

# THE NOVA SCOTIA MEDICAL BULLETIN

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## Editorials and Other Opinions

One of the distinguishing factors of our profession is that it publishes the results of its scientific efforts in order to disseminate, but also to allow scrutiny of its methods and thought processes. Exchange of opinion about much that concerns the profession and its relationship to patients is also important, especially when those opinions are well thought out and beneficial to both our patients and the science of medicine. This type of opinion writing allows one to become part of the literature without devoting one's whole life to a research career and should be encouraged.

Those with a literary interest or research tendency have been very generous with their efforts, and because of this we are able to publish this journal. While we have some evidence that the material is well received and read, feedback seems to be lacking.

If encouragement is needed, then perhaps readers need a reminder that letters to the editor are welcome in this journal and comments will be published whenever possible.

Is there an area of concern that has not been covered recently in other journals and that needs attention, particularly by Nova Scotia physicians? Even internal society matters can be addressed and *InforMed* has certainly agreed to publish these when appropriate. Whether such material has a direct bearing on the Health Care System as a whole or medicine in general, this journal needs and wants your comments.

Surely not everyone agrees with every editorial printed here, and Dr. Frank White's columns on Community Health must arouse some opinionated physicians. Guest editorials are also of interest to the Editorial Board and will be considered if timely and well thought out. Usually an editorial takes a firm position and then proceeds to defend it with references and/or logic. Brevity should be considered a virtue. In order to stimulate you, we might consider the following:

1. We have a new Deputy Minister (a non-physician by the way). We welcome you to the hot seat, Wayne.
2. A recent ethics course held in Halifax had very few doctors attending. Guide-lines on ethical care and how we practise can be expected from many sources that may be better prepared to defend ethical positions than we in the medical profession are. What ethical principal are we breaking when we do not prepare ourselves for dealing with questions in ethics?
3. One of the more recent issues of *The Nurses' Journal* was concerned with Primary Care and how nurses should play a prominent role in this area. The place of the physician was relegated to a few paragraphs only.
4. The Emergency Care System in this province has received some attention lately. Many things could be said in this area.
5. The Provincial Medical Board now has consumer representatives. Peer review by the profession is no longer just peer review. What are your opinions and why?
6. Some physicians must have strong ideas about AIDS Testing and how we are handling it in Nova Scotia or not handling it. Recent guidelines are certainly helpful but does everyone agree.
7. Transactions at our recent General Council, published in this issue, may stimulate some comment.

The above examples are merely ideas that deserve consideration. Perhaps some would-be writer might be tempted to do this in print, or he may choose more complicated issues demanding our attention. Editorials and letters to the editor of course are not the only suggestions we might have. Case reports are sometimes fascinating and useful for teaching and learning. We, of course, welcome review articles and anyone wishing to write under the Doctor at Leisure series. While encouraging the above, that is not to say that we expect any less numbers of first rate research based articles, but we do wish to remind you that there is room for everyone in your journal.

□

J.F. O'C.

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# Dr. Douglas Henshaw

## PRESIDENT

The Medical Society of Nova Scotia  
1987 - 1988

"We need to remain flexible and adapt to change if we are to retain the leadership and provide direction in our chosen field." That's the view of Dr. J.D.A. Henshaw the new President of The Medical Society of Nova Scotia.

Dr. Henshaw says that medicine is surrounded with change. He says, "In a very real sense, medicine has become a victim of its own technological achievements". But, Dr. Henshaw is not the kind to shy away from problems. He sees the problems facing medicine as challenges and opportunities.

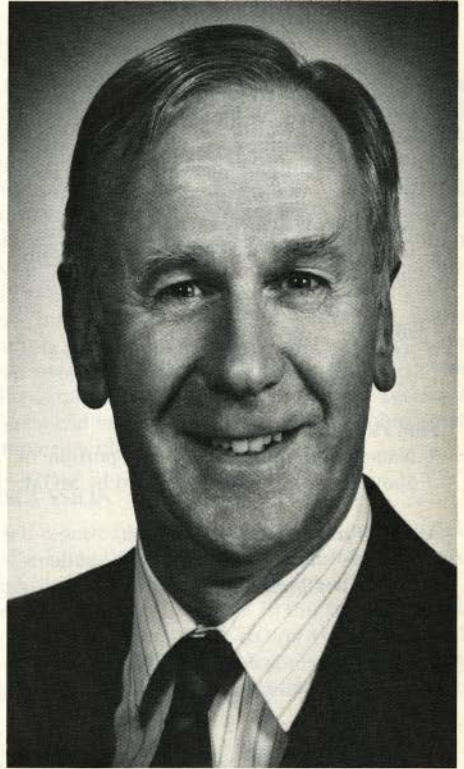
Douglas Henshaw is a general surgeon, one of a group he affectionately calls "a dying breed". He practises in Berwick where he readily acknowledges a staff that accepts challenges, most notably the challenge to cover for him while he tends to the duties of the Presidency.

As a graduate of Edinburgh University you can expect him to have the tenacity of a Scot along with the appropriate concern and respect for fiscal responsibility.

Dr. Henshaw has been active in organized medicine for many years. He served in leadership roles in the Valley Medical Society, The Section of Surgery, The Medical Society of Nova Scotia and the Canadian Medical Association. Of particular note was his long standing involvement as The Society's representative to the CMA Council on Medical Education. That experience will become all the more important as the focus on manpower issues becomes more and more intense.

During the past year, while serving as President Elect, Dr. Henshaw played an integral role in the Society's ever burgeoning activity in the public and political arena. In tandem with your Past President, Dr. Bill Acker, he made forays into the inner Cabinet of the Provincial Government. He also led discussions with allied health professionals in some closed door sessions where physicians badly needed representation.

Douglas Henshaw is an active man with some very diverse interests. He and his wife Sylvia spend a great deal of their leisure time on or in the sea. As an avid sailor, it is not surprising that your President is also a windsurfer and scuba diver. When the weather turns cold, he turns to Alpine skiing. In between he finds time for hunting, fishing and gardening. However, one of his more unusual pastimes is Scottish dancing, and, given their widespread travel for performances, Dr. and Mrs. Henshaw's dancing verges on the professional.



Dr. Henshaw has five children. His three sons are in various stages of study, two in Nova Scotia and one in England. His two daughters are also in England, where one is a veterinarian and the other is an assistant fashion editor for Vogue magazine.

Douglas Henshaw leads a full and vibrant life. He brings to the Office of President a penchant for precision and a humility that recognizes the job can only be done through team work.

His direction for the year was established in his address to the 134th Annual Meeting when he said, "We must stick to our first principle - to provide quality medical care to Nova Scotian citizens. None of us", and he included Government, "should allow this aim to be overshadowed or sidetracked by other issues." □

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# Health Habits of Four First Year Classes of Dalhousie Medical Students

Brian K.E. Hennen,\* MD, MA, CCFP, FCFP,

London, Ontario

For the past four years, while lecturing to first-year Dalhousie medical students, I have conducted a health-risk survey of six of their lifestyle and health maintenance behaviours. This review summarizes those surveys.

## METHOD

During the class, I asked students to indicate on a blank paper whether they were male or female, and to simply answer yes or no to the following six questions: Do you exercise at least four times a week for twenty minutes? Are you less than ten percent overweight? Do you buckle up nineteen times out of twenty anywhere you drive? Do you smoke less than one cigarette a day? Do you practise breast self-examination (or testicular self-examination), i.e. have you done so once in the past six months? Do you drink less than seven beers, shots or glasses of wine per week?

## RESULTS

Results are reported in Tables I and II. The "n" in each case represents the number of completed responses. The entering first-year class size at

## CONCLUSIONS

About half of these medical students in first year exercised at least twenty minutes four times a week. Sixteen percent were more than 10% overweight. Twenty-five percent did not wear seatbelts nineteen times out of twenty. (A notable improvement in buckling-up from the class of '87 to the class of '88 coincides with the publicity and legislation in Nova Scotia requiring seatbelt wearing). Six percent of all four classes smoked more than one cigarette a day as first-year students. Thirty-four percent of women students did not regularly practise self-examination of the breasts, and 77% of men did not regularly practise self-examination of the testicles. Eleven percent of women had more than seven drinks of alcohol a week compared with 32% of men.

## DISCUSSION

Self-reported behaviour in patient studies is about 75% accurate.<sup>1</sup> In studies depending on self reports of drinking behaviour, the reliability and validity is considered quite satisfactory.<sup>2</sup> In this study, these self-reported behaviours were recorded and handed in anonymously within less than a ten minute period during a lecture. The students had no reason to lie

TABLE I  
PERCENT OF STUDENTS NOT MEETING CRITERIA

CLASS	'87 (n=81)		'88 (n=85)		'89 (n=86)		'90 (n=89)	
	M (n=49)	F (n=32)	M (n=55)	F (n=35)	M (n=55)	F (n=31)	M (n=51)	F (n=38)
EXERCISE	39	44	45	43	58	68	72	47
WEIGHT	22	12	13	20	13	19	12	12
SEATBELTS	51	47	31	11	13	13	20	13
SMOKING	4	3	4	8	13	16	1	0
SELF-EXAM	83	25	73	23	73	48	78	40
ALCOHOL	29	3	33	23	38	13	29	5

Dalhousie has been ninety-six students, so none of these samples is fully representative of the total class, the overall sample representing 90% of the 284 students in the four classes.

TABLE II  
PERCENT OF STUDENTS NOT MEETING CRITERIA  
(four classes combined)

Habit	Male (n=210)	Female (n=136)	Total (n=346)
EXERCISE	54	50	52
WEIGHT	15	18	16
SEATBELTS	28	19	25
SMOKING	6	7	6
SELF-EXAM	77	34	60
ALCOHOL	32	11	24

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but the accuracy of their reports depends on some degree of self-awareness.

In the Canada Fitness Survey carried out in 1981, 48% of nineteen year old males and 29% of nineteen year old females consumed some alcohol at least one to three times weekly; and 37% of males and 46% of females reported at least occasional smoking.<sup>3</sup> Seventy percent of young men and women were reported to be active in exercises such as walking, jogging, cycling and team sports. As an example of the age distribution of Dalhousie students, in September 1985, 2/3 of first-year students were aged 20-22 years and most of the remainder were between 23 and 26 years.<sup>4</sup>

This Dalhousie survey was started in 1983. That class would have been picked from the general population sample of those who were about age 19 in 1981. A comparison would then suggest that first-year medical students at Dalhousie are less likely to smoke and somewhat less likely to exercise than others in their general age group.

In a study of 271 doctors in Nova Scotia in 1976, 61% failed to meet criteria similar to those used in this study for exercise, 18% for weight, 57% for seat belts, 27% for smoking and 39% for alcohol.<sup>5</sup> Self-examination behaviour was not determined. It appears hopeful that graduates of the late '80s from Dalhousie will be better at buckling up and will smoke less than their preceding generation of physicians did ten years ago.

A recent report from one American school studying 116 medical students (of which two-thirds were men and the mean age was 23.9 years) showed some interesting alcohol usage patterns.<sup>6</sup> Assessed six times during the first 3½ years, men had a group median tally of 4-6 drinks per week compared with 2-3 for women. A 40% decline in alcohol usage by men was noticed as they entered clerkship in third year. Surprisingly, excessive drinkers (defined as over the group mean of 9.19 oz./wk. for men and 6.7 oz./wk. for women) performed better academically first year than the half of the class below the mean. These findings suggest that men students tended to reduce their drinking substantially on entering the clinically demanding clerkship. The results also suggest that poor academic performance, at least in early years of medical school, cannot be depended upon as an identifying risk determinant for problem drinking.

The first year class of the University of Massachusetts Medical School in 1983 was studied using a health questionnaire.<sup>7</sup> Eighty-two (81%) of the 104 students who responded revealed four students (5%) who were smoking, eleven having previously quit. Sixty-six (80%) used alcohol at least twice weekly, averaging 2.7 drinks per time for men and 1.6 for women. Thirteen students reported they drank over six drinks each time of drinking. Interestingly, the study group

felt that nutrition, sleep, and exercise were more important health determinants than no smoking or moderation in the use of alcohol.

At Louisiana State Medical School in 1982, first year students completed a comprehensive lifestyle questionnaire at orientation and again seven months later.<sup>8</sup> The 152 respondents of 184 students in the class had a mean age of 23.8 years and included 108 men and 44 women. One hundred and thirty-nine did not smoke and 139 drank an average of 4.4 drinks of alcohol per week. The class improved its coping skills as the year progressed in that they watched their sleep habits and maintained a strong group of support people around them.

It would appear by comparison that Dalhousie students might be lesser drinkers than these three other groups but the measures used were somewhat varied. Generally, medical students do seem to have lower smoking frequency than average.

I am unable to explain why the first year class of '86 had 12 (14%) smokers compared with a total of 10 (3.8%) for the other three first year classes combined. Similarly, there were 8 (23%) women in the class of '88 who took 7 or more drinks a week compared with 7 (7.7%) in the other three classes combined. The classes in question might pursue these findings for an explanation and follow up.

The importance in this Dalhousie review of some of these behaviours to long range health remains debatable. In particular, the value of self-examination of breasts or testicles is still in doubt. I do not necessarily advocate that either examination ought to be done by them. The behaviour does indicate in one way the degree to which first year medical students actively demonstrated concern for their own health.

Traditionally, faculties have not shown a collective interest in lifestyles of their students, except perhaps for some attention to drinking and non-medical use of drugs. A special series of recommendations to Canadian and American medical schools concerning how Faculties could act to improve the health of medical students was made in 1970. By doing such things as careful admission health assessments, ensuring regular health checks during medical school and providing professional counselling services, it was hoped medical student health care could be improved. A follow-up review of these recommendations ten years later showed that they had been, for the most part, ignored.<sup>9</sup>

Dalhousie medical school offers a personal counselling service through June Penney, who operates out of the Dean's office, and who can assure her student advisees confidentiality and separation from the academic assessment process. Dalhousie Student Health Service has a strong counselling staff. For students in academic difficulty, who may have medical

problems contributing to a risk of their being asked to discontinue medicine, a special Faculty fitness panel has been set up separate from the academic assessment process, to rule on their fitness to continue their studies. Dean Murray has recently asked a group of experienced Faculty members to review the reinstatement of a Faculty mentor programme. These existing programmes depend on self-referral or academic difficulty to identify their users.

Dr. Patricia Beresford, interested in general university student health and lifestyle counselling which she does out of the Preventive Medicine Centre at the Halifax South Park YMCA, suggests future assessments such as this one might also consider asking students about caffeine use, salt and calcium intake and assessment of stress levels. Other substances abused besides tobacco and alcohol could also be reviewed.

Should we be doing something more or are we intruding into the private lifestyles of students? Perhaps the students could help us decide.

I am grateful to those students who cooperated in this survey. □

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# Cancer of the Breast: Recent Advances in Immunological Treatment

Tarunendu Ghose,\* MBBS, PhD, FRCPath (UK), A. Huntley Blair,\*\* PhD and Clennel E. vanRooyen,† MD,

Halifax, N.S.

Cancer of the breast is the most common cancer in women (i.e. 27% of all female cancers) and accounts for 18% of cancer deaths in females.<sup>1-3</sup> It is estimated for North America that breast cancer will strike one out of every eleven females at some time during their life.<sup>1</sup> At present, the incidence of breast cancer in Canada is 73/100,000 women per year.<sup>4,5</sup> In the 1986 census (verbal communication from Statistics, Canada), the populations of Halifax City, Metropolitan Halifax (i.e. Halifax, Dartmouth, Bedford and Sackville), Nova Scotia and Canada were 113,577; 295,990; 873,176 and 25,354,064 respectively. Assuming a male to female ratio of 1:1 (the precise ratio in Canada is 0.98:1)<sup>5</sup> the annual number of new cases of breast cancer will be Halifax City (41), Metropolitan Halifax (108), Nova Scotia (312) and Canada (9,254) respectively. In the U.S.A., 92 new cases of breast cancer are diagnosed every year for every 100,000 females.<sup>1</sup> The estimated incidence in the U.S.A. for 1986 was 123,000 new cases, and the expected mortality for 1986 was 40,200 (i.e. 39,900 females and 300 males).

## STATUS OF CURRENT METHODS OF TREATMENT

The death rates from breast cancer (i.e. .027% in the U.S.A. and .028% in Canada) have remained virtually unchanged for the past 50 years.<sup>1,4</sup> The most important reason why we have failed to have any positive effect on the mortality from this disease can be explained by the fact that most methods of treatment are directed towards local removal of tumors, even though there is spread of tumor cells beyond the initial site at the time of diagnosis. Thus a rational approach for improving the results of treatment of breast cancer and for having any impact on the inexorable mortality of this disease should be based on: i) early detection, especially before the spread of tumor cells beyond the primary site; and ii) development of methods of treatment that would eradicate tumor microemboli and micrometastases of the primary lesion that are not

removed or destroyed by local modalities of treatment such as surgery or irradiation. It is, therefore, not surprising that a variety of cytotoxic drugs and/or hormones are being used in the treatment of breast cancer after definitive primary therapy (i.e. adjuvant therapy) with the expectation that they would eradicate or inhibit micrometastases that otherwise would be fatal.

The Consensus Development Conference on Adjuvant Chemotherapy and Endocrine Therapy for Breast Cancer, September 9-11, 1985,<sup>6</sup> had concluded that "adjuvant chemotherapy has demonstrated a highly significant increase in disease-free survival and a significant reduction in mortality in premenopausal women with histologically positive axillary lymph nodes". However, "while survival advantages are evident, they remain far from ideal and improvement in the effectiveness of chemotherapy is a goal that must be given highest priority". The efficacy of adjuvant chemotherapy for postmenopausal women with histologically positive axillary lymph nodes is far more limited, and the estimates of increases in disease-free survival and overall survival are small.

