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Women (and Men) in Medicine

The first issue of *The Nova Scotia Medical Journal* in 1990 celebrated the 100th anniversary of Women in Medicine at Dalhousie Medical School. The Dalhousie Medical Alumni Journal "MeDAL" reprinted a number of articles but other reaction to this issue was sparse. This lack of response was surprising considering the number of important issues affected by the changing demographics of our profession as well as the new and differing attitudes brought to the profession by females.

More recently, a conference was held on 12th and 13th October in Halifax to mark "Women in Medicine, a Celebration". Day One was entitled, "Women as Medical Scientists" and Day Two, "The Impact of Women in Medicine". Once again, the small number of men attending this conference was surprising. Few male physicians showed interest in this interesting and important meeting which attracted a distinguished program of speakers.

Are men not interested in the changing face of the profession or the training, practice, or career problems of what will eventually be one half of the profession?

A recent survey of Canadian physicians by *Physician Management Magazine* showed that 90.6 percent of physicians surveyed felt that men and women have different approaches to practice. If that is the case, it is more than time we began to understand and take seriously these differences: The topics of power, income, career planning and the future of the profession are all subjects that are constantly on the minds of male doctors. The males certainly did not enter discussions at the recent meeting mentioned above.

Some writers suggest a basic lack of trust between males and females in our society. Is there a lack of trust between medical colleagues of the opposite sex? Is it significant that females are preferring female doctors or female gynecologists to their male counterparts. At the conference many of the issues discussed were human issues and not necessarily female issues. It was thought-provoking to hear female physicians admit they made conscious decisions to pursue careers rather than children. Is this ever a consideration with men, who do not have to consider a return to practice after child birth and choice of specialty to allow child rearing? Where do male doctors or husbands fit into the family now that women are claiming a more appropriate role? A real opportunity for dialogue was missed with men being absent from this conference.

It was suggested by the participants that many males may have been threatened by the discussions that were held. One would hope that it does not show a lack of male awareness of the changing times. One would also hope that the lack of male attendance simply reflected poor advertising and even that

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Dr. William D. Canham

PRESIDENT
The Medical Society of Nova Scotia
1990-1991

When Bill Canham was taking his honours degree in plant physiology at Mount Allison University, his intendion was to pursue a career in agriculture. Born in Amherst and raised in Parrsboro, this profession had special appeal for him. His plans changed, however, when soon after graduation, he discovered there weren't many jobs available for people with his kind of academic credentials.

Faced with this gloomy prospect, he had to make an important decision.He recalls that he quickly came to the conclusion that "maybe medicine would be interesting." Today, as the new President of The Medical Society of Nova Scotia, he has to admit that he never dreamed just how interesting it would prove to be!

After graduating from Dalhousie University's Medical School in 1974, he decided he would like to spend time in a small community. He chose Truro and describes the next four years as a very pleasant time in his life. In particular, he remembers some of the fine doctors he worked with. He speaks in glowing terms of the late Dr. Jim Vibert who he says, was a major factor in his decision to become a surgeon.

" At first, I wanted to do general surgery but I concluded that the future wasn't there so I went into what was then considered to be a sub-specialty - orthopedics." He adds, " I think having done four years of general practice and having had to deal with the hard realties of life like life threatening disease and diseases you can't do anything about, you think as an orthopedic surgeon you can get away from that, but it's not true. You still have to deal with it and its very, very hard."

Following the completion of his Fellowship, Dr. Canham considered going to New Brunswick, but the Dartmouth General attracted him because it was a new hospital and because in his own words," Like most Nova Scotians you believe you are never really successful unless you're successful in your own province."

He is sorry that many young physicians are no longer able to enjoy the same options he had in the early 1980's, but he sees a trade-off which he feels may well translate into an improved life style for contemporary doctors."It is very hard for physicians and surgeons to practice when work demands are too heavy, when the demands are too difficult. I think many physicians graduating 10 to 15 years ago were brought up to believe that they had to work 60 to 80 hour weeks because it was their duty. That's changing."

The new President also believes The Society must contemplate more change in a response to the challenges of the 1990's. He sees it continuing to play a key role in government negotiations and he stresses that it is equally as important that perceived differences between general practitioners and specialty sections be addressed.

He is convinced that his background helps prepare him for the latter task," I've done both jobs and being married to a general practitioner [Dr. Susan Canham], I think I understand the perception problems. e.g. Just because you work in a specialty doesn't mean you make an inordinate amount of money compared to your colleagues in general practice. At the same time, specialists sometimes view the G.P. as only having to take call a few nights a month and that they really don't have to shoulder as much responsibility. That's often not accurate. Many general practitioners take obstetric calls and in some community hospitals, have to perform to the extreme ends of their expertise.I think some specialists don't always appreciate this."

Dr. Canham wants to do something very positive about such differences. " I think a lot of dialogue is crucial. It may even be necessary from time to time, when things get polarized, to bring in a facilitator who can carry debate for them that is not too personal, not too intense."

The new President seems prepared for the very demanding year he is facing and he is adamant that anyone in his position should be a practicing physician who is able to appreciate the needs of the members of The Society. He feels being a good conciliator will be one of his most important roles." Maybe a conciliator with a hard edge. By sharpening issues, by letting members debate with a little more passion."

Bill Canham obviously relishes dialogue, healthy debate and even a little controversy. Some situations, however, will always continue to disturb him." I don't think that there is anything more intimidating then day to day practice. I spent an hour today talking to a patient who is terminally ill and I find that much more intimidating than talking to the provincial government about fee schedules."

In his private life, Dr.Bill Canham is a devoted father. " I'm not a golfer and I don't have any hobbies. When I have any free time, I want to spent it with my wife and five kids."

Finding free time during his 1990-1991 term of office, isn't going to be easy but the new President of The Medical Society of Nova Scotia seems ready for the very busy months ahead. □

The Role of the Physician in the Extra-Mural Hospital

Murray Nixon, MD, CCFP, FCFP

Fredericton, N.B.

The Extra-Mural Hospital is the home health care program for the Province of New Brunswick. Its establishment under the Public Hospitals Act encourages physician involvement. Each patient is admitted, cared for and discharged by his own doctor who receives medical privileges from the Board of Trustees. Medical Staff By-Laws describe physician responsibilities. The traditional deterrents to physician participation in home health care (concerns about quality of care, inconvenience, inadequate reimbursement and concerns about liability) are being addressed by the Hospital. Medical Advisory Committees function at local and provincial levels, providing physicians a role in the development and administration of the Hospital.

The relationship with physicians may very well be the characteristic that most distinguishes the New Brunswick Extra-Mural Hospital from many other home care programs.[1] Its establishment under the Public Hospitals Act encourages physician involvement. Each patient is admitted, cared for and discharged by his own physician who carries on the doctor-patient relationship and is the only member of the Extra-Mural Hospital treatment team actually chosen by the patient.

PHYSICIAN RESPONSIBILITIES

A physician applies to the Board of Trustees for medical privileges which means that he has access to the resources of the Extra-Mural Hospital in caring for patients at home and that he receives regular reports on the patient's progress from the staff. Most physicians caring for patients in the Extra-Mural Hospital are family physicians and this is encouraged because of their family and community orientation. A specialist may admit a patient he has been treating particularly in an acute care hospital, when he is perpared to follow the patient in the community. The Extra-Mural Hospital provides a substitute for the hospital component of the care of a patient, not for the physician's component and it is not intended that it intrude between the doctor and the patient but broaden the care, in the same manner as in a traditional hospital.

Although most of the actual delivery of care in the Extra-Mural Hospital can be accomplished by non-physician members of the team, the physician is needed to provide medical supervision and direction; besides, patients view home care as a component in the continuum of care and want their doctor to be involved. Although this may not be easy for physicians already very busy with office and regular hospital care of patients, many in New Brunswick incorporate it into their practices.

The Extra-Mural Hospital is addressing the traditional deterrents to physician participation in home health care: concern about the quality of care; inconvenience; inadequate reimbursement for the demands of home care; and concern about professional liability.[2] For example, hospital standards ensure the safe provision of a high quality of home care in the Extra-Mural Hospital and the same standards apply in all Units throughout the province. The delegated medical-nursing procedures performed by Extra-Mural Hospital Nurses have been endorsed as transferred procedures by the New Brunswick Medical Society, the Nurses Association of New Brunswick and the New Brunswick Hospital Association.

The coordinated and comprehensive team efforts of the Extra-Mural Hospital assist the physician to provide efficient care. When a doctor uses the services of the Extra-Mural Hospital he may not need to see the patient as frequently as he would if he were caring for the patient alone, a finding suggested in a recent study on the Extra-Mural Hospital by a Dalhousie University research team.[3]

Government reimbursement to physicians recognizes, to some extent, the special responsibilities physicians have in home health care.

As Keenan has indicated, litigation does not appear to be a problem in home health care as claims against physicians for care provided in the home seem to be virtually non-existent. Perhaps this says something about patient and family involvement in the care at home.[2]

When a physician admits a patient to the Extra-Mural Hospital he accepts certain responsibilities that are outlined in the Medical Staff By-Laws: the responsibility to maintain a satisfactory standard of professional knowledge and ability; the responsibility for the medical management of the patient (including ordering investigations and treatment; coordinating the care and regularly assessing the patient); and the responsibility to cooperate with and provide professional support to the hospital staff. Medical liability insurance is required to obtain medical privileges.

Physicians may admit patients directly from the home or office by telephoning the Unit and forwarding the completed admission form. They may use the services of the Extra-Mural Hospital Liaison Nurse to facilitate admissions from acute care hospitals. All orders for treatment must be in writing with an order considered to

Correspondence: Assistant Executive Director, Medical Services, the New Brunswick Extra-Mural Hospital, 200 Prospect Street, Fredericton, N.B. E3B 2T8

be in writing when dictated to a graduate Nurse or other authorized personnel and signed by the attending physician. The paper work required of physicians is kept to a minimum.

SPECTRUM OF PATIENTS

A family physician who regularly uses Extra-Mural Hospital services in his care of patients comments that over the past several years he has treated patients of all ages with diagnoses such as pneumonia, congestive failure, bacterial endocarditis, osteomyelitis, fractures with immobilization and diabetes. He mentions that he has not admitted a new diabetic to hospital in three years (except when patients are unable to nourish themselves), that the home is particularly appropriate for palliative care, that home intravenous therapy is here to stay, that young mothers are particularly appreciative of home care in lieu of breaking up their family for the duration of a child's illness, that he makes house calls and that treatment in the home situation is much easier than most physicians believe when competent nurses and therapists cooperate in patient care with an interested and accessible physician.[3]

Admission to the Extra-Mural Hospital implies that the patient will receive on-going assessments by his doctor, although Extra-Mural Hospital patients do not usually require the same intensity of physician contact as in a regular hospital. The attending physician determines the frequency of his visits, often seeing the patient at the request of the staff. Palliative care visit guidelines for physicians have been drawn up by a working party of doctors who care for terminally ill patients in the Extra-Mural Hospital and guidelines for other types of patients may follow. Many Extra-Mural Hospital patients are able to visit their doctor's office, while others, especially the elderly and those receiving palliative care need house calls. Joint home visits by the physician and Extra-Mural Hospital staff are encouraged but are difficult to arrange.

TEAM CARE

Home care is team care. As physicians and staff are not in a position to discuss patients in person as readily as in a regular hospital setting, the staff forward regular progress notes to the attending physician or telephone the doctor when they need immediate consultation. Doctors usually instruct their offices to put Extra-Mural Hospital calls directly through.

The Extra-Mural Hospital succeeds because of teamwork, the result of the professional respect that develops between physicians and the staff. Doctors may criticize the Extra-Mural Hospital system but they rarely criticize a nurse or therapist with whom they have been working.

Physicians are reimbursed for their services to Extra-Mural Hospital patients on a fee-for-service basis under the medical services payment act (Medicare). Medicare codes have been established specifically for the Extra-Mural Hospital. Physicians may bill for: admission to the Extra-Mural Hospital along with seeing the patient; house calls (emergency and regular); mileage for house calls; telephone calls from Extra-Mural Hospital staff; and conferences with Extra-Mural Hospital staff. Other billings, such as office visits, are covered under regular Medicare codes.

Physicians have Extra-Mural Hospital Medical Advisory Committees for each Unit providing them with a convenient means of communication at the local level. Their chairmen form the Provincial Medical Advisory Committee which advises with respect to the professional organization, standards and supervision of the Hospital and makes recommendations concerning medical policies.

