

THE NOVA SCOTIA MEDICAL BULLETIN

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Begging the Question

A wise teacher once told his class of medical students "Don't ask for advice unless you intend to take it". Recently, a questionnaire was mailed out to all members of The Medical Society of Nova Scotia with the object of finding out just what sort of Medical Bulletin the majority of readers would prefer. A third of our busy doctors thought the questionnaire sufficiently important to answer, and a summary of the replies gives a very clear indication of the information our readers require.

Your Editorial Board has made considerable efforts to produce a series of symposia on subjects of current interest, but we find to our chagrin that these only appeal to about 40% of our readers, the remainder apparently preferring to sit down at the end of a busy day to browse over a mixed collection of articles, flavoured with Medical Society news and Personal Interest notes on the activities of their colleagues.

While the majority favoured articles dealing with recent advances, review articles received considerable support. Original work reports, and abstracts, as candidates for election to the field of publication, almost lost their deposits.

There was a unanimous opinion in favour of more articles of interest to general practitioners, with the scales heavily weighted in favour of Pedi-

atrics, Obstetrics, and Gynaecology. Next in the race came Psychiatry, Endocrinology, Cardiology and Chest Disease, closely followed by Neurology and Haematology. Bringing up the rear of the main body were Metabolism, General Surgery and Gastroenterology, while the remainder could only be counted as 'also-rans'.

Individual remarks added to the questionnaire indicated a desire for a leavening of the clinical material with an expanded Personal Interest Notes section, humour along the lines of the 'Willow Tree' feature, and Book Reviews. More letters and opinions on subjects of a Medico-Political nature were suggested, especially on those questions dealing with Medical Society policy.

Your Board has spent many hours and drunk countless cups of coffee while racking their brains for ideas to improve the Bulletin. Now at last, we have the suggestions, and will implement those that require only a simple change of Editorial Policy as soon as the next issue goes to press.

Unfortunately, printers have not yet brought the computer into play, and the process of setting type, checking proofs, making photographs, and putting the Bulletin together takes about two months, so that only now in this October issue, can these policy changes begin to be effective.

There are many suggestions which cannot be put into effect by a simple change of policy, but which require your active cooperation. Your Board would dearly love to see a rip-snorting argument on some Medico-Political problem carried on in its correspondence columns, and have even discussed the possibility of writing letters themselves to stimulate an argument. However, it is quite clear that we cannot argue amongst ourselves indefinitely, and while we are prepared to start an argument, it is up to our readers to continue it. While many of our Society members are prepared to argue with each other during the coffee breaks at medical meetings, in hospital corridors, offices, and on the golf course, it seems that few of them ever get sufficiently hot under the collar to write to the Bulletin about it.

There must be many items of Personal Interest material known to the individuals making up a Branch of the Society, but these can never reach the membership at large unless they are first communicated to the Bulletin for publication.

To ask for more of these items is indeed begging the question: the answer lies with you, the members of The Medical Society of Nova Scotia, to use your pens in offense and defence, in justification, praise or vilification, to make the Medical Bulletin precisely what it should be - your Bulletin. □

I.E.P.

Announcement

The Roberta Bond Nichols Memorial Fund

The Nova Scotia Branch of the Federation of Medical Women of Canada have established a Roberta Bond Nichols Memorial Fund. This fund is entrusted to Dalhousie University Medical School so that the interest from it may be used to provide an annual prize in the form of a book voucher for the woman medical student with the highest standing in Anatomy.

To indicate her active association with the Anatomy Department and to keep her name alive for future medical students the departmental collection of books in the small Conference Room in the Anatomy Department in the Sir Charles Tupper Medical Building is being named "The Dr. Roberta Bond Nichols Collection". The Branch will hang a suitably inscribed framed picture of Dr. Nichols in the Conference Room and are designing book plates for the collection and also one to accompany the prize book voucher.

On September 30th, at 8.30 P.M., a ceremony was held in the Anatomy Conference Room when the prize was presented to the first winner, Miss Mary Edith Donovan, and the picture of Dr. Nichols was unveiled by one of our Federation senior members.

Many doctors in Nova Scotia as well as graduates of Dalhousie Medical School elsewhere will remember Dr. Nichols. Any who wish to contribute to the Memorial Fund may make contributions payable to Dalhousie University marking them for the Roberta Bond Nichols Fund. Contributions from residents of the United States should be made payable to the Dalhousie University Foundation Inc., 350 Park Avenue, New York, 15, N. Y. and similarly marked for the Nichols Fund. Tax exemption receipts will be issued by Dalhousie University.

115th Annual Meeting

The fourth Meeting of the Council of The Medical Society of Nova Scotia and the 115th Annual Meeting of this Society will be held on November 22nd and 23rd, 1968.

The importance of your attendance at these Meetings cannot be overemphasized. The Officers, Executive and certain Committees have been, and are, conducting very vital negotiations with Government on your behalf. It is the responsibility of all Society members to attend in order to become better informed on what the future holds and, perhaps of even greater importance, provide support and guidance for those labouring on your behalf.

For special mention, the 42nd Dalhousie Refresher Course immediately precedes the Society's Annual Meeting, as well as the social events associated with our Meeting.

Your attendance is strongly urged. Be informed, keep the Society strong and enjoy a Pre-Christmas reunion with your many friends.

A. L. Sutherland, M.D.
President
The Medical Society of Nova Scotia.

4th Meeting of the Council
and
115th Annual Meeting
of
The Medical Society of Nova Scotia
(N.S. Division C.M.A.)
Lord Nelson Hotel, Halifax
November 22nd & 23rd, 1968

Please print the name of the hotel or motel in which you wish to have accommodation:

First Choice..... Second Choice.....

Other.....

Date of Arrival:..... Expected Time of Arrival.....

Date of Departure:.....

Room will be occupied by: Name(s).....

Accommodation required: (please check one)

Single..... Double..... Twin..... Suite.....

Signed:-.....

N.B. If attending the Clinical Programme (Refresher Course) as well as the Council and Annual Meeting, please indicate by checking () yes () no.

Complete and forward to:-

The Executive Secretary
The Medical Society of Nova Scotia
Sir Charles Tupper Medical Building
University Avenue
Halifax, N. S.

Additional Note

The 42nd Dalhousie Refresher Course (November 18th - 21st inclusive) is the Clinical Programme of the Annual Meeting of the Society. Eligible expenses resulting from your attendance are allowable deductions for Income Tax purposes.

If you are planning to attend both functions please so indicate above.

Joint Registration for both Meetings will be available at the Refresher Course.

42nd Dalhousie Refresher Course

November 18th to 21st, Inclusive, 1968

Chairman: - Dr. J. F. Filbee

Special Visitors

Dr. Ricardo Ceballos
Associate Professor of Pathology
University of Alabama

Dr. S. Leon Israel
Director, Department of Obstetrics & Gynaecology
University of Pennsylvania
who will deliver the John Stewart Memorial Lecture on the subject: -

"The Epidemiology of Infertility
The Barren Couple in a World of Conception Control"

PROGRAMME

MONDAY

- 0830 - Registration - S. C. Tupper Bldg.
- 0900 - Videotape Clinic - S. C. Tupper Bldg.
- 1030 - Coffee
- 1100 - Lecture - "Hard Facts and Soft Bones"
- 1215 - Luncheon - Faculty Lounge - Tupper Bldg.
- 1400 - Small Group Clinics - V.G.H. and Children's Hospital

TUESDAY

- 0830 - Registration - Tupper Bldg.
- 0900 - Small Group Clinic - V. G. Hospital
- 1230 - Socratic Luncheon - V.G. Hospital
- 1400 - Small Group Clinic - V.G. Hospital, Children's, and Graec
- 1600 - Clinico-Pathology Conference, S.C. Tupper Bldg.

WEDNESDAY

- 0900 - Small Group Clinics - Children's Hosp., and Camp Hill Hospital
- 1230 - Socratic Luncheons - Camp Hill
- 1400 - John Stewart Lecture - Tupper Bldg.
- 1515 - Coffee
- 1530 - Small Group Clinics

THURSDAY

- 0900 - Small Group Clinics - a panel on Sex Education - Halifax Infirmary
- 1230 - Socratic Luncheon - Infirmary
- 1400 - Case Presentations (G.P.) Tupper Building
- 1515 - Coffee
- 1530 - Conjoint Sessions with N. S. Medical Society

Associated Meetings: Friday and Saturday, (Nov. 15, 16) Section of Pathology of The Medical Society of Nova Scotia.
Monday and Tuesday, N. S. Ophthalmological and Otolaryngological conference.
Tuesday, Dalhousie Medical Alumni.
Friday and Saturday, 115th Annual Meeting of The Medical Society of Nova Scotia.

Registration

Joint registration at the Dalhousie Refresher Course is available for those attending the Clinical Programme, the 4th Meeting of Council and the 115th Annual Meeting of the Medical Society.

Registration will also be available for the Meeting of Council and the Annual Meeting in the Lord Nelson Hotel.

Friday, November 22 0830

Saturday, November 23 0830

The Prosthetic Services Centre

R. E. LEMOINE, REGIONAL SUPERINTENDENT

Halifax, N. S.

The Prosthetic Services Centre is operated by the Department of National Health and Welfare and is located in a modern brick building adjacent to the east wing of Camp Hill Hospital in Halifax. Here, upper and lower extremity prostheses, orthoses, and orthopaedic footwear are fitted, constructed, and repaired, using the latest methods, materials, and equipment. The centre is supported by a central establishment at Sunnybrook Hospital in Toronto containing development and training facilities, expansive material and component stores, a complete factory operation and an accounting unit. There are 12 regional centres located across Canada in provinces where the service has been requested.

Any physician may refer a patient directly to the Centre and the main requirements as far as the practitioner is concerned are that the appliance is properly prescribed and the patient is in sufficiently good health to wear a prosthesis or orthosis. If the physician has any doubts concerning his prescription he may either consult or refer the patient to an orthopedist, physiatrist, or a practitioner who has had considerable experience in the prosthetic and orthotic field. It would also be prudent to ascertain if the patient can arrange for a sponsor or be prepared to personally accept responsibility for the necessary expenses. Charges for service are based on a self-supporting but non-profit operation.