Unfortunately, elimination of that last tumor cell by administering a cytotoxic agent (or radiation) cannot be assured because cytotoxic agents (and radiation) damage normal cells as well as tumor cells. Results of treatment with chemotherapeutic agents are improved by administering multiple agents in carefully designed treatment schedules and this is reflected in the greater survival rates for a number of cancers. Notwithstanding such improvements, tumor cells still survive therapy in many cases because of the necessity of limiting dosages of agents to levels that do not produce unacceptable side effects in the patient.<sup>7</sup>

## IMMUNOLOGICAL APPROACHES FOR THE TREATMENT OF BREAST CANCER

The key to more successful therapy lies in developing more specific modalities. One of the most specific interactions in nature is that between antibody and antigen, the basis of the immune reaction. Immune reactions may play a role in natural defence mechanisms against cancer. The application of immunological methods in the diagnosis and treatment of cancer is based on the fact that cancerous change is

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usually accompanied by the appearance on the surface of cancer cells of antigenic moieties, that are not demonstrable in the normal homologous tissue. There is also evidence that many human tumors synthesize substances that are either absent from or are produced in extremely limited amounts by adult normal tissues. These substances are called tumor associated antigens when either they provoke or serve as targets of immunologic reactivity. A number of tumor associated antigens has been detected in breast cancer tissue.<sup>8</sup>

Immunological methods that are currently under investigation for the treatment of cancer include: i) active immunization, either for the prevention of cancer or the treatment of an existing lesion and/or its metastases; ii) potentiation and amplification of the attack of a patient's own immune cells, especially cytotoxic T cells and killer cells against cancer cells with the use of products of T lymphocytes (e.g. interleukin 2), B lymphocytes (i.e. antibodies) or products of a variety of immune-system associated cells (e.g. interferon, tumor necrosis factor, etc.); and iii) use of antitumor antibodies, either to destroy cancer cells directly or to target cytotoxic agents selectively against cancer cells.<sup>9</sup>

### VACCINATION (ACTIVE IMMUNIZATION)

Active immunization has been remarkably successful in the prevention of those animal cancers that are caused by viruses, e.g. leukemia and leukemia-like conditions in cattle and poultry. Prevention of these cancers has contributed considerably to the financial well being of the food industry in several countries, including Canada. For example, vaccination has eliminated bovine leukemia in Canadian herds and the scourge of Marek's disease in turkeys.<sup>10</sup>

Viruses have been implicated in several human cancers.<sup>11</sup> For example, the hepatitis B virus may be one of the causes of liver cancer and the World Health Organization (WHO) has an ongoing program for vaccination against it. It will be interesting to see whether vaccination against hepatitis B prevents liver cancer as well.<sup>12</sup> Other human cancers against which vaccination may be effective include the Burkitt's lymphoma and nasopharyngeal carcinoma (etiologically associated with the infectious mononucleosis virus i.e. the Epstein-Barr virus), and carcinoma of the penis and the uterine cervix (associated with the human papilloma or genital wart virus).<sup>13</sup> However, there is no conclusive evidence for a viral etiology of human breast cancers.

### INTERFERON AND INTERLEUKINS

Though the rather unrealistic expectation of the effectiveness of interferon against all types of cancer has not been supported by the results of clinical trials, this agent has been found to be effective in the treatment of hairy cell leukemia, a rather uncommon

form of cancer.<sup>14</sup> Preliminary results from several centres, including the National Cancer Institute (U.S.A.) and the Harvard Medical School, have also demonstrated the effectiveness of interleukin-2 in activating killer cells against a patient's own tumor. The cells that are activated to attack and kill tumor cells, belong to the so called null cells (i.e. those that are neither T or B lymphocytes) and are more appropriately designated as lymphokine-activated killer cells (LAK cells). For activation, these cells have been obtained either from the patient's peripheral blood or from the tumor itself. The results of treatment of human cancer with interleukin-2 and LAK cells, though promising, are still very preliminary. Furthermore, this method of treatment is associated with considerable toxicity (at least one patient's death can be attributed to toxic side effects of treatment) and is also very expensive.<sup>15 16</sup> Studies are continuing at several centres to confirm the initial results and to devise methods for overcoming complications.

### ANTIBODIES

Antitumor antibodies, the product of tumor-antigen sensitized B cells, because of their specificity, were thought to be ideal for the selective destruction of tumor cells. However, our experience and that of others in experimental models, and results of recent phase I clinical trials of antitumor antibody alone have been disappointing, although, in an occasional patient, results were dramatic. Antibodies themselves are not inherently cytotoxic and their binding to a target cell does not affect growth except in rare instances. It is, therefore, essential to increase the cytotoxic effectiveness of antitumor antibodies, e.g. by their linkage to cytotoxic agents.<sup>8</sup>

Antibodies are protein molecules (i.e. immunoglobulins) that are produced by man and other animals after exposure to various foreign substances termed antigens. e.g. bacteria, viruses and chemicals. An antibody has the capacity to unite with and bind firmly to the antigen that elicited its production. This binding is highly specific; in other words, like locks and keys, only given pairs fit. Few chemical reactions can match the sensitivity and specificity of an antigen-antibody reaction. It is, therefore, not surprising that one approach has been to use antitumor antibodies, not as cytotoxic agents themselves, but rather to confer specificity on drugs and radionuclides by targeting them.<sup>8</sup> (This is necessary because, as already stated, most anticancer drugs and ionizing radiations are not cancer specific. They damage cancer cells as well as normal proliferating cells.<sup>7</sup>)

To circumvent this problem, the drug or radionuclide is linked to the antibody to form a conjugate that can be administered to the tumor host. The conjugate travels within the host to the tumor area, where binding can take place with the target antigen on the surface of tumor cells. In the case of conjugated

radionuclides, detection of emitted radiation by an imaging instrument such as a gamma camera, serves to delineate the site of the radioactivity and hence the tumor. In the case of a conjugated drug, bound conjugate may be taken up by cells through endocytosis which allows access of the drug to target molecules. However, the endocytosis process would not be required in cases where the target of the linked cytotoxic agent was on the cell surface.

## MONOCLONAL ANTIBODIES

The antibody-based targeting of drugs and radionuclides towards cancer cells has been greatly facilitated by the production and availability of monoclonal antibodies. Monoclonal antibodies are produced by individual clones of hybrid cells referred to as hybridomas. Their introduction by Kohler and Milstein in 1975 (for which they were awarded the Nobel Prize in Medicine), has revolutionized the scope of the application of antibodies in biology and medicine.<sup>17</sup> The methodology for their production provides, in principle, a technique for obtaining virtually unlimited quantities of antibody preparations in which 100% of the molecules are identical and will react identically (and uniquely) with a given antigen. It is the consistency of their reactivity that makes them so useful. Furthermore, for targeting, any substantial differential in tissue localization of an antibody in favour of tumor is likely to add to the chemotherapeutic index of linked agents.

Many laboratories, including our own, are now engaged in the production of monoclonal antitumor antibodies. For example, in our laboratory we have already produced monoclonal antibodies against human kidney cancer, human leukemic cells and are at present in the process of producing monoclonal antibodies against human breast cancer.<sup>18</sup>

In addition to their application for the treatment of cancer (either by themselves or as conjugates of cytotoxic agents), monoclonal antitumor antibodies are increasingly being used also for the diagnosis and monitoring of cancer and several other diseases. This includes the immunochemical diagnosis of cancer. For example, monoclonal antibodies are rapidly becoming a standard tool for diagnosis by microscopic examination of tissue samples in cancer and other diseases, especially autoimmune diseases involving kidneys, lungs, thyroid, etc. We shall use our anti-breast cancer monoclonal antibodies for distinguishing benign breast lesions from breast cancer and thus obtain reagents that will provide an objective basis for establishing the diagnosis of breast cancer, especially when lesions are early and when morphological examination by itself is not conclusive. Monoclonal antibodies can be used also to detect cancer- or fetus-produced materials in body fluids for the detection of cancer or pregnancy and evaluation of the success of cancer treatment.<sup>8</sup>

## TUMOR IMAGING WITH ANTIBODY LINKED RADIONUCLIDES (RADIOIMMUNOIMAGING OF TUMORS)

A fundamental requirement, for antibody mediated targeting, is that antibodies directed against tumor antigens consistently localize in tumor tissue when administered to the tumor host. That this is indeed the case was first demonstrated by studies in our laboratory using radiolabeled antitumor antibodies.<sup>19</sup> Localization was found to occur in amounts adequate for tumor detection and treatment in experimental tumors, human melanoma xenografts and cancer patients. The selective localization of radionuclide-labeled antitumor antibodies in tumors is the basis of radio-immunoinaging of tumors. It is recognized that our laboratory in Halifax was one of the first to demonstrate that antibody-linked radioactive iodine (and other radionuclides) can detect tumors in cancer patients.<sup>19 20</sup> Success rates at our centre and elsewhere have varied from 70% to 99.8%. One encouraging fact is that even very small deep seated tumors (that are undetectable by other currently available methods) can be visualized by radio-immunoinaging.<sup>8 19</sup> We expect that monoclonal anti-breast cancer antibodies will help us to detect small hidden metastases by radio-immunoinaging and then eradicate them with antibody-linked cytotoxic agents.

Among cytotoxic agents that have been linked to antitumor antibodies are: drugs such as Methotrexate®, daunomycin and chlorambucil; toxins such as gelonin, pokeweed antiviral protein, abrin, ricin, diphtheria toxin, and Pseudomonas exotoxin;<sup>21</sup> radionuclides such as <sup>131</sup>I.<sup>8 22</sup> In general, immunotoxins (i.e. antibody-linked toxins) have shown less consistent antitumor action than drug conjugates.<sup>8</sup> The very high potency of toxins makes specificity even more stringent. Uptake of conjugates by nonspecific processes also results in too high a toxicity to be clinically acceptable. The therapeutic use of immunotoxins has been confined mainly to the elimination of leukemia/lymphoma cells or T cells from bone marrow *in vitro*, prior to bone marrow transplantation.<sup>8</sup> Studies in our laboratory demonstrated that injection of <sup>131</sup>I labeled antibodies could prolong the survival and produce cure in a proportion of tumor bearing mice.<sup>22</sup> Further evidence of tumor regression has been obtained with antibody-bound <sup>131</sup>I after local administration, e.g., in ovarian cancer, ascites tumors and some liver tumors. However, responses were transient and the amounts of radioactivity necessary for tumor eradication may be unacceptably high.<sup>23</sup>

Long term survival of tumor-inoculated animals has been achieved with certain drugs in conjugate form, e.g. Methotrexate®, daunorubicin, and vindesine.<sup>8 21</sup> Because of its widespread clinical use and well elucidated structure-action relationships, modes of action and induction of drug resistance and the reversibility of its toxicity with leucovorin, etc., we

have focused our attention on the antimetabolite Methotrexate®. When covalently coupled to an antibody against mouse lymphoma, the conjugate inhibited tumor growth more effectively *in vivo* than did free Methotrexate, free antibody, Methotrexate followed by antibody or Methotrexate linked to nonspecific IgG antibody. Seventeen out of 27 treated mice survived tumor free for over a year, i.e. were cured.<sup>24</sup> Other studies in our laboratory showed that a Methotrexate® anti-melanoma monoclonal antibody conjugate inhibited a human melanoma xenografts more effectively than the monoclonal antibody, the free drug, a mixture of Methotrexate and monoclonal antibody, or the drug-linked to normal mouse IgG. A polyclonal anti-human melanoma IgG conjugate was tumor inhibitory to a lesser extent than the Methotrexate-monoclonal antibody conjugate.<sup>25</sup> Prior to this, we had shown that after i.v. injection, these two antibodies selectively localized in human melanoma xenografts.<sup>26</sup>

### CLINICAL TRIALS

Limited clinical trials have been carried out. In our Phase I study of melanoma, thirteen consecutive patients with inoperable recurrent malignant melanoma were treated with chlorambucil bound to goat or rabbit anti-human melanoma IgG. Two patients showed an objective tumor regression; 5 others showed stabilization; and 7 showed progression of their disease. The median survival of responders and stabilizers was 20 months. Immuno-chemotherapy prolonged survival compared to that in a DTIC-treated group ( $P < 0.05$ ). Our double-blind randomized study supports this conclusion (unpublished observations).<sup>27</sup> Melino and co-workers carried out a study of neuroblastoma. Of 7 neuroblastoma patients given injections of conjugated chlorambucil and daunorubicin (1 mg/kg), two with stage IV disease showed partial regression of tumor while those with less than stage IV disease had no evidence of disease after 3 years.<sup>28</sup> These phase I trials have demonstrated that this is a clinically feasible procedure with acceptable hazards; antibody-linked agents can be administered safely with only minor toxicity.

### PROSPECTS

We believe that like chemotherapy, the most promising use of immunochemotherapy (i.e. antibody-linked agents) will be for eradication of disseminated tumor cells and micrometastases (i.e. the real problems in the treatment of cancer). Surgery and/or radiation will remain the effective and preferred methods for local/regional treatment. Reasons for small metastatic lesions being most amenable to immunochemotherapy include ease of accessibility and diffusion of agents, and lack of avascular areas. We have demonstrated that small tumors show high specificity of localization of anti-tumor antibodies. Levels of circulating antigen that would neutralize carrier antibodies are also less likely. As the cytosidal

action of most chemotherapeutic agents follows first order kinetics, the smaller the tumor the smaller the number of residual cells. Also, there are likely to be smaller numbers of antigen-negative and drug-resistant cells. Lastly, cells in a small tumor are likely to be in cycle and in the logarithmic phase of proliferation, rendering them more vulnerable to chemotherapeutic agents.

Most monoclonal antitumor antibodies are at present of mouse origin and, therefore, likely to be immunogenic in patients and may provoke immediate hypersensitivity or immune complex mediated harmful reactions. However, after removal of aggregated IgG from chlorambucil-antimelanoma IgG conjugates, we failed to detect any precipitating antibody in patients given repeated injections of chlorambucil-polyclonal IgG.<sup>27</sup> Removal of IgG aggregates and initial high doses of anti-tumor IgG may induce tolerance instead of provoking a humoral response. Patients who are being given repeated injections of antibody-linked agents should be monitored by skin testing and assay of serum.

Fortunately, it has now become possible to produce monoclonal antibodies from human lymphocytes so that the antibodies, being of human origin, can be given more safely to patients.<sup>29</sup> Furthermore, using genetic engineering methods, it will soon be possible to dramatically scale up production of monoclonal antibodies of given specificities.<sup>8</sup> With the help of a Dalhousie Medical Research Foundation assisted medical student, we have started a project for the production of human monoclonal antibody against breast cancer.

Monoclonal antibodies of a specific type can behave as an antigen and thus have the potential for being used as a form of vaccine for active immunization against cancer. We have stated that an antigen fits like a key to the binding site of its antibody. It is now possible to produce antibodies to the binding site of an antibody. These are called anti-idiotypic antibodies. As both an antigen and an anti-idiotypic antibody fit with the binding site of a given antibody, the configurations of an antigen and the anti-idiotypic antibody have necessarily to be identical (i.e. two keys fitting a given lock have to be identical or at least have a major common configuration). Anti-idiotypic antibodies thus possess the steric configuration of the antigen and, therefore, hybridomas producing anti-idiotypic antibodies against antibreast cancer antibodies will provide an unlimited source of the cancer antigen configuration for immunization of susceptible populations.<sup>30</sup> The effectiveness and feasibility of this attractive hypothesis have to be explored.

Exciting developments in several allied scientific fields (i.e. our understanding of the biology of breast cancer cells and the reasons for the limitations of the current methods of treatment, the feasibility of the

production of monoclonal antibodies against breast cancer, the development of methods for the linkage of cancer chemotherapeutic agents to antibodies with retention of drug and antibody activities, etc.), have set the stage for devising novel and more effective methods for the treatment of breast cancer. We have, so far, failed to make any impact on the inexorable outcome of this dreadful disease that afflicts one out of every eleven females in this hemisphere. We hope that there will not be any hesitation in deploying enough resources to take advantage of these openings in our struggle against cancer. It should be pointed out that the monoclonal antibody technology is a very active and productive area of modern biotechnology, with the potential of a variety of applications in pharmaceutical and chemical industries, and it can generate economic activity based upon the co-operation, collaboration and technology transfer between university, government and industry. □

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# Gestational Trophoblastic Disease Registry

UPDATE - 1986

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A total of 30 new patients entered into the Nova Scotia Gestational Trophoblastic Disease Registry and Surveillance Program in 1986. Nineteen patients were confirmed to have benign hydatidiform mole (HCG titres returned to normal with no treatment other than the original D&C); four patients developed N.M.G.T.D.; one patient developed M.G.T.D.; one patient presented with non-gestational trophoblastic disease (choriocarcinoma); five patients had partial mole. (Table I)

TABLE I  
THE EXPERIENCE OF THE REGISTRY IN 1986

Benign Mole	19
NMGTD	4
MGTD	1
Non-gestational choriocarcinoma	1
Partial mole	5
TOTAL	30

## DIAGNOSIS

Ultrasound remains the diagnostic method of choice. Seventeen ultrasounds were performed on 24 patients. Fourteen were positive for hydatidiform mole. Three patients who had negative ultrasounds were subsequently found to have a molar pregnancy. This represents a false negative rate of 18% for ultrasonography in this condition.

Six patients were diagnosed following uterine curettage for the following; incomplete abortion (2), missed abortion (3), therapeutic abortion (1).

Two patients were diagnosed when suspected ectopic pregnancies were investigated.

Two patients had no information provided to the registry.

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## GLOSSARY:

D & C — Dilatation and Curettage

NMGTD — Non-metastatic gestational trophoblastic disease

MGTD — Metastatic gestational trophoblastic disease

HCG — Human chorionic gonadotrophon (serum - Beta subunit assay)

## Titres Normal

Of the nineteen patients confirmed to have benign hydatidiform mole, 11 had HCG titres which returned to normal in 4-8 weeks, 6 in 8-12 weeks, and 2 in 12-15 weeks.

## NMGTD

Four patients developed non-metastatic gestational trophoblastic disease and required adjunctive chemotherapy to eradicate their disease.

Two of the four were asymptomatic but had plateauing HCG titres. They were treated with two courses of alternating single agent chemotherapy and both remain in remission.

Two patients required a second D&C and one of the two had a hysterectomy performed. The pathology reports revealed residual molar tissue and invasive mole respectively. They were treated with two courses of alternating single agent chemotherapy and both remain in remission.