Representative physicians are consulted when new services are being planned. The Medical Director liaises with physicians, their professional organizations and the Medical Advisory Committees.

The Extra-Mural Hospital is active in continuing medical education, often in association with other organizations. At the undergraduate and post graduate medical education levels, a number of medical students and family medicine residents have exposure each year to the Extra-Mural Hospital through their preceptors' practices.

PHYSICIAN SUPPORT

A recent survey of physicians conducted through the New Brunswick Medical Society indicates support of the Extra-Mural Hospital. Of the 243 physicians who responded, 96% consider the hospital in the home a valid component of health care, 87% see it playing a greater role in the immediate future, 70% see the physician's role increasing, and 91% assess the Extra-Mural Hospital as being effective in meeting their patients' needs.

The Public Hospitals Act establishes a role for physicians in the Extra-Mural Hospital, physicians themselves are defining its practical dimensions in a changing health care scene. □

References

1. Stuart, N, *Operational and International Reviews of Canadian Home Care Programs.* Proceedings of the First National Home Care Conference; Québec City, 14 June 1989.
2. Keenan JM, Fanale JE, Home Care past and present, problems and potential. *JAGS* 1989; **37:** 1076-1083.
3. Dalhousie University Research Team. *Preliminary Evaluation of the New Brunswick Extra-Mural Hospital.* March 1990.
4. Barry T, The role of the G.P. in home care. *Home Care Today,* 1989; **1:** 1-4.

DRINKING PROBLEMS AMONG FIRST YEAR UNIVERSITY STUDENTS

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college students' attitudes, knowledge, and behaviour related to alcohol. *J Alcohol Drug Ed* 1980; **25:** 1-11.
19. Campus Alcohol Policies and Education (CAPE) for low risk drinking: Pilot project at the University of Western Ontario. In N. Giesbrecht, A.E. Cox (Eds.). *Prevention: Alcohol and the environment. Issues, constituencies, and strategies.* Toronto: Addiction Research Foundation, 1986.

Whiplash Shaken Infant Syndrome

INTERVENTION VIA EDUCATION

Stephen Ellis,* and John P. Anderson,** MD, FRCP(C),

Halifax, N.S.

Whiplash Shaken Infant Syndrome (WSIS) was first described by Caffey in 1974. Vigorous and not-so-vigorous shaking of small infants may produce intracranial and intraocular bleeding. This may lead to permanent brain and eye damage: resulting in cerebral palsy, mental retardation, and idiopathic epilepsy. Only a small number of children with the syndrome may be currently diagnosed. Missed diagnoses result because of the absence of external trauma, and also because many caregivers will deny any shaking that may have occurred.

It is possible that children with borderline Normal IQs, learning disabilities and attention deficit disorders might have been normal if they had not been habitually shaken and repeatedly "whiplashed" as infants. Reductions in the actual number of cases of WSIS might be seen if a few simple educational ideas, directed towards caregivers, were implemented.

Whiplash Shaken Infant Syndrome (WSIS) or shaken baby syndrome is a major area of clinical concern. However, many caregivers may not be aware of this condition. The etiology of WSIS, as indicated by the title, is a "whiplash" type of injury. Possible causes include shaking the child as a form of reprimand, the use of certain vigorous toys, such as "jolly jumpers" and ". . . apparently innocent, accepted habitual practices".[1] For the clinician, WSIS must be considered when intracranial and intraocular hemorrhages are present in infants with no history of trauma and the absence of evidence of external trauma.[2] A serious condition has become prevalant because ". . . a 'good shaking' is felt . . . to be socially more acceptable and physically less dangerous than a blow to the head or elsewhere." Through education via the media and literature, health care professionals have the responsibility to attempt to warn of dangerous practices which may lead to WSIS. The deleterious effects of WSIS on infant health is the major reason for wanting to disseminate information regarding the syndrome. Long-term effects may include visual loss, motor deficit, idiopathic epilepsy, developmental delay, hypopituitarism and death.[4]

Even though WSIS has been known for more than a decade, it is still difficult to diagnose. A patient presents with irritability, lethargy, decreased appetite and vomiting.[4] Upon physical examination the physician will usually note no external signs of trauma, such as bruising of the skin. A bulging anterior fontanelle and a head circumference greater than the 90th percentile may be indicative of WSIS.[4] In order to demonstrate retinal hemorrhages, a mydriatic agent may be necessary to dilate the pupils. It must be noted that retinal hemorrhage is ". . . an extremely important, though not absolutely necessary, physical finding for the diagnosis (WSIS) . . . this physical sign may often be the impetus to look further for intracranial injury."[4] A CT (computerized axial tomography) scan is the method of choice for exploring intracranial injury. The CT scan will most likely reveal subdural and/or subarachnoid hematoma.[6]

The issue of child abuse is very relevant to this matter since it is often a difficult topic for discussion between physicians and parents. Thus an infant presents with no external signs of trauma, and general irritability. However, a funduscopic examination leading to a CT scan may reveal WSIS. True positive diagnoses may only be made through painstaking histories. Denial of abuse must always be considered as a possibility. It is imperative that clinicians are thorough in their history taking and physical examination, if the diagnosis of this condition is to be made.

Although diagnostic procedures for WSIS are important, the prevention of the syndrome is of greater importance. Those who are caregivers of infants must realize the severity of some actions. Any activities which allow the child's relatively heavy head and soft brain to be ". . . shaken, jolted or jerked . . ." are dangerous.[2] A suggestion by a knowledgeable parent to a first time parent is to be sure and support the child's head. In order to warn against "shaking" behaviour, an awareness/education campaign is necessary. Common practices such as shaking as a form of punishment, tossing the infant too vigorously into the air, "riding the horse", "cracking the whip" or "skinning the cat", must all be termed dangerous.[1]

To reach the general population, it is most plausible to begin in maternity hospitals and prenatal classes to warn first time parents of the hazards. Those who are babysitters and day-care workers or those who already have children must also be made aware. The mass media represents an ideal mode in which to educate the general public. Other locales in which to inform parents are the doctor's office and the pharmacy. A simple display containing descriptive pamphlets, or a word with the

* First Year Medical Student, Dalhousie University; Halifax, N.S.

** Director of Child Advocacy, Department of Pediatrics, The Izaak Walton Killam Children's Hospital; Halifax, N.S.

Correspondence: Dr. John P. Anderson, Izaak Walton Killam Children's Hospital, 5850 University Avenue, P.O. Box 3070, Halifax, N.S. B3J 3G9

professional on hand, could have tremendous impact.

Although suggestions such as these were proposed by Dr. Caffey[2] in 1974 and again by Dykes in 1986,[4] very few centres have initiated such programs. The major age category at risk of WSIS is up to one year of age. Dr. Caffey continues to suggest that even later in life some activities are dangerous.[1] Things such as rough play with other children, contact sports, gymnastics, "jolting" toys and vibrational stimuli may also be methods for producing WSIS.[1] The above mentioned are most dangerous with prolonged exposure. Some toys Dr. Caffey mentions are "... baby bouncers, and infant jumpers; and, for younger children, swings, seesaws and playslides ... powered cradles and powered rocking horses, trampolines, skateboards and sled jumping."[1] Research has not been done in the area of toys and play activities for older children and their relationships to neurological injuries. It is tragic to think that one may be unknowingly subjecting a child to a dangerous environment. Such a campaign could prevent much morbidity later in life.

The exact impact or outcome of an educational program is difficult to calculate because the number of long-term effects directly attributable to WSIS is not known. The financial impact on society and on a family with a child who has moderately severe intracranial hemorrhage (resulting in hydrocephalus) is profound. Medical costs, special day-care, special education and rehabilitation, for the child's lifetime, will easily reach hundreds of thousands of dollars in costs for the taxpayer. Parental or caretaker admission of infant shaking is rare. Direct cause and effect associations are not readily apparent. However, some documented cases in which shaking was admitted have been studied with their resultant loss of visual ability, mental retardation, cerebral palsy and developmental problems.[4] Intervention programs to decrease such outcomes may not be statistically significant but their clinical significance is unquestionable.

Children's lives may be saved. A program such as this which is easy to implement and relatively inexpensive should be instituted even if only a few children are kept from harm.

Whiplash Shaken Infant Syndrome represents a pertinent, immediate community health challenge. The dangers associated with WSIS are plausible and the prevention program would be simple to elaborate upon. There are those who will continue to abuse their children and who will not benefit from the information. Many could benefit from a few simple words "Don't shake the baby" or "Babies are for hugging not shaking," — two slogans suggested by Dykes.[4] □

References

1. Caffey J. On the theory and practice of shaking infants. *Am J Dis Child* 1972; **124:** 161-169.
2. Caffey J. The whiplash shaken infant syndrome: Manual shaking by the extremities with whiplash-induced intracranial and intraocular bleeding, linked with residual permanent brain damage and mental retardation. *Pediatrics* 1974; **54:** 396-403.
3. Guthkelch AN. Infantile subdural haematoma and its relationship to whiplash injuries. *B Med J* 1971; **2:** 430-431.
4. Dykes LJ. The whiplash shaken infant syndrome: What has been learned? *Child Abuse and Neglect* 1986; **10:** 211-221.
5. Carter JE and McCormick AQ. Whiplash shaking syndrome: Retinal hemorrhages and computerized axial tomography of the brain. *Child Abuse and Neglect* 1983; **7:** 279-286.
6. Sinal SH, Marshall RB. Head trauma due to child abuse: Serial computerized tomography in diagnosis and management. *Southern Med J* 1987; **80:** 1505-1512.
7. Duhaime A, *et al.* The Shaken Baby Syndrome. *J Neurosurg* 1987; **66:** 409-415.

THE EMERGING RELATIONSHIP BETWEEN EXERCISE AND MENTAL HEALTH

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20. Kavanagh T, Shephard RJ, Tuck JA, Qereshi S. Depression following myocardial infarction: The effects of distance running. *Ann NY Acad Sci* 1977; **301:** 1029-1038.
21. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.). Washington, DC: Author, 1980.
22. Birchwood M, Hallett S, Preston M. *Schizophrenia: An Integrated Approach to Research and Treatment.* London: Longman Group Limited, 1988.
23. Gimino FA, Levin SJ. The effects of aerobic exercise on perceived self-image in post-hospitalized schizophrenic patients. *Med Sci Sports Exerc* 1984; **16:** 139.
24. Manchanda R, Hirsch SR, Barnes TR. Criteria for evaluating improvement in schizophrenia in psychopharmacological research (with special reference to gamma endrophin fragments). *Br J Psychiatry* 1988; **153:** 354-358.
25. Tamminga CA, Tighe PJ, Chase TN, DeFraites EG, Schaffer MH. Des-tyrosine-γ-endorphin administration in chronic schizophrenics: A preliminary report. *Arch Gen Psychiatry* 1981; **38:** 167-168.
26. American College of Sport Medicine. *Guidelines for Exercise Testing and Prescription* (3rd ed.). Philadelphia: Lea and Febiger, 1986.

If you have a morbid fear of peanut butter sticking to the roof of your mouth, there is a word for it: *arachibutyrophobia.*

Bill Bryson. *The Mother Tongue.* New York: William Morrow, 1990.

Avoidance of Air-Borne Allergens in Atopic Dermatitis

C. Zip,* MD, J. G. Gatien,** MD, FRCP(C) and J. B. Ross,*** MB, FRCP(C),

Halifax, N.S.

A multitude of factors can exacerbate atopic dermatitis, including infection, xerosis and environmental allergens.[1,2] In the majority of cases, the disease can be controlled by relatively simple measures. Standard treatment includes topical corticosteroids, antihistamines, emollients, and antibiotics.[3] In a small percentage of patients there is a specific indication for dietary alteration.[4] Moreover air-borne allergens may play a role in a further subgroup of patients acting as contact allergens.[5] It is often difficult to give specific advice aimed at minimizing exposure to such allergens because of inability to identify specific triggers. One of us (JG) has developed a strategy to minimize air-borne allergens in the environment. In modified form, this can be passed on to patients.