A view of the assembly shop. Note at the bench in the centre of the picture a Canadian hip disarticulation and a BK prosthesis ready for final fit and a BK socket with adjustable jig ready for the first fitting. On the bench in the right foreground is a child's patella tendon bearing appliance ready for finishing.

These centres were formerly operated by the Department of Veterans Affairs but the function was taken over by the Department of National Health and Welfare by an order in council in April 1965 in order to fulfill the acute requirement for non-veteran patients. At present the Halifax centre serves children and adults, of either sex, residing in the Nova Scotia and Prince Edward Island area.

The major sponsoring agencies are the Department of Veterans Affairs, Workmen's Compensation Board, and Nova Scotia Rehabilitation Centre. Others, such as The Crippled Children's Association, War Amps Association, Canadian Legion, Paraplegic Association, Red Cross, service clubs and the various municipal and provincial welfare agencies may also assist with payment for an appliance, travelling expenses, or accommodation, none of which are provided by the Centre itself.



A view of the plaster room showing a patient being prepared for the VAPC casting jig. On the bench at left is a BK cast ready for modification and a BE arm cast.



A 19 year old female AK amputee successfully wearing a total contact quadrilateral suction socket prosthesis following an immediate post-operative fitting.



A view of the male fitting room showing a patient, at left, walking a suction socket prosthesis during the initial fitting while the patient in the rails, at right, is being checked out at the final fit for a standard below knee prosthesis.

Trained Prosthetist-orthotists are available for area clinics or to prepare immediate post-operative prostheses. Inquiries may be addressed to the Superintendent, Prosthetic Services Centre, Camp Hill Hospital, Halifax, N. S., Tel 423-1371 Loc 325 and interested physicians or other members of the para-medical team are welcome to visit the Centre at any time. □

Social Work in the Health Setting

PAULINE C. MACDONALD, M Sc (Sec. Admin.) ACSW, RSW,*

Halifax, N. S.

HISTORICAL

In October, 1905 two Boston Hospitals hired social workers on successive days, quite independently and with no knowledge of the others' activities. The Berkeley Infirmary employed one social worker and the Massachusetts General Hospital Out-Patient Department two, one to work in Medical Clinics and the other in the Neurology Clinic. This development was soon followed by other medical centres, Presbyterian Hospital, New York and Johns Hopkins' Hospital, Baltimore, in 1907, representing a growing feeling that social factors are an important part of disease and its treatment. The role of the social worker as seen by these hospitals, was assistance to the physician in diagnosis and treatment through study of the patient in his social situation and by interpreting the patient and his environment to the physician. In addition the social worker was to assist by organizing resources, in the hospital as well as the patient's family and community at large, for making treatment effective.

Forerunners of this development extended back to the services provided for the after care of the insane, to the early efforts of Dr. Lindpainter of the Eberbach Asylum, Germany, in 1829 and Dr. Falret who founded the "Societe de Patronage" in France, in 1841. In England two similar societies were organized, a "Guide of Friends of the Infirm in Mind" and a "Society for the After Care of Poor Persons Discharged Recovered from Insane Asylums". Several decades passed until the "hospital lady almoner" was introduced into the Royal Free Hospital, London, England in 1891. The final impetus to the birth of social work in the health field came from Dr. Osler of Johns Hopkins who assigned medical students to field work in social agencies as early as 1902. He saw the necessity for medical students to see and understand the connection between bodily ills and home environment, as they observed how the poor man lived, worked and thought, and the community resources which might be used to assist him.

Hospital social work came to the Canadian scene at the end of World War I with the setting up of a Department of Social Service in the Montreal Gen-

eral Hospital. From there, departments have developed to the east and west until, at the end of 1965, 190 or 14% of the 1,337 general hospitals in Canada, associated with the Canadian Hospital Association, had Social Service Departments. This contrasts favourably with the United States figure of 16.66% for American hospitals. It should be noted that the Canadian statistics do not include any specialized hospitals such as Veterans, Mental or Tuberculosis Hospitals nor do they include social workers in medical or health centres outside hospitals such as community clinics or medical schools.

A quarter of a century more elapsed before hospitals in Nova Scotia introduced social workers to the treatment team. Camp Hill Hospital in Halifax first employed a medical social worker just after the conclusion of World War II. In 1949, the Victoria General became the first general hospital in Nova Scotia to employ social workers. Between 1949 and 1966 the Nova Scotia Hospital, Dartmouth, the Halifax Children's Hospital, The Nova Scotia Sanatorium, Kentville, Grace Maternity Hospital, Halifax, the Halifax Infirmary and St. Martha's Hospital, Antigonish, have employed social workers. The Windsor Hospital has contracted with the Hants County Family and Children's Service to provide social service for its patients. During 1967, the Nova Scotia Rehabilitation Centre, Halifax, has employed a full time social worker. The Halifax City Hospital, the Fisherman's Memorial Hospital, Lunenburg and Yarmouth Regional Hospital have each employed a social worker on a part-time basis.

While social service in Nova Scotia hospitals developed later than in most other Canadian provinces, the timing was an important impetus for rapid development of competent professional services. For it was in the early 1940's that the role of social work in the medical setting became clearly outlined and social work as a profession was able to define a body of knowledge as its own. Nova Scotia has been fortunate that her hospital social service began to develop during this period of intensive movement toward full professionalism in social work.

*Director of Social Services, Victoria General Hospital, Halifax, N. S.

Functions of the Social Worker in a Health Setting

The primary focus of the social worker is the social needs of individual patients who are receiving medical care in a hospital or clinical setting. In addition, the social worker will be concerned with the social and health needs of the patient's family, of groups of patients, of the community in which the patient lives, within the context of these social and/or health problems which may interfere with the patient achieving, following illness, the maximum degree of health possible.

This necessitates an *understanding of the natural history of the disease process*, for social diagnosis and treatment plans for the individual and in the application of research efforts which is a growing concern for social workers in health settings. Then there must be concern for the *consequences the illness will have to the social functioning of the individual patient*, and for his family and for the personal and social variables that influence adaptation to illness. Here the social worker uses social case work or social group work method as her contribution to the health team's treatment of the patient.

The social worker is concerned about *health planning* with the patient to help the individual alter unhealthy aspects of his environment, to prevent recurrence of illness, and to maintain the maximum possible level of recovery, or to enable the patient to function in his social setting despite irremediable disability or handicap. In the process of health planning a multiplicity of community resources may be mobilized, or created if necessary, to enable the patient to achieve the maximum level of rehabilitation possible for him.

Equally important in the health setting is the teaching function, of social work students, directed to medical students in hospitals affiliated with medical schools, to student nurses and to students of other disciplines represented on the treatment team. It is interesting that medical schools have broadened their scope significantly in the past decade, in that increasing numbers of them, particularly in the U.S.A., are appointing social workers to faculty positions with specific teaching responsibilities in the medical educational process.

A growing role of social workers who have specialized in the medical field is consultation with public health nurses and with district health units in both training and consulting capacities, as well as to municipal public welfare departments, on the social components of illness.

Specifically, we may say that the competence which the social worker brings to the health setting is the ability and skill to make an authoritative definition of the social situation of the patient. This necessitates skill, experience and judgment, to lo-

cate the significant data relating to relationship patterns in the home, job, and social context; weighing the patient's and family's ability to deal with stress, financial resources and liabilities, attitude to and understanding of his illness. The significant factor here, if the social worker is to contribute to the doctor's understanding of his patient and the treatment plan the physician will develop, is the social worker's ability to weigh the social data and put it in a perspective helpful to the physician.

Closely associated with this is the skill to identify social and psychological factors in the natural history of the patient's illness which will require modification or change in an adequate treatment plan for the patient. This area is of particular importance in the treatment of long term illness or disability where social and emotional factors are key aspects in both treatment and patient adjustment upon which may depend the success or failure of a long term treatment plan.

The social worker tends to be the member of the treatment team who selects the method of intervention in the situation which will be most helpful to the patient and most successfully modify the social and psychological factors. This may be with the patient himself, by working with his relatives or by using community welfare or health resources for services deemed appropriate.

The social worker's function should be as a member of the treatment team where joint discussion and evaluation occurs with the physician and other team members. This may occur on a formal basis during chart rounds but more frequently will be through informal contact.

Once the team has evaluated an integrated treatment program for a patient, the social worker assumes responsibility for carrying out those aspects of it within the competence of the social worker and maintains continual communication with the other team members caring for the patient.

Much of the social work is carried out by means of interviews during which the social worker develops ongoing relationships with the patient and members of his family. Increasingly social group work is also being used in health settings with extremely productive results. The media of choice depend upon the needs of the specific patients, the social goals to be achieved, and the skill and training of the social worker.

A most helpful component of the social worker's job performance is home visiting. Here one is able to review the situation and problem areas, which frequently innumerable interviews or group sessions will not reveal. The home visit to the patient's normal social setting is an aspect which is sometimes discouraged or by-passed, because of the time involved. Nonetheless, it provides the physician, particularly in a busy hospital, with data otherwise unavailable and can assist in unravelling many a diagnostic puzzle.

Professional Training

The quality and value of social service depend upon the caliber of the social work staff. Professional knowledge, skill, and adaptability are basic requirements. Basic professional qualification requires two years of professional education in a Graduate School of Social Work, after the Bachelor's degree, the academic standard then achieved is the Master degree in Social Work. Beyond this level, advanced qualification can be achieved by a third year of graduate training and further graduate years leading to the Doctorate degree in social work.

What of the Future?

Today the role of the hospital is changing. In the next several decades probably some of the greatest advances in medicine since this century began will occur. It can be anticipated that this will change the role of the hospital from an institution whose primary concern is treatment to one which has, at least, an equal concern for treatment and prevention. As prevention, at all levels, becomes a more important aspect of medical care it will become more important to know as much about the man who has the disease as it is to know about the disease.