## MGTD

One patient developed metastatic gestational trophoblastic disease. She presented with plateauing HCG titres and, on investigation, a positive chest x-ray established the diagnosis of low risk MGTD. She was treated with five courses of alternating single agent chemotherapy and remains in remission.

## Choriocarcinoma

One patient presented with non-gestational metastatic trophoblastic disease (choriocarcinoma) and her case study follows.

## Case Study Non-gestational Trophoblastic Disease (Choriocarcinoma)

This 23 year old women with primary amenorrhea

presented with excessive vaginal bleeding which initially settled following IV premarin. Four weeks later the bleeding recurred and at this time a biopsy taken from visible tumor in the lower anterior vagina was found to be highly suggestive of choriocarcinoma.

Past history was unremarkable other than investigation for primary amenorrhea at age 15. Subsequent testing on this admission revealed the patient to be an XY gonadal dysgenesis.

Investigations in hospital included a CT scan of the brain, abdomen, and pelvis, all of which were normal. The chest x-ray showed a coin lesion in the right mid-zone of the lung. A serum Beta sub unit HCG done at the time of admission was 58,002 IU/L. A CSF Beta HCG was 59.2.

Laparoscopy and repeat tumor biopsy for karyotyping were performed. The laparoscopy revealed an infantile uterus with streak gonads. A tumor mass involving the posterior aspect of the uterus, the left streak gonad, and the left broad ligament was visualized. Histology from the vaginal tumor biopsy confirmed the presence of choriocarcinoma (XY karyotype).

The patient was begun on a Bagshaw's modified regime (EMACO) for high risk choriocarcinoma which consisted of VP16, Methotrexate® with leucovorin rescue, and Actinomycin D on Day 1 and 2, and Cyclophosphamide and (oncovin) Vincristine on day 8 repeated in cyclic fashion.

Following six courses of chemotherapy the patient's HCG titres had returned to normal and an abdominal hysterectomy, bilateral salpingectomy and biopsy of omentum were performed. No viable tumor was found in the pelvis. Tissue from the right "streak" sent for cytogenetic testing revealed that all cells were diploid and showed XY chromosome constitution.

This patient subsequently received an additional five courses of the same chemotherapy. She tolerated the treatment well with only transient nausea and vomiting, no fever or lower GI symptoms and no findings of toxicity. At this time she is four weeks post completion of therapy and remains in remission. She continues to receive weekly HCG determinations.

### THE QUESTIONABLE OR PARTIAL MOLE

In 1981, a study to evaluate the clinical significance of the partial mole (hydatidiform degeneration) was begun.

To the end of 1986, a total of 30 patients with partial mole have been registered. Twenty-nine patients have had their pathology reviewed by Dr. I. Zayid of the Dr. D.J. MacKenzie Diagnostic Centre, Victoria General Hospital, Halifax, N.S. One patient was lost to follow-up.

Twenty-three patients had HCG titres which returned to normal in 8 weeks or less. The remaining 6 patients entered the study late (5 at 2½ months, 1 at 5 months) and their titres were normal on entry.

Follow-up for all 29 patients was uneventful and ranged from 5-12 months (27 pts) to 1-2 months (2 pts).

The registry will continue to recommend six months of follow-up with HCG titres for the patient with partial mole. This decision is based on recent literature which suggests that 5-9% of patients with partial mole will develop persistent gestational trophoblastic disease. (Berkowitz RS *et al.* *Natural History of Partial Molar Pregnancy. Obstet Gynecol* 1985; 66: 677-681).

### TOTAL EXPERIENCE — Gestational Trophoblastic Disease

A total of 398 patients (partial mole excluded) have been registered with the Nova Scotia Gestational Trophoblastic Disease Registry as of December, 1986. (Table II)

TABLE II  
SOURCE OF REGISTERED PATIENTS

	1965-70	1971-75	1976-80	1981-85	1986
Nova Scotia	13(4)	27(8)	108(13)	72(14)	18(1)
New Brunswick		8(6)	31(2)	46(8)	5(3)
Prince Edward Island			4(0)	9(0)	0
Newfoundland			15(4)	39(5)	2(2)
St. Pierre			1(0)		
Total number of patients			398		
Number requiring Rx (in parenthesis)			70 or 18 percent		

### Benign Disease

Three hundred and twenty-eight patients were confirmed to have benign disease requiring no treatment other than the original D & C. (Table III)

TABLE III  
TOTAL EXPERIENCE OF THE REGISTRY

Benign Mole	328
NMGTD post molar pregnancy	49
MGTD post molar pregnancy	11
Choriocarcinoma (confirmed)	9
	397
Non-gestational choriocarcinoma	1
	398

### Non-metastatic and Metastatic Disease

Fifty-two patients developed persistent non-metastatic gestational trophoblastic disease. Seventeen patients developed metastatic disease. Nine of these patients had histologically confirmed choriocarcinoma and are dealt with separately.

Sixty patients (49 had NMGTD, 11 had MGTD) were successfully treated with 1-8 courses of chemotherapy and remain in remission. (Table III)

### Choriocarcinoma

Nine patients had histologically confirmed choriocarcinoma. Six of the nine had metastatic disease and three non-metastatic disease. (Table IV)

**TABLE IV**  
**CHORIOCARCINOMA**  
(confirmed histologically)

Choriocarcinoma (confirmed histologically)		
9 patients		
Post ectopic	(M)	1
Post molar pregnancy	(NM)	1
Post normal pregnancy	(M)	4 (3 died)
	(NM)	1
Etiology unknown	(M)	1 (recurrent chorio — expired 1987)
Hyst - DUB - pos preg test	(NM)	1
5 patients alive and well		
M = Metastatic		
NM = non Metastatic		

Three of the six patients with metastatic choriocarcinoma died. All three were diagnosed following a normal pregnancy and died of either advanced disease or complications of chemotherapy.

Five patients (2 with non-metastatic disease and three with metastatic disease) are alive and well following adjunctive chemotherapy and/or surgery.

One patient, diagnosed and treated three years ago for metastatic choriocarcinoma is currently being treated for recurrent disease. This patient had a 2½ year remission between the time of her original Dx and 1st recurrence. (Expired - 1987).

### Non-gestational Choriocarcinoma

One patient presented with non-gestational metastatic choriocarcinoma. (See case study)

### FOLLOW-UP RECOMMENDATIONS

Approximately 16% of the patients who have had a molar pregnancy will require adjunctive chemotherapy and/or surgery to eradicate their disease. For this reason follow-up with HCG titres is essential and can not be too greatly emphasized. Registration with the Nova Scotia Registry is recommended and can be made by writing to the Nova Scotia Gestational Trophoblastic Disease Registry, c/o Department of Gynecology, Suite 5004, Dickson Bldg., Victoria General Hospital, Halifax, N.S. B3H 2Y9. Phone 428-2263 or 428-2366.

The follow-up protocol for patients with gestational trophoblastic disease as recommended by the Nova Scotia Gestational Trophoblastic Registry is as follows:

#### After hospital discharge:

- HCG weekly until three consecutive normal levels are achieved. Then. . . . .
- HCG monthly for one year. Pregnancy is permissible after 6 months of normal titres. If pregnancy is suspected an ultrasound is indicated for early confirmation.

#### If chemotherapy was required then follow-up as follows:

- HCG weekly until three consecutive normal levels are achieved. Then. . . . .
- HCG monthly for one year. Then. . . . .
- HCG once every three months for one year. Pregnancy is permissible after 12 months of normal titres. If pregnancy is suspected an ultrasound is indicated for early confirmation.

#### If chemotherapy was administered for high risk trophoblastic disease follow-up is as follows:

- HCG weekly until three consecutive normal levels are achieved. Then. . . . .
- HCG once a month for two years. Pregnancy is permissible after two years of normal titres. Once again if pregnancy is suspected an ultrasound is indicated.
- HCG once every three months for the third year.
- HCG once every six months for the fourth year.
- Yearly thereafter. □

### ACKNOWLEDGEMENT

Our sincere thanks to the patients, physicians, and pathologists for their continued support.

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## Doane Raymond

Chartered Accountants



**PROCEEDINGS OF  
23rd MEETING OF COUNCIL**

**and**

**134th ANNUAL MEETING**

**of**



**The Medical Society of Nova Scotia**

**HALIFAX**

**November 27 - 28, 1987**

**THE MEDICAL SOCIETY OF NOVA SCOTIA**  
**PROCEEDINGS OF**  
**23rd MEETING OF COUNCIL**  
**AND**  
**134th ANNUAL MEETING**  
**November 27 - 28, 1987**

The 23rd Meeting of Council began as the Medical Society Officers, accompanied by Dr. Athol Roberts, President of The Canadian Medical Association, the Division Presidents, and Mr. D.D. Peacocke paraded through Council Chambers to the head table. Following call to order by Dr. Rob Stokes, Chairman of the Executive and General Council, the Officers and Dr. Roberts were introduced.

Mr. Peacocke read the names of Society members deceased since October 1, 1986 as follows: Dr. David B. Archibald of North Sydney; Dr. Ralph Wm. M. Ballem of Dartmouth; Dr. Robert M. Caldwell of Yarmouth; Dr. Herbert R. Corbett of Sydney; Dr. William A. Hewat of Lunenburg; Dr. Herbert L. Knodell of Halifax; Dr. Daniel A. MacDougall of Antigonish; Dr. Donald A. MacFadyen of Truro; Dr. Samuel Marcus of Bridgewater; Dr. Kaushika C. Marfatia of Bridgewater; Dr. Robert Matthey of Berwick; Dr. A.G. Patrick McDermott of Halifax; Dr. Devere T. Mosher of Louisbourg; Dr. Roy G. Munroe of Stellarton; Dr. Robert W. Napier of Halifax; Dr. Donald M. Nicholson of Halifax; Dr. Henry C. Reardon of Annapolis Royal; Dr. Arthur Shane of Halifax; Dr. Albert M. Sinclair of Halifax; Dr. Gordon K. Smith of Hantsport; and Dr. Bentley R. Wilson of Middleton.

The Transactions of the 22nd Meeting of Council and 133rd Annual Meeting (1986) as printed in the December 1986 issue of The Nova Scotia Medical Bulletin were approved.

Council approved a motion that the narrative of all reports and supplementary reports be received for information.

#### EXECUTIVE DIRECTOR'S REPORT

Mr. Peacocke's report provided Council with information on action taken by the Society relative to decisions made at Council 1986. Highlighted was his reference to doctor/patient communications regarding the volume of complaints directed to the Society. He drew attention to C.M.P.A. Information Letter Vol. 2, No. 3, Page 2 - i.e. the quote of Dr. James Todd, President

of the Physician Insurers' Association of America "with almost any lawsuit that we investigate in our company, somewhere along the line there is a breakdown in communication followed by a breakdown in confidence". He added that many examples could be given where the motivation that made a patient a plaintiff was borne of a breakdown in communications, either with the physician or a member of his staff. Mr. Peacocke, continuing with the reference, stressed that receptionists and other office personnel must know how each physician wants telephone calls handled adding that physicians who have designed instruction charts for their office staff on this matter find it helpful indeed.

Mr. Peacocke paid tribute to the Society office staff whom he declared to be efficient, capable, loyal and dedicated.

#### EXECUTIVE COMMITTEE CHAIRMAN'S REPORT

In his report to Council Dr. Stokes provided a concise resume of business conducted by the Executive Committee during the past year.

He noted that in September 1987 the Executive Committee approved By-Law changes which had been examined by the Executive Committee and the By-Laws Committee on numerous occasions during the year. Dr. Stokes gave Council a brief explanation of the rationale for each of the proposed changes which follow:

#### RESOLUTION 1

*"THAT Sections 5.2.1 and 5.2.2. of the By-Laws of The Medical Society of Nova Scotia be amended to read:*  
*5.2.1 Application for recognition as a Section of the Society must be presented to the Executive Committee not less than three months before the Annual Meeting, and shall be published in the Bulletin at least one month prior to the Annual Meeting.*

5.2.2 The application shall include:

- (a) The name of the proposed Section.
- (b) The names of ten or more Society members sponsoring the proposed Section.
- (c) The names of the interim chairman and secretary of the proposed Section.
- (d) Reason why the formation of a new Section will benefit both the members of the proposed new Section and the Society as a whole."

CARRIED

#### RESOLUTION 2

"THAT Section 6.15.6 of the By-Laws of The Medical Society of Nova Scotia be renumbered to read 8.1.2."

CARRIED

#### RESOLUTION 3

"THAT SECTION 11.6.1 of the By-Laws of The Medical Society of Nova Scotia be amended to read:

11.6.1 The Treasurer shall be the custodian of all monies, securities and deeds which are the property of the Society. He shall pay by cheque only; such cheques shall be signed by two persons authorized by the Executive Committee. All such cheques are to be covered by voucher. He shall provide an annual financial statement audited by a chartered accountant. He shall furnish a suitable bond for the faithful discharge of his duties, the cost of such bond to be borne by the Society. He shall be responsible for the annual review of all salaries of the secretariat and bring recommendations to the Executive Committee. He shall be Chairman of the Finance Committee."

CARRIED

#### RESOLUTION 4

"THAT Section 12.2 of the By-Laws of The Medical Society of Nova Scotia be amended to read:

12.2 Appointment of Statutory Committees:  
Statutory Committees shall be:  
The Nominating Committee  
The Executive Committee  
The Finance Committee, and

THAT Section 12.2.1 be amended to read:

12.2.1 The Executive Committee shall be elected at the Annual Meeting of the Society."

CARRIED

#### RESOLUTION 5

"THAT Section 12.3.1 of The By-Laws of The Medical Society of Nova Scotia be amended to read:

12.3.1 The Nominating Committee shall be composed of one member of each Branch Society, who shall be the immediate Past-President of the Branch Society or his designated alternate. The chairman of the Nominating Committee shall be the President of the Society. In the absence of the President the Committee shall elect its own chairman."

CARRIED

#### RESOLUTION 6

"THAT SECTION 12.3.2.1 of the By-Laws of The Medical Society of Nova Scotia be amended to read :

12.3.2.1 At the Annual Meeting the Nominating Committee shall place in nomination the Executive Committee of the Society as follows:

Executive Committee

i) Officers:

A President-Elect

A Chairman of the Executive Committee

A Vice-Chairman of the Executive Committee

A Treasurer

An Honorary Secretary

A Member-At-Large (When Required)

In the event that the Presidency will not, for whatever reason, be taken by the President-Elect, then the Nominating Committee will nominate a President."

CARRIED

#### RESOLUTION 7

"THAT Section 12.3.4.1 of the By-Laws of The Medical Society of Nova Scotia be amended to read:

12.3.4.1 When the report of the Nominating Committee has been received by the Annual Meeting other nominations, as delineated in 12.3.2.1 (i), may be received from the floor, provided such nominations are placed in writing in the hands of the Executive Director not less than one week prior to the Annual Meeting. Such nominations must be signed by ten members of the Society in good standing and such nominations must be accompanied by the written consent of the nominee to serve, together with his Curriculum Vitae. A ballot shall be taken for each of the offices in turn as well as for the elected membership of the Executive Committee."

CARRIED

## RESOLUTION 8

*"THAT Section 12 of the By-Laws of The Medical Society of Nova Scotia be amended by deletion of Section 12.5 - Discipline Committee: and deletion of Sub-Section 12.5.1. in its entirety."*

CARRIED

During debate of the foregoing resolution the following paragraph, an extract from legal counsel's letter regarding deletion of the terms of reference of the Discipline Committee, was presented. It reads as follows:

"It is our respectful opinion that if the Medical Society's Discipline By-Laws were to be challenged in a court of law (for example, by a member who had been disciplined), the by-law would be struck down and with it the punishment that was meted out. In the context of the general law, the Medical Society's enabling legislation does not expressly provide powers to the Medical Society to discipline its members, contrary to the principle enunciated in the KEOGH case. In the context of the Medical Society's Act of Incorporation, By-Laws relating to Discipline do not meet the test provided for in Section 2 in that they are repugnant to the laws of the Province which, in our opinion, include the KEOGH principle."

## RESOLUTION 9

*"THAT the By-Laws of The Medical Society of Nova Scotia be amended by insertion of:  
12.5 The Finance Committee*

*12.5.1 Terms of Reference - The Committee shall consist of the Treasurer as Chairman and four voting members of the Society approved by the Executive Committee. The Committee shall meet at least twice yearly.*

*Two voting members of the Committee and the Chairman shall constitute a quorum.*

*The Committee shall be charged with a special duty of studying the immediate and long-term financial needs of The Society, including the establishing of reserve funds, and shall present in its Annual Report to Council appropriate fiscal policies to meet these needs.*

*The Committee shall follow Society Investment Policy in managing Society investments, and may seek professional investment counsel in directing the policy.*

*When directed the Committee shall assess the financial implications of programs and projects and make recommendations to the Executive Committee.*

*The Committee shall prepare for approval by the Executive Committee a budget for the ensuing year indicating distribution of monies to be made available for all purposes.*

*This Committee shall report regularly to the Society's Executive Committee.*

*The Committee shall report annually to Council. Its report shall cover all financial activities of the Society during the previous calendar year and shall indicate the revenues necessary for the subsequent year.*

*The adoption by Council of the annual reports of the Finance Committee and of the Auditor shall validate all financial transactions of the Executive Committee, the Finance Committee and other Committees of the Society during the year covered. The Committee shall recommend the appointment of Auditors to the Council annually.*

*The Committee shall check all expenditures of funds to ascertain that they are properly made, and bring to the attention of the Executive Committee any likely over-expenditures, misappropriation, misuse, or discrepancy in the Society's funds.*

*The Committee shall be responsible to the Executive Committee for classification of positions, salaries, management and general welfare of the staff of the Society."*

CARRIED

## RESOLUTION 10

*"THAT Section 12.7.1 of the By-Laws of The Medical Society of Nova Scotia be amended to read:*

*12.7.1 The Executive Committee shall have power to establish Standing Committees, to vary their number from time to time and to discontinue their activities. The Chairman of Committees designated by the Executive Committee as Standing Committees shall be appointed by the Executive Committee which, in addition to the duties provided in 12.8 of this chapter, shall also provide or vary their terms of reference. Standing Committees shall report to the Executive Committee when requested to do so, and to the Annual Meeting after prior submission of that report to the Executive Committee. The Chairman of any Standing Committee shall not serve for more than three consecutive years, after one year's absence he shall become eligible for re-election."*

CARRIED

## RESOLUTION 11

"THAT Section 3 of the Rules and Regulations of the By-Laws of The Medical Society of Nova Scotia be amended to read:

### 3. STANDING COMMITTEES

3.1 Recognized as of the date of the adoption of these By-Laws are the following Standing Committees. This list may be varied by the Executive Committee as it may determine.