TECHNIQUES TO AVOID AIR-BORNE ALLERGENS

I. Pollens and Mould Avoidance

1. From May to November inclusive:

a) Fibreglass or polyester filter pads measuring 1/2-1 inch in thickness should be applied to the inside of any open screening in the patient's bedroom and any other frequently occupied room. These filters should be sealed in place using wide strips of Velcro or tightly adhesive water resistant tape. The filters should be sprayed with Lysol every 1 to 4 days and changed every 1 to 4 weeks. Suitable filters include:

   i) washable fibreglass furnace filters (available on order at better quality hardware stores)
   ii) hammock style air filters (marketed by Home Hardware Stores)
   iii) polyester quilt batting (available in fabric depts or fabric stores)

b) Personal clothing and bedding should be dried indoors rather than out-of-doors.

c) Whenever hayfever symptoms are anticipated or are developing, activities should be limited as much as possible to these protected rooms within your home. This is particularly important during the late afternoon and evening.

2. At all times:

Minimize exposure to areas of high pollen and mould concentration, particularly the following:

Trees	Grasses
groves of trees	tall fields of grass or weeds
wooded areas	fresh mown lawns
natural Christmas trees	fresh cut hay or ball fields
wood piles	farming country (late spring or summer)
wood dust	
wood smoke	
wood cinders	
sawdust piles	

Moulds	Miscellaneous
foam containing stuffed toys, pillows and bedding	perfume containing products
poorly cleaned humidification, dehumidification and air conditioning equipment	cosmetic containing products
air conditioned automobiles	swimming pools
damp or musty basements, cellars and barns	indoor skating rinks
	shallow bodies of calm water
	fresh budding trees
	fresh cut flowers

II. Animal Allergen Avoidance

1. No feather, fur or hair bearing animal should be permitted within your home.
2. No fabrics containing wool, feathers, or fur should be permitted in your close personal clothing or bedding. Likewise such fabrics should not be permitted in your bedroom or family recreation area.
3. Visits to indoor areas where animals are permitted should be minimized.
4. Direct contact with feather, fur and hair bearing animals should be kept to an absolute minimum.

III. Environmental Control

1. The doors to your bedroom and other frequently occupied rooms should be kept closed at all times.
2. For homes heated with forced hot air, fibreglass or polyester filter pads, as described in section I should be placed inside or over forced hot air ducts which heat the patient's bedroom or other frequently occupied rooms.[1] These filters should be maintained as described in Section I above.[1]
3. Clutter within these rooms should be minimized. Specifically the floors should be bare, nothing should be stored under the bed, and the closet should be used only for clothes in season.
4. At a freqency NOT TO EXCEED every three to four

* Resident, Division of Dermatology
**Assistant Professor, Department of Pediatrics.
***Professor and Head, Division of Dermatology, Department of Medicine, Assistant Professor Department of Pediatrics, Dalhousie University, Halifax, N.S.

days, these rooms should be cleaned using damp mopping and damp dusting methods. The dusting cloth may be dampened with water or linseed oil.

5. Complete waterproof covers should be placed around the box spring and around the mattress of your bed. Wide strips of waterproof tape should be placed over their zipper or velcro seals. A doubly folded flannelette sheet, covered with a polyester-filled, tightly fitted mattress pad should be placed over the waterproof mattress cover for comfort.
6. Pillows should be filled with Dacron, Fortrel, or polyester fibre. Chip foam containing pillows should be discarded.
7. One or two washable non-plush synthetic stuffed toys filled with similar fabric are permissible.
8. Stuffed animals, pillows and bed clothes should be
   a) tumbled in the clothes dryer for 20-30 minutes every 4-7 days
   b) thoroughly washed and dried every 2-6 weeks
9. An accurate portable thermometer-hygrometer should be placed on a central wall at bed head level in or near your bedroom. This may be purchased at reasonable cost from most hardware stores. Regulate the ambient temperature to between 15-19 celsius (60-66 F) and keep the relative humidity between 30-45%. Good quality automatic portable humidification equipment may be necessary. If used this equipment must be thoroughly cleaned internally every 5-7 days. In addition, 15-30 ml of a fungistatic agent such as Aquafresh, Javex, Calsol powders or white vinegar should be instilled daily into its water reservoir.

IV. Laundry

1. All personal clothing and bedding should be washed with a plain white or blue soap powder or detergent which is suitable only for use in hot water.
2. Personal clothing and bedding should be rinsed at least twice, and preferably three times after washing.
3. From May to November inclusively, all personal clothing and bedding should be dried indoors rather than out-of-doors where pollens are felt to be part of the problem.
4. No other chemicals should be added to the wash, rinse or dry cycles except for the following:
   a) a modest amount of simple bleach such as Javex or Borax
   b) 1-2 cups of white vinegar added to the final rinse cycle to act as a fabric softener.

DISCUSSION

Clearly, these measures should be recommended to only a small subgroup of patients with atopic dermatitis. Most likely to benefit include those with respiratory triggers, hayfever, and urticaria. In addition, those selected must have the intellect and economic resources to carry out the precautions. The goal should be restriction of exposure to a tolerance level rather than complete elimination of air-borne allergens. In many cases, a minimal reduction will be satisfactory. In unusual cases of exquisite sensitivity, rigorous adherence to the precautions outlined above may be necessary but even then may prove futile. □

References

1. Hanifin JM. Atopic Dermatitis. *J Allergy Clin Immunol* 1984; **73:** 211-222.
2. Rajka G. *Atopic Dermatitis* London, 1975. WB Saunders Col, Ltd.
3. Hurwitz S. Atopic Dermatitis. *Pediatr Ann* 1982; **11:** 237-250.
4. Caputo RV, Frieden I, *et al.* Diet and Atopic Dermatitis. *J Am Acad Dermatol* 1986; **15:** 534-545.
5. Rohn HL. Atopic Dermatitis Revisited. *Int J Dermatol* 1987; **26:** 139-140.

PAP SCREENING IN THE OVER 60 YEAR OLD FEMALE

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2. Ayiomamitis A: The Epidemiology of Cancer of the Uterine Cervix in Canada 1931 to 1984. *Am J Obstet Gynecol* 1987; **156**:1076-80.
3. Tupper WRC, Tompkins MG, Nolan M: Cancer of the Cervix in Nova Scotia. *Nova Scotia Med Bull* 1984;**17**:22-32.
4. Anderson GH et al: Organization and Results of the Cervical Cytology Screening Program in British Columbia, 1955-85. *Br Med J* 1988;**296**:975-8.
5. Worth AJ: The Walton Report and Its Subsequent Impact on Cervical Cancer Screening Programs in Canada. *Obstet Gynecol* 1984;**63**:136-9.
6. Lynge E, Poll P: Incidence of Cervical Cancer Following Negative Smear: A Cohert Study from Maribo County, Denmark. *Am J Epidemiol* 1986;**124**:345-52.
7. Graaf Y, Vooijs PG, Zielhuis GA: Population Screening for Cervical Cancer in the Region of Nijmegen, The Netherlands 1976-85. *Gynecologic Oncol* 1988;**30**:388-97.
8. Holmes FF, Hearne III E: Cancer Stage-to-Age Relationship: Implications for Cancer Screening in the Elderly. *J Am Geriatrics Soc* 1981;**29**:55-7.
9. Mandelblatt JS, Hammond DN: Primary Base of Elderly Women: Is Pap Smear Screening Necessary? *Mount Sinai J Med* 1985;**52**:284-90.
10. Celentano DD, Klassen AC, Weisman CS, Rasenshein NB: Cervical Cancer Screening Practices Among Older Women: Results From the Maryland Cervical Cancer Case-Control Study. *J Clin Epidemiol* 1988;**41**:531-41.
11. Ebeling K, Nischan P: Organization and Results of Cervical Cancer Screening in the German Democratic Republic. Hakama M, Miller A B & Day N E. WHO International Agency for Research on Cancer, *Screening for Cancer of the Uterine Cervix*, IARC Pub. 76 Lyon 1986.
12. Mandelblatt JS, Fahs MC: The Cost-Effectiveness of Cervical Cancer Screening for Low-Income Elderly Women. *JAMA* 1988;**259**:2409-13.
13. Coppleson LW, Brown B: Observations on a Model of the Biology of Carcinoma of the Cervix: A poor fit between observation and theory. *Am J Obstet Gynecol* 1976;**122**:127-136.
14. Tarr D, Palacio H, Mandelblatt J: Pap smear screening in elderly high-risk women. *NY State J Med* 1988;**88**:296-9.
15. Mandelblatt J, Gopaul I, Wistreich M: Gynecologic Care of Elderly Women: Another Look at Papanicolaou Smear Testing. *JAMA* 1986;**256**:367-71.
16. National Institute of Health Consensus Development Panel, Cervical Cancer Screening: The Pap Smear. *South Med J* 1981;**74**:87-8.
17. Brown DC: Early Detection of Cancer in Women (Editorial). *Primary Care Clinics in Office Practice*, Vol 3, No 2, June 1976, W B Saunders Co, Philadelphia.

The Emerging Relationship Between Exercise and Mental Health

Thomas W. Pelham,* MSc,

Halifax, N.S.

Exercise has been recognized as an important factor in reducing the risk of many somatic conditions. Whereas exercise therapy is playing a significant role in primary care, rehabilitation, and prevention programming for somatic conditions, current research has suggested that exercise may also have preventive and post-intervention psychotherapeutic benefits for individuals carrying an affective or schizophrenic disorder. As a consequence, exercise as a psychotherapeutic measure is having an increased prominence in health and medical issues and research.

This paper addresses the issue of exercise therapy, highlighting studies showing the anxiolytic and anti-depressant benefits of exercise therapy, as well as the mood stabilizing effects of exercise with individuals carrying a diagnosis of schizophrenia.

Kinesiology is becoming an increasingly important body of knowledge in many health sciences and many areas of medicine. Research has shown that health-related exercise reduces the risks of many debilitating somatic conditions and improves physical function. Indeed, this emerging body of knowledge is playing a significant role in primary care, rehabilitation, and prevention programming for somatic conditions. In addition, a connection between exercise and enhanced mental well-being is emerging. To a large extent, the accumulation of evidence demonstrating a beneficial link between exercise and enhanced emotional well-being has shown the successful use of exercise therapy in reducing anxiety and depression in both healthy individuals[1] and psychiatric patients.[2] In fact, current research has suggested that exercise therapy may also have preventive and post-intervention psychological benefits for individuals carrying an affective[2-5] or schizophrenic disorder.[6]

Although nonpsychiatric physicians treat about 60 per cent of patients with psychiatric disorders, especially those with clinical depression and anxiety,[2] surveys have reported that 93 per cent of psychiatrists recommend exercise as a psychotherapeutic intervention for anxiety and depression.[7] As a consequence, exercise, as a psychotherapeutic tool, is having an increased prominence in many areas of medicine.

In an attempt to appreciate the mental health benefits of regular exercise, the paper will address the issue of exercise therapy, highlighting studies showing the anxiolytic and anti-depressant benefits of exercise therapy, as well as the mood stabilizing effects of exercise with individuals carrying a diagnosis of schizophrenia.

ANXIETY AND EXERCISE

Anxiety is a complex psychobiological relationship between stressors, emotional states, personality traits, and adjustments.[8]Epidemiological findings have suggested that five to fifteen percent of the North American population experience an anxiety disorder at some point in their life.[9] Prolonged anxiety may have a variety of adverse effects on physical health and mental well-being, as well as contributing to serious somatic disorders such as coronary heart disease and cancer.[8]

Given the pandemic nature of anxiety and the cost and time associated with psychotherapy, as well as the cost and potential side effects of various drugs used in the treatment of anxiety,[10,11] many physicians are examining the efficacy of exercise as an alternative psychotherapeutic measure.[2,3,5,11]

Studies have shown that exercise is most effective in reducing anxiety when performed vigorously,[4] and is more influential in highly anxious individuals.[1] When compared with meditation, exercise was shown to be as effective in reducing anxiety.[12] A number of exercise related features have been suggested as factors that may reduce anxiety, such as diversion, attention, mastery, or self-efficacy. Whereas these proposed features of exercise lack useful biochemical markers, another common hypothesis proposes that exercise may actually be counterproductive. Pitts and McClure have suggested that exercise can induce symptoms of anxiety and attacks in anxiety neurotics by raising blood lactate (LA) levels.[13] Indeed, research has shown that symptoms of anxiety are induced within minutes of intravenous administration of LA. In addition, high levels of blood LA can be found in both post-exercise serum samples and samples obtained during the exercise session. However, Morgan has demonstrated that subjects who have achieved high levels of blood LA by exercising, in fact show no symptoms of anxiety either during the exercise session or post-exercise.[1]

Additional research has investigated different biochemical features attempting to identify the biochemical basis for the anxiolytic benefits of exercise. Preliminary work by Sinyor and his associates has shown that at the end of a controlled experimental stress session well conditioned subjects had lower levels of circulating

*Exercise Physiologist, DalPlex, Dalhousie University, Halifax, N.S. From the Division of Physical Education/Kinesiology, School of Recreation, Physical and Health Education, Dalhousie University.