If clinical medicine moves in this direction, it can be anticipated that social service will move with it and be catapulted into new responsibilities in the medical team's care of the patient. Increasingly, emphasis will be put on rehabilitation of the patient to a productive place in society. This direction will extend social service to all patients receiving medical care and result in opportunities for more "non-indigent" patients to receive social service.

Concentration on prevention and rehabilitation will move social workers outside the hospital's walls and necessitate greater emphasis, by this team member, on community work, to prepare the environment for the patient's return.

The movement of social workers, with a health focus into medical health units, public health offices and departments can be expected to increase, as is now occurring in some areas of the United States. Graduate Schools of Social Work can be anticipated to incorporate in graduate programs an increasing content of public health concepts. This will equip the social workers of the future both in hospital and community, to move ahead as competent members of the medical team of the future, concerned at least equally with clinical and preventative medicine. □



Most people understand the feeling of helping one's neighbour when trouble and sickness strike. And so they help in various ways, among them through our united appeals and community chests. Show you understand and care, too, by supporting the united campaign in our community. Give to help the sick, the handicapped, the troubled, and give generously.

We don't have to know the many people we help through our gift to the united fund. Knowing that we are helping, wisely and well, that is enough.

**HELP THE UNITED
WAY
GIVE GENEROUSLY**



MEDICAL-LEGAL ENQUIRIES

IAN MAXWELL, M.B., Ch.B.

RESPONSIBILITY FOR THE ACTS OF ANOTHER PART II

PARAMEDICAL PERSONNEL

C. NURSES

Q: "Nurses frequently refuse to carry out a doctor's orders and pass on the administration of drugs to interns. Any competent person can give an intramuscular injection - the fact that side effects may occur is not her responsibility.

A: In its position of **respondeat superior** the hospital is directly accountable for the actions of ward personnel, as is the private non-salaried physician for his own orders. For example, if the physician were to make an error in a written order and the common standard of nursing would not require that she realize that it was a mistake, successful suit might be brought against the doctor himself, but not against either the hospital or the nurse. On the other hand, if the order were such that the nurse should realize that it was wrong - such as 8 grains of morphine - she would be required to refuse to carry it out even if the doctor were insistent.

With increasing complexity of medicine the team approach has of necessity evolved. Many tasks that previously could only be performed by physicians are now being undertaken by paramedical personnel. The development of intensive care units will be impossible unless nurses with special training and skills are available. These persons will have to shoulder extra responsibilities. In such cases it may be that specially trained nurses like these will be considered under the law in the same category as are operating room staff; that is, that they will be under the direct responsibility of the physician in charge following the "borrowed servant" doctrine. In this case, though nominally agents of the hospital, they will be loaned in law to the attending private physician and the hospital will not be accountable to the patient for their actions while so loaned, though it may have to account to the doctor if it has misled him regarding their training or competence.

* * * * *

D. PHARMACY

Q: "If a physician makes an inadvertent error in a prescription and the pharmacist fills it without question, who may be held responsible at law for the error?"

A: A pharmacist is required by law, in the first place to possess a reasonable and ordinary degree of knowledge and skill with respect to the pharmaceutical duties which he professes to be competent to perform. In the second place the law imposes upon him the obligation to exercise all reasonable and ordinary care and prudence in applying his knowledge and skill in compounding medicine, filling prescriptions, and performing all the other duties of an apothecary. Ordinary care with reference to the business of a pharmacist must, therefore, be held to signify the highest practicable degree of prudence, thoughtfulness, and vigilance, and the most exact and reliable safeguards consistent with the reasonable conduct of the business.¹ If, therefore, the pharmacist fills a prescription according to its terms, ordinarily he is not responsible if it fails to cure or even does harm to the person taking it. Cases, however, may arise where a pharmacist is under special duty to guard the patient from harm. Where unusual circumstances show that the physician who wrote the prescription could not have been aware of the dangerous nature of the ingredients prescribed, a duty rests upon the pharmacist to refuse to fill the prescription. In practice what usually happens is that the pharmacist immediately contacts the prescriber to explain that the prescription as written constitutes an overdose or underdose, a therapeutic or physical incompatibility, or even that the patient has an allergy of which the prescriber may not have been aware. The prescriber, having been contacted by the pharmacist, will either give a satisfactory explanation for the prescription as written, or verbally instruct the pharmacist to change the order to comply with his original intent in writing the prescription. For a pharmacist to fail in this duty would constitute negligence.

Q "I am a pharmacist. One of my chief problems is that doctors almost invariably order medications by brand name and that each doctor favours a different brand. If I were to stock all these drugs, I should be unable to move. May I substitute one brand for another?"

A This is a very common problem. Many hospitals have solved it, in part at least, by instituting a formulary system whereby all prescription medication orders are dispensed by generic name even when prescribed by a brand name. Under such a system the members of the medical staff implicitly agree to this substitution, and unless the physician indicates a special exception, the pharmacist is at liberty to make a substitution. On the other hand, if there has been no previous consent to the policy by the medical staff, the pharmacist is professionally and morally duty bound to honour the prescriber's wishes as to brand.²

A variation of the "generic-versus-brand-name" problem arises where a brand name used in a foreign country is prescribed. This may or may not be available under a different trade name domestically. In the case where for practical reasons there is no brand or generic preparation immediately available, the prescriber must be so informed by the pharmacist. The onus for prescribing a therapeutic equivalent then rests with the prescriber, and the pharmacist is spared the charge of substitution.

References

1. Martin, E. W. and Cook, E. F. (Editors): *Remington's Practice of Pharmacy*, 12th Edition. Easton, Pa.: Mack Publishing Co., 1961.
2. Hassan, William E., Jr. *Hospital Pharmacy*, 2nd Edition. Philadelphia, Pa.: Lea & Febiger, 1960

Acknowledgement: To Mr. James Ferguson, Registered Pharmacist for assistance in answering the question concerning pharmaceutical law.

I.M.

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

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

INTEGRITY . . .

IMPARTIALITY

HUMAN UNDERSTANDING

AND EXPERIENCE

IN ADMINISTERING FAMILY ESTATES

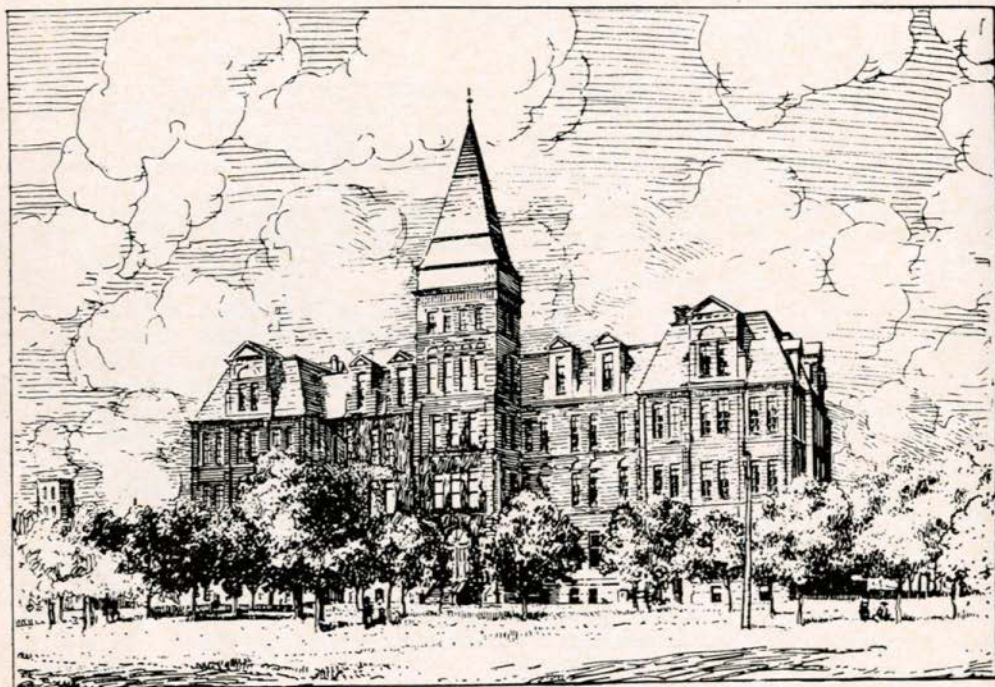


ROYAL TRUST

CANADA'S LEADING EXECUTOR AND TRUSTEE

Serving Nova Scotians for 60 Years

One Hundred Years Ago



FORREST BUILDING — THE SECOND DALHOUSIE

Erected 1887 on Carleton Street.

Extract from the Minutes of The Faculty of Medicine, Dalhousie University, 1868.

The Dean also reported the Receipt of a Communication from J. C. Dalton, M.D. Secretary of Faculty of College of Physicians and Surgeons recognizing our session as equivalent to the attendance upon one of their spring courses or six months study with a preceptor.

The Dean also reported that he in concert with Professor Lawson drew up a circular or Annual Announcement and an advertisement each of which were submitted to the individual members of the Faculty and the Chief of Justice before being published and accepted by all.

The advertisement was only inserted in the Colonist Express and Chronicle - \$4 being the amount given to each.

The Chief Justice announced through the Dean that the College had voted (\$30) thirty dollars toward advertising and could not do more owing to the state of their finances. □

Erythema Nodosum*

H. M. HOLDEN, MD, AND J. E. HILTZ, MD

Nova Scotia Sanatorium, Kentville, N. S.

Erythema nodosum is a relatively rare skin condition that may serve as a manifestation of recent tuberculous infection. Interest in this condition has been renewed of late owing to the fact that in recent months there have been admitted to the Nova Scotia Sanatorium seven young patients in whom erythema nodosum was one of the presenting symptoms.

Unlike chicken-pox, measles and other more common skin diseases, erythema nodosum is not an entity in itself, but is rather a manifestation of some underlying condition. In these seven recent cases, there was little difficulty in making a diagnosis, as all were associated with a new tuberculous infection during an epidemic in southwestern Nova Scotia. The situation, however, is not always so straightforward and the diagnosis of the underlying disease state may present considerable difficulty. Indeed, initially rheumatic fever was thought to be the etiological factor in two of these seven cases.

