i.d. for five days then stopped.

Following the second course of treatment the patient continued to have positive stools for Salmonella Thompson, so it was decided that Penbritin obviously was not going to work in this instance.

The patient in the meantime was becoming very restless, was anxious to get to work and the Public Health would not permit her to go back to food handling.

She got a job in a laundry and was very unhappy (no tips - which left her hard pressed). After she had been working at the laundry for three months she developed an attack of cholecystitis and a cholecystogram showed a non functioning gall bladder. This was repeated using a double dose of tablets and was reported non functioning. She had no previous history to suggest she had gall bladder disease.

At operation she had a thickened, fibrosed gall bladder and several small stones. At operation cultures were taken from the gall bladder and were negative for Salmonella Thompson.

Following operation the patient submitted several stools which were all negative for Salmonella Thompson. She has remained negative for eight months now and has regained her smile. (She is back with the trays and the tips as a waitress).

In conclusion I would like to make the following observations:

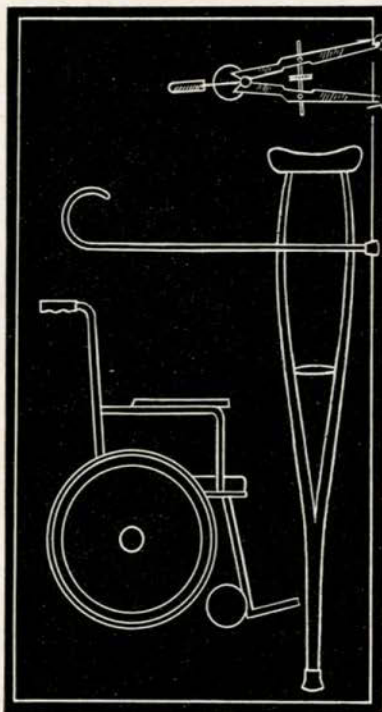
- (1) Cholecystectomy proved very successful in this chronic carrier of Salmonella Thompson.
- (2) Penbritin proved very effective in the other infected members who did not have a concomitant cholecystitis.
- (3) Penbritin in doses as high as four grams per day for three weeks is very well tolerated and the only side reactions in this group were mild proctitis and urticaria which were relieved with Benadryl.

Finally I would like to express once again my thanks to Ayerst & McKenna for their generous supply of Penbritin for this worthy working family. □

## SQUIGGLES, M.D.

One of the least admirable fetishes, so it seems to me, is the medical tradition decreeing that doctors should write illegibly. It is a never-failing source of amazement to my simple mind how the squiggles on many a prescription are ever interpreted correctly. Chemists, I suspect, must be gifted with second sight.

The mystery is why we have all put up with this medical foible for so long. Now, at last, there are the first signs of revolt. The reading of barely-legible prescriptions is part of the study course for pharmaceutical students but students are not so docile as they used to be. One of them complains in print, "A badly written prescription is the work of a selfish and ill-mannered person." □



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# Continuing Medical Education The Practitioners Greatest Problem

PAUL CUDMORE, M.D.<sup>1</sup>

Halifax, N. S.

*This issue of the Bulletin focuses attention on General Practice. General Practitioners as well as all physicians may benefit from this project of the Postgraduate Division of Dalhousie's Faculty of Medicine.*

The rapid growth of scientific information makes medical knowledge and skills soon obsolete. Medical education must be a continuous life long process.

The University is the only organization capable of bridging the gap between the source of new knowledge - research - and its application by the practising physician. (1)%

Dalhousie University with the financial assistance of the W. K. Kellogg Foundation pioneered in continuing medical education when most Universities had still not accepted this responsibility. As a result we have one of the most complete programmes of off-campus teaching to be found anywhere in North America. (2)%

It is in an effort to increase the effectiveness of these off-campus programmes that the Faculty of Medicine Postgraduate Division Executive Committee has authorized a new phase of programme development in the form of a pilot project.

Recognizing that medical education must become a daily activity of the practising physician if he is to keep abreast of developments and with the knowledge that group work is more likely to continue where individual efforts may falter, we concluded that our programme must be directed to the Medical Staff of the community hospital.

## The Pilot Project

We are adapting to our use a method (3)% whereby the medical staff may determine those diseases which are most important within their own hospital. Basically, this involves a review of charts by the medical records librarian to find out the number of cases in a given period in the various diagnostic classifications. Several other factors are then considered such as length of stay, complications developing in hospital, the "treatability" of the illness, socio-economic factors, and from this consideration we arrive at a "Medical Education Importance Index". This is a listing of the conditions treated in a hospital in order of their importance to the staff in developing their

own specific programme of continuing medical education.

The next step is to take the most important diseases and to compare the practice in the community hospital with a standard. Here we propose to develop within the various clinical departments of the Faculty a series of criterion performance lists or simply "check lists" based on the current teaching in the Medical School. This comparison would also be done by the Medical Records librarian as a chart review.

The results of this review will then be studied by the Medical Education Committee who will present the findings to the Medical Staff, not considering the practice of any one member of the staff, but reporting areas of significant difference between the local practice and the standard.

Programmes will then be planned by the Education Committee of the Medical Staff on these findings using primarily the manpower resources of the Staff itself and the Hospital Library. Faculty teachers could be invited at this stage to supplement the staff programme where this was considered helpful.

The stimulation of a continual review of our medical practice brings us one step closer to the ideal of "continuing medical education as a day-to-day, studious way of life". (4)%

In summary, the University is now developing methods and materials for use by the medical staff of community hospitals in determining the educational importance of various medical problems. A method of comparing local practice with a standard is being developed. Educational programmes based on demonstrated problems would then be developed within the hospital.