Committees on:

Allied Health Disciplines

Annual Meetings

Archives

Awards Committee

By-Laws

Cancer

Child Health

Community Health

Drug & Alcohol Abuse

Editorial

Environment

Ethics

Hospital & Emergency Services

Liaison Committees

(i) Faculty of Medicine

(ii) Minister of Health

(iii) Registered Nurses' Assoc.

(iv) Workers' Compensation Board

Maternal & Perinatal Health

Medical Education

Membership Services

Nutrition

Occupational Health

Pharmacy

Physical Fitness

Presidents' Committee

Professionals' Support Program

Risk Management

Senior Advisory Committee"

CARRIED

During 1987 the Chairman of the Executive Committee was authorized to strike a Search Committee for Committee Chairmen of the Society and Representatives to Other Organizations. Arising from the report of that Search Committee was

## RESOLUTION 12

"THAT the appointment of Committee Chairmen as set out at the end of 1987 Transactions be approved."

CARRIED

## RESOLUTION 13

"THAT the appointment of Representatives to Other Organizations as set out at the end of 1987 Transactions be approved."

CARRIED

## PRESIDENT'S REPORT

Dr. Bill Acker highlighted his comprehensive overview of Society activities during the past year by bringing the members up to date on such items as the M.M.C./M.S.I. administration issue, the portable/non-portable budget for hospitals problem, the contrast media situation, as well as implementation of the Evidence Act changes so long sought after by the Medical Society. He also updated Council on the changes to the terms of reference of the Economics Committee, the essence of which are to relieve the workload of the Economics Committee and more directly involve the Officers in tariff negotiations. Working closely with the Economics Committee, a committee of the Officers will in future be responsible for negotiating tariff settlements with the Economics Committee providing background data and being responsible for the distribution of a tariff settlement.

The Economics Committee Report was considered in-camera at a later time; however, the details follow at this point since the Economics Committee is a Committee of the Officers, responsible to the Officers, thus the unique reporting arrangement.

After reviewing briefly the contents of his report to Council, Dr. Sandy Cameron then described an economics scenario of the future with utilization playing the key role. He stated that the Medical Society's study of this issue will assume great importance in relations with government in the future.

Dr. Cameron outlined the approach taken by his Committee for distribution of the tariff settlement for April 1, 1988, and how the distribution would address the general practitioner/specialist net income ratio. Extended and lively debate ensued with many comments and opinions being presented which will be of value to the Economics Committee as it deals with this difficult issue.

Dr. Cameron introduced the chairmen of the numerous sub-committees and task forces functioning under the direction of the Economics Committee, and expressed sincere appreciation to them for the long and difficult hours they put in on Society work.

## REPORTS OF STANDING COMMITTEES

### ARCHIVES COMMITTEE

Dr. Ian Cameron's Report to Council outlined the Current, In Progress, and Proposed projects receiving the attention of his Committee. Following this he gave Council some idea of the types of archival material in the Committee's possession by the use of slides. Dr. Cameron also pointed to the important work being undertaken By Mr. Owen McNerny who is serving as the Archivist on behalf of the Joint Archives Committee. He recommended continued support for retaining the services of an archivist.

#### **RESOLUTION 14**

*"THAT The Medical Society of Nova Scotia continue to support the salary of the Medical Archivist with an annual grant of \$7,000.00."*

CARRIED

### BUILDING COMMITTEE

Dr. John Hamm reminded Council of the resolutions passed at Council 1986, these being:

- A. THAT The Medical Society of Nova Scotia purchase the property in the City of Lakes Business Park on the site indicated in Appendix "A" to the Report of the Relocation Committee.
- B. THAT The membership dues for ordinary members be increased by \$100.00 commencing October 1, 1987. Such increase to remain in place for five successive years, with the revenues from said increases to be applied to the Relocation Project.
- C. THAT the Relocation Committee be redesignated the Building Committee.
- D. THAT the Building Committee be authorized to proceed with the proposal to build a Society office in the City of Lakes Business Park,  
THAT for the Fiscal Year 1987 this authorization pertain solely to preparation of an architectural concept and design; and  
THAT the amount of money for this purpose be restricted to \$40,000.00.

Dr. Hamm and the Architects (Drew Sperry and Peter Connor) then provided a description of the proposed building and financing for the project.

### RESOLUTION 15

*"THAT Council endorse the proposal of the Building Committee and the Medical Society proceed with construction of its headquarters building as heretofore described."*

CARRIED

### EDITORIAL BOARD

Dr. J.F. O.'Connor reported another successful year for the Bulletin.

#### **RESOLUTION 16**

*"THAT the name of the Nova Scotia Medical Bulletin be changed to The Nova Scotia Medical Journal."*

CARRIED

#### **RESOLUTION 17**

*"THAT The Nova Scotia Medical Journal be published by The Medical Society of Nova Scotia following the tradition of The Nova Scotia Medical Bulletin."*

CARRIED

### FINANCE COMMITTEE

Dr. Vince Audain, to begin his report, drew Council's attention to the Budget for Fiscal Year 1988 noting that it had been approved by the Executive Committee on September 19, 1987.

Dr. Audain then introduced the Financial Statements of the Society for Fiscal Year 1987 which had been prepared by Doane Raymond and circulated just prior to the meeting. The Treasurer then highlighted the significant points set out in the Statements.

#### **RESOLUTION 18**

*"THAT the Financial Statements of The Medical Society of Nova Scotia for Fiscal Year 1987 be approved."*

CARRIED

#### **RESOLUTION 19**

*"THAT Doane Raymond be retained as The Medical Society of Nova Scotia Auditors for Fiscal Year 1988."*

CARRIED

## RESOLUTION 20

*"THAT membership dues for Ordinary Members of the Medical Society for Fiscal Year 1989 be increased by \$30.00 with other categories of membership dues to be increased proportionately."*

CARRIED

Discussion ensued regarding pre-circulation of financial material to members of the Society. It was noted that the Budget, normally approved at the September meeting of the Executive Committee, was circulated by the Minutes of that meeting to literally all of Council prior to the end of September. This was done in the expectation that Branch Presidents would discuss the Budget with their members if this was desired at that time or subsequently when the Budget was published in Reports to Council approximately one month prior to Council. The consensus was that each member should receive this personally rather than discuss it at Branch Society level.

## RESOLUTION 21

*"THAT the Finance Committee distribute annually to the entire membership its Budget with a President's Letter as early in the Fall as possible."*

CARRIED

## MEDIATION COMMITTEE

Dr. Bill Acker, explaining that this Committee is struck for the purpose of providing a means for investigating and resolving private disputes as separate from complaints against the conduct of a physician, expressed his concern that the work of this Committee continues to grow in scope with each passing year. He expressed the well-founded view that in the main doctor/patient communications is the fundamental problem underlying the situation. Noting that the Risk Management Committee of the Society was working with this subject, he urged, as does the Risk Management Committee, that doctors give increased attention and consideration to the matter of their relations with their patients.

## MEDICAL EDUCATION

Dr. Vonda Hayes briefly recounted the history of the development of the integrated two-year postgraduate preclicensing training program, noting that the Medical Society has endorsed the C.M.A. Policy that an integrated two-year family medicine training program should become the preferred route to general family practice. She pointed out that the next step would be adoption by the licensing authorities across Canada of this educational policy for physicians, and that this would have to be followed by provision of funds by government to undertake the programs. Lengthy discussion ensued regarding the Medical

Society's policy in this respect. The President of the Ontario Medical Association described the situation in Ontario by noting that there is still a wide difference of opinion as to the necessity or otherwise of a two-year postgraduate preclicensing training program for family physicians. The consensus was that urging the Provincial Medical Board to adopt the two-year program was premature and that an approach to government for funding would be inappropriate until the Society's policy was clarified.

## RESOLUTION 22

*"THAT The Medical Society of Nova Scotia urge the Provincial Medical Board to:*

- (a) adopt a two-year preclicensure training requirements, and*
- (b) ensure that this training be of suitable content relevant to the practice of family medicine."*

REFERRED TO EXECUTIVE COMMITTEE

## RESOLUTION 23

*"THAT The Medical Society of Nova Scotia express to the government its support of the two-year program and impress on the government the necessity of government financial support of the program."*

REFERRED TO EXECUTIVE COMMITTEE

## RESOLUTION 24

*"THAT The Medical Society of Nova Scotia continue to support Continuing Medical Education both financially and by attendance and participation in C.M.E. Programs."*

CARRIED

## RESOLUTION 25

*"THAT The Medical Society of Nova Scotia explore various methods of educating the public about current health concerns."*

CARRIED

## RISK MANAGEMENT COMMITTEE

Dr. John Anderson, reporting on behalf of Dr. Harold Yazer, informed Council that he, representing the Committee and Mr. Peacocke representing the Society had met with the advance guard of the Federal/Provincial/Territorial Task Force on Liability and Compensation issues in Health Care at which time Dr. Frank Sellers encouraged presentation of Briefs from all Divisions. Dr. Anderson noted these should be presented by the end of March 1988 and that Dr. Sellers had been informed that the Society with the support of the Risk Management Committee would be preparing a Brief on this topic.

## SENIOR ADVISORY COMMITTEE

Dr. Judy Kazimirski, speaking for the Past Presidents of The Medical Society of Nova Scotia following their breakfast meeting Saturday morning took pleasure in announcing the Past Presidents' support for the Building project and noted that they had offered to take on the task of decorating/furnishing the President's office in the new building. The Presidents, through Dr. Kazimirski, expressed the hope that Branches and Sections of the Society would also consider how they could provide similar support to the Medical Society.

## OTHER COMMITTEES

The following committees of the Medical Society reported to Council without there being motions presented. It is recommended that their reports be reviewed using the Reports to Council as a reference.

### ALLIED HEALTH DISCIPLINES

(including Task Force on Health Personnel Standards Act)

#### BY-LAWS COMMITTEE

#### CANCER COMMITTEE

#### DISCIPLINE COMMITTEE

#### DRUG & ALCOHOL ABUSE COMMITTEE

#### ENVIRONMENT COMMITTEE

#### ETHICS COMMITTEE

#### FACULTY OF MEDICINE LIAISON COMMITTEE

#### MINISTER OF HEALTH LIAISON COMMITTEE

#### REGISTERED NURSES' ASSOC. LIAISON

#### WORKERS' COMPENSATION BOARD LIAISON

#### MATERNAL & PERINATAL HEALTH COMMITTEE

#### MEMBERSHIP SERVICES COMMITTEE

#### NUTRITION COMMITTEE

#### OCCUPATIONAL HEALTH COMMITTEE

#### PHARMACY COMMITTEE

#### PHYSICAL FITNESS COMMITTEE

#### PROFESSIONALS' SUPPORT PROGRAM

## REPORTS OF NOVA SCOTIA REPRESENTATIVES TO C.M.A.

### C.M.A. BOARD OF DIRECTORS

Dr. Judy Kazimirski highlighted the extensive range of business conducted by the C.M.A. Board of Directors. The subject of the Society's representation on the C.M.A. Board was discussed. The C.M.A. President and the Past Presidents suggested that the current stipulation of two years maximum be extended to three years normal with an up to two year extension if deemed appropriate. It was noted that this subject will be discussed in the near future by both the Officers and Executive Committee.

## COUNCIL ON HEALTH CARE

Dr. Dan Reid highlighted the business of his Council during the past year, following which three recommendations were introduced.

### RESOLUTION 26

*"THAT The Medical Society of Nova Scotia urge the Provincial Department of Education to institute educational programs concerning drug abuse in all schools and that all members of The Medical Society of Nova Scotia be encouraged to provide assistance and consultation on such matters at their local levels."*

CARRIED

### RESOLUTION 27

*"THAT The Medical Society of Nova Scotia encourage the Provincial Departments of Health and Education to immediately introduce a public education program on AIDS, including offering such programs to the school population."*

CARRIED

### RESOLUTION 28

*"WHEREAS Canadian women express high levels of satisfaction with the system of delivery of obstetrical care in Canada, and WHEREAS the CMA believes that the current system of delivery of obstetrical care in Canada is basically sound, and WHEREAS neither a need nor a significant demand for the services of midwives has been demonstrated:  
BE IT RESOLVED THAT The Medical Society of Nova Scotia urge the Government of Nova Scotia to refrain from introducing legislation that will allow the licensing of midwives."*

CARRIED

## COUNCIL ON MEDICAL ECONOMICS

Dr. Phil Muirhead's report was received for information there being no recommendations.

## COUNCIL ON MEDICAL EDUCATION

Although only recently appointed as the Medical Society's representative to this Council, Dr. Gerry Myatt provided a very detailed review of the work of his Council during the past year, plus a brief summary of activities the Council expected to pursue during the forthcoming year.



## **RESOLUTION 29**

*"THAT The Medical Society of Nova Scotia encourage the development and implementation of action plans to recruit physicians to work in underserved areas in Nova Scotia."*

**CARRIED**

## **MD MANAGEMENT LIMITED**

In speaking to his report, Dr. George Sapp brought Council up to date on the status of MD Management plans since the market has "undergone a correction". He stated that the high quality of advice being provided to MD Management has left the plans in comparatively good position. He also described the experience of MD Management plans on both short, medium, and long term and urged all members to carefully consider them as their best options.

## **REPORTS OF SECTIONS**

Council received for information reports from Sections of the Society listed below which did not include recommendations. These are included in reports to Council and where there is interest they are recommended for your consideration.

### **ANAESTHESIA**

(including Anaesthesia Mortality Review Committee)

**EMERGENCY MEDICINE  
GENERAL PRACTICE  
INTERNAL MEDICINE  
INTERNES/RESIDENTS  
LABORATORY MEDICINE  
OPHTHALMOLOGY  
ORTHOPAEDIC SURGERY  
OTOLARYNGOLOGY  
PAEDIATRICS  
PSYCHIATRY  
RADIOLOGY  
SURGERY**

## **REPORTS OF REPRESENTATIVES TO OTHER ORGANIZATIONS**

### **COMMUNICABLE DISEASE CONTROL ADVISORY COMMITTEE**

In speaking to his report, Dr. Marrie noted that it dealt entirely with AIDS. He updated Council on developments which have occurred since his report was written, adding that it contained two recommendations arising from concerns about this disease.

## **RESOLUTION 30**

*"THAT The Medical Society of Nova Scotia strike a committee to begin a multi-faceted program directed at educating the public about AIDS."*

**CARRIED**

## **RESOLUTION 31**

*"THAT physicians who are caring for patients who are HIV positive and refer these patients to other health professionals indicate as part of the referring note that their patient is on blood and body precautions."*

**CARRIED**

There followed lengthy discussion regarding the matter of maintenance of confidentiality in doctors' offices particularly in relation to AIDS and AIDS testing. Strong and decisive action was proposed taking the form of

## **RESOLUTION 32**

*"THAT The Medical Society of Nova Scotia recommend that any employee of a doctor's office or a public hospital be informed that divulging confidential medical information on any patient be reprimanded, which may include dismissal."*

**DEFEATED**

## **RESOLUTION 33**

*"THAT the matter of confidentiality of medical records and information be referred to the Medical Society Executive Committee for a complete discussion of all the ramifications of maintaining such confidentiality so that a Policy Statement can come forward as soon as possible."*

**CARRIED UNANIMOUSLY**

## **MARITIME MEDICAL CARE INC.**

Dr. J.M. O'Brien informed Council that he was pleased to report that the administration of M.S.I. Contract had been reinstated, at least until May 1989, adding that he was hopeful that M.M.C. will be able to administer the Program for many years to come. He expressed the view that the Royal Commission would likely find that M.M.C. is clearly the superior organization to undertake this important activity.

## PROVINCIAL MEDICAL BOARD

Although the report of Dr. H.S. MacDonald was not actually presented and discussed the subject of costs of Disciplinary Hearings was raised.

### RESOLUTION 34

*"THAT The Medical Society of Nova Scotia request the Provincial Medical Board to look into the matter of the cost of Disciplinary Hearings, and, in particular, the practice of taxing the costs back to the physician involved, should he be found guilty of even a minor misdemeanor."*

CARRIED

## SMOKING AND HEALTH (NOVA SCOTIA COUNCIL ON)

Dr. Don Fay, in presenting his report, provided one recommendation for Council to consider.

### RESOLUTION 35

*"THAT The Medical Society of Nova Scotia contact chief administrators and heads of medical staff at each hospital in Nova Scotia and strongly urge implementation of a comprehensive hospital non-smoking policy, whereas many hospitals in Nova Scotia fail to implement an effective "non-smoking" policy."*

CARRIED

## UNDERGRADUATE MEDICAL EDUCATION COMMITTEE

Dr. Dave MacLean, in presenting his report, expressed the view that he needed more precise direction regarding his role on this Committee. He also pointed to the onerous financial implications of participating in a committee that meets weekly.

### RESOLUTION 36

*"THAT The Medical Society of Nova Scotia through the Executive Committee in consultation with the Medical Education Committee, provide some direction to the Society's UMEC representative on issues to be brought forward to this Committee on behalf of the Society."*

CARRIED

### RESOLUTION 37

*"THAT The Medical Society of Nova Scotia consider establishing financial remuneration for the Society's representative to the Undergraduate Medical Education Committee."*

CARRIED

Numerous other Representatives to Other Organizations listed below reported to Council without making specific recommendations. Their reports deserve your interest and consideration. They are contained in Reports to Council.