The term erythema nodosum, first used in 1798, was derived from the Greek work "erythema" meaning "flush", and the Latin word "nodus" meaning "knot". The French term for the condition is "erythème noueux".

There are a number of skin conditions which are classified as erythemata. In these the flush or redness results from an increased blood supply to the involved area as a result of a vascular disturbance. The redness disappears under pressure and returns when the pressure is removed. At times the erythema will progress from a stage of swelling to the formation of blister-like areas and in some instances seepage will occur as a result of the escape of serum from the dilated vessels.

In erythema nodosum, however, the eruption consists of reddened nodules which do not progress through these various stages. These nodules characteristically occur over the front of the legs between the knee and the ankle, and also on the back of the forearms between wrist and elbow. Less frequently, the nodules will be found in other locations. They may vary in diameter from 2 or 3 mms to 4 or 5 cms. Sometimes only three or four nodules may be present, while at other times there may be many more. In some instances, a group of nodules may coalesce, thereby presenting an extensive area of involvement. Reddish in colour at the onset, the nodules gradually undergo colour changes,

through purple shades, to duller shades of blue and green, and ultimately develop the brownish colour of a bruise or contusion. Another name for the condition has been dermatitis contusiformis on account of this final resemblance to a bruise or contusion.

The nodules may be extremely tender to touch, so much so that even the weight of the bed clothes may be painful. However, they are not itchy and drainage does not occur. In two to six weeks, the skin will have returned to normal apart from occasional brownish pigmented areas that may remain.

Occasionally, the joints may be somewhat swollen and painful at the time of the eruption and, very rarely, there may be soreness of the eyes. Usually, the eruption is preceded or accompanied by fever, appetite loss, general malaise and sometimes by chills or sore throat.

In individual instances, there have been successive crops of nodules, or even a recurrence many years following the original attack. In the majority of patients there is but a single episode.

When a biopsy is carried out, microscopic examination of an involved area will reveal dilatation of the blood vessels together with characteristic groupings of inflammatory cells into granulomatous formations. Sporadic reports through the years have mentioned the isolation of tubercle bacilli from the lesions but this finding has never been substantiated.

Primarily a disease of adolescence, the condition is more common in the female sex. Before adolescence, it occurs with equal frequency in both sexes. There is a seasonal incidence as it is most common in December and January, and also early spring.

When presented with a case of erythema nodosum, the physician must immediately carry out certain diagnostic procedures in order to determine the underlying cause. Not only can erythema nodosum be initiated by disease processes but also by noninfectious agents. It may be a sign of active tuberculosis or, in other instances, it may be attributable to rheumatic fever, a streptococcal infection, a fungus infection, or even a rare condition such as leprosy. It may result from toxicity to a drug such as one of the sulphonamides, particularly sulphathiazole, or to bromides or iodides.

Necessary diagnostic procedures may include any of the following:

*Presented to the Valley Chapter of the Nova Scotia Institute of Science, Kentville, Nova Scotia, March 6, 1967.

- (1) A tuberculin test to determine the presence or absence of tuberculous infection in the body.
- (2) Examination of the sputum or, if necessary, the performance of gastric lavages in a search for tubercle bacilli.
- (3) A chest x-ray film to determine whether there is any evidence of tuberculosis or some other underlying chest condition.
- (4) Serial complement fixation and appropriate skin tests in order to rule out the presence of a possible fungus infection such as coccidioidomycosis or histoplasmosis.
- (5) Estimation of the blood content of bromides or iodides if toxicity from these drugs is suspected.
- (6) A test dose of a suspected drug to see whether or not the condition is aggravated.
- (7) A search of the blood for L.E. cells which are present in lupus erythematosus, a condition which may be confused with erythema nodosum.
- (8) Blood protein studies, which may be abnormal, if the case be one of sarcoidosis.
- (9) A Kveim test to rule out the presence of sarcoidosis.
- (10) Serological tests for syphilis.
- (11) Examination of the stools for parasites which, in rare instances, could be responsible.
- (12) Skin tests for leprosy and cat scratch disease.
- (13) Complement fixation test for psittacosis.

In addition to the confirmatory laboratory tests listed above, a careful clinical history and physical examination will often provide clear-cut and definite indications of the nature of the specific underlying condition.

At the Nova Scotia Sanatorium between 1940 and 1950 there were 20 patients admitted with a history of erythema nodosum, in all instances associated with tuberculous infection.

Since 1950, only eleven further cases have been admitted. The first four of these arrived in 1952, 1956, 1963, and 1964 respectively. The last seven were admitted in January and February 1967. In most of these patients, the eruption was preceded by symptoms of an upper respiratory infection with head cold or cough, fever, and sore throat. In some instances, the fever was very high. The tuberculin test was positive in all eleven patients and abnormalities were present in the chest films of nine of them at the time of admission. In two, the appearance of the lung lesion was delayed until a few weeks after the eruption.

The sedimentation rate showed considerable elevation in all eleven cases and the white count was elevated in four out of nine. Sputum examination revealed tubercle bacilli in six of the eleven cases. In all instances, the rash subsided within a few days of the onset and there was no evidence of recurrence of it.

Nine of the eleven patients were female and ranged in age from 7 to 18 years. The two male patients were aged 14 years.

Had the tuberculin test been negative, and had some of the more recent cases not been associated with an epidemic of tuberculosis, diagnosis would not have been so clear-cut. In fact, as already mentioned, in two instances a diagnosis of suspected rheumatic fever was made by the family physician and one of these patients was treated first in a general hospital for 43 days with this tentative diagnosis.

This was not surprising, as rheumatic fever is probably the second commonest cause of erythema nodosum in this country. The incidence of acute rheumatic fever is low in this part of Canada but it is still a relatively common affliction in certain areas of the country. When the erythema nodosum is due to rheumatic fever the tuberculin test may be negative but not necessarily so. In addition to the joint involvement in rheumatic fever, one might find evidence of involvement of the heart but differentiation is much more difficult when the tuberculin test is positive.

One of the seven children recently admitted to the Nova Scotia Sanatorium was treated for a streptococcal throat shortly prior to the development of the eruption. Streptococcal infection may also cause erythema nodosum. In such instances, the throat culture should reveal a growth of hemolytic streptococci and the rash would have developed about a week after the onset of the original illness. One of the diagnostic difficulties derives from the fact that a streptococcal infection may precede the onset of rheumatic fever and it may be difficult to distinguish between these two etiological conditions.

Other tests will aid the diagnosis in certain circumstances. For example, in a native of California, coccidioidomycosis might be the etiological condition and, if so, a specific skin test using coccidioidin would be positive and the complement fixation test might be diagnostic.

Sarcoidosis in some series of cases has been associated with erythema nodosum. The blood protein studies, a Kveim skin test, and glandular tissue biopsy would help to determine the presence or absence of this condition.

The association of erythema nodosum with the onset of tuberculous infection has been recognized for many years. However, this has been recorded most commonly from the Scandinavian countries where, indeed, the eruption has been reported as the

exanthem of primary infection because it is seen so often in that area of the world as the original manifestation of first infection tuberculosis. Wallgren, an authority on tuberculosis of children and a native of Sweden, has written extensively concerning this matter. He estimates that tuberculous infection is the etiological factor in 90 per cent of cases of erythema nodosum in the Scandinavian countries, as compared with approximately 70 per cent in England and a much lower incidence in the United States. Children with erythema nodosum in Scandinavia were found to have a much higher incidence of positive tuberculin tests than other children. In addition, the majority of these children presented signs of active tuberculosis; 90 per cent of these children showed active tuberculosis as compared with 5 per cent of those in whom a positive tuberculin test alone was present. In other words, the children with erythema nodosum and a positive tuberculin test nearly all exhibited active tuberculous disease as determined by x-ray examination. Many of these children also had tubercle bacilli isolated from their sputum.

The tuberculin test does not become positive until approximately three to twelve weeks following infection by the tubercle bacillus, and it is at the time of developing allergy that erythema nodosum usually occurs. The erythema is an allergic manifestation and, as a general rule, the tuberculin sensitivity is at its maximum at the time of the eruption. Certainly, one can be reasonably sure that infection occurred recently and it should be an aid in the detection of the original source of the infection, as one can estimate the approximate date of entry of bacilli into the body.

It is interesting to speculate on the relatively high incidence of erythema nodosum in the recent Nova Scotian outbreak. As noted above, only four such cases had been admitted to the institution between 1950 and 1966. Now seven new cases have been added to the list and others have been reported among the tuberculin converters in the same locality. No doubt this relatively high incidence is largely accounted for by the fact that approximately 250 children experienced a relatively recent tuberculous infection, they were in the age group

where erythema nodosum is most common, many of them were females and, in addition, the season of the year was propitious to its onset. As mentioned previously, it is commonest in winter and early spring. A relatively large number of these have been afflicted with this cutaneous eruption, as compared with the tuberculosis population in general. One must point out that between January 1, 1950 and the present time, 3952 first admissions to the Sanatorium have taken place. In only eleven of these, including our recent seven cases, was a history of erythema nodosum elicited.

In the individual case of erythema nodosum, the presence of a positive tuberculin test does not of itself necessarily mean that active tuberculosis is present. Should there be no other clinical or radiological signs of active tuberculous disease, an exhaustive search must be made to detect some other underlying infectious or noninfectious state that may have led to this condition. The presence of rheumatic fever, streptococcal infection or coccidioidomycosis, among others, can be equally hazardous to the patient. As in other disease conditions, an exhaustive search must be made in order to reach an accurate diagnosis so that an appropriate course of treatment can be instituted. When caused by tuberculosis, chemotherapy should be instituted immediately; in the case of rheumatic fever, salicylate therapy would be in order, and even corticosteroid agents in the most severe cases; in a streptococcal infection, penicillin would be indicated. If due to a drug reaction, withdrawal of the drug will suffice, and in the other possible etiological states, corresponding appropriate therapy should be instituted.