Correspondence: Thomas Pelham, 26 Pembrooke St., Waverley, Nova Scotia B0N 2S0

catecholamines and a more rapid autonomic recovery from psychosocial stress, as well as lower anxiety levels.[14]

More recent non-invasive neuromuscular investigations have demonstrated reductions in anxiety-tension levels using electromyographic evaluation of resting muscle action potentials in a single exercise bout, as was also found in five and ten week exercise programmes.[4] Indeed, considerable evidence suggests that exercise relaxes the reflexogenic projections of the muscle spindle afferents, such as the Golgi tendon organ afferents, to such an extent that collateral branches of these afferents exert inhibitory presynaptic effects on the nociceptive afferent.[4]

Although exercise therapy appears to be a safe and cost-effective treatment for many anxious patients seen by the physician, having comparable effects to that of the minor tranquillizer meprobamate at a dosage of 400mg, the full anxiolytic potential of exercise is merely speculative, and more research is required in this area.[11]

DEPRESSION AND EXERCISE

Frequently associated with anxiety is depression. Indeed, at any given time, ten percent of the North American population may carry a diagnosis of depression.[5] In fact, depression is the most prevalent disorder in western society. Usually associated with depression are suicide, alcoholism, and drug abuse.[5]

Psychotropic medication, psychotherapy, and electroconvulsive therapy (ECT) are the common treatments available for depressions. However, these treatments have their drawbacks. Many individuals will not adhere to medication regimens.[5] In addition, pharmacological interventions used in the management of depression may have detrimental side effects in some individuals.[10,11]

Along with the problems of drug side effects and adherence to pharmacological interventions, some individuals are unwilling to participate in costly psychotherapy or ECT.[5] Indeed, many health care professionals are exploring alternative forms of treatment for depression.

At a time of escalating cost of medical services, some investigators have suggested exercise as an appropriate and inexpensive form of secondary preventive/rehabilitative medicine for depressed patients.[2,5,15] Administration and supervision of an effective exercise programme require only a limited amount of staff time, with equipment and space rental costs being minimal. In contrast to other transitional forms of treatment recent research has shown psychiatric patients have higher adherence to an exercise programme.[6] Indeed, when compared with psychotherapy, exercise was as effective in reducing moderate (neurotic-reactive) depression in psychiatric inpatients.[5]

As was the case for anxiety, the apparent anti-depressant effect of exercise may depend to some degree on the intensity, duration, and frequency of the physical activity.[15] This hypothesis was postulated after non-randomized subjects participated for ten weeks in either softball, tennis, or jogging sessions of varying intensity. The results indicated that depression levels were unchanged with the softball sessions, slightly improved for tennis, and significantly reduced for joggers. As well, the subjects that jogged five days a week had a greater reduction in depression score than subjects who jogged three days per week. However, the above results must be viewed with caution since the subjects were not randomly selected and a control group was not used.

There are at least two biochemical sources of evidence regarding the psychotherapeutic benefits of exercise in depressed patients. The β-endorphin (β-EP) hypothesis suggests that strenuous exercise increases circulating levels of endogenous opioids, with evidence derived from experimentally controlled exercise studies demonstrating increased plasma β-EP levels[16] and decreased sensitivity to pain[1] while studies of depressed patients showed significantly lower circulating levels of β-EP.[17] Another strong neurochemical candidate is the aminergic hypothesis. It has been well recognized that monoamine malfunction is involved in the pathogenesis of depression.[18] Moreover, even though it has been reported that the consequences of exercise have been shown to enhance the dopaminergic, noradrenergic, and serotonergic systems[19] resembling those of tricyclic antidepressants and ECT,[1,3,11] one of the effects of aerobic conditioning is a significant reduction of circulating catecholamines.[4]

Regardless of the anti-depressant mechanism involved, exercise therapy has been incorporated into a wide range of comprehensive treatment programmes. Its anti-depressant benefits have been reported by renal dialysis patients,[3] post-myocardial infarction patients,[20] long-term cancer survivors,[3] and individuals carrying a diagnosis of schizophrenia.[6] Indeed, the evidence for the anti-depressant nature of exercise is impressive. However, many studies are not well controlled and a biochemical basis remains to be elucidated, preventing any definitive conclusion from being drawn.

SCHIZOPHRENIA AND EXERCISE

Although the concept of schizophrenia is unclear,[21] between one and two percent of the North American population carry a diagnosis of schizophrenia.[22] According to the Diagnostic and Statistical Manual of Mental Disorder III (1980) criteria,[21] a diagnosis of a schizophrenic disorder requires at least one of the following symptoms: presence of delusions, hallucinations, incomprehensible speech, disturbed sense of self, gross disorganized behaviour, blunted, flat, or inappropriate affect lasting at least six months. Other residual symptoms are social isolation, or withdrawal and a marked impairment in role functioning, peculiar behaviour, personal hygiene, and grooming.

In the past, few studies have explored the psychological and physiological benefits of exercise in a schizophrenic population. Gimino and Levin studied post-hospitalized chronic schizophrenic patients in a social

rehabilitation clinic.[23] The subjects jogged for ten weeks for a duration of forty minutes three times a week. A control group was matched for sex, age, and diagnostic category, and was involved in either ancillary therapeutic activities, or in a meditation group. All groups underwent physiological and psychological testing before and after the experimental period. Only the exercise group demonstrated a significant increase on self-report scores in self-esteem.However, results from this study must be interpreted cautiously as there is the question as to whether: 1) controls were provided treatment perceived as equivalent; 2) fitness levels were reported; and 3) selection to groups was random. Nevertheless, the study suggests that aerobic exercise can be an effective treatment in improving the self-esteem of a chronic schizophrenic.

An interdisciplinary group of health professionals has investigated the psychological benefits of exercise using a combined single subject-comparative group design in a schizophrenic population.[6] In this study, 32 chronic male and female outpatients attending a psychiatric rehabilitation clinic participated in an aerobic exercise programme for periods ranging from 3 to 36 months. Improvements in cardiovascular fitness levels ranged from 10 per cent to 67 per cent. Psychological results derived from comparative group, correlational, and single-subject methodologies indicated subjects showed significant correlations between lower cardiovascular fitness and deeper levels of depression, as well as positive associations between increases in cardiovascular fitness and depression. In addition, comments in the structured interviews revealed that a high percentage of patients reported that participation in exercise sessions were associated with consistent anti-depressant and/or anxiolytic effect for durations of 2 to 48 hours. Indeed, subjects reported significantly higher levels of energy and activity, improved concentration, improved ability to manage mood-affect states, and improved participation in other rehabilitation treatment modalities.

Unfortunately, few studies have focused on the effects of exercise in the rehabilitation of a schizophrenic. Evidence suggests that involvement in an exercise programme appears to improve, to some extent, the psychological well-being of an individual carrying a diagnosis of schizophrenia.

As already pointed out, experimentally controlled exercise studies have been shown to cause marked increases in plasma levels of endogenous opioid peptides including β-lipotropin (β-LPH).[17] Although the neurophysiologic functioning of β-LPH is unknown, preliminary evidence has suggested that β-LPH contains a fragment, des-tyrosine-γ-endorphin, reportingly having antipsychotic properties similar to neuroleptics, and experimentally used in the treatment of the symptoms of schizophrenia.[24] In addition, the symptoms have been shown to be related to an excess production of dopamine, noradrenaline, and serotonin while drugs that are effective in the treatment of schizophrenia, such as chlorpromazine, decrease the secretions or activity of at least one of these neurotransmitters, an effect similar to that of aerobic conditioning.[4,12] Although speculative, given the limited antipsychotic efficacy of currently available neuroleptics, the use of exercise as an adjunct therapy for the symptoms of schizophrenia is encouraging.[25]

In summary, a review of the hypotheses regarding the psychotherapeutic benefits of exercise illustrates that: 1) exercise effects are complex and multifaceted; and 2) prevailing hypotheses are not mutually exclusive; some or all may be implicated in different degrees with patients.

GUIDELINES FOR EXERCISE PRESCRIPTION

Although the physician is aware of the physical benefits and demands of exercise, the practitioner may gain significant advantage by following several basic guidelines recommended by the American College of Sport Medicine:[26] 1) exercise prescription should be individualized, meeting the needs and interests of each patient; 2) to enhance motivation levels the exercise prescription should incorporate a variety of activities which are enjoyable for the patient; 3) these activities should be rhythmical and aerobic in nature, involving the large muscle groups. Typical activities are walking-jogging-running, hiking, swimming, skating, cycling, rowing, canoeing, cross country skiing, rope skipping, (etc.); 4) intensity of activity should be between 60 per cent and 90 per cent of maximum heart rate which can be monitored by heart rate monitor or self-administered palpations; 5) the patient should exercise three to five days per week; 6) duration of activity should range between 15 and 60 minutes of continuous aerobic activity. However, the duration will depend on the exercise intensity. For example, a low to moderate intensity of exercise will require a longer duration to achieve desired results; 7) the rate of progression should be dictated by the conditioning effects of the exercise and usually measured by the physiological performance of the individual on an exercise stress test; and 8) for individuals receiving psychotropic medications the physician must be aware of the effect of medication on the cardiovascular response to exercise and adjust the exercise prescription accordingly.

RECOMMENDATIONS FOR FUTURE STUDIES

As already mentioned, many psychiatric patients receive psychotropic drugs. However, little is known of the interaction between medication and exercise. In this regard, the Norwegian psychiatrist, Martinsen[12] has some relevant questions: 1) What is the effect of medication on the cardiovascular response to exercise? 2) Is there a risk of special complications from exercise during pharmacological treatment? 3) Can exercise reduce or increase the side effects of medication? 4) Can exercise increase or reduce the therapeutic effect of medication? 5) Can exercise replace medication?

With few exceptions, exercise has been shown to have psychotherapeutic benefits for individuals carrying an

affective or schizophrenic disorder. Moreover, exercise therapy may provide a self-regulating method for stabilizing mood and reduced anxiety and depression without requiring extensive cognitive organization or insight for individuals with affective or schizophrenic disorders. Whereas, medication has been the most effective treatment to control the symptoms of an affective and schizophrenic disorder, this treatment modality may produce severe side effects. Indeed, at a time of escalating cost of medical services, and the treatment of psychiatric patients becoming community-based, exercise may be an appropriate and inexpensive form of secondary preventive/rehabilitative medicine. □

References

1. Morgan WP. Affective beneficience of vigorous physical activity. *Med Sci Sports Exerc* 1985; **17:** 94-100.
2. Hill JW. Exercise prescription. *Prim Care* 1987; **14:** 817-825.
3. Brown RS. Exercise and treatment of mental disorders. In: Morgan WP, Goldston SE, eds. *Exercise and Mental Health.* Washington: Hemisphere Publishing Corporation, 1987: pg 131-137.
4. deVries HA. Tension reduction with exercise. In: Morgan WP, Goldston SE, eds. *Exercise and Mental Health.* Washington: Hemisphere Publishing Corporation, 1987: pg 99-103.
5. Greist JH. Exercise intervention with depressed outpatients. In: Morgan WP, Goldston SE, eds. *Exercise and Mental Health.* Washington: Hemisphere Publishing Corporation, 1987: pg 117-129.
6. Ritvo P, Campagna P, Pelham T, Birnie W. *Aerobic and anaerobic exercise as a treatment modality in the rehabilitation of chronic psychiatric patients.* Paper presented at The Canadian Psychiatric Association Annual Meeting. Halifax, Nova Scotia, 1988.
7. Byrd OE. Survey of beliefs and practices of psychiatrists on the relief of tension by moderate exercise. *J Sch Health* 1963; **33:** 426-427.
8. Spielberger CD. Stress, emotions and health. In: Morgan WP, Goldston SE, eds. *Exercise and Mental Health.* Washington: Hemisphere Publishing Corporation, 1987: pg 11-16.
9. Robins LN, Hilzer JE, Weissman MM, et al. Lifetime prevalence of specific psychiatric disorders in three sites. *Arch Gen Psychiatry* 1984; **41:** 949-958.
10. Canadian Pharmaceutical Association. *Compendium of Pharmaceuticals and Specialities* (22th ed.). Ottawa: Author, 1988.
11. Martinsen EW. Exercise and medication in the psychiatric patient. In: Morgan WP, Goldston SE, eds. *Exercise and Mental Health.* Washington: Hemisphere Publishing Corporation, 1987: pg 85-95.
12. Bahrke MS. Exercise, meditation and anxiety reduction: A review. *Am Correct Ther J* 1979; **33:** 41-44.
13. Pitts FN, McClure JN. Lactate metabolism in anxiety neurosis. *N Engl J Med* 1967; **277:** 1329-1336.
14. Sinyor D, Schwartz S, Peronnet F, Brisson G, Seraganian P. Aerobic fitness level and reactivity to psychosocial stress: Physiological, biochemical, and subjective measures. *Psychosom Med* 1983; **45:** 205-217.
15. Brown RS, Ramirez DE, Taub JM. The prescription of exercise for depression. *Phys Sportsmed* 1978; **6:** 34-37, 40-41, 44-45.
16. Carr DB, Bullen BA, Skrinar GS, *et al.* Physical conditioning facilitates the exercise-induced secretion of beta-endorphin and beta-lipotropin in women. *N Engl J Med* 1981; **305:** 560-563.
17. Galard R, Gallart J, Arguello JM, Schwartz S, Castellanos JM, Catalan R. Plasma levels of B-endorphin, cortisol, prolactin and growth hormone in depressed patients. *Acta Psychiatr Scand* 1988; **78:** 230-233.
18. Schildkraut JJ. The catecholamine hypothesis of affective disorders: A review of supporting evidence. *Am J Psychiatry* 1965; **122:** 509-522.
19. Chaouloff F. Physical exercise and brain monoamines: A review. *Acta Physiol Scand* 1989; **137:** 1-13.