ABILITIES FOUNDATION OF NOVA SCOTIA  
CANADIAN CANCER SOCIETY  
DALHOUSIE REFRESHER COURSE PLANNING  
COMMITTEE  
MEDICAL ADVISORY CTTE. ON DRIVER LICENSING  
DRUG INFORMATION ADVISORY COMMITTEE  
HEALTH PROFESSIONS FOR ORGAN DONATION  
LABORATORY SERVICES COMMITTEE  
LUNG ASSOCIATION OF NOVA SCOTIA  
CANADIAN PHYSICIANS FOR PREVENTION OF  
NUCLEAR WAR  
BOARD OF REGISTRATION OF NURSING  
ASSISTANTS  
NURSING LIAISON COMMITTEE  
OCCUPATIONAL MEDICAL ASSOC. OF CANADA  
PHYSICIAN MANPOWER ADVISORY COMMITTEE  
Rh COMMITTEE  
SAINT JOHN AMBULANCE ASSOCIATION  
NOVA SCOTIA SAFETY COUNCIL  
SCHOOL HEALTH EDUCATION IN NOVA SCOTIA  
(Association for the Advancement of)  
VICTORIAN ORDER OF NURSES

## NEW BUSINESS OF COUNCIL

### AMBULANCE PERSONNEL

On behalf of the Dartmouth Branch Dr. W.D. Canham raised the issue of adequacy of ambulance services in Nova Scotia.

### RESOLUTION 38

*"THAT The Medical Society of Nova Scotia urge the Province of Nova Scotia to enact legislation in the form of an Act to regulate the training, equipping, and functioning of ambulances and personnel in the Province of Nova Scotia."*

CARRIED

In speaking to the foregoing resolution Dr. Canham stated that in Dartmouth physicians are being asked by ambulance personnel to authorize them to undertake medical services - for example, defibrillation, administering of drugs, commencing i.v.'s, etc. This has presented a difficult position for the physicians in the absence of legislation defining what may or may not be authorized. There was widespread support for the proposal.

## ELECTION OF BRANCH REPRESENTATIVES TO THE 1988 EXECUTIVE COMMITTEE

Antigonish-Guysborough	Dr. M.A. MacKenzie
Bedford-Sackville	Dr. G.L. Myatt
Cape Breton	Dr. P.W. Littlejohn
Colchester East Hants	Dr. D.E. Ryan-Sheridan
Cumberland	Dr. W.G. Gill
Dartmouth	Dr. G.L. Roy
	Dr. M.F. Moriarity
Eastern Shore	Dr. D.R. Barnard
Halifax	Dr. C.W.G. Phillips
	Dr. A.H. Murray
Inverness-Victoria	Dr. G.W. Thomas
Lunenburg-Queens	Dr. D.V. Wright
Pictou	Dr. F.A.C. Galvon
Shelburne	Dr. Mark Riley
Sydney	Dr. R.H. Bedard
Valley	Dr. W.M. Enright
Western	Dr. S.M.T. Leahey
Student Members	D. Jones, M. Atwell & B. Carr
I.R.A. Representatives	L. Pereira & D. Mosher

## ELECTION OF OFFICERS

President	Dr. J.D.A. Henshaw (Berwick)
President-Elect	Dr. V.P. Audain (Halifax)
Chairman of the Executive Committee	Dr. A.H. Parsons (Halifax)
Vice-Chairman	Dr. G.A. Ferrier (Liverpool)
Treasurer	Dr. R. Brewer Auld (Halifax)
Honorary Secretary	Dr. E.R. Sperker (Westville)
Executive Director	Mr. D.D. Peacocke

The 134th Annual Meeting of The Medical Society of Nova Scotia adjourned at 2:00 p.m., Saturday, November 28, 1987.

The 135th Annual Meeting and 24th Meeting of Council of The Medical Society of Nova Scotia will take place November 24 through 26, 1988 in the World Trade and Convention Centre and the Prince George Hotel, Halifax, Nova Scotia.

## APPOINTMENT OF COMMITTEE CHAIRMEN

Allied Health Disciplines	Dr. J.H. Quigley
Archives	Dr. I.A. Cameron
Awards	Dr. E.V. Rafuse
By-Laws	Dr. P.W. Littlejohn
Cancer	Dr. A.J. Bodurtha
Child Health	Dr. P.C. Bagnell
Community Health	
Drug & Alcohol Abuse	Dr. E.L. Reid
Editorial Board	Dr. J.F. O'Connor
Environment	Dr. D.B. Shires
Ethics	Dr. D.M. Rippey
Finance (Treasurer)	Dr. R. Brewer Auld
Horizons	Dr. E.V. Rafuse
Hospitals & Emergency Services	Dr. G.P. Reardon
<i>Liaison Committees</i>	President
(i) Faculty of Medicine	
(ii) Minister of Health	
(iii) Registered Nurses Association	
(iv) Workers' Compensation Board	

Maternal & Perinatal Health	Dr. E.R. Luther
Mediation	President
Medical Education	Dr. V.M. Hayes
Membership Services	Dr. G.L. Myatt
Mortality Review (Anaesthetic)	Dr. K.W. Fairhurst
Nutrition	Dr. M.S. Tan
Occupational Health	Dr. A.D. Doucet
Pharmacy	Dr. J.P. Anderson
Physical Fitness	Dr. M.K. Pottle
President's Committee	President
Professionals' Support Program	Dr. W.G. Gill
Risk Management	Dr. H. Yazer
Senior Advisory	T.B.A.

## APPOINTMENT OF REPRESENTATIVES TO OTHER ORGANIZATIONS

Abilities Foundation of NS	Dr. J.J.P. Patil
Canadian Cancer Society (NS Division)	Dr. A.J. Bodurtha
Communicable Disease Control (Advisory Committee)	Dr. T.J. Marrie
Diagnostic Imaging Committee	Dr. D.W.F. King
	Dr. J.A. Chadwick
Driver Licensing (Medical Advisory Com)	Dr. C.C. Giffen
Drug Information Committee (Camp Hill)	Dr. R.A. Purdy
	Dr. Jean Gray
Drugs & Therapeutics (Formulary)	Dr. G.C. Jollymore
	Dr. C.R.T. Dean
Kellogg Health Sciences Library	Dr. R.McI. Washburn
Laboratory Services (Joint)	Dr. G.K. Kini
	Dr. S.E. York
Lung Association (NS)	Dr. R.T. Michael
Nuclear War (Cdn. Physicians for Prevention of)	Dr. D.F. Fay
Nursing Assistants (Board of Registration)	Dr. G.B. Ferguson
Nursing Liaison Committee (NSAHO/MSNS/PMB/RNANS)	Dr. Michele Murphy
Occupational Medical Association of Canada	Dr. J.D. Prentice
Health Professions for Organ Donation	Mr. Bill Martin
Pharmacy Review Committee	Dr. D.C. Elliott
Physician Manpower (Provincial Advisory Committee)	Mr. D.D. Peacocke
Provincial Medical Board	Dr. T. J. Marrie
RH Committee Director	Dr. H.S. MacDonald
Refresher Course (CME)	Dr. T.F. Baskett
	Dr. G.W. Thomas
	Dr. A.G. Cameron
	Dr. J.D.A. Henshaw
St. John Ambulance Association (Provincial Advisory Committee)	
Safety Council (NS)	Dr. R.A. Perry
School Health Education	
Smoking & Health	Dr. D.F. Fay
Undergraduate Medical Education	Dr. D.R. MacLean
Victorian Order of Nurses	Dr. Mark Kazimirski
MMC Inc. Observers (Chairman, Executive Committee and Executive Director)	Dr. A.H. Parsons
	Mr. D.D. Peacocke
Reproductive Care Program	Dr. J.C. Kazimirski
	Dr. C. Folsbee

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AUDITORS' REPORT

To the Members of  
The Medical Society of Nova Scotia

We have examined the balance sheet of The Medical Society of Nova Scotia as at September 30, 1987 and the statements of income and surplus, and related statements of the Cogswell Library Fund for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position of the Society and its related funds as at September 30, 1987 and the results of its operations for the year then ended in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Halifax, Nova Scotia

October 29, 1987

*Doane Raymond*

Chartered Accountants

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**Doane Raymond**

## BALANCE SHEET

SEPTEMBER 30, 1987

	<u>ASSETS</u>	<u>1987</u>	<u>1986</u>
Current			
Cash and short term investments		\$ 653,476	\$ 572,558
Receivables			
Members		300	1,120
Other		5,740	3,672
Accrued interest		5,841	5,346
Prepaid expenses		<u>14,400</u>	<u>10,972</u>
		679,757	593,668
Investments (Note 1)		797,722	665,979
Equipment and leasehold improvements (Note 2)		<u>46,453</u>	<u>42,296</u>
		<u>\$1,523,932</u>	<u>\$1,301,943</u>

LIABILITIES

Current			
Payables and accruals			
Trade		\$ 17,760	\$ 16,425
Honoraria		4,128	
Cogswell Library Fund		487	3,615
Deferred revenue (Note 3)		<u>773,425</u>	<u>659,486</u>
		795,800	679,526

CAPITAL

Contingency Fund (Note 8)		120,999	111,250
Surplus		<u>607,133</u>	<u>511,167</u>
		728,132	622,417
		<u>\$1,523,932</u>	<u>\$1,301,943</u>

Contingent liability (Note 4)  
Commitments (Note 5)

ON BEHALF OF THE EXECUTIVE

\_\_\_\_\_ Treasurer  
\_\_\_\_\_ Executive Secretary

**Doane Raymond**

## THE MEDICAL SOCIETY OF NOVA SCOTIA

## STATEMENT OF INCOME AND SURPLUS

YEAR ENDED SEPTEMBER 30, 1987

1986 Actual		1987 Actual	1987 Budget
	Revenue		
	Annual membership dues		
	The Medical Society of Nova Scotia	\$ 825,305	\$ 762,700
\$ 779,168	The Canadian Medical Association	214,610	210,210
177,499	Intern and Resident Students	5,025	5,000
5,115		788	700
<u>768</u>			
962,550		1,045,728	978,610
	Investment income (Note 6)	77,266	50,000
79,111	Bulletin (net)	3,716	-
652	Gain (loss) on sale of investments	(928)	-
3,320	Other income (Note 7)	3,724	2,000
<u>2,525</u>			
1,048,158		1,129,506	1,030,610
<u>945,344</u>	Expenses (Page 5)	<u>1,033,540</u>	<u>1,049,598</u>
102,814	Excess of revenue over expenses	95,966	\$ (18,988)
<u>408,353</u>	Surplus, beginning of year	<u>511,167</u>	
<u>\$ 511,167</u>	Surplus, end of year	<u>\$ 607,133</u>	

*Doane Raymond*

**Doane Raymond**

## THE MEDICAL SOCIETY OF NOVA SCOTIA

## NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 1987

## 1. Investments

Operating Fund, at cost

Bonds, Debentures and Term Deposits	Interest Rate	Maturity Date	Par Value	Cost	Approximate Market Value
Bell Canada	11.00%	2004	\$ 10,000	\$ 10,000	\$ 9,378
Government of Canada	8.75%	2002	5,000	4,888	4,115
Government of Canada	8.75%	2002	3,000	2,824	2,378
Government of Canada	9.50%	1994	25,000	25,937	24,446
Government of Canada	13.75%	1990	10,000	10,000	10,625
District of Guysborough	9.75%	1988	10,000	10,000	9,850
District of Guysborough	9.75%	1990	15,000	15,000	14,400
Nova Scotia Power Corporation	10.00%	1991	50,000	50,000	49,500
Nova Scotia Savings & Loan	9.15%	1987	96,000	96,000	96,000
Nova Scotia Savings & Loan	9.05%	1987	200,000	200,000	200,000
Province of Nova Scotia	9.25%	2000	20,000	19,700	17,040
			<u>444,000</u>	<u>444,349</u>	<u>437,732</u>

Shares	No. of Shares			
Bank of Nova Scotia	750 common shares		4,658	11,438
Maritime Tel & Tel Co. Ltd.	600 common shares		4,585	9,075
Nova, An Alberta Corp.	584 common shares		4,994	13,342
Royal Bank of Canada	200 common shares		2,469	6,450
Stelco Inc.	200 preferred series C		4,964	4,725
Toronto Dominion Bank	500 common shares		8,254	12,625
MD Growth Fund	12,337.26 units		172,450	245,018
MD Realty Fund	292.042 units		30,000	34,992
			<u>232,374</u>	<u>337,665</u>

Contingency Fund, at cost plus accrued interest

Evangeline Trust - G.I.C.	8.75%	1987	60,470	60,470
Household Trust - G.I.C.	8.875%	1987	60,529	60,529
			<u>120,999</u>	<u>120,999</u>
			<u>\$ 797,722</u>	<u>\$ 896,396</u>

## 2. Equipment and leasehold improvements

	1987		1986	
	Cost	Accumulated Depreciation	Net Book Value	Net Book Value
Office furniture and equipment	\$ 62,365	\$ 54,451	\$ 7,914	\$ 6,893
Leasehold improvements	38,827	32,507	6,320	
Computer	64,891	32,672	32,219	35,403
	<u>\$166,083</u>	<u>\$119,630</u>	<u>\$46,453</u>	<u>\$42,296</u>

Expenditures for equipment, furniture or leasehold improvements are capitalized and depreciated over a five year period on a straight line basis.

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**Doane Raymond**


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THE MEDICAL SOCIETY OF NOVA SCOTIA

COGSWELL LIBRARY FUND

BALANCE SHEET

SEPTEMBER 30, 1987

	<u>1987</u>	<u>1986</u>
<u>ASSETS</u>		
Receivable from The Medical Society of Nova Scotia	\$ 487	\$ 3,615
Investments, at cost		
Province of Nova Scotia	2,000	2,000
Nova Scotia Power Corporation	<u>3,000</u>	<u>          </u>
	<u>\$ 5,487</u>	<u>\$ 5,615</u>
<u>SURPLUS</u>		
Reserve for Cogswell Library Fund	<u>\$ 5,487</u>	<u>\$ 5,615</u>

COGSWELL LIBRARY FUND

STATEMENT OF REVENUE, EXPENSE AND FUND BALANCE

YEAR ENDED SEPTEMBER 30, 1987

	<u>1987</u>	<u>1986</u>
Income from investments	\$ 306	\$ 418
Contributions to Dalhousie University	<u>434</u>	<u>496</u>
Excess of expense over revenue	(128)	(78)
Fund Balance, beginning of year	<u>5,615</u>	<u>5,693</u>
Fund Balance, end of year	<u>\$ 5,487</u>	<u>\$ 5,615</u>

**Doane Raymond**



EXPENSES	BUDGET	FORECAST	PROPOSED	
	1987	YEAR END	BUDGET	
	Oct. 1/86 to	to Sept. 30/87	Oct. 1/87 to	
	Sept. 30/87		Sept. 30/88	
<b>Administration:</b>				
400	Audit Fees	\$ 10,000.	\$ 7,500.	\$ 8,300.
401	Insurance - Travel, Bonding & Property	1,000.	799.	1,000.
402	Investment Trustee Fees	1,700.	3,000.	3,000.
403	Legal Fees	5,000.	6,000.	5,000.
404	Office Rent / Operating Costs (inc Property Tax)	71,572.	67,500.	75,000.
405	Office Services	23,000.	34,500.	35,000.
406	Petty Cash and Miscellaneous	1,000.	800.	1,000.
407	Postage	11,000.	11,000.	12,000.
408	Repairs and Maintenance	3,000.	2,500.	3,000.
409	Taxes - Business Occupancy	2,650.	6,116.	6,000.
410	Telephone	13,000.	12,500.	14,700.
411	Travel - Secretariat	12,000.	10,000.	12,000.
412	Unforeseen Expenses	5,000.	12,400.	5,000.
<b>Salaries and Benefits:</b>				
430	Salaries	366,463.	355,500.	398,000.
431	Canada Pension Plan	3,736.	3,900.	4,200.
432	Pension Plan (CMA) and Insurances	55,860.	52,400.	60,500.
433	Unemployment Insurance	6,875.	7,000.	7,500.
434	Vehicle Leasing			
<b>Departments:</b>				
440	Communications Department	16,550.	17,000.	20,000.
445	Economics Department	5,000.	2,500.	3,500.
446	Professionals Support Program	22,345.	1,000.	23,000.
<b>Committee Expenses - Including Travel:</b>				
450	Executive Meetings	12,500.	12,500.	13,000.
451	Officers and Branch Meetings	12,000.	12,000.	12,000.
452	President's Travel		8,000.	15,000.
453	Branch Secretaries	500.	100.	500.
454	Specialty Sections	500.	60.	500.
455	Membership Services Committee	1,500.	20.	
456	Nominating Committee	1,000.	608.	1,000.
457	President's Meeting	500.	---	
458	Other Committees	6,000.	6,000.	5,000.
459	Archives Committee	5,000.	5,000.	5,000.
460	Professional Challenge	(a) 2,000.	2,421.	
461	Horizons Committee	1,500.	1,500.	2,000.
462	Health Care Task Force	22,000.	---	
463	Building Committee (see Bldg Committee Report)			
464	Awards Committee			5,000.
<b>Miscellaneous:</b>				
480	Annual Meeting	15,000.	21,360.	20,000.
481	Bad Debts	---	---	---
482	The Canadian Medical Association Membership	210,210.	217,845.	240,000.
483	C.M.A. General Council	8,000.	8,000.	28,750.
484	C.M.E. (Dalhousie) Grant	30,937.	30,937.	30,000.
485	Depreciation	12,000.	12,000.	12,000.
486	Drugs and Therapeutics Bulletin	4,000.	3,610.	4,000.
487	Honoraria	55,000.	55,000.	55,000.
488	Staff Development	1,000.	1,590.	2,500.
489	Student Assistance Loan Plan	5,000.	4,300.	7,000.
490	Unpaid Student Loans	---	(500).	500.
491	Eastern Divisions Annual Conference	2,000.	2,000.	2,000.
<b>Capital Accounts:</b>				
110	Office Equipment	3,500.	5,500.	5,000.
114	Computer Equipment	3,500.	9,800.	15,600.
<i>(a) Expense Approved by Council Nov. 28/86</i>				
		\$ 1,051,898.	\$ 1,033,566.	\$ 1,179,050.