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<sup>1</sup>Associate Director, Postgraduate Division, Dalhousie University.

## Appreciation

### Mrs. Muriel G. Currie

Many of our members will have noticed with more than passing interest and with sincere regret the passing of Mrs. Muriel G. Currie on April 15th, 1966, in the Eastern King's Memorial Hospital at Wolfville.

Coming to Halifax at the time of the Halifax explosion in 1917 to become secretary of the Massachusetts Relief Commission, she has been associated closely with the medical profession ever since. She was in the Dalhousie Public Health Clinic in one capacity or another from about 1930 until her retirement from Dalhousie in 1947 and after that with the Medical Society until 1960.

She must have noticed many changes in the medical life in her time with us and of these perhaps the greatest is the paper avalanche.

In her earlier years at Dalhousie the late Dr. H. G. Grant was Dean of the Faculty but he was also acting as the Secretary of the Medical Society. Mrs. Currie was his secretary and was fully able to handle both positions and, in addition, to look after the Bulletin. The Editors of course were responsible for the articles and reviews and those features that made it important to us but for many years Mrs. Currie was the one who put it together and saw it through the printers and looked after the details of its production. Furthermore, as there were very few departmental secretaries in those days, a good deal of the departmental work was done by her as well. Now, just think of the

multiplicity of secretaries and the ever present demand for more.

She could only cope with her work by being a most efficient person and by rationing her time rather rigidly. Casual interference with her routine was not well received, but somehow she always found it possible to accomplish a little more if it really was important. Her very dedication to her work made her appear somewhat reserved and she was almost invariably called Mrs. Currie, rather than Muriel. She probably knew or at least had the opportunity to learn more interesting secrets about the members of the Society than anyone else, but one never learned gossip from her.

She was not all business however; she was interested in the Arts and Crafts and at one time was an active weaver and a member of the Weaver's Guild, and she has done considerable interesting leather work. She also has been for years a very enthusiastic stamp collector and has built up a very large and interesting group of stamps. She was one of the early members of the Halifax Business-Professional Women's Society and was very active in that group. Since her retirement in 1960 she has lived in Martin's River and more lately in Wolfville and has kept her active church affiliation. In Halifax it was St. Paul's Anglican and in Wolfville, St. John's.

She was a fine woman and her passing will be a loss to us all.

C.B.W.

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# How Do Practicing Physicians Use New Drugs?

HARRY F. DOWLING, M.D.<sup>1</sup>

Chicago

Geronte: Yes, I have but one daughter; and I would never get over it if she were to die.

SGANARELLE: Do not let her do anything of the kind. She must not die without a prescription of the physician.

Moliere, *The Physician in Spite of Himself*

We laugh at Moliere's humor, yet we recognize the kernel of truth in his quip. Most visits to the doctor do result in the patients' swallowing pills, and what is more, the patients seem to want it that way. As Osler put it, "The desire to take medicine is one feature which distinguishes man. . . from his fellow creatures."<sup>1</sup> Not only are many drugs used, but every drug of significance is prescribed or administered by a physician. Thus, the fruits of the labor of thousands of scientists in laboratories, the mountains of data amassed by these and other investigators, the millions of words spawned by the advertising copywriters, all must be beamed to a single spot - to the brain of the individual physician, who must decide whether or not to give a particular drug to a particular patient. Experts may advise, salesmen may cajole, and patients may plead. But the physician must decide.

This paper therefore looks at the use of new drugs by physicians. And it is fitting and timely that we look at ourselves in this manner. The pharmaceutical industry has been forced to look at itself because the public eye has recently been focused upon it. We physicians should also examine our role in therapy. How well do we choose the drugs we administer? Our self-examination might be based on three questions: (1) How hard is the physician's task? (2) How well does he do it? (3) Can he do it better?

In answer to the question, "How hard is the task of selecting and using drugs properly?" deHaen<sup>2</sup> has reported that 4,562 new products, including 1,050 new dosage forms, were marketed during the past 10 years. Although some of these were duplicate products marketed by different companies and some were compounded products, all had at least two names, a trade name and a public or nonproprietary name, and most also had one or

more chemical names. The physician tries to glean information about these drugs from the 440 medical journals published in the United States, from meetings of medical societies and hospital staffs, from postgraduate courses, from his colleagues, from detail men, and sometimes, in desperation, from *Time* magazine. And yet, when physicians were questioned regarding a drug they had recently prescribed for the first time, 48% stated that they had learned about it from detail men, 20%, from direct-mail advertising; and 8%, from other doctors.<sup>3</sup> Thus, the doctor suffers from an excess of information, much of which is duplication and some of which is biased. He might exclaim, as Thomas Sydenham did two centuries ago: "We are overwhelmed as it is, with an infinite abundance of vaunted medicaments, and here they add a new one."

Under these circumstances it is no wonder that the second question, "How is the physician doing his job in relation to drugs?" can only be answered, "Not as well as he could." Compare the sound and unsound reasons for the use of a new drug given in the Table. Among the unsound reasons, listed in the left-hand column, the most unscientific is suggestion - suggestion derived from a fleeting look at an advertisement, the receipt of a sample in the morning's mail, the chance remark of a colleague in the doctors' lounge. Suggestion, shallow and flighty wanton from the dark alleys of the unconscious, has no place in the sunlight that illuminates our sick beds; yet she often slips in unobserved.