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PROCEEDINGS OF

26th MEETING OF COUNCIL

and

137th ANNUAL MEETING

of

The Medical Society of Nova

HALIFAX

November 16 - 17, 1990

THE MEDICAL SOCIETY OF NOVA SCOTIA
PROCEEDINGS OF
26th MEETING OF COUNCIL
137th ANNUAL MEETING
November 16-17, 1990

Friday morning - November 17, 1990

The 26th Meeting of Council began as the Medical Society Officers, accompanied by Dr. Judy Kazimirski, C.M.A. Board Chairman, representing Dr. Lionel Lavoie, President of The Canadian Medical Association, the Division Presidents, and the Executive Director paraded through Council Chambers to the head table. Following call to order by Dr. George Ferrier, Chairman of the Executive and General Council, the Officers were introduced and Dr. Judy Kazimirski brought greetings from The Canadian Medical Association.

The Executive Director read the names of Society members deceased since October 1, 1989 as follows: Dr. Douglas W. Archibald of Grand Pre; Dr. Charles I. Cohen of Dorset; Dr. Sidney J. Crabtree of Dartmouth; Dr. Ritchie G. Douglas of New Glasgow; Dr. Peter D. Ferguson of Dartmouth; Dr. Kenneth V. Gass of Pugwash; Dr. Margaret E.B. Gosse of Halifax; Dr. Noel J. Jackson of Lockeport; Dr. John W. MacIntosh of Halifax; Dr. Thomas J. McKeough of Sydney Mines; Dr. William E. Pollett of Halifax; and Dr. William A. Taylor of Bridgewater.

The Transactions of the 25th Meeting of Council and 136th Annual Meeting (1989) as printed in the December 1989 issue of The Nova Scotia Medical Journal were approved.

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

These Transactions are a concise record of reports which were presented and the decisions arising therefrom. It may be necessary for the reader to refer to Reports to Council (1990) for detailed background information. The Reports are available through the Society office, all Branch Societies, and members of Council. All information is available for viewing at the office upon reasonable notice.

REPORTS

Executive Director

Mr. Epstein made reference to the useful discussions with many individual members he had benefited from in the eight months since taking up the position of Executive Director. He added that he was looking forward to meeting many more members at this Annual Meeting and looking forward to discussing ideas of future directions for The Society.

Mr. Epstein noted that he did not come to The Society without an agenda, noting that it is one that is shared by the Officers who feel it represents the best interests of members. He added that his hope was to continue to have The Society do well what it has particularly been successful at in the past — negotiating with the Provincial Government over economic matters, and representing the medical profession's interests to the government and other bodies — and at the same time to develop an expertise and a public presence on a whole host of health care issues. He added that this latter function is one that is expected to take a great deal of The Society's attention in the coming years.

He noted that the past year had been an extremely busy one for The Society, making reference to the pace of transformation of health care that includes a broadening of the issues on which The Society is looked to for comment or leadership. AIDS testing, pesticide use, peer review, C-Section rates, the confidentiality of health records, procedure at the Provincial Medical Board, and bargaining between hospitals and their workers, are all issues that have come before The Society in just the last few months. He expressed the view that in all likelihood The Society will be particularly active in the coming years on environmental questions that impact on human health.

Mr. Epstein concluded his remarks by noting that he was looking forward to continuing to work on the public activities of The Society. He advised Council that research, analysis, and policy development must be central pre-occupations if The Society is to be effective.

Executive Committee Chairman

In speaking to his report Dr. George Ferrier reminded Council that The Executive Committee of The Medical Society of Nova Scotia is the directing and governing body that works on behalf of The Medical Society between annual meetings. The Executive Committee is composed of the Officers of The Medical Society, representatives from each of the Provincial Branch Societies, The Dalhousie Medical Students' Society, and the Section of Interns and Residents. During 1990 the Executive Committee met on five occasions. As part of each meeting regular reports were received from the President, the Chairman of the Economics Committee, the Chairman of the Building Committee, the Treasurer, and the representatives to the CMA Board of Directors, the CMA Council on Health Care, the CMA Council on Health Policy and Economics, and the Council on Medical Education. He noted that between meetings of the Executive Committee, the Officers are charged with the responsibility of carrying out the business of The Society. He reported that the Executive had accomplished a great deal for The Society in the last year on both economic and policy matters.

Dr. Ferrier informed Council that discussions with Society members have been taking place as to how the Executive Committee structure might be changed to better respond to the needs of the Society. He added that these discussions are very much in the preliminary stages.

President's Report

Dr. Jackson noted that his report is a summary of his activities and a brief outline of the many, activities with which The Society had been involved. He outlined for Council the various changes which had occurred within the Society during the past year. He noted the retirement of Mr. Anton "Doc" Schellinck after seventeen years as Director of Economics and one year as Executive Director.

In speaking to his report, he thanked the many members who had devoted so much time on behalf of the Society serving on committee, serving as Society representatives to C.M.A., the Branch Societies for their interest and spirit of co-operation, as well as Society staff for their dedication and hard work. He extended particular thanks to The Officers who had provided much discussion and debate, advice and assistance and sustained support throughout the year.He welcomed Mr. Howard Epstein, as new chief executive officer to the Society noting he brings to The Society a new perspective that should challenge members in a most productive way.

Dr. Jackson noted that in many ways this has been a very difficult year for this Society. One reason for has been the concurrent exercise of trying to make our fees more relative both within and among our sections, together with our contractual obligations to reduce millions of dollars in the first two years of the three-year contract with the Health Services and Insurance Commission; this has produced enormous stress amongst our members in a process that has come to be known as ATR "Adjustments Towards Relativity". He noted that every attempt has been made through the introduction of a NIPH (Net Income Per Hour) Index to develop as accurate and fair a distribution of fee reductions throughout our membership as possible, whilst ensuring that no physician should receive less than a one percent per annum increase in income overall. Many of the decisions regarding ATR have had to be made within tight deadlines in regard to time and have proven very difficult for both the Officers and Executive Committee. He extended his sincere thanks to all who have been involved, for the non-partisan way that these decisions have been made.

He reminded Council that as we enter the third and final year of ATR it is appropriate to recall that this Council has endorsed the concept of relativity at past annual meetings. Last year the membership at large endorsed our present three-year agreement with government, as a preferable choice to global or individual capping. Although ATR has proven somewhat contentious. The President stated his belief that this Society for the first time has confronted some very real problems in a very meaningful way. Once this process is further developed The Society will have a much more sure-footed stance when dealing with both the public and the government.

Dr. Jackson did note that as we move into the final decade of this century, he questions whether the Society is structured in the most effective way to handle the needs of our members. A review of our structure should be undertaken and a clear statement of mission for the Society should be developed.

Concluding his remarks, Dr. Jackson stated that it has been a most stimulating experience to serve as President of this Society, adding that he has enjoyed working and getting to know so many more of his colleagues both within this Province and within this country. He advised Council that it has been an opportunity which he will long remember.

Finance Committee

In speaking to his report Dr. Auld opened his remarks by thanking his committee members, Mr. Howard Epstein, Executive Director and Mrs. Tove Clahane.

He reported that overall, there were no problems with the 1989-90 budget and noted that a surplus of $130,455 was generated. The Committee has recommended, and the Officers and Executive have accepted, that the sum of $50,000. should be kept as a reserve, and the balance be transferred to the building fund account, in order to reduce the amount of necessary borrowing. This surplus was generated even though The Society's Honorariums and Expense Policy was revised this year, in line with instructions given at last year's Annual Meeting. It is the intention of the Finance Committee to continue to monitor the cost of this item and to assess whether further changes are appropriate.

Dr. Auld reported that on the subject of reserves, the Committee has been concerned that The Society's reserves have been depleted by the expense of constructing the new headquarters building. It is recognized that the building is an asset which could be used to raise funds in an emergency, but it is felt that some cash reserves should be held, and needs are continuing to be assessed in that regard.

Regarding the proposed Budget for The Society for 1990-91, Dr. Auld noted that dues for this year were set at last year's Annual Meeting, and control revenue. Expenditures are projected to match revenues; that is, we have produced a balanced budget. Nonetheless, he noed that two items might have impact on the Budget: one is the cost of occupying the new building, of which we have as yet no direct experience; the other is the possibility of adding to staff complement, a matter now being considered by the Officers.

Dr. Auld advised Council that no GST has been charged or will be charged on the 1990-91 dues. He noted that as a non-profit entity, The Society has a choice of whether to charge the GST on its dues and at the moment thinking is against charging GST on dues.

Resolution

"THAT The Financial Statements of The Medical Society of Nova Scotia for Fiscal Year 1990 be approved." CARRIED.

Resolution

"THAT Doane Raymond be retained as The Medical Society's Auditors for Fiscal Year 1991." CARRIED.

Resolution

"THAT the revised Honorariums and Expense Policy be endorsed by Council." CARRIED.

Resolution

"THAT membership dues for ordinary members of The Medical Society for Fiscal Year 1992 be increased by $50.00 with other categories of membership dues to be increased proportionately." CARRIED.

Allied Health Disciplines, including Task Force on Health Personnel Standards Act

These two reports were presented by Dr. Shears, Chairman of the Task Force and accepted as written. In speaking to his report Dr. Shears outlined the main objective of these two committees, that being to try to achieve legislation by the government of Nova Scotia for the regulation of health care occupations.

Dr. Jackson informed Council that when he had met recently with the Minister of Health he had once more brought the problems of these two committees to his attention and hopefully they will addressed in the revisions resulting from the Government's Response to the Report of the Royal Commission on Health Care.

Archives Committee

Although there was no report presented and the committee is currently without a chairman one recommendation was put before Council.

Resolution

"THAT The Medical Society of Nova Scotia continue to support the salary of the Medical Archivist with an annual grant of $7,500.00." CARRIED

Building Committee

In presenting his report to Council Dr. Hamm advised that construction of the new Society headquarters building had commenced on December 11, 1989 and was completed as planned on October 12, 1990. He noted that the general contract at present is $1,639,788 which is $10,222. under the $1,650,000. approved. He stated that the total project cost is $2,243,928. The projected total cost presented to Council last year was $2,260,318.

He expressed pleasure in reporting that only $600,000. would be required of the $800,000. approved for the mortgage financing of this project. This has been arranged at 13.75% with suitable terms. He added that this debt could be retired as early as October 1994.

He informed Council that a satisfactory five-year lease has been negotiated with MD Management reflecting the investment the Society has made in their suite. MD Management occupies 7.8% (907 sq.ft.) of the building total (11,623 sq.ft).