This paper has presented a review of erythema nodosum, at one time considered a disease entity but later established as a cutaneous manifestation of certain infectious and noninfectious conditions; chief among these are tuberculosis, streptococcal infection, rheumatic fever, sarcoidosis, and certain therapeutic agents. □

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Book Review

The Law and Mental Disorder

A Report on Legislation and Psychiatric Disorder in Canada

Part Two - Civil Rights and Privileges of The Mentally Ill

Canadian Mental Health Association, Toronto 7, 1967

100 pp. Paperback \$2.50

This, the second part of a comprehensive trilogy prepared by the Committee on Legislation and Psychiatric Disorder of the CMHA, represents a distillation of the results of discussion in depth which the Committee has been conducting since 1962 into an examination of Canadian Law, both federal and provincial, as it affects mental illness and mental health.

Part One, reviewing the law concerning hospital and patient care, was published in 1964. The present volume reviews current statutes which have been set up to protect the civil rights of the mentally ill on the one hand, and those of society at large on the other.

Legislation in the past was based largely on the false premise that society could be divided sharply into two water-tight groups; those competent to act in a rational manner, who could be held accountable for their actions and whose civil rights were protected under Common Law, and those persons who had been committed to a mental hospital, who were considered to be totally irrational, incompetent to look after their affairs and a danger both to themselves and to the rest of society.

Furthermore, mental illness was regarded as a semi-permanent state and, although there are considerable differences between the various provincial statutes, committal at present results here and there in a curtailment of the right to vote, operate a motor car, have the care of one's children, hold property, hold office, make a will, immigrate or emigrate, or to engage in certain professions or trades. In many cases the criteria originally specified have been extended beyond the primary intent of the legislators who proposed and adopted them, despite the fact that most psychiatric patients are now admitted to hospital for periods less than two months.

In Part One of their report the Committee proposed twenty-five principles, many of which have been reflected in new provincial regulations dealing with mental hospitals and mental health services. Part Two now delineates forty-seven further principles, whereby although the individual and society continue protected from dangerous behaviour of the sick person, his personal rights and privileges which are presently denied him on grounds incompatible with current thinking, are restored.

The Committee proposes that each case be judged individually with respect to which restrictions need be applied, and that these restrictions be revoked as soon as they are no longer necessary.

Statutory provisions relating to mental competence of members of individual professions or

occupations vary widely from province to province; thus the Medical Acts of B.C., Ontario and P.E.I. constrain - often under vague terms such as "mentally ill" - the rights of physicians to practice, whereas Nova Scotia, Ontario and Saskatchewan bar lawyers under terms such as "insane" or "mental disability." In individual provinces school teachers, pharmacists, physiotherapists, engineers, nurses, ophthalmic dispensers, accountants or funeral directors may be barred from practice despite the fact that the majority of provinces have no such provision. The Committee recommend most strongly that all such statutory provisions be rescinded, that each case be considered individually by a properly constituted Board of Examiners in a full but private hearing, and that there should be adequate statutory provisions for prompt reinstatement of the right to practice when the patient has recovered. Other sections are concerned with the administration of estates, mental and domestic relationships, voting rights, with suggested regulations regarding the operation of a motor vehicle and with the confidentiality of psychiatric reports.

This "new look" at the quixotic restrictions which traditionally have continued to apply to the mentally ill, long after the need for them has diminished or vanished, has been sorely required. The Canadian Mental Health Association is to be commended both for the thoroughness of the Committee deliberations and for the clarity and incisiveness of its recommendations. This is "required reading" for legislators, for those who are concerned with the care of the mentally ill, and for all who are interested in reforms based on modern concepts of psychiatry and of the civil rights of the individual.

I.D.M.

Keeping Up With Medical Literature

Recognising the difficulty that most practitioners have in making the best use of their reading time, the National Library of Medicine has undertaken to issue, as a separate publication, the bibliography of medical reviews which it prints in each monthly issue of the *Index Medicus*. This separate listing of review articles enables the doctor to pick out the subjects that he is interested in rapidly, and through the services of a regional library, have the relevant articles forwarded to him either on loan, or as reprints. This is equivalent to having a librarian at your elbow, and may save hours of tedious combing in many journals.

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Statement of the Catholic Bishops of Canada on Abortion

One of the main opponents of revisions in the law regarding induced abortions is the Roman Catholic Church. Non-Catholics have some difficulty in understanding the basis of this opposition. In February of this year the Catholic Bishops of Canada presented a brief to the Parliamentary Sub-Committee which is presently considering revisions in the law with respect to therapeutic abortion. The text of their brief follows:

Prologue

About a month ago, draft amendments to the Criminal Code were introduced in the Canadian House of Commons. One amendment would so change the law on abortion that a medical doctor, with the approval of a hospital committee, would be permitted to perform an abortion when continuation of pregnancy "would endanger, or would be likely to endanger, the life or the health of the mother."

With Parliament about to discuss a law of such serious consequence, careful study of the question is a duty of conscience for everyone, especially for doctors, lawyers, politicians and all who influence public opinion. Therefore we, too, must try to set before you as clearly as possible what we believe to be in harmony with Christian faith, moral norms worthy of man, and the requirements of civilized life. Our concern for the common good compels us to do this. While speaking primarily to Catholics we hope to receive sympathetic hearing from all who want to serve the best interests of the Canadian people in the study of this grave and complex problem.

Abortion and Respect for Life

The Mind of the Church

Although it did not deal at length with abortion, the recent Vatican Council repeated in general yet forceful terms the traditional teaching of the Church. "God, the Lord of life," it said, "has conferred on men the surpassing ministry of safeguarding life - a ministry which must be fulfilled in a manner which is worthy of man. Therefore, from the moment of its conception, life must be guarded with the greatest care, while abortion and infanticide are unspeakable crimes" (*Constitution on the Church in the Modern World, Art. 51*). The Council's teaching, it is clear, condemns the direct taking of foetal life, but not treatments needed to save a mother's life even if they sometimes result in the unwanted and unsought death of the foetus.

No one should be surprised that the Church takes so firm a position on this question. Her words in this case are but a faithful echo of God's solemn and grave commandment, "Thou shalt not kill." They also give witness to the great law of Christian love (*Rom. 13, 8-10*). These words touch on something that is fundamental for any true civilization

or real progress — respect for life and for the human person. It is clear that this commandment of God obliges in conscience, no matter what legislation may be in force in a country.

Must Respect for Man Apply in the Foetus?

"The Church's principles," it is sometimes said, "are noble in themselves but do not take into account the basic difference between life in the womb and life after birth." This prompts us to make the following points which will clarify the Church's position on abortion.

First, we note that science has not established a fundamental difference between life in the womb and the child's life after birth. Instead, scientific findings lead us to look upon the whole development that begins with conception as the slow, complex maturing process of a distinct individual, an autonomous biological reality progressing towards full human stature. Scientists even affirm that this individuality is already perceptible in the fertilized ovum itself, that is, from the time of conception. To be sure, it is difficult to determine the exact moment when we can be certain that the foetus is human. At least in the latter stages of its development there can be no doubt. A mother knows very well, long before giving birth, that she bears not merely vegetable or animal life but a human offspring with the right to be recognized as such.

Moreover, for those who think they have good reasons to doubt the human character of the foetus in the early stages of its development, and therefore argue that abortion is legitimate in certain cases, we have a question: Since you too consider human life sacred, can you justify even the risk of taking a human life?

Border-line Cases

The question is sometimes asked: The Church advocates that the unborn be regarded as human and invites man to respect human life in its very origins. In so doing, does not the Church treat too lightly the very serious dangers that sometimes threaten the mother because of the new life within her? The question is asked as if the concern for the human person expressed and fostered by the Church were accompanied by an inability to grasp concrete situations and provide satisfactory answers to them.

We know the anguish felt by mother, husband and doctor when two equally innocent lives are in a mysterious conflict that involves risk of death for the mother, or at least danger of serious or permanent effects on her physical or mental health. When such cases occur, they are always difficult and sometimes tragic. But resort to abortion, because it involves the taking of innocent life, does not render the situation less tragic.

When the mother's life is truly in danger, we understand that there may be a temptation to consider abortion, even direct abortion, as justifiable. Nevertheless, we must point out that this view is contrary to a persistent Judeo-Christian tradition that life is sacred. Likewise, to advocate abortion in order to protect something other than the very life of the mother, even if it be her physical or mental health, is to disregard the sacred right of the foetus to life; also, it is to sacrifice a greater value for a lesser one.

Besides, abortion itself often has harmful effects on the physical, mental and moral well-being of the mother. And it is also relevant that advances in medicine and psychiatry now make it possible to find positive solutions that respect life in many border-line cases.

Medical opinion is virtually unanimous that cases where a direct abortion is necessary to save the mother's life are fortunately so rare these days that their existence is becoming merely theoretical. Less rare, to be sure, is the case where a pregnancy may seriously and permanently endanger the mother's physical or mental health. At any rate, it certainly would be a false approach to think that solution of such border-line cases calls for legislative changes of the kind proposed.

Abortion and the Law

A bill to amend the law on abortion has been presented in the House of Commons. We must also consider what the state's role in this matter should be and, more precisely still, what one should think of the proposed amendments.

The State, Protector of Life

Effective protection of human life, especially of the weakest, is always a foremost duty of the state. Considering the complexity of modern living and the new and often hidden dangers that threaten life, this protective function of the state is today more important than ever. Through criminal law, police forces, control of public health and drugs, protection for children, social legislation and many other means, the state must strive today, even more than in the past, to fulfill effectively its role as protector of life. We note here, for example, the government's recent praiseworthy measures to assure greater traffic safety and better control over possession and use of firearms.

Everyone speaks of progress, and there is surely no one unwilling to promote it. But do we automatically have to accept as progress every measure made out to be, sometimes in a rather pecu-

liar way, a "liberalization" or a "broadening" of the law?

When it is a matter of respect and protection of human life, progress does not lie in laxity but in ever more attentive and effective concern and vigilance. Progress in civilization, we say without hesitation, consists in the increasingly clear recognition of the dignity, sacredness and absolute inviolability of the human person, on both the theoretical and practical levels.