Another unsound reason for prescribing a drug is to use a drug in place of a diagnosis. In such instances physicians do not study their patients carefully in order to make a diagnosis; instead, they prescribe a drug or a succession of drugs in the hope that one of them may cure the patient.

Matthew Arnold said in "The Wish":

Nor bring, to see me cease to live,  
Some doctor full of phrase and fame,  
To shake his sapient head and give  
The ill he cannot cure a name.

<sup>1</sup>Professor and Head, Department of Medicine, University of Illinois College of Medicine, and Chairman, AMA Council on Drugs.

Read in part at the Conference on Evaluation of Therapeutic Agents and Cosmetics at the School of Medicine, University of California at Los Angeles, Aug. 16-18, 1962.

But instead of giving the ill they cannot cure a name, these physicians give the ill they cannot name a drug.

It is unnecessary to explain how reprehensible is this practice and how dangerous its consequences. To use a drug as a therapeutic test in order to help make the proper diagnosis is a justified procedure under certain circumstances, but only in selected cases and when done with meticulous care. This is a far cry from making a habit of treating exclusively on the basis of symptoms. When all the needed laboratory tests are not available, the physician can still establish many diagnoses successfully on the basis of a careful history and a thorough physical examination.

The physician also may prescribe a drug because he is afraid of "not doing anything." Doctors are active men. They chafe under the restraints of taking long histories, doing complete physical examinations, waiting for results of laboratory tests, and poring through the literature to find out what has happened in similar cases. They are restive under inaction; to them inaction smells of defeat. But whereas, as men of action, we know that we must often act before all of the evidence is in, we can all remember times when action taken too soon has led to catastrophe.

Our frenetic society has had its influence on the physician. If automobiles and television sets must be this year's model, if two-button suits are in to-

the news media. Finally, the doctor may fear that if he does not give a new drug that "everyone else is using" he may be liable for malpractice. I shall comment upon this later.

Unfortunately, these spurious reasons, singly or in combination, frequently prompt the practicing physician to give a new drug. Acting against these are the healthy motivations shown in the right-hand column of the table. The rational physician decides to treat his patient on the basis of the disease the patient has, its pathophysiology, its natural history, and the drugs that will combat the disease and how they work. He learns all he can about the absorption, metabolism and excretion of the therapeutic agents he uses. In those cases in which he does not fully understand the mechanism of the drug's action nor know how effective it has been when used in similar cases treated by others, the wise doctor seeks the advice of experts, either through consultation or by reading what they recommend. These procedures are elementary, but how often are they followed?

Also, as shown in the table, a sensible physician is desirous of having his colleagues' approval (and of avoiding this disapproval). The best way to gain this is by understanding what he is doing and by following the example of those who have had more experience with a particular drug. To be "the first by whom the new is tried" may bring momentary satisfaction; it will hardly win lasting respect. Finally, although the wise physician has a healthy fear of malpractice suits, he knows that these are more likely to occur because a wrong diagnosis has been made or because a drug has been used by a physician who is not familiar with it than because a physician fails to give the "latest drug out."

It can be seen that the reasons listed in the right-hand column not only encourage a physician to use a worthwhile drug, but also deter him from using a drug that is not indicated, in spite of pressure from the spurious reasons in the left-hand column. How a physician uses a particular new drug depends on the balance between the two columns; sometimes the balance is tipped one way and sometimes the other. This leads to our third question: How can we improve therapy with drugs, or how can we swing the balance consistently in favor of the right-hand column?

First, it is important that the doctor remain abreast of the latest knowledge concerning the human body and the drugs that act on it. The average life expectancy today of a male physician after he graduates from an American medical school is 44.7 years.<sup>4</sup> If the experience of the past 45 years serves as a guide, hundreds of laboratory tests incorporating newly-learned basic principles will be devised during his life, and 90% of the drugs in the present edition of the *United States Pharmacopoeia* will be replaced. The practicing

#### Reasons for Using a New Drug

Unsound	Sound
1. Suggestion	1. Desire to understand
a. from advertisements and samples	a. the disease to be treated (pathophysiology and natural history)
b. from remarks of colleagues	b. the drug and how it acts
2. Using drugs in place of diagnoses	c. what experts recommend
3. Fear	2. Desire for colleagues' approval
a. of "not doing anything"	3. Fear of malpractice suits
b. of being "behind the times"	
c. of displeasing the patient	
d. of malpractice suits	

morrow and three-button suits went out yesterday, then perhaps medicines become outdated as easily. Thus, there is a tendency for physicians to think that the latest is the best and that failure to use a new drug will stamp them as being irrevocably behind the times. Again, doctors are frequently importuned to prescribe a drug about which they know little or nothing because a patient has heard about it over the radio or over the bridge table or read about it in a newspaper or magazine. If the doctor yields, he is abdicating his position as doctor to his patient and his position as a teacher to



physician should learn the latest findings on the heels of the investigators. But it is more important that he integrate these discoveries into his day-by-day practice of medicine. As the Committee on Professional Education of the American Heart Association so aptly put it:

Undue emphasis has been placed on the goal of "bringing new information to the physician." It is more important to help him cultivate his analytical ability and improve his critical judgment.<sup>5</sup>

On the basis of a study of 88 general practitioners in North Carolina, Peterson and his associates<sup>6</sup> concluded:

The practice which was above average in quality was characterized first of all by evidence of knowledge of clinical medicine. The physician providing a higher grade of medical care showed a real interest in his patients and their medical problems. These provided for him an intellectual challenge. The better doctor also demonstrated an awareness of and a willingness to accept the responsibilities inherent in undertaking the care of a patient. At the opposite extreme, physicians operated on such a superficial plane as to give the appearance of a lack of preparation for assuming these responsibilities.