On behalf of his committee, Dr. Hamm acknowledged with thanks gifts made to the building by the Past Presidents, Maritime Medical Care, and the Cape Breton Branch. As well, the committee acknowledged the contributions of Mr. David McAvoy of M.M.C., Mr. Keith Allen of United Equities, Mr. John Klaas of MD Management, Medical Society Staff - Mr. Doug Peacocke, Mr. Anton Schellinck, Mrs. Shirley Miller, Mrs. Tove Clahane, Mrs. Dorothy Grant, Mr. Bill Martin, and Ms. Pam Fancy - and The Society Presidents from 1982-1990.

The following motions were introduced and passed.

Resolution

"THAT a plaque be mounted in a suitable location in The Medical Society of Nova Scotia new building to read 'In recognition of Mr. Douglas D. Peacocke, Executive Director 1968-1988 for his tireless work towards the erection of this Building." CARRIED UNANIMOUSLY.

Resolution

"THAT the magnificent contribution of Dr. John F. Hamm and the Building Committee of time, effort, and expertise, be recognized by the setting of a commemorative plaque in the new Society office." CARRIED.

By-Laws Committee

Dr. P.W. Littlejohn in speaking to his report noted that the very extensive changes proposed to The Society's By-Laws were for the most part editorial. Dr. Littlejohn highlighted for Council the various proposed amendments as they appear in the Notice of Motion published in the October 1990 issue of the Nova Scotia Medical Journal and in the Reports to Council Book.

Section 10.3 "Duties of the Officers' Committee" generated lively lengthy debate as to its consequences. It was the general consensus of Council that while the authority of the Officers ought to be specified, the nature of its relation to the Executive ought to be clarified.

Finally the following motions were put forth:

Resolution

"THAT Section 10.3 'Duties of the Offices' Committee' be deleted from the Proposed By-Law amendments." CARRIED.

Resolution

"THAT the proposed amendments be adopted as amended by deletion of 10.3." CARRIED.

Resolution

"THAT the By-Laws Committee be instructed to rework section 10.3. 'Duties of the Officers Committee' of the proposed By-Law Amendments." CARRIED.

Pharmacy Committee

In speaking to his report, Dr. Carruthers mentioned briefly some of the matters discussed within his committee during the past year; these included — Medication Selection/Substitution and labeling; a complaint with respect to advertising by Lawton's Drug Stores was investigated; the introduction of ibuprofen as an over-the-counter drug was discussed; members supported the Seniors and their Medicine Project and have been kept informed of progress.

Dr. Carruthers noted that with the passing of Bill C-22 - "An Act to amend the Patent Act", drug companies are spending more on drug-related research in Canada. It was felt important that members of the MSNS be aware of potential conflicts of interest in participating in such studies where the individual physician benefits from a clinical decision to start or switch a patient to the study drug.

Dr. Carruthers noted that the Triplicate Prescription Program as initiated in Alberta was discussed. He urged members to read the article on this subject in the most recent issue of InforMed. Dr. Carruthers informed Council that the article summarizes progress to date.

Recent changes in the Pharmacare Program were discussed. He informed Council that there could be problems substituting generic drugs when adverse reactions have not been documented according to the Government guidelines. His committee is awaiting information from the Department of Health concerning who is legally responsible should problems arise for a patient because a generic drug has been used.

Communications Committee

Dr. Audain in speaking to his report outlined for Council the reason for the inception of this new committee, that being in response to a concern from the Branches that The Society must become more proactive. He noted that it was the feeling of his committee that there are many innovative things that The Society could be doing in a dignified way to enhance the image of the profession. At the present time the committee is gathering information on the most appropriate way to do this. However, in order to do this considerable financial resources are necessary. Dr. Audain concluded by stating that many polls have shown that physician popularity is ascending but cautioned that we, as a profession, must continue to work very hard at showing the public that we are worthy of its support when needed.

Community Health Committee

In speaking to his report Dr. Langille outlined for Council the matters discussed and/or dealt with by his committee during the past year — i.e. Smoking and Minors, Preparation of a booklet entitled "Woman Abuse: A Handbook For Physicians", Preparing Comments for the MSNS on the Report of the Royal Commission on Health Care, Bill C-43 (Abortion), and Needle Exchange Programs for Intravenous Drug Users. Dr. Langille thanked Dr. Jackson for the Society's support and endorsement of his committee's efforts to curtail the sale of tobacco products to minors. He also expressed his appreciation to The Society for agreeing to circulate "Woman Abuse: A Handbook For Physicians" to all physicians in Nova Scotia.

The following motion was introduced: "THAT The Medical Society of Nova Scotia inquire of its members their wishes for a Society policy on Bill C-43 "An Act to Amend the Criminal Code", and that such inquiry be done as soon as possible, in consultation with the Community Health Committee on the subject of the methodology to be used." and subsequently defeated because of its timing. By the time The Society's information would be available the status of the Bill would already be accomplished.

Subsequently the following motion was introduced and passed.

Resolution

"THAT Council 1990 opposes Bill C-43, "An Act to Amend the Criminal Code" and its implications for access to appropriate medical services in relation to abortion for the women of Canada, and directs The Medical Society of Nova Scotia to convey this message to the Senate Committee and the Minister of Justice as soon as possible." CARRIED.

Environment Committee

Dr. Bethune outlined for Council the activities of his committee during the past year. He noted that the Minister had rejected The Nova Scotia Pest Control Products Advisory Committee's recommendation to amend the regulations so as to remove, pending further study, the requirement of a medical certificate as part of the licensing of spray operators. The Society will continue to discuss the matter with the Environment Department.

Dr. Bethune reported that over the past few months the committee had been restructuring itself to take on a new direction and priorities. The Officers are supportive of having The Society become more actively involved in environmental issues and in this regard the Committee is planning on educating both Committee and Society members on significant environment problems and attempting to achieve an attitude/behavior change amongst physicians (e.g. — demonstrating a "model" physician's office from the environmental stand-point); canvassing other Medical Societies to seek out what they are doing in this area; and considering meeting occasionally in other regions of the province to observe first hand locales of interest in environmental issues (e.g. — Pictou and Cape Breton).

Resolution

"THAT The Medical Society of Nova Scotia support the Environment Task Force in its efforts to educate Society members on environmental issues, to influence members' behavior therein, and in general, to expand The Society's role in areas of local or global environmental concern." CARRIED.

Home Care Committee

In speaking to his report, Dr. Cudmore reported that the Committee had five meetings in the past year, including four meetings with representatives of the Co-ordinated Home Care Program (CHCP). He noted that the committee also had a meeting with the Medical Director of the New Brunswick Extra-Mural Hospital Program and the Head of the Department of Family Medicine at Dalhousie. Issues brought before the committee were addressed. It was recommended that physicians be appointed to the regional Home Care Advisory Committees of the CHCP. Co-operation between

CHCP and hospitals with regard to discharge planning was strongly encouraged. Communication problems between the CHCP and physicians were discussed. As well, the committee further defined the role of the family physician in home care. New Fee Schedule items were drafted to take into account the new types of services necessary to work within the CHCP.

Arising out of this report were two resolutions.

Resolution

"THAT The Medical Society of Nova Scotia provide leadership in defining the role of physicians in home health care in Nova Scotia and in particular within the Co-ordinated Home Care Program." CARRIED.

Resolution

"THAT The Medical Society of Nova Scotia identify specific priority areas for the the expansion of home health care within the Co-ordinated Home Care Program." CARRIED.

Liaison Committee - MSNS/Faculty of Medicine

Dr. Jackson spoke briefly to his report noting that one formal meeting had been held, and informal meetings and discussions have been held on several occasions. He reported with pleasure that lines of communication between The Society and the Dean remain open and relations between The Medical Society and the Medical School are excellent. He extended special thanks to Dean Murray for his Part in ensuring this.

Liaison Committee - MSNS/Minister of Health and Fitness

Dr. Jackson informed Council that three formal meetings have been held by this Committee with the Hon. David Nantes this current year. On October 31st a meeting had been held with the recently appointed Minister The Hon. George Moody. Dr. Jackson advised that as of today (November 16th) the Department is now called the Department of Health due to the restructuring of the Department as a result of the Government's response to the Report of the Nova Scotia Royal Commission on Health Care. He stated that those present would hear more on this when The Hon. George Moody addresses Council on Saturday. Dr. Jackson reported that a good working relationship exists between The Society and the Minister of Health and his Department. He concluded by stating that there is the probability of significant change in the health care field during the next few years and this Society should be able to have significant input.

Liaison Committee - MSNS/Registered Nurses' Association

Dr. Jackson informed Council that although there had been no formal meetings during the past year, representatives from RNANS had made a presentation to the Executive Committee outlining the degree program that they wish to see introduced as the only option for nursing by the end of this decade. Dr. Jackson reported that the relationship between the two groups remains cordial and open.

The role of nurses and how this role is changing brought forth lively debate with the consensus being that physicians must be ablel to justify their roles as the best providers of good entry level health care. The Society must be ready with a well defined response concerning this issue.

Resolution

"THAT The Medical Society of Nova Scotia Executive Committee investigate the role of non-physicians in primary care and the policy of nurses' organizations in this regard." CARRIED.

Liaison Committee - MSNS/Workers' Compensation Board

In speaking to his report Dr. Jackson reported that there have been no meetings of this committee during the current year, but one is scheduled for November 30, 1990.

Dr. Jackson informed Council that The Society had made a presentation to the Select Committee of the Legislature on Bill 99 - "An Act to Amend and Revise the Law Respecting Workers' Compensation" on November 6th. The Executive Director advised Council that when this presentation was made the members' concerns as they have been provided to The Society office over the years were made known in no uncertain terms to the Legislative Committee.

Friday Afternoon

NOVA SCOTIA REPRESENATIVES TO C.M.A.

C.M.A. Board of Directors

Dr. Audain in speaking briefly to his report reminded

Council that this report is but a summary of the activities of the C.M.A. during the past year. Dr. Audain reported that some of these activities included:

Strategic Management Project — During the year Mr. Dennis Redding, the CMA's Consultant on the Strategic Management Process, visited all of the provincial Divisions to review the results and obtain some feedback on the preliminary results of the project.The general objectives have been achieved in three phases: 1. Background research, general data gathering, situational analysis and market research. 2. Analysis and interpretation of this research. and, 3. Development of a Mission Statement, and a resulting objective and implementation strategies on the basis of the research. The Board helped to develop the following CMA Mission Statement: "To provide leadership for physicians and to promote a high standard of health and health care for all Canadians".

Building Committee —The Building Committee was established to review the long term space requirements at CMA House.

Leadership Conference — The second National Medical Leadership Conference was held in Ottawa, March 1-3, 1990. The theme to the Conference was "Allocation and Decision-Making: Balancing Access and Quality with Affordability". Arrangements are being made for the 1991 Conference, which is scheduled to be held in Ottawa in March.

Canada Health Act —The CMA challenge to the Canada Health Act, which started in 1985 had been lagging behind in all its timetables. In April of 1990 the CMA was advised by the OMA that they were considering deferring and ultimately dropping the legal challenge. The CMA then reassessed its position, and after having received independent legal opinions, recommended to General Council that steps be taken to institute procedures designed to end this pursuit, provided that strategies can be developed to address the legitimate concerns of the CMA, and the public with respect to the implementation of the Canada Health Act.

Presentations to Government — During the year the CMA made several presentations on a variety of health related issues:

Bill C-43, an Act Respecting Abortion, was opposed by a delegation from the CMA in a presentation to the House of Commons Legislative Committee on Abortion. The basis for opposing this legislation was primarily because it singles out abortion as the only medical act to draw criminal sanctions.

Goods and Services Tax — A delegation from the CMA appeared before the House of Commons Finance Committee to address the impact of the proposed G.S.T. on the health care system.

Compulsory Blood and Alcohol Testing — A delegation from the CMA presented a brief to the House of Commons Standing Committee on Transportation on Compulsory Blood Alcohol Testing.

The CMA also submitted a Brief to the House of Commons Standing Committee on Finance with respect to Bill C-69, the Established Programs Financing transfers to provinces for health and post-secondary education.

Committee on Finance — The firm of Arthur Andersen and Company was retained to conduct a review of three general areas: Reserves; Investment Policies; and Legal and financial relationships between the CMA and its subsidiaries. The Board reviewed the report and accepted all of the recommendations. One of the chief recommendations is related to the restructuring of the MDIS Board and its reporting procedures.

Dr. Neil K. MacLennan of Sydney and Dr. Harold B. Sabean of Truro were elected as senior members in the Canadian Medical Association.