Consequences of the Proposed Amendments

The proposed amendments on abortion are well known. According to the bill, those who procure an abortion would be liable, as in the past, to life imprisonment; but a qualified doctor would be allowed to perform an abortion if pregnancy endangered, or was likely to endanger, the life or health of the mother, provided the abortion was performed in an accredited hospital and a written certificate obtained from the hospital's therapeutic abortion committee. This brings us to the following considerations.

This amendment of the law not only allows the direct and voluntary taking of an innocent life but opens the door to the broadest interpretations. Through the press, radio and television we are already getting expressions of public opinion that show a clear and alarming decline in respect for the life of the unborn. Some, for example, see the amendment proposed in the House of Commons as only the first step towards official recognition of "abortion on demand". Others believe that the amendment, as it stands, already provides the possibility for abortion in a very large number of cases.

Such reactions are not at all reassuring. When we consider also what has happened in countries where similar legislation has been adopted, we can easily foresee what will happen here.

On this point, it should be noted that the parliamentary committee looking into the question acknowledged in its first report last December that there had not been sufficient study and investigation. We must ask, therefore, whether the Canadian people really have before them all the necessary information. Secondly, is it right for Parliament, without measuring through appropriate research the moral, psychological and sociological implications, to venture into new legislation on a problem of such grave consequence for man and for civilization itself?

Illicit Abortions

Many who find the very idea of abortion repugnant still see some merit in the amendment proposed by the government. They think that the new law would significantly reduce the number of illicit abortions and their disastrous consequences.

With regard to illicit abortions, arbitrary unverifiable figures are produced which catch public attention simply by being repeated. To be sure, such abortions are too common; and they do have

serious consequences. Every effort must be made to eliminate them. But the real question is what means should be used to bring about the desired result.

There is good evidence that it is only an illusion to expect that the proposed amendment will succeed in reducing the number of illicit abortions. Judging by the experience of countries with laws similar to the one proposed for Canada, we may justly fear the very opposite result. In fact, could it be otherwise? A law that lessens the right of the foetus to life by the exceptions it allows leads to a lax attitude that abortion is no longer a real crime. Law-makers should never underestimate the educational value of law. Men are all too ready to consider as morally permissible whatever the law itself permits.

True Reform

Progress, especially in human affairs, is rarely achieved by easy solutions. The proposed amendment is just a too-simple solution to a serious and complex problem. We have in mind a completely different approach. Respect for human life at all stages of development should be fostered through education and through laws that teach respect for life. A serious study of the frequency of illicit abortions and of means to eliminate them should be undertaken. Medical research should be encouraged.

Real efforts should be made to provide mothers in distress with the medical and psychiatric care they need. There should be a more humane understanding of unwed mothers and their children and we should provide them with real help. Greater effort must go into the care of those afflicted by mental illness. More adequate social and family policies should be planned and developed with all seriousness and great generosity. The state must devote itself to a program of this kind. For our part, we call on the Catholic people to become active leaders and ardent collaborators in this common undertaking.

This is the way to real social progress and true freedom. For us only one approach is worthy of mankind, of civilization, and of Canada's spiritual mission in the world. That approach calls for creative imagination, not the all-to-easy imitation of other countries. It calls for ever-increasing respect for all human life, including the defenceless and most dependent.

During the recent parliamentary debate on capital punishment, this was said: "We can set an example of our respect for the sanctity of human life to a world that is sorely in need of a higher regard for human life and a higher standard of human conduct." These words, you will agree, touch the heart of the matter. They throw light on the present debate. May they also be its inspiration! □

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The Medical Advisory Committee on Driver Licensing

ANNUAL REPORT, 1967.

General

The Medical Advisory Committee on Driver Licensing completed its sixth year of operation in December 1967.

Membership

The Committee consisted of the following:

- Mr. J. C. Douglas - Chairman
Dr. H. Kenneth Hall - nominated by The Medical Society of Nova Scotia
Dr. Alan J. MacLeod - nominated by The Medical Society of Nova Scotia
Dr. H. D. Beach - nominated by the Association of Psychologists of Nova Scotia
Dr. D. J. Tully - Registrar of Motor Vehicles
Mr. C. E. Pass - Secretary

Regional Representatives

The following are Regional Representatives of the Medical Advisory Committee:

- Dr. R. Sers, Antigonish
Antigonish-Guysborough Medical Society
Dr. P. R. Little, Truro
Colchester-East Hants Medical Society
Dr. H. C. Still, Halifax
Halifax Medical Society
Dr. R. G. A. Wood, Lunenburg
Lunenburg-Queens Medical Society
Dr. J. N. Park, New Glasgow
Pietou County Medical Society
Dr. F. W. Morse, Lawrencetown
Valley Medical Society
Dr. B. C. Trask, Sydney
Cape Breton Medical Society

Regular monthly meetings of the Committee were held during 1967.

Proceedings

During the year, 78 individual cases were

studied by the Committee. On some of these, further information was required with the result that some cases were referred back to the Committee on more than one occasion. The total number of referrals to the Committee, as the result of this, was 93.

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

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

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

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

Two persons were denied a Public Vehicle Chauffeur's license as the result of recommendations made by the Committee.

Two persons had their licenses restricted to hand controls.

One person was recommended medically fit but had to have a vision and rules test before a beginner's license was issued.

Two persons had their licenses suspended for visual impairment.

One unlicensed person was refused a license on the grounds of medical unfitness.

One person was required to submit a medical report before renewal of license.

Four cases were discussed but medical reports were not felt to be necessary.

Five cases are awaiting further information.

The above report re the activities of the Medical Advisory Committee on Driver Licensing during 1967 is respectfully submitted.

J. C. Douglas,
Chairman
Medical Advisory Committee
on Driver Licensing. □

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**Actual practice in Nova Scotia.

Eclampsia and Cerebral Hemorrhage*

Reprinted from The Canadian Medical Association Journal, February 19, 1966, Vol 94, page 3 & 6.

A 28 year-old white married woman, pregnant for the third time, first consulted a physician for prenatal care when she was 18 weeks pregnant. At that time her weight was 170 lb., her blood pressure was 120/70 mm. Hg., her urine was normal and the hemoglobin (Hb.) was 13 g. % It is not recorded whether quickening had occurred or whether fetal heart sounds were present.

Her two previous pregnancies, which had terminated five years and one and one-half years previously, had been accompanied by marked edema and some proteinuria. The second pregnancy was complicated by postpartum hypertension; the blood pressure, which rose to 180/100 mm. Hg, was controlled by the administration of meperidine (Demerol) and phenobarbital. (This information regarding the previous pregnancies was not entered in the hospital record of the present pregnancy and was obtained from the previous hospital admission records by the reviewing officer.)

The second prenatal visit was five weeks after the first and at this time the patient was approximately 23 weeks pregnant. She had gained 12 lb. and her blood pressure, urine and Hb. were normal. She made the third office visit five weeks later, at which time she had lost 2 lb. and now weighed 180 lb. The blood pressure was 130/70 mm. Hg, the urine was normal and the Hb. was 12.5 g. %. She was advised to return for the next office visit in two weeks' time, but she did not return until five weeks later. At this time it was estimated that she was 35 weeks pregnant. Her weight was 202 lb., the blood pressure was 130/80 mm. Hg, the urine contained two plus protein, the Hb. was 10.5 g. % and there was moderate generalized edema. Despite a weight gain of 22 lb. in five weeks, the presence of proteinuria, the generalized edema and what was obviously a large fetus or twin pregnancy, she was permitted to return home. However, she was admitted to hospital in labour that evening.

After a four and one-half hour labour, a healthy 12 lb. 2 oz. male was delivered vaginally. Some difficulty was encountered with the delivery of the shoulders. The patient did not receive any medication during her labour, but an anesthetic of intermittent nitrous oxide and ether was given for the delivery. She was given 5 units of oxytocin (Pitocin) 12 minutes before the delivery of the infant and 1 c.c. of ergometrine maleate (Ergometrine) one minute after the delivery of the pla-

centa. (It is not known if this 1 c.c. contained 0.5 mg. or 0.25 mg. of ergometrine maleate.) The third stage was completed 10 minutes after the delivery of the infant and the blood loss was 300 c.c.

Her blood pressure was 170/90 mm. Hg and she was nauseated one hour post partum. No medication was given at this time. She complained of headache four and one-half hours after delivery and shortly afterwards appeared to be sleeping. The patient could not be aroused seven and one-half hours post partum and the attending physician examined her at this time and found that she had pinpoint pupils and was comatose.

She was examined by a consultant obstetrician 13½ hours after delivery and he made a diagnosis of postpartum eclampsia. He prescribed 2.5 mg. of reserpine (Serpasil) intramuscularly, 50 c.c. of 50% glucose in water intravenously and 5 g. of magnesium sulfate intramuscularly every six hours. Her body was rigid and her respirations were laboured. A catheter specimen of urine showed three-plus protein, and a microscopic examination of the urine revealed 1 to 3 white blood cells and 85 to 100 red blood cells per high-power field. The fasting blood sugar was 156.7 mg. %.

Bloody spinal fluid was obtained on spinal puncture by a neurological consultant. There was fixed dilatation of the left pupil and the patient remained deeply comatose. A diagnosis of ruptured cerebral aneurysm was made. Her blood pressure was 138/60 mm. Hg and the temperature was 102° F. 36 hours post partum. She was transferred to a larger hospital, but her condition prohibited any type of surgical intervention and she died 62 hours after delivery.

A complete autopsy was performed and reported: "The right ventricle of the brain is filled with blood and the surrounding brain tissue is soft and edematous. The hemorrhage has been quite extensive, with blood distributed throughout the subarachnoid space. Pressure on the brain causes blood to come from the fourth ventricle through a small hole on the medial side of the right parietal lobe. The source of the hemorrhage cannot be identified.

"There are patchy hemorrhagic areas in the lungs. The liver weighs 2370 g. and there are scattered petechial and blotchy hemorrhages on the surface. Similar interstitial hemorrhage is seen on section.

*This series of articles arranged by an editorial subcommittee of the C.M.A. Committee on Maternal Welfare, and originally published in the Canadian Medical Association Journal, is being reproduced in the Bulletin at the request of The Medical Society of N. S. Committee on Maternal and Perinatal Health, by kind permission of the Editor of the Canadian Medical Association Journal.