The principal criticism to be offered of the physicians whose performance appeared to be at the other end of the scale was that they apparently lacked fundamental clinical medical knowledge and skill.

Obviously we should restudy the means available for providing postgraduate medical education in the light of present-day physicians' needs, and we must utilize our resources to make the practicing doctor as competent as he should be if he is to follow the ideals set for him by today's undergraduate medical education. This would be a basic step in improving the prescribing of drugs.

A second step involves the superfluity of information, suggestion, and misinformation that comes to the physician. We might compare the doctor's encounter with drugs to driving a car at night. It is not like driving on a dark road where his headlights will pick out the signs he is looking for. Instead, it resembles driving on a busy city street where the myriad lights of automobiles approaching, receding, and crossing are surrounded by other lights of red, yellow, and blue, steady, bright, or dim. Out of this bewildering array he tries to pick the signal lights of red, amber, and green as they wink on and off to tell him whether he may proceed with safety or whether he invites a disastrous crash if he does not stop. Part of the driver's skill comes in learning to ignore the irrelevant, just as the doctor must ignore nine-tenths of the printed material that comes to his eye. But even with the exercise of this skill, the driver's safety would not be assured unless the most glaring signs were removed and those that obstructed the signal lights

were forbidden. This is also true of advertising. The responsible members of the medical profession do not approve of misleading and suggestive advertising, and it must not be allowed to exist in media over which we have control, such as medical journals and exhibits at medical society meetings. The responsibility for eliminating such advertising is placed on editors and editorial boards and on the elected and appointed officials of medical societies. In other words, practicing physicians, collectively, have the power, if they wish to use it, to eliminate advertising that they consider improper.

Third, the physician must realize that the responsibility for prescribing drugs rests in the last analysis on him. He is in a unique position. Nowhere else that I know of does one person do all the ordering of goods that are delivered to, used, and paid for by another person. The confidence that our patients place in us is a tribute to our profession, but it should, in turn, make us all the more zealous to protect their interests.

Fourth, the physician should explain to patients what drugs he is prescribing and what he expects to accomplish with them. Such explanations serve several purposes: They make the physician keener in his judgments, they ensure more cooperation and better reporting from the patient, they prevent serious untoward reactions, and they protect the physician if untoward reactions occur.

Finally, the physician should let others know about his experience with drugs. The practitioner is not usually in a position to test a drug on a large number of patients with a single disease, so that he is best advised to follow the lead of someone who has made a careful study of the action of the drug in that disease. But the practicing physician can make a significant contribution when he encounters a reaction to a drug. His experience alone may not mean much to him, but the combined experience of many doctors is the best check on the toxicity of a drug. When the physician observes a significant reaction to a drug, he should inform the Council on Drugs of the American Medical Association, which keeps records of untoward reactions and makes reports periodically. He should also inform the manufacturer, who can watch for reports of similar reactions, warn physicians to modify the dose or method of administration, or withdraw the drug from the market if necessary. In addition, the Federal Food and Drug Administration can be notified since they have the power to remove a toxic drug from the market.

In the final analysis, it is the practicing physician who must make the decision whether or not to use a new drug on the particular patient. It is he who must observe carefully every patient whom he treats with any drug, and it is he who must bear the ultimate responsibility for the effects of the drug he has used. □

References on page II.



# Etiology of Upper Respiratory Illness Among Civilian Adults

*Of viruses isolated in 221 upper-respiratory-tract illnesses, rhinoviruses were the most frequently implicated, but fever was most common with infection due to influenza A virus.*

In recent years many newly recognized viruses have been implicated as etiologic agents of acute undifferentiated upper-respiratory-tract illnesses in adults. Of these viruses, the rhino-viruses are apparently the ones most commonly isolated in adults ill with the "common cold."

Approximately 60 antigenically distinct serotypes have been recognized. The agents are associated with between 10 and 30 per cent of these mild illnesses in adults. Parainfluenza viruses and respiratory syncytial virus are associated with a smaller proportion, although they are important causes of bronchiolitis, croup, and pneumonia in children. Adenoviruses and coxsackievirus A-21 account for a minor amount of civilian adult respiratory-tract diseases.

Since there is limited information on the prevalence and relationship to disease of individual rhinovirus serotypes, an investigation was made of the relative frequency of rhinovirus infection and the pattern of occurrence of individual rhinovirus serotypes among civilian adults with minor respiratory-tract illness.

A total of 193 persons, who had 221 illnesses, constituted the study population. All were employees of the National Institutes of Health. Specimens were obtained within six days of onset of illness. Virus isolation was attempted from the nasopharyngeal or throat-swab specimens of all patients. Sera, obtained during acute and convalescent phases of illness, were tested by complement fixation.

## Rhinoviruses Common

Evidence of virus infection was detected either by virus isolation or serologic response or both in 74 (34 per cent) of the 221 illnesses. Rhinoviruses were recovered more commonly than any other group of viruses and were isolated during most months of the study. Seventeen distinct serotypes were identified from among the 40 rhinoviruses recovered. No one serotype predominated. Nine strains could not be identified. All patients from whom an identified rhinovirus was recovered were tested for homologous neutralizing antibody with the prototype strain

of that serotype. In these tests, 22 (55 per cent) of 40 patients from whom a rhinovirus was recovered had a four-fold or greater rise in homologous neutralizing antibody.

The rate of recovery of other viruses varied from 2 per cent to 5 per cent. A single sharp outbreak of influenza A virus infection occurred in January and February 1963. With one exception, influenza A virus was not detected again.