### REVENUE

<b>Annual Membership Dues:</b>				
300	The Medical Society of Nova Scotia	762,700.	\$ 817,219.	\$ 840,000.
301	The Canadian Medical Association	210,210.	224,745.	240,000.
303	Student Membership	700.	788.	700.
304	Interne/Resident Memberships	5,000.	5,025.	5,000.
<b>Other Income:</b>				
340	InforMed (net)	(b) (4,700.)	(5,000.)	---
350	Bulletin - Editorial Board (net)	---	---	---
360	Investment Income	50,000.	70,000.	45,000.
380	Miscellaneous	2,000.	2,035.	2,000.
390	Rental Income			
<i>(b) Additional Postage Expense for \$8,000. approved by Executive Committee Jan. 12/87</i>				
		\$ 1,025,910.	\$ 1,114,812.	\$ 1,132,700.

## THE MEDICAL SOCIETY OF NOVA SCOTIA

## NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 1987

## 3. Deferred revenue

Annual membership dues for the next fiscal year received by the Medical Society before September 30, 1987 are recorded as deferred revenue.

## 4. Contingent liability

The Medical Society of Nova Scotia has guaranteed the bank loans of Nova Scotia Medical Society students with the Bank of Montreal totalling \$36,900 (1986 - \$34,300).

## 5. Commitments

The future minimum lease payments on the operating lease for office space is \$51,750 per year until 1989 and \$47,438 in 1990. These payments do not include a provision for operating costs which are presently \$4.61 per square foot annually.

## 6. Investment income

	<u>1987</u>	<u>1986</u>
Interest on short term investments	\$48,765	\$64,158
Interest on other investments	25,700	11,429
Dividends	<u>2,801</u>	<u>3,524</u>
	<u>\$77,266</u>	<u>\$79,111</u>

## 7. Other income

	<u>1987</u>	<u>1986</u>
Grant from CMA	\$ 2,200	\$2,225
Miscellaneous	<u>1,524</u>	<u>300</u>
	<u>\$ 3,724</u>	<u>\$2,525</u>

## 8. Contingency Fund

	<u>1987</u>	<u>1986</u>
Balance, beginning of year	\$111,250	\$101,650
Interest earned on investments	<u>9,749</u>	<u>9,600</u>
Balance, end of year	<u>\$120,999</u>	<u>\$111,250</u>

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**Doane Raymond**


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THE MEDICAL SOCIETY OF NOVA SCOTIA

5.

EXPENSES

YEAR ENDED SEPTEMBER 30, 1987

1986 Actual		1987 Actual	1987 Budget
	Administration		
\$ 5,800	Audit fees	\$ 9,300	\$ 10,000
818	Insurance, travel, bonding and property	799	1,000
1,644	Investment trustee fees	2,153	1,700
11,091	Legal fees	4,315	5,000
61,158	Office rent	68,145	71,572
22,722	Office services	35,807	23,000
614	Petty cash and miscellaneous	700	1,000
10,774	Postage	10,240	11,000
1,050	Repairs and maintenance	1,386	3,000
2,461	Taxes	5,255	2,650
14,458	Telephone and telegraph	13,325	13,000
15,079	Travel - secretariat	12,598	12,000
13,741	Unforseen expenses	1,040	5,000
	Salaries and benefits		
298,152	Salaries	355,466	366,463
3,142	Canada pension plan	3,887	3,736
40,905	C.M.A. pension plan and insurance	49,750	55,860
5,508	Unemployment insurance	6,914	6,875
7,790	Vehicle leasing		
24,502	Communication department	16,766	16,550
16,311	Economics department	1,498	5,000
-	Professional Support Program	773	22,345
	Committee expenses including travel		
-	Archives committee	5,000	5,000
68	Branch secretaries	100	500
14,415	Executive meetings	14,455	12,500
	Health Care Task Force	-	22,000
1,556	Horizon committee	1,710	1,500
12,108	Officers and branch meetings	12,021	12,000
-	President's meetings	-	500
-	President's travel	8,585	-
83	Specialty sections	60	500
74	Membership services committee	20	1,500
987	Nominating committee	608	1,000
4,662	Other committees	5,788	6,000
2,000	Professional challenge	1,921	2,000
18,259	Annual meeting	21,360	15,000
179,569	Canadian Medical Association membership	217,845	210,210
11,978	C.M.A. general council - travel	5,615	8,000
25,813	C.M.E. grant	30,937	30,937
22,187	Depreciation	18,834	12,000
3,610	Drugs and therapeutics bulletin	3,610	4,000
1,952	Eastern division conference	1,728	2,000
-	InfoMed (net)	6,961	4,700
83,817	Honoraria	70,991	55,000
923	Staff development	1,590	1,000
3,063	Student assistance loan plan	3,684	5,000
500	Unpaid student loans		
<u>\$945,344</u>		<u>\$1,033,540</u>	<u>\$1,049,598</u>

**Doane Raymond**

# The Midnight Ride of Dr. Samuel Prescott

T.J. Murray,\* MD, FRCP(C), FACP and J.K.P. Murray, BA,

Halifax, N.S.

Listen my children, and you shall hear, of the doctor who rode with Paul Revere, and who, because of a quirk of fate, is unknown to generations of American school children.

On that historic night three, not one, Sons of Freedom rode to warn Concord of the coming of the British. The riders were Paul Revere, William Dawes and Dr. Samuel Prescott. Despite the fact that the young Dr. Samuel Prescott, age 26, was the only one to finish the ride and warn Concord, the famous poem by Longfellow incorrectly romanticizes the ride of Revere as if Revere alone warned Concord, thus erasing the doctor from history.<sup>1</sup>

Dr. Samuel Prescott was the son of Abel and Abigail (Brigham) Prescott; Abel was a descendant of John Prescott, who left Lancashire, England and settled in New England in 1604.<sup>2</sup> He acquired a good estate and defended it against the Indians, to whom he appeared periodically as a formidable big man with a coat of mail armour brought from England.

Samuel Prescott was born in Concord, Massachusetts on August 19, 1751, the son, grandson, nephew and brother of doctors. The family was an extraordinary family by all standards.<sup>2 3 4 5</sup> They were English Puritans, and they settled first in Waterton and Boston and later moved to many parts of New England and Canada, settling and naming Lancaster, New Brunswick, and Lancaster, Ontario. *The Prescott Memorial: or a Genealogical Memoir of the Prescott Families in America*, traces 9044 Prescotts up to 1870.<sup>2</sup>

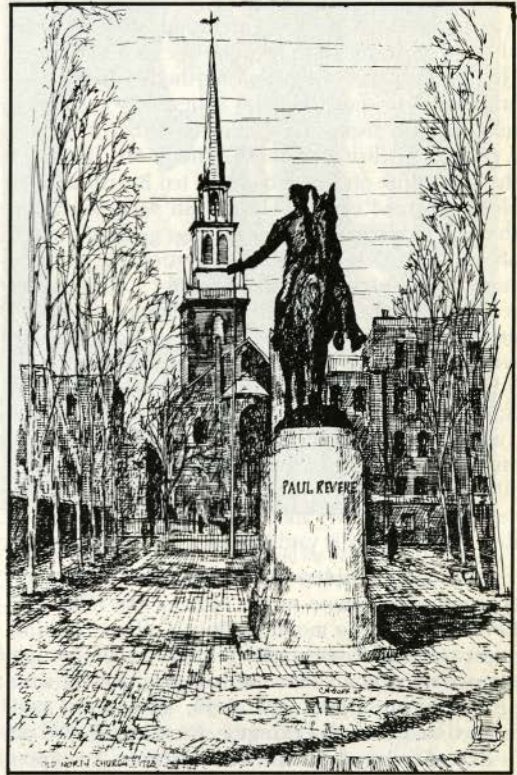
## THE RIDE OF DR. SAMUEL PRESCOTT

The night of April 18, 1775 was lighted by a bright moon. There had been a mild winter, the robins had already returned, and the fruit trees were blooming.<sup>6</sup> That was the night when Paul Revere, silversmith and member of the Committee of Safety, said to his friend:

'If the British march  
By land or by sea from the town to-night,  
Hang a lantern aloft in the belfry-arch  
of the North Church tower as a signal light,—  
One, if by land, and two, if by sea;  
And I on the opposite shore will be  
Ready to ride and spread the alarm  
Through every Middlesex village and farm,  
For the country-folk to be up and to arm.'<sup>1</sup>

\*Dean of Medicine, Dalhousie University, Halifax, N.S.

Correspondence: Dr. T.J. Murray, Dean of Medicine, Dalhousie University, Sir Charles Tupper Medical Building, Halifax, N.S. B3K 9Z9.



The Old North Church has a statue of Revere, and a brief mention of Davis on a plaque in the courtyard. I could find no mention of Dr. Prescott.

Two lanterns did burn in the old North Church that night and Paul Revere rode to warn the countryside. But Paul Revere did not leave Charleston alone. He was accompanied by William Dawes Jr., and the two riders set out towards the villages of Lexington and Concord by different routes, in case they were caught by the British.<sup>7</sup> The more important of the two villages was Concord, because it was the intention of the British troops under General Gage to seize the store of munitions which was being collected there.<sup>8</sup> The riders awoke John Hancock and Samuel Adams at the parsonage and continued on to warn the farmers and villagers.

Revere and Dawes both arrived at Lexington safely. Revere and Dawes then set out for Concord. Longfellow tells it this way: "It was two by the village clock, when he [Revere] came to the bridge in Concord town",

suggesting Revere alone rode warning villagers and then arrived to warn Concord. That is not the way it happened.

That evening, 26 year old Dr. Samuel Prescott of Concord had been courting a Miss Mulliken in Lexington. Shortly after one a.m. he heard the news that had been brought by Revere and Dawes and he started the six mile ride home to Concord. On the way he overtook the two riders and offered to ride along with them, since he knew the area and route. He also suggested the people in the area knew him and would be more likely to believe the warning if he were with them. They recognized that there was a danger of a British ambush, since a Mr. Devens of the Committee on Safety had seen ten British soldiers along the road earlier. The British were patrolling the road so as to prevent any message getting through about General Gage's plan to destroy the military stores of the provincials in Concord.<sup>9 10</sup> Revere later wrote that Prescott seemed "a high son of liberty" and agreed to have him ride and sound the warning with them.<sup>11</sup>

Prescott went to the Bull Tavern, where he met Nathaniel Baker [who was courting young Elizabeth Taylor], and sent him off to warn the Lincoln minutemen. Nathaniel warned his brothers and father, all of whom were at the Battle of Concord Bridge the next morning. Dawes and Prescott then raced to catch Revere, who was 200 yards ahead.

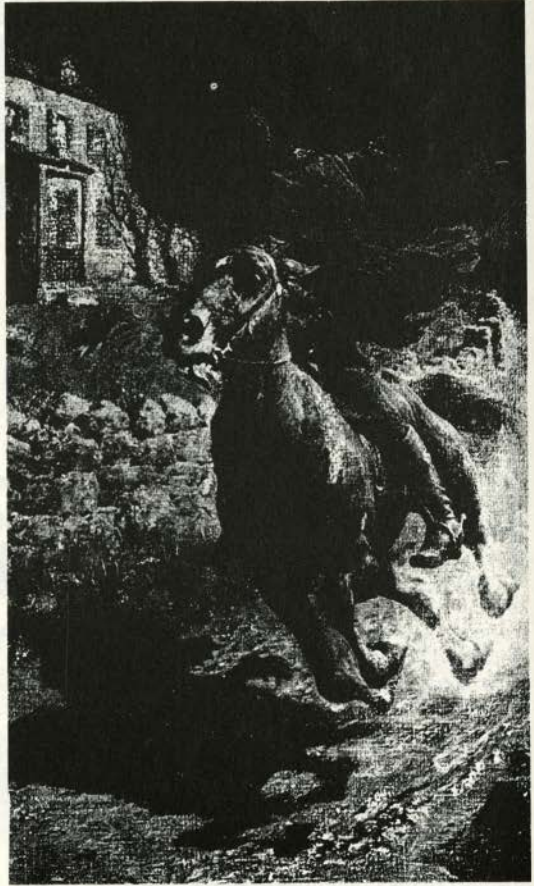
As the three riders continued their ride they approached a pasture to the right of the road, and Revere spotted two mounted British officers waiting under a tree in the moonlight. Two more came through the pasture, and all four spurred up to Revere with pistols drawn. Dawes saw them, and turned and escaped back towards Lexington. Prescott galloped up to Revere and used the butt of his whip as a weapon to try and push through. The British forced them into a pasture; Revere took off to the right and was captured by six officers waiting there. Prescott yelled to Revere "Put on!", jumped his horse over a stone wall, and made off down a rough farmway into a ravine by a swamp. He circled westward, warning farmers as he went. He came out into the fields behind the house of Samuel Hartwell of the Lincoln Minutemen and awakened him.<sup>12</sup> They sped off towards Concord.

Prescott arrived in Concord at about two a.m. and found Amos Melven on guard at the courthouse. Prescott gave him the message and Melven rang the bell to sound the alarm. Prescott then rode on to Acton, where he gave the news to Francis Faulkner, the colonel of the minutemen, who raised his men.

The inhabitants of Concord secured the stores of ammunition and collected several hundred minutemen. At about seven a.m. the British appeared and began searching for the ammunition stores. They dumped 60 barrels of flour on the road, destroyed three cannons, and dumped 500 pounds of bullets into the

mill pond. They chopped down the liberty pole and set fire to the courthouse. But the assembled minutemen counterattacked, and the British eventually retreated with 73 killed and 200 wounded or missing, as opposed to 49 killed and 44 wounded or missing of the Colonists. The war had begun.

Why do we know so little of what happened to Dr. Prescott after two a.m. on that morning? There is detailed information on everyone else over the next few days and months, but not on Prescott.<sup>6 12 13 14</sup>



Illustrations of The Midnight Ride of Paul Revere, William Davis and Dr. Samuel Prescott usually show only Revere as the one who sounded the alarm and warned Concord. In fact, it was Dr. Prescott who brought the message to Concord when Revere was captured.

Every history book we searched — including the Prescott Genealogy,<sup>2</sup> the *Encyclopedia of the American Revolution*,<sup>10</sup> and *Dictionary of American Biography*<sup>15</sup> — dismisses him with the same one line: "He joined the militiamen, and saw service at Ticonderoga. He was taken prisoner on board a privateer, and taken to Halifax, where he died in jail." He is mentioned in Paul Revere's two accounts of the ride,<sup>9 10</sup> but it is Longfellow's image of a solitary rider that persists.<sup>1</sup>

The book *Massachusetts Soldiers and Sailors of the Revolutionary War* mentions a private Samuel Prescott, but says little about him except that he was in Captain Isaac Sherman's company, collected his pay, and in November 1776, was reported to be sick.<sup>16</sup> After Ticonderoga, Dr. Prescott apparently signed on with an American privateer that was captured by a British privateer out of Nova Scotia. There were more than 2,000 American vessels employed as privateers during the revolution, and we have been unable to trace the vessel on which Samuel sailed.

It is of interest that not only did the eminent American historian and relative William Hinkley Prescott<sup>17</sup> never mention his name as an ancestor, but Ticknor, in an appendix documenting the history of the Prescott family, made no mention of Dr. Prescott.<sup>18</sup> William, grandfather of W.H. Prescott, fought at Bunker Hill and was posted in Nova Scotia, in the regular service of the colonial troops sent to remove the French from Nova Scotia. He was quoted by William Hinkley Prescott as stating, "The moral courage demanded for the opening of the revolution was of a much higher order than what is required in an ordinary conflict, where the memory of the brave if he falls is covered with glory; but an unsuccessful rebellion brings only ignominy, and in case of capture an ignominious death." Perhaps this attitude towards capture explains the family silence about Dr. Prescott.

When Prescott was brought to Halifax he would have been put into the "old gaol", where prisoners from captured privateers were held. John Blatchford was held in this jail when he was also taken prisoner from a privateer that same year. His experience would give us a view of what happened to Dr. Prescott: "I was kept prisoner among a number of my countrymen, on board the *Rainbow*, until we arrived in Halifax. On our arrival there we were taken on shore and confined in a prison which had formerly been a sugar house — a large number of prisoners confined in this house (nearly 300) together with a scanty allowance of provisions, occasioned it to be very sickly."<sup>19</sup>

Bushnell in Blatchford's narrative describes the jail: "On the west or upper side of Hollis Street, not far from the Halifax Hotel, there is an old wooden building, now in ruin, which is known as the 'old jail' in which Ethan Allen, Honorable James Lovell and others are said to have been confined. . . This building, as originally built, was a long, one-story house, with a sharp pitched roof, running perhaps 50 to 60 feet in length from the street to the end of the lot. It stood in a rough kind of stone wall which elevated it a few feet (perhaps 6 feet) above the ground, and steps were attached to the building outside, not on the street, but within the enclosure." Prisoners who died in jail were buried in the original burial ground in Halifax, just north of Jacob Street.

No marker marks the grave of the brave young physician who was one of the earliest heroes of the



The poem of Longfellow gives the world the impression that Revere rode alone and elevated him to a lasting place as a great hero of The Revolution.\*

American Revolution. It is sad that Longfellow, in glorifying Paul Revere, innocently robbed William Dawes Jr., and Dr. Prescott of well-earned honors, especially when it was Prescott who completed the journey to Concord, not Revere. Each year The Ride of Revere is re-enacted on Memorial Day, with less attention to the re-enacted ride of William Dawes.

I hope someone, perhaps a Massachusetts physician, will join next years ride and help restore the memory of Dr. Prescott. Perhaps it is time for a revisionist historian-poet to remedy the situation and tell the story of Dr. Sam Prescott, of memory clear, the man who rode with Paul Revere.

□

\*Painting of Paul Revere by John Singleton Copley. 1737-1815 Museum of Fine Arts, Boston.

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# Presidential Valedictory Address - 1987

W.C. Acker, MD,

Halifax, N.S.

## **"The Recognition of the Existence of a Problem is the first step in its solution."**

One year ago today I was given the honor of being your President. It has been a year that I will never forget. I was told by many of my predecessors it would be an exciting and unpredictable year -- some of my friends said it would play havoc with my practice -- some of my peers said "somebody has to do the job" -- and my family said go for it, we will stand behind you.

It has been a year in which I called on many of you to help with various committees or at presentations on behalf of the Medical Society. I even had time to discuss specific issues which come before any large, organized, professional society like ours. It has been a taxing year because of the time commitment, because of "internal" issues, and also because of "external" issues in our province and our Country which require comment from doctors -- whether solicited or not -- Believe me it has been a rewarding year.