"The kidneys weigh 190 g. and 108 g. Petechial hemorrhages are present. They are somewhat edematous, with the cortex pale and the pyramids congested.

"The uterus shows no change from that of a normal postpartum state.

"The cause of death is cerebral hemorrhage with subarachnoid extension and eclampsia."

Decision of Committee on Maternal Welfare

The conclusions reached by the Provincial Committee on Maternal Welfare after a review of the case were as follows: "This was a preventable direct maternal death due to eclampsia. The preventable factors were primarily professional and these were: The attending physician failed to take into account the hypertensive crisis of the previous pregnancy and he failed to admit the patient to hospital because of pre-eclampsia at her last prenatal visit. The attending physician used ergometrine maleate at the end of the third stage of labour despite the present and past hypertension and he also failed to treat the hypertension immediately when it was noted post partum. The patient factor was her failure to keep the prearranged office appointments for adequate prenatal care. This maternal mortality has been considered to be ideally 'preventable' under the terms of reference of the Provincial Maternal Welfare Committee and there is no implication of any negligence."

Discussion

The past history of the two previous pregnancies was not recorded on the physician's office record or on the patient's hospital record when she was confined with this pregnancy. This patient had evidence of pre-eclampsia with both previous pregnancies and a hypertensive crisis following the delivery of the second child. If this evidence had been heeded, the patient would have been supervised much more closely throughout her pregnancy, confinement and postpartum period. She was not so supervised, and was allowed to return home following a prenatal visit when it was noted that she had gained 22 lb. in five weeks and had generalized edema and proteinuria. The routine use of a carbon duplicate prenatal record form, one copy of which precedes or accompanies the patient to hospital for review by the labour-floor nurses and doctor, would have alerted those attending this patient concerning the previous toxemia of pregnancy and postpartum hemorrhage. The Nucleus Committee of the Maternal Welfare Committee of The Canadian Medical Association endorses and recommends the routine use of such a duplicate prenatal record form.

Prenatal office visits should begin no later than 12 weeks of gestation and the patient should be examined every four weeks up to 28 weeks. From 28 to 36 weeks, prenatal office visits should be every two weeks and then weekly until delivery. More frequent office visits or admission to hospital is warranted if complications of pregnancy occur.

This patient reported for prenatal care presumably at 18 weeks' gestation, but more careful observation—noting the date of quickening, for example—would have alerted the attending physician that she must have been pregnant for a longer period. The responsibility of requesting prenatal care and keeping prenatal office appointments is primarily the patient's; nevertheless, the attending physician has a duty to inform the patient of her responsibilities in this respect.

Ergot derivatives should not be given to any patient who is pre-eclamptic or to any patient who has had a previous postpartum hypertensive reaction. The routine use of this drug without reviewing the history is particularly dangerous and undoubtedly contributed to the development of cerebral hemorrhage in this patient. Drug dosage should not be recorded in fluid quantities but as the weight or unit of the drug received.

All maternity patients should be observed in a recovery room for one or two hours post partum for evidence of excessive vaginal bleeding as well as alterations in blood pressure. Immediate treatment for these complications should be initiated. No treatment was given to this patient when hypertension was discovered one hour post partum.

Summary

A maternal mortality was reviewed by the Provincial Committee on Maternal Welfare. The pathological cause of death was cerebral hemorrhage and eclampsia. The preventable factors are discussed. □

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† Pneumonias Caused by Escherichia Coli

Pneumonia due to Escherichia coli, one of the common gram-negative bacilli in the intestinal tract, is described in twenty patients. The bacilli appeared to reach the lungs by way of the blood stream from sources in the kidneys and intestines, often following surgery.

Since the increasing seriousness of infections due to gram-negative bacilli is generally recognized and since these are among the most difficult illnesses to treat, an effort has been made further to define these pneumonias and to determine how to recognize them early.

During a 30-month period, 82 episodes of gram-negative pneumonias were observed in 81 patients at the Detroit General Hospital. It became obvious that each gram-negative bacillus produces characteristic illnesses in particular groups especially prone to these infections. In the present report, 20 cases of *Escherichia coli* pneumonia are described.

One of the following procedures was the basis for the diagnosis of a pneumonia caused by a gram-negative bacillus: isolation of the same predominant bacterium from two or more consecutive sputum cultures; isolation at approximately the same time of the same bacterium as a pure culture from blood and as the predominant organism from sputum; or isolation of appropriate bacteria from pleural fluid. A diagnosis of "mixed pneumonia" was made when pneumococci and gram-negative bacilli were isolated from sputum and blood.

Methods of Identification

Bacilli of the family enterobacteriaceae or the genera pseudomonas or bacteroides were identified by gram stain, colonial morphology, and sugar fermentations, as well as by their ability to decompose urea, produce hydrogen sulfide and indole, and to utilize citrate. Species were identified only for *Escherichia coli* and *Proteus*.

The 82 episodes represented 4.3 per cent of the pneumonias in the hospital during the period of the study. Of the total, 78 were primary, 64 being acquired outside the hospital, while 14 were nosocomial. Four other hospital-acquired secondary infections followed pneumococcal pneumonias. Secondary pneumonias were caused by the klebsiella-enterobacter group, or the "colon bacillus." Five patients had mixed pneumonias with pneumococci and either klebsiella-enterobacter or *Proteus vulgaris*.

Among the gram-negative pneumonias the organisms seen were klebsiella-enterobacter, *Esch. coli*, pseudomonas, bacteroides, proteus, *H. influenzae*, and achromobacter. Overall mortality was 49 per cent, with deaths significantly more frequent with *Esch. coli* and pseudomonas.

"Colon-bacillus" pneumonias occurred in persons 17 to 84 years of age. One or more serious chronic diseases were present in every case. They involved the kidneys, heart, or lungs. Diabetes mellitus and pyelonephritis were among the most common.

Respiratory symptoms developed one to three days before hospitalization, with chills, feverishness, dyspnea, cough, thick sputum, and pleuritic chest pain. Only one patient had had a recent upper-respiratory tract infection. Gastrointestinal symptoms, noted in six patients, consisted of nausea, abdominal pain, dysphagia, diarrhea, or vomiting.

Signs of upper-respiratory tract involvement were found in five patients, but rales at the base of the lungs were uniformly heard. Signs of lobar consolidation were rare. Eight patients had empyema.

Anemia Rare

Only three patients were anemic at admission. The average initial white-cell count was 15,300. In one patient, a known alcoholic, the first recorded white-cell count was 23,000, which rose to 27,000.

Esch. coli organisms were recovered from sputum samples (18 of 20 patients), blood, urine, pleural fluid, or throat. All patients had gram-negative bacilli on smears of all sputum specimens and empyema fluids. Negative cultures were observed in patients already receiving antibiotics before specimens were obtained; in each of these cases cultures of blood were positive.

Roentgenographic examination revealed lower-lobe bronchopneumonias in 19 of the 20 patients. Pneumonic infiltrates gradually resolved in five to 20 days. In two fatal cases, pneumonia progressed. Three of the eight patients with large empyemas died.

James R. Tillotson, M.D., and A. Martin Lerner, M.D. *The New England Journal of Medicine*, July 20, 1967.

¹Reprinted from the Abstracts of the National Tuberculosis Association, January 1968.

Printed through cooperation Nova Scotia Tuberculosis Association.

Antibiotics were administered to all the patients, most of them receiving several. The antimicrobials included penicillin, erythromycin, tetracycline, and chloramphenicol. Antibiotics with in vitro activity against the particular *Esch. coli* were the most satisfactory. Most of the strains were sensitive to kanamycin and colistin.

Adjunctive therapy included surgical procedures, blood transfusions, corticosteroids, and vasopressors.

Death generally occurred in patients with serious chronic underlying diseases. In those who survived, clinical amelioration was observed within the first week with appropriate antibiotics or drainage of empyema. Deaths during the first hospital week were usually due to infection, while those occurring later were more often due to complicating underlying disease.

Esch. coli pneumonia generally followed bacteremias seeded from acute or chronic infections of the gastrointestinal or genitourinary tract. Eight patients had pyelonephritis due to that organism. In two patients aspiration seemed likely as the cause.

The most abundant aerobic of the bacteria in the normal human intestine, these bacilli have been clearly associated with infections of the kidneys, gallbladder, peritoneum, appendix, and other occasional distant loci after bacteremias that may result from surgical procedures involving the gastrointestinal or genitourinary tracts. The "colon bacillus" is the most frequent cause of septicemias due to gram-negative organisms in hospitals.

Increasing Incidence?

The present series of pneumonias suggests either that there is an increasing incidence of pneumonias due to *Esch. coli* or that most of these infections had remained undiagnosed. These pneumonias occurred in men or women in their fifties and followed bacteremias. The pneumonias were lower-lobe infiltrates, with frequent meta-pneumonic empyemas.

Patients in this series with pneumonias caused by *Esch. coli* who recovered had appropriate diagnoses and treatment, but patients with more serious underlying disease seemed more likely to die. On the basis of sensitivity studies in the laboratory, kanamycin was the drug of choice. Its administration, however must be circumspect in these patients since pyelonephritis and at least subclinical diminished renal function are likely. □

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Clinical Staff Conferences Effective Oct. 1968

PATHOLOGY INSTITUTE

Seminars in Pathology and Bacteriology	Monday	4:00 p.m.	Lecture Rm. 327	Weekly
Surgical Pathology	Tuesday	4:00 p.m.	Lecture Rm. 327	Weekly
Gynecological Pathology	Tuesday	5:00 p.m.	Lecture Rm. 327	Monthly
	(1st of mo.)			
Neurosurgical Pathology	Wednesday	9:00 a.m.	Autopsy Room	Monthly
	(1st of mo.)			
Neuropathology	Wednesday	2:00 p.m.	Autopsy Room	Weekly
Autopsy Cases (Gross)	Friday	2:30 p.m.	Autopsy Room	Weekly
Autopsy Cases (Micro.)	Friday	4:00 p.m.	Lecture Rm. 327	Weekly

THE CHILDREN'S HOSPITAL

Cardiology Rounds	Monday	10:30 a.m.	
Basic Science Seminar	Monday	12:30 p.m.	
Neonatal Rounds	Monday	4:00 p.m.	
Grace Hospital*			
Children's Hospital*			
Admission Rounds	Tuesday	9:00 a.m.	
	Thursday	9:00 a.m.	
Hematology*	Tuesday	11:00 a.m.	
Genetic*			
Conference			
Bedside Teaching Rounds	Tuesday	4:00 p.m.	
Medical Grand Rounds	Wednesday	9:00 a.m.	
Physician-in-Chief's	Wednesday	4:00 p.m.	
Resident Rounds			
Case Presentation and Discussion			
Metabolism-Endocrinology*	Thursday	11:00 a.m.	
Neurology*			
Conference			
Radiology	Thursday	4:00 p.m.	
Pathology*			
Conference			
Surgical Grand Rounds	Friday	11:00 a.m.	
Orthopedic Rounds	Friday	2:00 p.m.	
O.P.C.			
*Alternates Weekly.			