Parainfluenza virus types 1 and 3 infections were detected in 4 per cent and 2 per cent of illnesses, respectively. The majority of parainfluenza 1 infections were detected from November 1962 to January 1963; one additional patient had parainfluenza infection in June 1964. Parainfluenza 3 infections occurred during three different periods of the study.

Herpes virus was recovered from 3 per cent of the patients tested, a sporadic pattern of occurrence being evident. Infections due to respiratory syncytial virus, parainfluenza virus type 2, adenovirus or coxsackievirus A-21 were uncommon.

Only three patients had evidence of infection with two or more agents. Infection with influenza Type B or *Mycoplasma pneumoniae* was not detected.

## Fever Rare

Temperature elevation above 99° F occurred in only 15 (7 per cent) of the patients during the course of illness. Except for influenza A virus, the rate of virus recovery from patients with or without fever was similar. Influenza A virus was recovered significantly more often from persons with febrile illness. Recovery rates for a number of viruses did not vary significantly during the first three to five days of illness.

Influenza A2 virus was epidemic in the United States during the winter of 1963, and, except for one case, all infections with this agent in the study population were detected during January and February 1963. The overall rate of infection with influenza A2 virus was only 5 per cent; however, during January and February 1963, 11 (44 per cent) of 25 patients tested had evidence of infection with this virus. Influenza A infection occurred in all age groups.

Maurice A. Mufson, M.D.; Patricia A. Webb, M.D.; Hilda Kennedy; Virginia Gill; and Robert M. Chanock, M.D. *The Journal of the American Medical Association*, January 3, 1966.

Reprinted from the Abstracts of the National Tuberculosis Association, May 1966.

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## Medicare 1999

### Part I

"George."

"Yes, dear."

"I think I'll not send Susan to school this morning; she doesn't seem well. I'm going to call the doctor. Oh, I forgot. Doctors don't go out on 'calls' now; we have to use the Health Services."

"George, do you remember where you put those forms that the Health Department sent everyone months ago? You know, the ones with the long list of symptoms and signs - the "S-S" form I think it's called?"

"Oh, I remember. It's on the bathroom wall. I've been trying to memorize The Signs and Symptoms during my spare time."

"Get it for me, George, please."

"Thank you, dear."

"Now let me see. I must ask her all these questions and tick off her answers "yes" or "no".

#### *Interval*

"Now, George, take this list down to the corner "Diagnostic Computer" by the mail-box, push it through the slot, and we'll know what to do in no time."

#### *Longer Interval*

"What kept you so long, George?"

"Guess everyone's sick this morning, dear. There was a long queue at the "Diagnostic Computer". However, it says to call the Regional Health Centre, No. 4, and the telephone number is given, too."

#### *Interval of repeated busy signals*

"No. 4 R.H.C. speaking. May I help you?"

"Yes, please. I have an "S and S" form from the "D.C." on my little girl . . . . ."

"Little girl, did you say? How old is she?"

"9, I think."

"Just a minute, please. You want the Pediatric Section."

#### *Coffee Break*

"Mary, ye gods! Come here. Look through the telephone. It looks like the aftermath of a good old-fashioned air-raid."

"Oh, George, don't be silly. That's just the usual Monday sick parade at No. 4, R.H.C. Oh, there's that gay little widow who lives next door; wonder what's wrong with her."

"Hello. Pediatric Department, No. 4, R.H.C. speaking. May I help you?"

"I'm beginning to wonder. . . . ."

"I beg your pardon."

"I mean no, yes, I hope so. You see, I have an "S and S" from the "D.C." on my little girl and. . . . ."

"Is it medical or surgical?"

"Well, I don't know. It doesn't say - but she's sick and. . . . ."

"I'm sorry. If you'd only read the instructions on the "S-S" form you'd save everyone a lot of trouble. Now, take it back to the corner "D.C." and push button "D". This will tell you which department you need; pediatric medicine, pediatric urology, pediatric psychiatry, pediatric dermatology, and so on. This will save us all a great deal of time. Do you understand?"

"Yes, ma'am. Thank you, ma'am."

"George, George, where are you going?"

#### *Interval*

"George, where have you been?"

"Sorry, Mary. I forgot to press button "D" on my first trip to the "D.C."

"What's the "D.C." say now, George?"

"It says: 'call general, No. 4, R.H.C.'"

"Well, call it, George, don't sit staring at the phone."

"Yes, dear."

"No. 4, R.H.C. Speaking. May I help you?"

"Yes, please. I want "general".

"'general' what?" Medicine, Psychiatry, Anthropology?"

"Please, miss, I have a little girl. . . ."

"Well, why didn't you say so? You want "general Pediatrics Female."

"Yes, please, miss."

"I'm sorry. 'General Pediatrics Female' are having lunch. I can disturb them if it's urgent. Is it urgent?"

"No, miss, I guess not."

"George, perhaps an Aspirin?"

"George, I meant for Susan!"

"George!"

## Part II

"I must admit, Mary, these Regional Health Centres of ours are, as we used to say years ago, pretty "snazzy". I like these moveable side walks from the parking area to the front doors, but how does a fellow with a broken leg get aboard?"

"Don't be silly, George. People who can't walk are taken by ambulance around the back, where they are placed on a conveyor belt and conveyed to the "Reception of Unstable Patients" (R.U.P.) area. Here, they glide on to stretchers and go to. . . . Well, they go to. . . . Well, anyway, they go!"

"Mummy, what are those funny things on the outside walls?"