Perhaps I could be permitted to comment on the Society as I see it. For the past number of years I have sensed the strengthening of our Organization, and this year was no exception. This is in spite of many spirited discussions and sometime criticism of plans, projects, services or policy which have come before us. Professional associations or societies like ours draw their nourishment and strength from the grass roots. I recognize this and so, I feel, do more and more of you. Our grass roots, of course, would be the Branch Societies, and I would suggest the various Sections as well. At this level we have our common ground and common problems, but as the "roots" of the organization we must supply nutrient so that the rest of the organization can grow. Here, as I see it, is where we are having our problems--here is where we tend to get a we--they attitude. Here is where the health of our Society falters.

It would be unfair to give the impression that the Branches or Sections don't relate to the Society, this of course is not true, but we do have some work to do at this level and I have noted, with great satisfaction, and some pride the efforts being made to "bridge this gap". Your Communications Department and CEO spend a great deal of time and effort and undergo a great deal of frustration at this task, but I see from my perspective, movement being made in the right direction.

Many of you are no doubt tired of hearing me talk about the importance of two-way communication, both from the Branches to the Society office and, of course, the other way from the Society office to the Branches. Believe me, as we proceed through the next five to ten years, and have to deal with

governments on the many issues that we can see and can predict along the way, we must be strong and we must be united.

If I may be permitted to look into the future a bit, there are some disturbing trends that can be seen. For example, I am bothered by the trend I see and hear discussed in other provinces, and there is no reason to believe that it won't happen here, and that is the trend toward doctors expecting to work 9 to 5. Now, I don't want to give the impression that this is totally wrong. In my personal view, and at my stage in life, time off away from work is more "valuable" than time working, but think of the repercussions this could have on the delivery of health care. We are members of a profession that for centuries provided 24-hour 7 day coverage for sick people and we cannot expect that to change over the short term, and believe me governments won't allow this to happen. I do sense, however, a generation of doctors coming along who feel this to be an issue. This is one small example of why we must be united as a Society in order to discuss this and other issues that will face us in the future.

We also have to continue to try and understand each other, and be patient with each other when we discuss money or fee matters. Money has the potential of being the most divisive matter in this and any other professional medical society. It clearly has driven a deep wedge between various groups in the province. I use the word understand -- perhaps I should have used the word trust, because my observations over the past eight years, as an Officer, which include three years as Treasurer, three years as Economics Chairman, suggest to me that the bottom line often is a lack of "trust" between various groups or individuals.

Let's relate to what we do everyday-- we treat people who come to our offices feeling ill or seeking advice on health matters. They, for the most part, trust our judgment. Let's use this as an example and trust those we choose to help us in our fee allocation matters. This, to my mind, is yet another matter that shows how we must have our "house in order" as we posture ourselves for nose-to-nose sessions with government, an almost guaranteed event for the future. I should, of course, express my satisfaction with the large number of you who provide your time and expertise in the many committees our organization requires.

One year ago when I accepted the challenge of being your President I made the comment that I felt I was like the captain of a ship and that I could not possibly function without a dedicated and hardworking crew. Well, I had no idea how



important that concept would be. We have among us some of our peers who either "don't know how to say no" or properly feel so committed to organized medicine in this province that they are willing to spend hours, days and weeks (often with little thanks) doing your business. This reinforces my notion that "all is well" as long as our confreres will continue to serve in this way in the future. This also bodes well for your Society in the future, but let's remember it takes effort and commitment to stick together -- in the end we will all benefit.

Maybe I could be permitted to share some of my thoughts about the future and the interplay with government. I suggest to you that medicare has interfered with the genetics of how medicine is practised and delivered in Nova Scotia and Canada. That's not surprising because when you "promise the farm" but can't afford to pay, you have to cut back in some way or other. This is exactly what governments have begun to do -- much more so in some of our sister provinces. We, as Providers of health care, are often made the government's "scape goats". -- The cutbacks and restrictions are often applied to the doctors. We cannot allow this to happen, we do have influence on the direction of medicine in the future. But, we have to be constructive and well educated and well prepared before we sit down to influence government. It would be imperative that we go as a single, unified, body. -- So as I said earlier, we must have our house in order first. We also must be prepared to be innovative and to take into account helpful past events.-- We must go with a "that was then -- this is now" attitude.

It became more and more obvious to me during my visits to other Provincial Meetings this past year that our Provincial Government and the provincial governments of all other provinces are receiving, percentage wise, less and less money from the Federal Government for health care. The major problem is the Canada Health Act; the system under which all the provinces work. It is so restrictive that the provinces are not able to finance their share of the load to "pay for the promised farm", so in my humble opinion it needs to be changed. I don't believe that I or we in the Province are the only ones who feel this way.

I suggest the Canada Health Act needs major surgery -- at the least it needs an exchange transfusion and perhaps even a heart transplant!! Others in other provinces share this view, in fact, as you know Ontario is in the midst of preparations to challenge the Canada Health Act in court. We, in our province, can play a role in this process by convincing our politicians that the Canada Health Act must change, otherwise medical care will suffer and gradual cutbacks will deny accessibility to more and more people either by restriction and elimination of certain services or by forcing people to wait intolerable lengths of time to get the care they need.

Governments seem reluctant to consult -- they seem reluctant to *accept* advice -- too many of their decisions seem to be made for political reasons or political gain. Truly,

**GOOD** government relations cannot exist unless or until we can discuss issues at their face value, without the incumbrances of politics, and with an open mind. Recently, I was told "*even the best plastic surgeon in the world cannot graft a new idea to a closed mind*".

Still looking ahead, here are some issues that will have major impact in the years to come.

The funding of the health care system both at the Federal and Provincial level and the role of the private sector in medicine have to be examined. Already in the USA (and to a minor extent in Canada) there are privately run hospitals. There are also medical care schemes sponsored by large industries which provide as good, if not better care, to their patients than do the government run medicare plans. Maybe this is an idea whose "time has come" -- Maybe we need more of this in Canada and in our Province.

The issue of AIDS. It is like an iceberg with only its tip showing. We know the major impact is yet to come, but we can't accurately predict how bad or exactly what the numbers will be and we can only guess at the cost, but we know it will be horrendous both in dollar terms and human suffering, sadness and death.

Over a two-week period from the last of October to the first week in November of this year, The Medical Society of Nova Scotia played a major role in advising our government about the AIDS problem in Nova Scotia and what we were prepared to do and what we felt should be done to help fight and control this disease. Although we didn't receive any press or publicity you should know that the advice and wisdom of The Medical Society of Nova Scotia was instrumental in restructuring the hastily formed and narrowly directed AIDS Task Force in Education into the recently announced Task Force on AIDS for Nova Scotia. The AIDS epidemic, however, is far more than a Provincial problem and the Canadian Medical Association has recognized this and at this moment has a committee working on a National Policy.

I don't think I could talk about the future without mentioning the cancerous effect that the liability issue has on medicine. Of course, other sectors in our society are also affected by the skyrocketing premium cost, but my concern is its lethal effect on doctor/patient care. The bond between doctor and patient -- the good will between doctor and doctor and the comradery between the professions of medicine and law all suffer.

I don't have an answer to this problem but do suggest the various levels of government are key players and therefore will have to become more involved and convinced that they are part of the solution. Like it or not, in this present climate and with the new Canada Charter of Rights and Freedoms, doctors are more accountable than ever before and -- as I see it -- this trend will continue.

Recently there was a movie in town entitled "Back to

the Future", and I couldn't help but think of this play on words. I hope and pray that for us in Nova Scotia in medicine it will be "forward to the future".

My final remarks have to do with the people I worked with this past year -- the people who without exception took their responsibility very seriously. Your Officers and Executive Committee, with whom I worked most closely, served you well and I choose not to single out anyone for fear of missing many more-- they all worked selflessly on your behalf. I will though mention names of our loyal, dedicated, ethical staff without whom the Society could not function. A personal thank you to Doug Peacocke, Anton Schellinck, Bill Martin, Shirley Miller, Tove Clahane, Celie Manuel, Glenda Crews, Pam Fancy, Jeannette Osborne, Christina Jones and Richard Dyke.

Andy Warhol once said, "every person on earth has 15 minutes of glory once in his lifetime". Our office staff and you people, by asking me to serve as your President, have given me 365 days, and for that I will be eternally grateful.

Thank you. □

## Correspondence

To the Editor:

The paper by Hogan and Whiting entitled "Predictors of Vertebral Bone Density in Nova Scotian Females" (NS Med Bull August 1987, p 105) brought to light very useful information about a segment of our local female population. This study was looking for factors which: 1) could be used to help prevent osteoporosis; or 2) could be used to identify incipient cases so that deterioration could be delayed.

In their selected sample of Nova Scotia women, mostly pre or peri-menopausal (average age 41), bone density was related only to age, height and weight. Two statements in their discussion could I think be easily misconstrued. The first "One finding our study did show was that there was not a strong correlation between dietary calcium intake and vertebral bone density", and the second "Other historical risk factors or variables to determine, do not in themselves appear to be as important in predicting bone density, in particular this is true for historical and current calcium intake". In fact, their findings could be interpreted as suggesting that "normal" calcium intake results in normal bone mineralization.

Sandler (to whom the authors refer) studied a larger group (255) of women of comparable social characteristics and also used a recall assessment of lifetime calcium intake.<sup>1</sup> The mean age of that group was, however, 16 years older (57) and most of the subjects were postmenopausal and, therefore, had presumably entered into the period of more rapid bone mineral loss. The groups were quite similar as regards height and weight. They used vertebral CT scan to measure bone mineral density and this assessment in trabecular bone may possibly be more sensitive than dual photon densitometry at the lower radius. Sandler and her group were indeed able to demonstrate lower bone density in individuals who had habitually consumed less calcium (milk). Her group's mean calcium intake was 720 mgs per day as opposed to 854 mgs in the Hogan/Whiting study. I am sure these authors would agree that it is important to continue to urge children and adults to consume calcium (chiefly as milk and its products) through life up to the current dietary recommendations of 700 to 800 mgs per day as a means of developing optimal premenopausal bone mineral mass. I fully agree with the authors that there is little evidence to support the larger calcium intakes suggested by the National Institute of Health Consensus Development Conference Statement #5 (on osteoporosis).<sup>2</sup>

It is interesting to note that we may soon have available a practical means of determining who should receive estrogen replacement at menopause to delay

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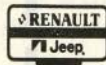
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osteoporosis. Christiansen, Riis and Rodbro have just published a simplified method of identifying "fast calcium losers" using fat mass, urinary calcium and hydroxyproline and serum alkaline phosphatase.<sup>3</sup> Should this screening stand up to clinical trials we shall indeed be in a better position to prescribe estrogen replacement to those menopausal women at risk for osteoporosis.

Yours truly,

S.C. Robinson, MD, FRCS(C)  
Professor, Department of Obstetrics & Gynaecology,  
Dalhousie University, Halifax, N.S.

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#### To the Editor:

Thank you for the opportunity to respond to the letter of Dr. Robinson. The points he makes are germane and I do not feel we differ with regards to any substantive issues.

The point of our article is that within a fairly large range of dietary intakes of calcium, there appears to be no striking correlation between intake and bone density. That is not to say that markedly deficient

intakes of calcium are advisable. I agree with the recent recommendations of the Osteoporosis Society of Canada dealing with calcium intakes — that the current dietary recommendations of 700-800 mg for mature adult females be endorsed.

As for the last comment of Dr. Robinson dealing with the proposed methodology for identifying "fast calcium losers", only time will tell if this is of clinical utility.

Yours truly,

David B. Hogan, MD, FACP, FRCP (C),  
Assistant Professor, Department of Medicine,  
Dalhousie University, Halifax, N.S.

#### To the Editor:

The 5th edition of the Dalhousie University Formulary of Topical Preparations, 1987, was recently published. This is a formulary agreed upon by the representatives of various interested bodies of the Pharmaceutical and Medical Associations of the Provinces of Nova Scotia, New Brunswick and Prince Edward Island. It has been found of use in practice by family doctors and pediatricians. Dermatologists in the region use the formulae which are accepted extemporaneous preparations not available commercially.

The booklet gives advice on the nature of dermatological prescribing, quantitation and contains a table noting the potency of topical cortico-steroid preparations.

It is available from:  
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at \$2.00 post-paid.

This may be of interest to your readers.

Yours sincerely,

J.B. Ross, MB, FRCP(C),  
Head, Division of Dermatology,  
Department of Medicine,  
Dalhousie University,  
Halifax, N.S.

#### Editor's note:

A worthwhile reference to own. □

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# Appreciations

## DR. ROBERT MARSDEN CALDWELL

Dr. Robert Marsden Caldwell, 80, of Yarmouth, died Saturday, September 6, 1987 at home. Born in Woodstock, N.B., he was a son of the late William and Harriett (McBride) Caldwell. He was educated at Yarmouth Elementary School and Yarmouth Academy. He graduated from Dalhousie Medical School in 1932 and interned at Camp Hill Hospital, Victoria General Hospital and the Nova Scotia Sanitarium. He took an extra year of residency at Bridgeport Hospital, Bridgeport, Conn. He returned to Yarmouth in 1933 and began general practice.

He served in the 22nd Field Ambulance Corps, Royal Canadian Army Medical Corps, during World War II. After being stationed in the south of England, he was posted to the Royal Winnipeg Rifles as chief medical officer. He went ashore at Normandy on D-Day and was wounded two months later in Cannes. Following his return to Canada in 1945 with the rank of major, he resumed his medical practice in Yarmouth and continued his association with the military as a member of the 14th Field Regiment reserves.

He was long-time treasurer of the Western Nova Scotia Medical Society and served several terms on the board of the Yarmouth Regional Hospital. He was plant medical officer at Dominion Textile, in Yarmouth, for 30 years. In later years, he maintained a practice in anaesthesia. Before his retirement in 1979, he was installed as a senior member of the Nova Scotia Medical Society. He was a member of the Yarmouth Golf and Country Club and the Zion Baptist Church.

With the passing of Dr. Caldwell, the medical profession of this province and the community of Yarmouth has lost a very loyal and dedicated physician.

He is survived by his son, Michael of Sudbury, Ontario; two daughters, Patricia of Yarmouth and Elizabeth Arenburg of Yarmouth; and two grandchildren.

Dr. Ashwin K. Madhavani

□

## DR. WALTER FISHER

On September 8th 1987 Dr. Walter Fisher, the well known Halifax psychiatrist, died quietly in his sleep after a short illness. His many friends and grateful patients mourn the passing of a remarkable man.

Walter Fisher was born in Breslau, Germany, where he also received his early education. His experiences during two years of military service during the first world war led him to the study of medicine at the University of Breslau, where he graduated *cum laude* in 1923. Shortly afterwards he married Ilse Hauschner, who became his life-long companion, sharing the rich life of a man dedicated to his profession as one way of helping others.

Early in his career Walter Fisher had decided to take up psychiatry (largely under the influence of the prominent men at the University who were his teachers and in whose work he was fortunate enough to participate). A successful career in his chosen field was interrupted by events in Europe which induced him to emigrate. In 1938 he and his family arrived in Canada, living for a time in St. John N.B. but ultimately settling in Halifax-Dartmouth where, as Walter Fisher often said, they found their home. He was always grateful for life in Canada where he found a satisfying and rewarding career. His skill and reputation made him a highly valued member of the staff of the Nova Scotia Hospital and of the clinic of the Cole Harbour Hospital, where he served until his final retirement in 1977. Throughout his career he retained an abiding interest in psychiatry, shown not only by his scientific publications and his membership in many learned societies, but above all by the concern and care for his many patients.

He had also a wide range of literary and historical interests. A highly educated and civilized man, he had a deep respect for learning and culture, and understanding of the weaknesses of others and an intolerance only for the intolerant.

He is mourned by his wife, Ilse, daughter Renate, son-in-law Dr. Amoz Chernoff, his three grandchildren and his many friends and former patients.

Dr. K. Aterman

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*Lordes, ladies and gentlemen, learned or unlearned of what estate or degree so ever you be of, think not that no man can be holpen by no manner of medicine, if so be God do send the sickness, for He hath put a time to every man.*

*Breviary of Health, 1547*

Andrew Boorde (1490-1549)

## Pictorial Highlights 134th Annual Meeting

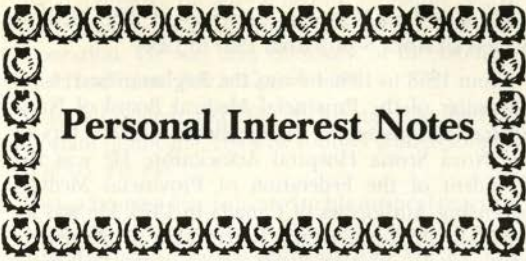


Physicians from across the Province attended the Annual President's Banquet and Ball to pay tribute to four colleagues who were honoured with Senior Membership in The Medical Society. The award, which requires the unanimous approval of the Executive Committee, recognizes outstanding service to medicine and the community. Pictured above at the ceremony are (left to right): Drs. R. Arnold Burden, Springhill; M.R. Macdonald, Halifax; T.J. McKeough, Sydney Mines; and W.A. MacQuarrie, Trenton.

The Presidents of The Medical Society exchanged jewellery at the 134th Annual Meeting. Dr. Bill Acker (left) offered the chain-of-office to the new Society President Dr. Douglas Henshaw who responded with a Past President's lapel pin.



Dr. Paul Landry, Secretary General of the CMA, read the C.M.A. Senior Membership citations at The Medical Society's Annual Meeting in November. Pictured above with CMA President Dr. Athol Roberts (left) is Dr. Alvin J. Buhr of Halifax, the photo on the right pictures Dr. G. Ritchie Douglas of Pictou.



## Personal Interest Notes

### SENIOR MEMBERSHIP CITATIONS THE MEDICAL SOCIETY OF NOVA SCOTIA

#### Dr. R. Arnold Burden

After receiving his education in Cumberland County, Dr. Arnold Burden enlisted in the Royal Canadian Army Medical Corps. He went overseas in 1941 and served throughout World War II with the No. 7 Canadian General Hospital, R.C.A.M.C. at postings in England, France, Belgium, Holland, and Germany. He began his career in the military as a medical orderly, but later rose in the administrative ranks and was commissioned as Captain.