Dr. Audain said he was pleased to report that Dr. Judy Kazimirski, who did an outstanding job as Chairman of the Board of Directors of the Canadian Medical Association for the year 1989-90, has been re-elected to the same position for the year 1990-91

MD Management Limited

Dr. Sapp's report was presented by Dr. Audain as Dr. Sapp was absent attending a MD Investment Services meeting in Florida. In speaking to this report Dr. Audain reminded Council that MD Management has provided Association members and their families with a broad range of investment plans and financial services for over 20 years, although certain investment programs such as CMARSP have been available to the membership since the late 1950's. This CMA subsidiary receives its policy guidance from the Board of Directors of MD Investment Services Limited.

Dr. Audain reported that total investment plan assets under management is now $3.4 billion and has ranged from $3 billion to $3.5 billion over the last two years reflecting continued uncertainty in major world equity markets. MD Management is now the third largest mutual fund management company in Canada. During 1989, deposits to all investment plans amounted to $515 million compared to

$400 million in 1988. Redemptions amounted to $285 million. Currently, there are approximately 110,000 active accounts administered by MD Management.

Concluding his remarks Dr. Audain stated that further information on MD Management can be obtained from Mr. John Klaas at our local MD Management office.

C.M.A. Council on Health Care

Dr. Patterson spoke briefly to his report highlighting the work of his Council and its subcommittees. Dr. Patterson reported the following:

His Council continues to monitor issues relative to native health and continues dialogue with the Assembly of First Nations and with other native groups on health care issues.

The Subcommittee on Environmental Health is continuing to study the impact of the practice of medicine on the environment. The Council on Health Care recommends to all physicians that we become more involved in public discussion of environmental issues.

Through the Committee on Drugs and Pharmacotherapy, the CMA statements on drug labelling and drug product substitution were produced based on the principle that patients have a right to be informed about their condition and about the different kinds of therapy available.

The continued existence of the Subcommittee on Obstetrics is in itself a question of debate at the present time. Dr. Patterson stated his views that obstetrics should continue to be dealt with through the subcommittee, perhaps with a change of name to broaden its terms of reference to include all reproductive care and perinatal issues.

Dr. Patterson noted that much of his time in the past 12 months has been spent dealing with issues related to the Subcommittee on Emergency Medical Services. That has included work on the fifth revision of the C.M.A. Physician's Guide to Driver Licensure, and a program to promote safe use of bicycles.

Dr. Patterson noted that of particular satisfaction to him has been the establishment of the principle that active practicing physicians should be able to provide basic cardiac life support. In addition, CMA Council accepted a statement of basic emergency equipment for doctors' offices. A finalized list of basic emergency equipment for doctors' offices is now being prepared and will be provided to the membership , likely through the C.M.A. Journal. Dr. Patterson expressed the hope that this list would be retained by physicians as a guide in equipping their offices.

Also, a proposal for basic medical equipment for airlines was accepted by General Council in August of 1990.

REPORTS OF SECTIONS

Anaesthesia

This report was presented by Dr. Finlayson incoming Chairman of the Section. In speaking to this report Dr. Finlayson noted a major concern to the Section is the continued disparities in remuneration between sections and the means by which remuneration for sections has been calculated. In addition, distribution of CME and CMPA funds has to be equitable to all members. The Society must continue to assess these issues but on a more sound and reliable basis.
Enhanced participation of sections, on a similar basis to that of branches, within the framework of The Society is urgently needed. The Executive is requested to give serious attention to this matter.

General Practice

Dr. Hayes in speaking to his report noted that the Section has had a busy and productive year. The Section prepared a submission to the Royal Commission on Health Care, as requested by The Society. The Section Ad Hoc Committee continues to provide input to the operation of the Home Care Committee In addition, members throughout the province are providing advice at the community level. The Section Executive is preparing a position paper on Interspecialty Consultations and hopes to have recommendations for The Society in the near future. The Section endorses the proposals put forward by Dr. Joyce Curtis for province-wide participation, a team approach, and proper remuneration for physicians undertaking a service for sexual assault victims which frequently includes attendance at court. The Economics Committee Chairman, Dr. Don Pugsley, and members, Drs. Mike Fleming and Peter Littlejohn, continue to act as liaison with The Society's Economics Committee and spend a great deal of time attending to the Section's economic interests for which members are all most grateful.

Dr. Hayes took the opportunity to draw Section members' attention to a joint meeting with the College of Family Physicians to be held at White Point Beach Lodge next Spring. Dr. Hayes encouraged members to attend and make their views known on these and other topics relevant to

General Practice

Dr. Hayes' report contained two recommendations: "THAT an average net hourly income ratio of General Practice to Specialties of 1:1.3 be established as the policy of this Society." and "THAT the 1:1.3 General Practice/specialty ratio be attained by The Society within ten years." These recommendations were subsequently WITHDRAWN and a new one put forth. Moved by Dr. Mike Fleming, and seconded by Dr. P.W Littlejohn "THAT further adjustment of fees be based on the principle of equal net earnings for equal work." This recommendation was discussed during the closed session and subsequently TABLED.

Internal Medicine

In speaking to his report, Dr. John Sapp stated that as in past years a major item of business has been to deal with the economic matters related to the implementation of the three-year tariff agreement. He added that this process continues to be a frustrating exercise. However, he extended special thanks to the Economics Committee for their efforts to have full consultation with the Sections.

Laboratory Medicine

Dr. Bernardo outlined briefly for Council the activities of his Section during the past year. He reported as follows: The Department of Health and Fitness requested the Section to look into the credit system for surgical specimens and managerial responsibilities. A subcommittee was formed to examine the credit system for surgical specimens and provide input for possible revisions. The subcommittee submitted its report on credit values for histopathological procedures in June 1990. In January 1990, representatives from the Section attended a general meeting of The Medical Society of Nova Scotia to discuss the Report of the Royal Commission on Health Care. Following this, a written response was sent from the Section to the Task Force to establish The Medical Society's position on the Report. In March 1990, representatives from the Economics Committee met with the Executive of The Medical Society of Nova Scotia, an information session on Adjustments Toward Relativity. Negotiations with the Attorney General's Department have retained pay parity with hospital autopsies for Forensic work in the province.

Concluding his remarks, he noted that the Section in continuing its support and participation in the development of a Gynecological Cancer Screening Program for the province of Nova Scotia. He stated that his Section is attempting to achieve consensus on the recommendations of the Education, Cytology, Colposcopy/Histology and Data Management Committees toward an integrated and quality controlled Provincial Screening Program in Cytology and Colposcopy.

Ophthalmology

Dr. Keating informed Council that this past year was a difficult year, particularly on the economic front. The Section of Ophthalmology objected strenuously to the methods being employed by the Economics Committee in implementing Adjustments Towards Relativity. He noed that it must be clearly understood by the membership that the Section of Ophthalmology does not disagree with the concept of Adjustments Toward Relativity but with the methodology used by those empowered to implement these adjustments. He said that it is the Section's firm belief that this process can lead to the destruction of The Society unless it is implemented in a way that is fair and equitable to every Section. In order to assure fairness, further study of the process will be carried out.

He also reported that it is the belief of his Section that the basic structure of The Society is in need of change. In these days of difficult economic times, The Society must be structured to respond quickly and appropriately to initiatives raised both by its members as well as government. In order to do this, Sections must be better represented in The Society. The present structure of The Society does not allow Sections a voice in the day to day operation of The Society. He was pleased to report to Council that his Section is encouraged by the discussions which were held at the Officers/Sections Think Tank on September 92, 1990 concerning The Society's structure.

He concluded by stating that "we have come to the conclusion that The Society must seek expert advice in its dealings with Government, particularly when economic issues are discussed. We feel that the days of The Society negotiating contracts on its own, without the benefits of the advice of an expert labour negotiator, should be at an end."

Otolaryngology

Dr. Cron reported that his Section is still concerned about manpower shortages which may very well get worse within the next five years. Of the 32 registered Otolaryngologists in Nova Scotia; 1.5 are involved in Administration and 14 are retired from active practice; 2.5 are engaged in only part-time practice. Out of the total of 32 only 14 are engaged in active full-time practice. Of these Otolaryngologists four are over 60 years of age, one in fact is 70; seven are

in the 50-60 year age group; four are in the 40-50 year age group and only two are under 40.

The Section has continued to spend much time in attempting to create a relative value system for fees, however, much of our efforts have been undermined to some degree by changes required by government and negotiations with the Economics Committee.

The report contained two recommendations: (1)"THAT no changes be made in endoscopy fee schedules without prior consultation with this Section (since the Section of Otolaryngology has a large vested interest in endoscopy procedures)." subsequently amended to read "THAT the Section of Otolaryngology requests that it be consulted prior to changes in endoscopy fees affecting our specialty." and (2)"THAT the Chairman of the Section of Otolaryngology, Fee Negotiating Committee, or his designated alternate be included in any Medical Society Committee concerning endoscopy." The first recommendation was withdrawn, and the second not put forth due to the disposition of the first recommendation.

Psychiatry

Dr. O'Brien in presentation of his report informed Council that the past year has been a year more of consolidation than innovation. He noted that his Section wished to publicly thank The Society for its support in negotiating the contract system, but urged that The Society keep the new contract system in mind when making ATR or other fee adjustments.

Ethics Committee

In presenting his report, Dr. Fay noted for Council the disciplines of his committee members who had been chosen for their particular area of expertise — e.g.. law, social work, etc. He outlined briefly issues that have been brought to his committee over the past year; these include: Royal Commission on New Reproductive Technologies, CMA Discussion Paper: Guidelines for an Ethical Association with Pharmaceutical Industry, CMA Discussion Document — the Status of the Human Fetus, and Anencephalic Organ Donation.

Dr. Fay reported that some members of the Committee have expressed concern about some of the CMA position papers and feel that The Director of Ethics at CMA seems to be issuing a set of neat rules for complex situations. He noted the committee is considering its role as the Ethics Committee of The Medical Society of Nova Scotia. The Committee did not want to be a "reading club" for papers produced by the CMA, although the papers are certainly thought-provoking. Dr. Fay advised Council that his committee would like to circulate to members of The Society a number of ethical questions that perhaps Society members would like the Ethics Committee to work on — e.g.. negligent referrals, sexual misconduct, the way the law treats the physician (the tort system). Dr. Fay asked for Council's guidance.

The satatement that "We do not want to be a "reading club" for papers produced by the CMA." generated lively discussion. Various members asked what had made th Committee come to that conclusion and went on to explain for Council how the Ethics Department of the CMA operates — i.e. it sends out 'working documents' to divisions to gather feedback from physicians across Canada. The Director of Ethics cannot devise rules — it operates under direction of C.M.A. General Council. The role of C.M.A. in ethics is seen as being a consensus builder. Dr. Fay responded by saying that his committee did not want their major focus to be the examination of C.M.A. working documents and that it would be useful if there were more members on the committee.

Risk Management Committee

Dr. Anderson advised Council that his committee had now received the "Prichard Report". He added that they are hoping to receive feedback from the Department of Health, our division, the CMA and the CMPA regarding it. Dr. Jackson reported that this Report has been given a low key reception across the Country, perhaps because the flavour of the report is complimentary to the CMPA.

Dr. Anderson noted that one of the major recommendations is with regard to endorsing some type of no fault insurance. Dr. Anderson said he believed that the Federal Government thinks it is a good report, but the Provincial Government looks at it with skepticism.

Dr. Ed Coffey, Chairman of the C.M.A. Committee on Professional Liability, of the Quebec Medical Association shared Dr. Anderson's views. He noted that the CMA will be meeting in mid-January and will be dealing with it in more detail. A first draft of a response has been drawn up for the committee to deal with. He noted that the Provincial Government did not appear interested in hearing from CMA but feel they will be receptive to a meeting in the Spring after they have had a chance more fully to digest the Report. It was felt that the Provincial Governments would feel it a good tool to justify quality assurance.

Annual Meeting - First Session - Friday November 16, 1990

The first item of business following adjournment of Council was ratification of the deliberations of Council.

Resolution

"THAT the actions of the 1st Session of Council be ratified." CARRIED.

Nominating Committee Report

Resolution - Society Officers

"THAT the Report of the Nominating Committee with respect to the Officers be accepted and that the names contained therein are the new officials of The Medical Society of Nova Scotia. - President-Elect - Dr. Rob Stokes of Baddeck; Chairman of the Executive Committee - Dr. G.A. Ferrier of Liverpool; Vice-Chairman of the Executive Committee - vacant; Treasurer - Dr. Debora Ryan-Sheridan of Truro; Honorary Secretary - Dr. Shelagh Leahey of Yarmouth." CARRIED.