"Those, Susan dear, are elevators for people with claustrophobia."

"What is that, Mummy?"

"That's another department, dear. Now, let's go inside."

"Gad. It's like a Shopping Centre on Friday night."

"George, behave yourself. What does that big sign say?"

"All patients must give their "S-S" form to the appropriate attendant. You will be given a number in exchange. When your number is called, please report to the designated department.

The colour of the attendant's uniform indicates the department to which each is attached:

eg. Medicine:	pink
Surgery:	red
Psychiatry:	gray
Dermatology:	polka dots
Pediatrics:	yellow

"George, see if you can find someone dressed in yellow."

"Pardon me, miss, here's my daughter's S-S form."

"Sir, I am not an attendant. Can't you tell the difference between yellow and mustard?"

"Pardon me, sir, can I help you? Oh, yes, your daughter's "S-S" form. Here's her number, now, just sit down. . . . well, just. . . . well, perhaps you can find a section of the wall to lean against until you're called."

## Interval

"Good afternoon, Doctor."

"Sir, I am not a doctor. I am a certified technician in female medical pediatrics. In this room, Sir, are machines capable of determining the electrical impulses of every organ of your child's body - and if any are out of kilter we will soon know. It has taken six months to master these machines but mastered them I have."

"Now, Susan, up on the table."

"Now, let me show you. I put this little microphone on her head - watch the "graph". Perfect; no nits, no sebaceous cysts, no rashes, no brains - I mean, her brains are normal."

"Now, on her eyes, sinuses, nose, in her ears, mouth, and so on. As long as the graphs are between those two horizontal lines, everything is fine."

"How do you know?"

"Sir?"

"How do you know everything's fine?"

"Sir, I spent six months. . . ."

"Oh, yes. I remember."

"Now, I'll continue with the examination."

"Madam, I'm happy to say there's nothing the matter with your child - the graphs are all perfect. You need go no further. You may take her home."

"But. . . ."

"Next please."

Susan, Susan dear. You mustn't be sick all over the nice man's uniform. Oh, well. Put your microphone in that and see what it says. Come, George."

## Part III

"George."

"Yes, dear."

"Wake up. I've arranged a meeting here tonight of all the families on this street and they'll soon be here."

"What's the meeting about?"

"We're going to ask that nice old Dr. Smith, who retired when medicare came in, to return to practice, just for the people in this neighbourhood."

"We thought he might be willing to look after us in the mornings, and play his golf in the afternoons."

"If we get sick during the night, he could still treat us as he used to - over the telephone."

F.M. □

## Personal Interest Notes

Not often does Dalhousie give two gold medals in any faculty, but to **Dr. Joan Casey**, Halifax, goes this honor which she shares with **Dr. L. William Caines**, Corner Brook, Newfoundland, with whom she struggled for first place throughout their entire medical course, ending up with barely a point's difference in their average over the five years.

Dr. Casey has also won the **Ross Stewart Smith Fellowship in Medical Research** of \$3,400 given to a student who plans to spend at least one year in research at Dalhousie University after graduation.

The second girl in two years to win the medal, won then for the first time by a woman student, Dr. Casey also shared in the prize awarded by St. Rita's Hospital, Sydney and won that presented by the Board of Management of the Children's Hospital, Halifax.

**Dr. Joyce Canfield**, Crapaud, P.E.I. won the Saint John General Hospital prize.

These and the seven other women graduates, the largest number ever to graduate at one time in Medicine from Dalhousie, are just beginning their careers. On the other side of the world, in Korea, **Dr. Florence Murray**, a graduate of Dalhousie in 1929, has "retired" three times - after a career which has included being interned in Japan for six months, a decoration from the King of Denmark, an Honorary B.D. and LL.D., has done a great deal of work in Tuberculosis and Leprosy and is now in charge of medical records in Severance Hos-

pital in Seoul. She is Canada's nominee for the **Elizabeth Blackwell Award** for 1966 which will be presented at the Tenth Congress of the **Medical Women's International Association** which is being held for the first time on this continent in July at Rochester, New York when Canada and the U.S.A. medical women will be the joint hostesses.

At **Mount Allison's** Convocation, an Honorary LL.D. was awarded to **Dr. Martin Hoffman**, who graduated from Mt. Allison, with High Honours in Chemistry, took his M.Sc. at Dalhousie, and later his Ph.D. and MD., C.M. from McGill and later was on the Dalhousie Medical Faculty and medical research specialist at the Victoria General Hospital, Halifax. He later went to McGill and is associated with Allan Memorial Hospital and the Jewish General and Royal Victoria, Hospitals where he has recently been named Chief of the clinical section in the division of endocrinology and metabolism, and attending physician at the Royal Victoria Hospital. He continues as director of the hospital's Fraser Laboratories for research in diabetes. Dr. Hoffman also gave the Convocation address to the graduates.

At **Dalhousie**, an Honorary LL.D. was bestowed on **Dr. Walter MacKenzie**, who graduated in Medicine from Dalhousie in 1933 and is at present Dean of Medicine University of Alberta and President-Elect of the American College of Surgeons. Earlier in the week Dr. MacKenzie, along with

ten other "Illustrious Native Sons" were honoured by the **Rotary Club of Sydney** at a unique banquet and reception at the Isle Royale Hotel at which Rotary President, **Dr. Ken MacLennan** presided. Premier Stanfield welcomed the special guests to the province, Mayor Russel Urquhart extended greetings on behalf of the city of Sydney and from Ottawa came a message from Prime Minister Pearson who said, in part, that he had heard that there are only two kinds of Canadians - Cape Bretoners and those who wish they were Cape Bretoners. Dr. MacKenzie has just finished a two-year term of office as president of the Royal College of Physicians and Surgeons of Canada.