GRACE MATERNITY HOSPITAL

Staff Meeting	Monday	12:00 noon
Luncheon	(Last)	
Obstetrical Conference	Tuesday	5:00 p.m.
	(Third)	
Ward Rounds	Daily	10:00 a.m.
Journal Club Luncheon	Thursday	12:15 p.m.
Prenatal Clinic	Tuesday,	
	Thursday,	
	Friday	2:00 p.m.

Well Baby Clinic	Tuesday,	
	Thursday,	
	Friday	2:00 p.m.
Postnatal Clinic	Tuesday,	
	Thursday,	
	Friday	2:00 p.m.
Family Planning Clinic -	by appointment	
	Wednesday	2:00 p.m.

HALIFAX INFIRMARY

Department of Anaesthesia			
Monthly Conference	3rd Monday	4:00 p.m.	O.R. Suite
Department of General Practice			
Grand Rounds	Tuesday	8:30 a.m.	4A Clinie Room
Department of Medicine			
Grand Rounds	Thursday	11:30 a.m.	4C Clinie Room
Intern-Resident			
Conference	Friday	12:00 Noon	4C Clinie Room
Monthly Meeting	1st Tuesday	5:30 p.m.	3C Clinie Room
Department of Obstetrics and Gynecology			
Daily Conference	Mon.-Fri.	9:00 a.m.	3C Clinie Room
Weekly Rounds	Friday	12:00 Noon	3C Clinie Room
Monthly Meeting	3rd Tuesday	5:00 p.m.	3C Clinie Room
Department of Ophthalmology			
Weekly Conference	Tuesday	6:30 p.m.	Outpatient Dept.
Monthly Conference	3rd Tuesday	6:30 p.m.	Outpatient Dept.
Department of Otolaryngology			
University Dept.			
Joint Meeting	Thursday	7:00 p.m.	Alternate Hospitals
Department of Pathology			
Clinical Pathological			
Conference	4th Wednesday	12:00 Noon	Auditorium
Department of Psychiatry			
Daily Ward Rounds		8:00 a.m.	Psychiatric Dept.
Case Presentation	Wednesday	9:00 a.m.	2A Clinie Room
Monthly Conference	3rd Wednesday	9:00 a.m.	2A Clinie Room
Department of Radiology			
House Staff Conference	Tuesday	1:00 p.m.	Radiology Dept.
Weekly Conference	Thursday	3:30 p.m.	Radiology Dept.
Department of Therapeutic Radiology			
Grand Rounds	1st & 3rd	12:30 p.m.	3C Clinie Room
	Mondays	12:30 p.m.	3C Clinie Room
Department of Surgery			
Weekly Grand Rounds	Wednesday	8:00 a.m.	
Monthly Departmental			
Meeting	2nd Wednesday	12:30 p.m.	3C Clinie Room
Department of Urology			
Weekly Conference	Thursday	12:00 Noon	Urology Dept.
Monthly Meeting	Last Thursday	4:30 p.m.	Urology Dept.

This listing is as complete as possible, and all excerpts listed are open to any interested Physician. Information regarding other areas of the Province is welcomed and will be published when available.

VICTORIA GENERAL HOSPITAL

Department of Medicine

Cardiac Working Conference			
Metabolism & Endocrinology	Monday	1:00- 2:00 p.m.	Room 4-017
Renology	Monday	1:00- 2:00 p.m.	Room 3-077
Medical Grand Rounds	Monday	1:00- 2:00 p.m.	Room 3-077
Cardiology	(1st & 3rd)		
Pulmonary	Monday	1:00- 2:00 p.m.	Room 3-077
Haematology (Out Patients)	(2nd & 4th)		
Neurology-Neurosurgery	Tuesday	8:30-10:00 a.m.	Room 3-077
Haematology	Tuesday	1:00- 2:00 p.m.	Room 3-077
Gastroenterology	Tuesday	1:00- 2:00 p.m.	Room 3-077
Rheumatology (Out Patients)	Tuesday	2:00- 4:30 p.m.	OPD 3rd Floor
Resident Orals	Wednesday	9:00-10:00 a.m.	Room 11-018
Neurology	Wednesday	1:00- 2:00 p.m.	Room 3-077
Rheumatology	Wednesday	1:00- 2:00 p.m.	Room 3-077
Cardiology	Wednesday	1:00- 2:00 p.m.	Room 3-077
	Thursday	1:00- 2:00 p.m.	Room 4-017
	Friday	1:00- 2:00 p.m.	Room 3-077
	(1st & 3rd)		
	Friday	1:00- 2:00 p.m.	OPD Conference Rm.
	(2nd & 4th)		
	Friday	2:00- 4:00 p.m.	OPD 3rd Floor

Department of Surgery

Weekly Clinical Conf.	Saturday	11:00 a.m.	Room 11-018
Surgical Pathology			
Conference	Tuesday	4:00 p.m.	Path. Bldg.
Ward Rounds			
Surgery A	Friday	9:00 a.m.	7B
Surgery B	Thursday	8:00 a.m.	6B
Surgery C	Wednesday	8:30 a.m.	6A
Surgery D	Saturday	9:00 a.m.	7A
Orthopaedics	Tuesday	11:00 a.m.	7A & B
Out Patients Clinics			
Surgery A	Friday	9:30 a.m.	Outpatient Dept.
Surgery B	Thursday	9:30 a.m.	Outpatient Dept.
Surgery C	Wednesday	9:30 a.m.	Outpatient Dept.
Surgery D	Tuesday	9:30 a.m.	Outpatient Dept.
Orthopaedic	Tuesday	9:00 a.m.	Outpatient Dept.

Department of Gynaecology

Ward Rounds	Daily	9:00 a.m.	5A
Grand Rounds	Monday	8:00 a.m.	5A
Pathology Conference	Tuesday	5:00 p.m.	Path. Institute
Tumour Clinic	(First)		
	Tuesday &		
	Friday	11:30 a.m.	Outpatient Dept
Gyn. Outpatient Clinic	Monday	2:00 p.m.	Outpatient Dept.
Gyn. Endocrine Clinic	Wednesday	2:00 p.m.	Outpatient Dept.

Department of Radiology

Nuclear Medicine Conference			
	Tuesday,		
	Wednesday,		
	Thursday		
	& Friday	2:00 p.m.	Radiology Dept.
Therapeutic Radiology			
Ward Rounds	Thursday	8:30 a.m.	11th Floor, Victoria
Diagnostic Radiology	Conference	Daily	3:00 p.m.
Proven Case Conference			
	Thursday	1:00 p.m.	Radiology Dept
	Thursday	5:30 p.m.	Radiology Dept.
	(3rd)		
Departmental Conference	Friday	3:00 p.m.	Radiology Dept.
Radiological &			
Pathological Conference	Tuesdays &	4:30 p.m.	Radiology Dept.
	Friday		
	Friday	10:30 a.m.	Room 9-064
	Friday	4:00 p.m.	Room 9-023
Seminar	Thursday	9:00 a.m.	Child Guidance Clinic
Child Guidance Clinic	Monday, Tuesday, Friday &	9:00 a.m.	Room 9-023
Case Presentations	Saturday		

Department of Urology

Conference	Monday		
	Wednesday &		
	Friday	4:30 p.m.	5B
Seminar	Tuesday	4:30 p.m.	X-ray Conf. Room
Opd. Clinic	Thursday	10:00 a.m.	Out Patient Dept.

Department of Anaesthesia

Conference	Friday	3:30 p.m.	Room 10-021
	(First)		

Nova Scotia Tumour Clinic

Conference	Friday	12:30 p.m.	Tumour Clinic
	(Third)		
Clinics			
Rectal	Thursday	10:00 a.m.	Tumour Clinic
Breast	Monday	2:00 p.m.	Tumour Clinic
Gynaecology	Tuesday	11:00 a.m.	Outpatient Dept.
Skin, Soft Tissue	Tuesday	11:30 a.m.	Tumour Clinic
Colon	Tuesday	11:30 a.m.	Tumour Clinic
Leukemia &			
Lymphoma	Tuesday	2:00 p.m.	Tumour Clinic
Paediatric	Tuesday	2:00 p.m.	Tumour Clinic
	(Fourth)		
Ophthalmology	Tuesday	2:30 p.m.	Outpatient Dept.
Head & Neck	Wednesday	11:30 a.m.	Tumour Clinic
Otolaryngology	Wednesday	11:00 a.m.	Outpatient Dept.
Neurosurgery	Wednesday	11:00 a.m.	Outpatient Dept.
Urology	Thursday	10:00 a.m.	Outpatient Dept.
Breast	Thursday	11:00 a.m.	Tumour Clinic
Pulmonary	Friday	12:00 noon	Tumour Clinic
Gastric &			
Esophageal	Friday	12:00 noon	Tumour Clinic
Orthopaedic	Friday	10:00 a.m.	Tumour Clinic
	(2nd & 4th)		
Gynaecology	Friday	11:00 a.m.	Outpatient Dept.