In 1946, Arnold entered a pre-med class at Dalhousie University and in 1948 he entered Dalhousie Medical School on an entrance scholarship. After graduation in 1952, Arnold established a general medical and surgical practice in St. Peter's Bay, P.E.I. He acted as coroner for King's and Queen's Counties for five years, and served three year terms on both the P.E.I. Commission for Maternal Health and Child Welfare, and the Provincial Laboratory Council.

Arnold's participation in professional associations began early in his medical career. He became a member of the Canadian Medical Association and the P.E.I. Medical Society in 1952, and served on the executive of the provincial body. He was one of the organizers of the P.E.I. Chapter of the College of General Practice, and remains a charter member of the College of Family Physicians of Canada.

In 1956, while still practising in P.E.I., Arnold returned to his native Springhill to render medical assistance during the disastrous "Explosion" which occurred in the Springhill coal mines. He was the first doctor to enter the No. 4 mine after the explosion, and during three different trips down the mine, spent twenty-two hours underground in rescue operations. He was rendered unconscious with gas on one occasion.

In 1957, Arnold moved to Springhill, established a medical practice at the Springhill Medical Centre, with privileges at All Saints Hospital. In 1958, Springhill was struck with another major mining disaster, "the Bump". Arnold entered the mine with the dreagermen, and spent thirty-three hours in underground rescue work. Along with other underground rescuers, he was awarded the Ribbon of the Carnegie Hero Award. In 1986, he was presented an award by the International President of the United Mine

Workers of America for his contribution to the rescue in the two mine disasters.

In 1957, he became a member of the Cumberland Branch Society. In the ensuing thirty years, he has served terms as Secretary-Treasurer, Vice President, and President. He was the Cumberland Branch's representative on the Board of Maritime Medical Care for fourteen years; eleven of those years were spent on the Executive, including two years as Vice-President and two years as President.

Arnold's participation in health related community activities has been exemplary. He was on the founding committee and, later, the Executive of the Cumberland Mental Health Association. He has been the medical representative for the Springhill Branch of the Canadian Cancer Society for the last thirty years. He currently functions as the Medical Officer for the E.M.O. in the area, and is a resource person for the Springhill Search and Rescue Unit. He was the Medical Officer for the local chapter of the St. John Ambulance and was awarded the Priority Vote of Thanks.

Arnold has actively supported All Saints Hospital. He has been on the Medical Staff Executive more than twenty years, including twelve years as President and ten years as Chief of Staff. As Chief of Staff, he has served on the Board of Trustees of the hospital, and has been active in the Nova Scotia Association of Health Organizations. All Saints Hospital has an impressive record in achieving accreditation awards; Arnold has been one of the persons instrumental in having the hospital work toward that goal.

Arnold remains in full-time general practice, and, in addition, is completing his twentieth year as a Medical Officer for the Springhill Medium Security Institution.

Arnold is married to the former Helen Dewar of Springhill; they have four children.

Arnold's record of community service is outstanding. When in Prince Edward Island, he served as Chairman of the St. Peter's Bay South School Board. The Royal Canadian Legion presented him with both the Forty Year Pin and the Diamond Jubilee Medal. He was a member of the Springhill Rotary Club for twenty-five years, and now enjoys honorary member status. He held the office of President in the club on two separate occasions, and was instrumental in setting up the protocol for the Rotary Children's Clinics held in Springhill. Arnold was an Assistant Scout Master in the late 1960s in Springhill, and assisted in the training of seven Queen Scouts. He was Vice-President and then President of the Springhill District Scout Association. This year, he was honoured by that association and was presented with the Lord Baden-Powell Badge.

He has set an example to both the community and to his colleagues, having been a Red Cross blood donor on forty-two occasions.

Arnold enjoys numerous hobbies. He has been a member of the Truro Philatelic Society for seven years and has been awarded two gold, two silver, and three bronze medals at the Society's annual stamp exhibit. He is an avid painter, and has participated in exhibits of watercolours and oil paintings. He also does some work with ceramics, and is a member of the Cumberland Craft Association. He is somewhat of a "computer buff" and has computerized a genealogical study of over three thousand of his and his wife's ancestors and family members. Over the years, he has been active in square dancing, and various sports including hunting, fishing, downhill skiing, snowmobiling, canoeing, golf, curling, and all terrain vehicle touring. He holds an open water certification in scuba diving. Having keen interest and proficiency in photography, Arnold has documented in pictures many of these activities.

We in the Cumberland Branch would hope that the Society would give favourable consideration to Dr. Arnold Burden for Senior Membership. He has struck an example of community service, of courage, and of support for this Society and its membership that few can equal.

D.M. Rippey, M.D.  
President, Cumberland Branch Society

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## Dr. Michael Raymond Macdonald

Dr. Michael Raymond Macdonald is a native of Sydney Mines, Cape Breton. He received his early education in Sydney Mines and subsequently attended St. Francis Xavier University, Antigonish, where he graduated with a B.A. and a B.Sc. in 1932 and 1933. Dr. Macdonald proceeded to McGill University to pursue his medical studies and graduated from McGill University in 1938.

Following his graduation from McGill, Dr. Macdonald was engaged in family medical practice in industrial Cape Breton. Later he pursued studies in public health at the University of Toronto receiving his Diploma in Public Health in 1943. He was the Divisional Medical Health Officer with the Department of Public Health of Nova Scotia in the Sydney area from 1943 to 1951.

In 1951 he assumed the position of Assistant Executive Medical Administrator of the Victoria General Hospital in Halifax where he served in this position from 1951 to 1969. From 1969 to 1979 he was the Executive Director of the Victoria General Hospital.

Dr. Macdonald is a Fellow of the American Public Health Association and a Fellow of the Royal College of Physicians and Surgeons of Canada.

He served as Honorary Secretary of The Medical Society of Nova Scotia from 1955 to 1957.

From 1958 to 1986 he was the Registrar/Secretary/Treasurer of the Provincial Medical Board of Nova Scotia. He has served on the Board of Directors of the Nova Scotia Hospital Association. He was the President of the Federation of Provincial Medical Licensing Authorities of Canada in 1976. He was an Assistant Professor in the Department of Preventive Medicine in the Faculty of Medicine of Dalhousie University until his retirement. He was the recipient of the Centennial Medal in 1967 and the Queen Elizabeth II Silver Jubilee Medal.

Dr. Macdonald has served on many committees as an adviser and since his retirement from his job as Executive Director of the Victoria General Hospital he has served on a number of consulting committees to the administration of the Victoria General Hospital. Dr. Macdonald's career has spanned the time from the preantibiotic era to the present day when so many technological advancements have been achieved.

Dr. Macdonald is married to the former Eileen Hartigan from Sydney Mines. They have one son, Thomas, who is a practising lawyer in Halifax.

Dr. Macdonald can look back upon a career which encompassed many different facets of the practice of medicine. He has made a significant contribution to the medical profession in his native province. It is with pleasure that I present him for senior membership in The Medical Society of Nova Scotia.

B.J. Steele, MD,  
Registrar, The Provincial Medical Board of N.S.

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## Dr. Thomas J. McKeough

Dr. T.J. McKeough grew up in Sydney Mines where he attended school. He then attended St. Francis Xavier University and, later, the University of Ottawa Medical School.

He began general practice in Sydney Mines in 1951 where he worked with his father, Dr. W.T. McKeough.

He was elected to the Nova Scotia Legislature in 1960. In 1964 he held the portfolio of Municipal Affairs. In 1967, he became Minister of Labour. In 1968, he added Minister of Trade and Industry to his portfolio and later, in 1969, he dropped the portfolio of Minister of Trade and Industry, retaining Minister of Labour and adding Minister of Finance. He ran in five provincial elections in Cape Breton North, resigning undefeated in 1978.

Dr. McKeough was President of The Medical Society of Nova Scotia in 1975-76.

He is a director on several boards, including Sysco, Stora Industries, and Northside Harbourview Hospital Corporation. He was also chairman of the Occupational Health and Safety Commission.

It is self-evident that Dr. McKeough has had an important public life. His wise counsel is often sought, and never refused.

He has been no less dedicated to his medical practice, as his many loyal patients over the years would readily testify. He now practices with his son, Michel, one of his six children.

In summary, we find a rich and varied career, but integral to all of it is an unselfish, capable doctor.

The Cape Breton Medical Society is very pleased to present for Senior Membership, Dr. T.J. McKeough.

Paul C. Boyd, MD,  
President, Cape Breton Branch Society.

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### Dr. William A. MacQuarrie

Dr. Bill MacQuarrie began his medical career with pre-med and medical training at Dalhousie University. He graduated with degrees of MDCM and LMCC in 1943.

For the past 44 years Bill has engaged in general practice in Pictou County. In his current practice he has numerous families in whom he has delivered and provided care for three generations. Bill has also provided industrial medical supervision in the present Hawker Siddeley Trenton Works and in its three predecessors. After 44 years in the occupational health field, he is eagerly awaiting his fifth appointment as industrial medical supervisor, this time for the "hoped-to-be-soon announced" Hawker Siddeley successor.

Bill has been an active member of the American Occupational Medical Association since 1950. He is also a founding member of the Nova Scotia Chapter of the College of Family Practice of Canada in 1976.

He has been a member of The Medical Society of Nova Scotia since the early 1950's and has served as the President of the Pictou County Branch as well as participated on numerous committees of the Branch.

Bill and his wife, Carolyn, will always be known for their wonderful hospitality to all members of the medical community and to their families. The annual Pictou Medical Society summer outing on Bill MacQuarrie's boat will long be remembered by every doctor in the area and will stand out as a highlight of the summer for those who were lucky enough to serve as locums in the area for the summer.

Bill has served as president of the Aberdeen Hospital Medical Staff and president of the Gyro Club of New Glasgow. Because he is so well known and respected,

he was nominated by the medical staff of the Aberdeen Hospital as a founding member of the Aberdeen Hospital Foundation and currently presides as its first Chairman.

I take great pleasure in nominating Bill MacQuarrie for Senior Membership in this Society.

R.P. (Dick) Felderhof, MD,  
President, Pictou Branch Society.

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### SENIOR MEMBERSHIP CITATIONS THE CANADIAN MEDICAL ASSOCIATION

### Dr. Alvin Jacob Buhr

Dr. Alvin Buhr is an outstanding surgeon, teacher, humanitarian, husband, and father. Not only has he distinguished himself in his field of orthopedic surgery, but also he has always shown a sincere interest in Third World and other underdeveloped countries and has done extensive teaching and travel there. And in his role as a teacher at Dalhousie University, there have been few students or residents in the last 25 years that Dr. Buhr has not touched in a meaningful way. Both by word and action he served as a role model and example of excellence to the countless numbers of physicians who have been exposed to his practice.

Alvin Jacob Buhr is a native of Manitoba. After his early education there, he obtained a Bachelor of Arts degree at the University of Manitoba, winning Manitoba and Richardson scholarships. He then served overseas with the Royal Canadian Army Medical Corps and the Canadian Far East Forces. Following his discharge he enrolled in medical school at the University of Western Ontario in London. He graduated in 1949 and did residencies in general surgery at Westminister Hospital there and at the Hospital for Sick Children in Toronto. Dr. Buhr then did some general practice in Clinton, Ontario, and also served as the medical officer-in-charge in the Grenfell Hospital in Labrador. Between 1953 and 1956 he studied in England at, first, the Royal National Orthopaedic Hospital in Stanmore, and then at the Churchill Hospital in Oxford. He subsequently worked as a house surgeon at the Nuffield Orthopaedic Centre in Oxford and was a research assistant with a Nuffield Grant at the Radcliffe Infirmary until 1959. Dr. Buhr was a fellow in orthopedics at the Toronto General Hospital for two years after leaving Oxford.

Dr. Buhr joined the attending staff at the Victoria General Hospital in Halifax in 1961 and since then has also held appointments at the Halifax Infirmary, the Izaak Walton Killam Hospital for Children, the Halifax Civic Hospital and the Dartmouth General Hospital, as well as the Nova Scotia Rehabilitation



Center. He was a member of the executive of the Victoria General Hospital staff and has served as president of the medical staff of the Halifax Civic Hospital.

Among Dr. Buhr's medical and surgical memberships are those with the Canadian Orthopaedic Association, the Toronto Academy of Medicine, the Canadian Academy of Sport Medicine, the American College of Surgeons, the Canadian Society for Surgery of the Hands, and the Oxford Society, the latter of which he is a life member. He is also a member of the executive for World Orthopaedic Concern, the Third World Medical Equipment Assistance Project, and the Commission on Training and Education in Developing Countries for the International Society of Orthopaedic Surgeons. He is a fellow of the Royal College of Physicians and Surgeons of Canada, the Royal Society of Medicine and the British Orthopaedic Association. He is a past president of the Atlantic Provinces Orthopaedic Society, a vice-chairman of American Orthopaedics Overseas Incorporated and past chairman of the Committee of Orthopaedics Overseas for the Canadian Orthopaedic Foundation.

In his local community he has contributed significantly as a board member for the Orthotics and Prosthetic Unit of the Rehabilitation Centre, as a chairman of the International Service Committee for the Halifax Rotary Club and as a member of the Royal Commonwealth Society serving the greater Nova Scotia community. He has for years participated in travelling orthopedic clinics to Cape Breton.

He has numerous other academic achievements with more than 20 publications to his credit. Indeed, he was chairman of the editorial board and editor-in-chief of *The Nova Scotia Medical Bulletin* from 1972 to 1976 and still sits on the editorial board of that publication.

Dr. Buhr has been married since August 1953 to the former Elizabeth Joy Gornall, an occupational therapist who has done outstanding work in local volunteer activities, assisting in Third World projects and raising the Buhr's four children: Christina, Gavin, Roderick and Vanessa.

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## Dr. George Ritchie Douglas

Colleagues of Dr. Ritchie Douglas at Aberdeen Hospital in New Glasgow have long considered themselves fortunate to have a surgeon of Dr. Douglas's calibre working with them. Indeed, Dr. Douglas has been acclaimed as one of the leading surgeons of Atlantic Canada.

George Ritchie Douglas was born in New Glasgow, Nova Scotia, in 1913. After early education there, he obtained his medical degree from Dalhousie University in 1939 and then began practice at Aberdeen Hospital.

When the war intervened, he served as a medical officer with the Royal Canadian Air Force until 1945. After the war he undertook postgraduate study in surgery at the Royal Victoria Hospital in Montreal and then returned to New Glasgow to accept an appointment as chief surgeon at Aberdeen Hospital, a position he held until 1979 when he became the hospital's chief of staff. He retired in 1980.

Over the years Dr. Douglas has been president of the medical staff at Aberdeen Hospital, has served two terms as a governor with the American College of Surgeons, and has been on the Board of Governors of Dalhousie University. For four years he was an examiner in general surgery at Dalhousie University for the provincial medical board.

Dr. Douglas became a Fellow of the Royal College of Physicians and Surgeons in 1947 and of the American College of Surgeons in 1951. He has been awarded life membership in the Pictou County Medical Society and senior membership in both the Nova Scotia Surgical Society and the Medical Society of Nova Scotia. In 1977 he received the Queen's Silver Jubilee Medal.

Throughout the past 39 years, Dr. Douglas has displayed not only his medical abilities and his compassion for his patients, but also a very keen interest in the Aberdeen Hospital and in the community of Pictou County.

Dr. Douglas is married to the former Elizabeth Miller, and they have two daughters and one son. □

## CLINICAL PATHOLOGIST

Sydney City Hospital, Sydney, Nova Scotia requires a clinical pathologist for its Cape Breton Regional Laboratory. Specialty interest and experience in hematology and biochemistry preferred. Or Anatomic Pathologist with specialty interest and experience in hematology and biochemistry. Remuneration by negotiable salary with benefits.

*Please reply to:*

Francis D. Ellison  
Executive Director  
Sydney City Hospital  
Sydney, Nova Scotia  
B1P 2H8

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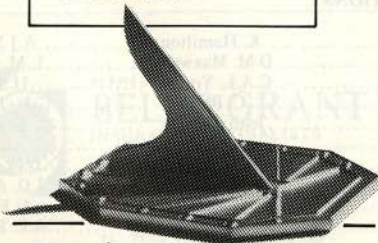
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**Dr. Donald J. MacKenzie**, (92) of Sydney, N.S. died on June 28, 1987. Born in Cape Breton he received his medical degree from Dalhousie Medical School in 1918. He attended the Johns Hopkins University to study bacteriology. He then initiated a laboratory medicine program for medical students. The pathology building in Halifax is named in his honour. He is survived by neices and nephews, to whom the *Bulletin* extends sincere sympathy.

**Dr. David B. Archibald**, (68) of Sydney Mines, N.S. died on September 23, 1987. Born in Sydney Mines he received his medical degree from Dalhousie Medical School in 1943. He obtained his specialty in urology doing his training at the Montreal General Hospital. He was a member of The Medical Society of Nova Scotia and the Canadian Medical Association. He is survived by his wife and a daughter. The *Bulletin* extends sincere sympathy to his wife and family.

**Dr. Albert M. Sinclair**, (61) of Halifax, N.S. died November 19, 1987. Born in Prince Edward Island he graduated from Dalhousie Medical School in 1952 and then went on to do post graduate studies in surgery and orthopaedics. He started practice in Halifax in 1960 and was appointed orthopaedic surgeon-in-chief at the Children's Hospital in 1964. He was a member of The Medical Society of Nova Scotia and the Canadian Medical Association. He is survived by his wife, two daughters and four sons. The *Bulletin* extends sincere sympathy to his wife and family.

**Dr. Donald A. Fayden**, (53) of Truro, N.S. died November 21, 1987. Born in Sydney, he graduated from Dalhousie Medical School in 1959. He was a general practitioner in Truro as well as a member of the anaesthesiology department of the Colchester Regional Hospital. He was a member of The Medical Society of Nova Scotia and the Canadian Medical Association. He is survived by his wife, two daughters and four sons. Our sympathy is extended to his family. □

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