### CAPE BRETON

Cape Breton doctors have called for public support in a campaign to provide the island with improved medical facilities. A committee has been formed by the Cape Breton Medical Society to study the medical needs of the community. Pointing up the dire need is the report from Glace Bay stating that recently all available doctors in the area were summoned to the hospital where they remained for over six hours assisting in an emergency following a mine disaster. With all available men at the institution all offices in the area were without an attending physician.

The 20th anniversary banquet of the **Glace Bay Cancer Unit** was held recently at St. Anne's Family Centre. The principal speaker was **Dr. Alexander C. Wallace**, head of the Department of Pathology of the University of Western Ontario. Other speakers were **Dr. Margaret Gosse**, Halifax, immediate past president of the provincial society and provincial convener of welfare, and **Dr. J. B. Tompkins** of the Bay Medical Clinic. Dr. Tompkins' father, **Dr. M. G. Tompkins** and his mother were also present. Dr. Tompkins senior has been medical adviser to

the Glace Bay unit since its organization as the first such unit in Nova Scotia. Mrs. Tompkins has been one of its most loyal workers.

**Dr. Donald MacKenzie**, a native of Glace Bay was the guest speaker at the seventh annual meeting of the Glace Bay branch of the Canadian Arthritis and Rheumatism Society held early in May. He was introduced by **Dr. Austin MacDonald**, Sydney who later reported for the medical advisory committee of which he is a member.

The Ancient and Accepted Scottish Rite of Freemasonry established a Cape Breton Lodge at a colorful ceremony in Sydney on April 23. **Dr. T. M. Sieniewicz**, Deputy for Canada in the Atlantic Provinces took part in the ceremony.

Early in April **Dr. Deodath T. Maharaj**, who graduated from Dalhousie in 1965, moved into a beautiful new house built for him and Mrs. Maharaj and their two young sons by their friends in Neil's Harbour and surrounding communities. An "Open House" was held and the key presented to the doctor by Mr. MacDonald chairman of the Board of directors of the Buchanan Memorial Hospital.

#### COLCHESTER

Upper Stewiacke: Residents of the Stewiacke Valley met in the community hall at Upper Stewiacke in a farewell to **Dr. and Mrs. Munroe C. Bell** and family. They are moving to their new home in Brookfield after 11 years in this community. Dr. Bell, a graduate of Edinburgh, is on the staff of the Colchester County Hospital.

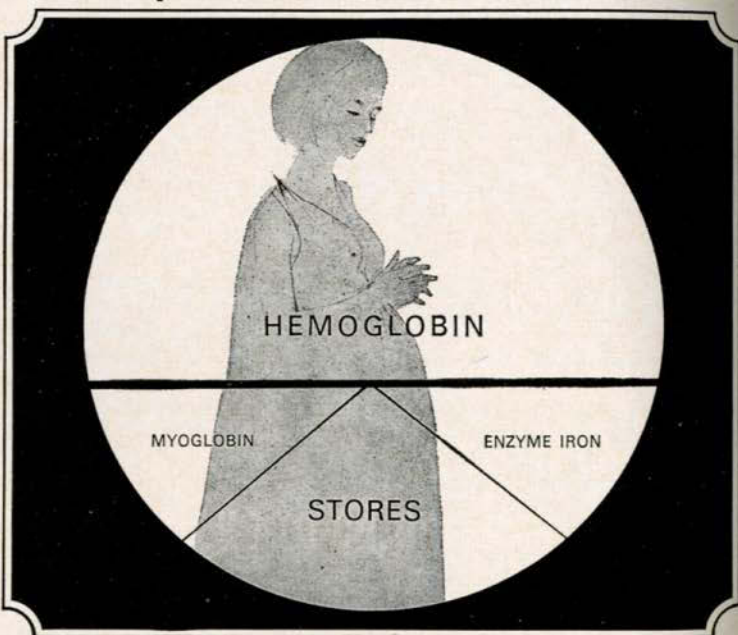
#### UNIVERSITY

A \$25,000 mass spectrometer, an instrument which has probably been a factor in keeping the Russians ahead of the U.S. in certain aspects of the space race will shortly be installed for use in the cardiopulmonary laboratory of which Dr. Cudkowiez is head, as he pursues his research into the

human lung. This instrument can measure almost instantaneously the concentration of oxygen in each breath and until now no such instrument has been used for this purpose in North America. Dr. Cudkowiez is associate professor of Physiology and Medicine (research), and has also been granted \$2000. to continue his studies on the effect of radiation on lung function in patients following surgery for cancer of the breast.

**Drs. C. W. Helleiner and S. D. Wainwright**, of the Department of Biochemistry, have been awarded grants from the Cancer Society totalling \$22,195.00 to enable them to carry on their individual research projects. So too, have **Dr. S. T. Norvell** of the Surgery Department and **Dr. C. E. vanRooyen** of Bacteriology been awarded grants from the same source. In toto the grants amount to \$48,318.00.

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**Dr. William T. Josenhans**, Professor of Physiology, has been granted a research sabbatical to carry out studies in circulatory and respiratory physiology. He will be working in the huge university at Bochum, Germany. Dr. Josenhans is a graduate in Medicine from Tubingen, Germany, and has also been invited to participate in the International Symposium on Physical Activity and Cardiovascular Health in Toronto next fall sponsored by the Canadian Heart Foundation, both as speaker and moderator of other sessions.

**Dr. A. D. Dickson**, at present associate professor of Anatomy at Dalhousie is to be associate professor of Anatomy at the University of Western Ontario. Dr. Dickson is a graduate of Queen's University, Belfast and of Cambridge and taught at Aberdeen before coming to Dalhousie in 1963.

#### ANNOUNCEMENT

Dalhousie University's School of Nursing will offer a two-year course leading to a diploma in Outpost Nursing beginning in September. Miss Ruth May, B.A., R.N., C.M. has been appointed as lecturer in Midwifery and out-post nursing. Miss May, a B.A. of Wellesley, graduated from the Massachusetts General Hospital in Boston and worked in St. Anthony, Labrador, with the Grenfell Association. Realising the great need of a nurse in the north to know midwifery, she obtained her certificate at the Frontier Graduate School of Midwifery in Hyden, Kentucky. Returning to Labrador, she has spent the last eight years in Mary's Harbour overseeing the health and welfare of the 1500 people scattered along the rocky coast. Full details of the requirements for the course may be obtained from the School of Nursing. It is intended to prepare nurses for a career in Canada's northern outposts from the Yukon to Labrador and Newfoundland.

#### VACATIONERS

**Dr. and Mrs. J. R. Greening** and family have returned from a trip to South Carolina.

**Dr. and Mrs. A. J. MacLellan** vacationed in the eastern United States.

**Dr. and Mrs. E. F. Ross** had a motor trip in southern France accompanied by their daughter, Sally, who has been in France for some months.

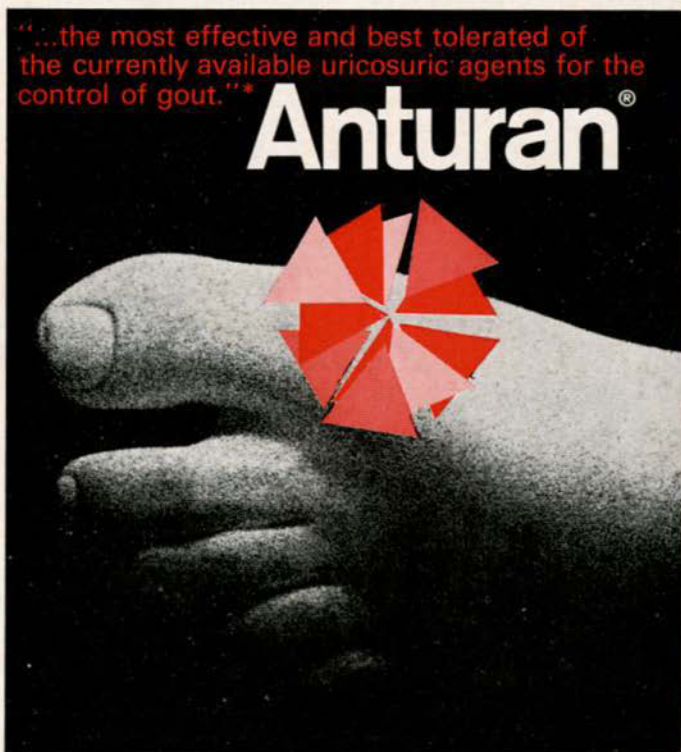
**Dr. and Mrs. Douglas Murray** are going to Labrador in June to make the acquaintance of their new grandson.

**Dr. and Mrs. Frank Bell** recently returned from a vacation in Bermuda.

**Dr. and Mrs. Robert M. Rowter** are just back from a vacation spent in New Jersey and Long Island.

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\*Kuzell, W. C., et al.: "Effect of sulfipyrazone on serum uric acid in gout." Geniatrics 19: 894, 1964.

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## BIRTHS

To **Dr. and Mrs. Grant Matheson**, (née Nancy Rice), a son, John Roderick, on May 8, 1966.

To **Dr. and Mrs. R. A. Ross**, (née Bonnie Murray), a son, Duncan Alexander, at Happy Valley, Goose Bay, Labrador on May 7, 1966.

## OBITUARY

Surgeon Commander **Ralph F. Plumer** died suddenly in Lancaster, N. B. on May 11, 1966. He was born in Woodstock and graduated in Medicine from Dalhousie in 1941. He took up general practice in Glace Bay before joining the R.C.N.V.R. in 1943. In 1948, he transferred to the RCN and has served at various shore establishments including

five years at Cornwallis. In Halifax he was deputy regional supervisor of Atlantic Command before retiring April 28. While with the Navy he did work in Dermatology at the Graduate School of Medicine, Philadelphia. He had taken up an appointment with the Department of Veteran Affairs at Lancaster Hospital on May 1. We extend our sympathy to his wife and son.

**“Doctor Wilson Randolph Strickland** died on February 27th at the age of 42. A native of North Sydney, he attended Acadia University, and graduated from Dalhousie Medical School in 1951. He established a practice in Sydney Mines and lived there until his death. Doctor Strickland is survived by his wife and four daughters.

Dr. Strickland was a man of remarkable qualities, a man who manifested great love for suffering humanity. Kind, gentle and understanding, he ministered to the sick armed with a great sense of humour, which was one of his most valuable tools.

We mourn his loss, but we are grateful for the work that he did, as each day he went forth, “To bend back the brier, that for others edges life's long way”. His philosophy as a Medical Doctor may best be expressed in the quotation from Penn, “I shall pass this life but once. If, therefore, there be any good thing that I can do to my fellow human beings let me do it now. Let me not neglect or defer it, for I shall not pass this way again”.

L. L. McK. □

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