Resolution - Branch Representatives, Intern/Resident, and Student Members on MSNS Executive Committee

"THAT 1991 Executive Committee members be approved as read from the Nominating Committee Report.

Antigonish-Guysborough
- Dr. A. Wm. Booth
alt. Dr. John D. Chiasson
Bedford-Sackville
Dr. Bruce M. O'Hearn
alt. Dr. John Ramanauskas
Cape Breton
Dr. Mary E. Lynk
alt. None
Colchester East Hants
Dr. Steve M. Owen
alt. Dr. Graeme A. Corbett
Cumberland
Dr. Joe P. Donachie
alt. Dr. W.G. (Bill) Gill
Dartmouth
Dr. Miles W. Ellis
alt. - Dr. Lorraine N. Hardy
Dr. Dr. G.G.R. Stewart
alt. Dr. Chris Gallant
Eastern Shore
Dr. Inder N. Bhattia
alt. Dr. Michael MacQuarrie
Halifax
Dr. D.C.S. Brown
alt. Dr. P. Michael Reardon
Dr. Ron D. Gregor
alt. Dr. Dora Stinson
Inverness-Victoria
Dr. Carlyle W. Chow
alt. Dr. Jaime O. Belen
Lunenburg-Queens
Dr. Brian N. Chutskoff
alt. Dr. Gary P. Ernest
Pictou
Dr. H.P. MacDonald
alt. Dr. A. Kent Clark
Shelburne
Dr. Gordon J. Hollway
alt. Dr. John E. Keeler
Sydney
Dr. John R. LeMoine
alt. Dr. Gail M. Bisson
Valley
Dr. Cathy L. Smith
alt. Dr. Robin G. Bustin
Dr. Kenneth Buchholz
alt. Dr. Robin G. Bustin
Western
Dr. Peter L. Loveridge
alt. to be advised
Interns/Residents - Dr. Daniel Vaughan & Dr. Andrew Orr
Students - Dianne McLennaghan, Sarah Kerr, and Alexandros Alexiadis." CAR-
RIED.

Saturday Morning - November 18, 1990

Senior Advisory Committee

Dr. Audain informed Council that resulting from their most recent meeting, his committee had four issues they wanted to bring before Council. Dr. Audain drew Council's attention to the apparent apathy of the membership. He said it was the strong feeling of Past Presidents that there is a serious problem of members not taking their responsibilities seriously enough. He noted that this was reflected in the low attendance at Council during the past two days. Secondly, he reported that it was the wish of his committee that Officers and staff endeavor to come up with innovative and creative ways to increase Council attendance. On behalf of his committee he stressed that this is a matter that should be seriously considered. Thirdly, The Society's billing process should be reconsidered in an attempt to find some other way

than billing annually such as pre-authorized payments, or quarterly payments. The fourth concern was in the form of a motion which resulted in the following resolution.

Resolution

"BE IT RESOLVED THAT Council re-affirms the policy that the President is the spokesperson for The Medical Society of Nova Scotia." CARRIED.

It was recognized by Councl that the President may delegate his authority in this regard.

Economics Committee

Presenting his report to Council, Dr. Rick Gibson went through the report item by item.

Referring to Consultation Fees, Dr. Gibson noted that during the course of negotiations regarding ATR's for year two, the Commission was unwilling to accept a position of "no action" on consultations. After extensive discussion, The Medical Society had agreed to the introduction of Minor Consultations for those specialties which had not previously had Minor Consultations, specifically including, Neurology, Internal Medicine, Paediatrics, Physical Medicine, and Psychiatry. He noted that preliminary costings were prepared for the implementation of this new fee structure and will be subject to ongoing audit. Dr. Gibson informed Council that a letter had gone out to these Sections urging members to ensure that they are billing properly - i.e. using minor consultations where appropriate. Also these Sections are being urged to have meetings to determine what constitutes a minor or major consultation.

Speaking to the Net Income Per Hour Methodology, he noted that this data is becoming increasingly out of date and that new allocation mechanisms will likely be needed in the future.

Regarding Adjustments Towards Relativity allocations, Dr. Gibson expressed pleasure in having received good co-operation from the Sections during the past year, and stressed the importance of looking at this task seriously. He suggested that consideration might be given to changing Preamble Rules, and/or changing fees for procedures.

Following the presentation of his report, Dr. Gibson introduced the following motion: "THAT The Medical Society of Nova Scotia establish a broadly based Relative Value Guide Task Force to create and implement a Relative Value Fee Schedule for The Society.

The above motion was subsequently amended with the deletion of "and implement" after the word "create".

Resolution

"THAT The Medical Society of Nova Scotia establish a broadly based Relative Value Guide Task Force to create a Relative Value Fee Schedule for The Society." CARRIED.

Dr. Gibson reviewed for Council the Terms of Reference of the Relative Value Guide Task Force - i.e. - Introduction, Objective, Composition, Methodology, time frame, and an estimate of resources that would be required.

Prior to the vote being taken, this motion generated extensive and lively debate with almost every member present speaking to it. Comments from Council members included: concerns over cost, importance of taking action, possibility of borrowing research from other jurisdictions, long term goals of The Society and possible financial assistance from government.

Discussion was put on hold at this point during debate to hear the speech by the Minister of Health, The Hon. George Moody.

Address by The Hon.George C. Moody, Minister of Health To The General Council of The Medical Society of Nova Scotia - November 17, 1990

The Minister began by indicating that he plans to develop a very close relationship with the Society which he hopes will result in new health benefits to Nova Scotians.

He reviewed the government's "Health Strategy for the Nineties" emphasizing that there is an evolutionary process yet to come. In particular, he responded to criticism that his Department had taken almost a year to respond to the Royal Commission on Health Care.

Mr. Moody stressed that his Department, like The Society, recognizes that the health care system is very complex. He said chaos could have ensued if the Commission's recommendations had not been carefully studied.

The Minister reaffirmed that his Department intends to draw on the expertise of

health professionals and to make sure The Society will have representatives on regional health authorities.

He also reviewed his Department's efforts to develop a more definitive picture of the health status of Nova Scotians. This will involve special studies including ones on smoking and nutrition.

Attention to physician services, distribution, and cost, also drew comment from the Minister who told Council members that a special Ministerial Committee on Physician Policy will be struck with the mandate to actively explore the best methods to bring about positive change. He made it clear that the Committee must address a number of key issues such as: alternative forms of payments, numbers of physicians by specialty, total number, and geographic distribution. He also outlined a time schedule for this committee. He said this major undertaking is being done at a time when government money is "stretched as far as it will go".

The Minister concluded his address by reviewing his Department's achievements over the last year or so. This included the construction of the Cape Breton Hospital, the Grace Maternity Hospital and the IWK Link.

In closing, he re-iterated his Department's commitment to work closely with The Medical Society of Nova Scotia.

continuation of Economics Committee Report:

At this point a motion was introduced: "THAT a maximum levy of $50.00/year/member be implemented for the two-year duration of the Relative Value Task Force Study." RULED OUT OF ORDER.

A number of members spoke against this motion with the general consensus being that they could not vote in favour of a further dues increase since it requires a notice of motion. In response to questions as to whether or not the cost of this Study could be "fine tuned", Dr. Canham reiterated that we cannot have it both ways - i.e. a study that does not cost the Society; however, he acknowledged that the budget cannot be "tweeked" any closer and that The Society would do what it can with the money that it has.

A few comments followed that the motion and its costing seemed too imprecise and should have been discussed by the Executive Committee.

Responding to this criticism, Dr. Gibson advised that Council has the right to decide on matters such as this particularly when they are contentious. The motion had been circulated well in advance and the Executive Committee had been advised to pay particular attention to it at its last meeting. As regards costs, it was noted that they had been fully specified in as much detail as possible including expenditure limits pending further direction from the Task Force. Dr. Gibson also expressed his strong displeasure at the poor turnout at Council in general and especially when contentious issues like economics are being discussed. He noted the absence of many Section Executive especially those who had written letters and complained about Society actions all year long. Many members voiced their agreement.

Concluding his report Dr. Gibson thanked his committee members - Drs. L.P.M. Heffernan, W.H. Lenco, Mark Kazimirski, and G.P. Reardon (who had been a member until recently), and extended a vote of thanks and gratitude to Mr. Richard J. Dyke, for his conscientious work.

Dr. Jackson thanked Dr. Gibson and his committee members including Mr. Dyke, and recognized the enormous debt owed to this very important hard-working committee. Council responded unanimously.

At this point there was consideration of a motion put forth during the presentation of the report of the Section of General Practice. "THAT further adjustment of fees be based on the principle of equal net earnings for equal work." TABLED.

Concern was expressed regarding the difficulty of interpretation of the motion leading to the motion to table. It was moved that the motion be tabled.

Reports not dealt with at Council due to time constraints and subsequently referred to the Executive Committee are as follows:

MSNS Standing Committee Reports

Gynecological Cancer (Screening for) - page 72-73
Hospital & Emergency Services - page 75
Mediation - page 77
Membership Services - page 128

Reports of Nova Scotia Representatives to C.M.A.

Reports of Sections

Reports of Representatives to other Organizations

Annual Meeting - Second Session - Saturday, November 17, 1989

Resolution

"THAT the actions of the 2nd Session of Council be ratified." CARRIED.

ADJOURNMENT

There being no further items of business the 2nd Session of the 137th Annual Meeting of The Medical Society of Nova Scotia adjourned at 12:45 p.m. on Saturday, November 17, 1990.

The Medical Society of Nova Scotia would like to thank the following corporate sponsors for their contributions to our 1990 Annual Meeting:

League Savings and Mortgages
McCurdy Printing and Typesetting Limited
MD Management Limited
Montreal Trust
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The Bank of Montreal

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Auditors' Report

To the Members of
The Medical Society of Nova Scotia

We have examined the Operating Fund and Building Fund balance sheets of The Medical Society of Nova Scotia as at September 30, 1990 and the statements of Operating Fund income and surplus, changes in financial position, Building Fund revenue, expenditures and fund balance, 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, 1990 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.

Doane Raymond

October 31, 1990
Halifax, Nova Scotia

Chartered Accountants

The Medical Society of Nova Scotia
Operating Fund
Balance Sheet

	September 30 1990	1989
Assets		
Current		
Cash and short term investments	$ 1,022,711	$ 758,064
Receivables		
Members	292	1,380
Other	13,870	10,599
Accrued interest	25,357	34,762
Prepaid expenses	16,364	31,134
	1,078,594	835,939
Investments		15,000
Furniture and equipment (Note 1)	22,860	36,233
	$ 1,101,454	$ 887,172
Liabilities and Equity		
Current		
Payables and accruals		
Trade	$ 9,916	$ 14,287
Cogswell Library Fund	390	3,397
Deferred revenue (Note 2)	1,041,148	819,488
	1,051,454	837,172
Surplus	50,000	50,000
	$ 1,101,454	$ 887,172

Contingent (Note 3)

On behalf of the Board

_____ Treasurer

_____ Executive Secretary

Doane Raymond

The Medical Society of Nova Scotia
Operating Fund
Statement of Income and Surplus

1989 Actual		Year Ended September 30 1990 Budget	1990 Actual
	Revenue		
	Membership dues		
$ 911,032	Medical Society of Nova Scotia	$ 982,000	$ 1,008,806
279,810	The Canadian Medical Association	297,615	307,840
5,190	Intern and Resident	5,000	5,235
730	Students	700	712
1,196,762		1,285,315	1,322,593
112,238	Investment income		99,930
(3,132)	Bulletin	(9,000)	(4,731)
9,783	InforMed	5,000	898
45,043	Gain on sale of investments		
2,302	Other income	5,000	2,360
1,362,996		1,286,315	1,421,050
955,692	Expenses (Page 6)	972,630	1,012,566
279,525	Canadian Medical Assoc. remittance	297,615	307,870
1,235,217		1,270,245	1,320,436
127,779	Net income	$ 16,070	100,614
566,275	Surplus, beginning of year		50,000
(644,054)	Transfer to Building Fund		(100,614)
$ 50,000	Surplus, end of year		$ 50,000

Doane Raymond

The Medical Society of Nova Scotia
Operating Fund
Statement of Changes in Financial Position

	Year Ended September 30 1990	1989
Cash provided from (used for)		
Operations		
Net income	$ 100,614	$ 127,779
Depreciation	18,337	19,411
Gain on sale of investments		(45,043)
	118,951	102,147
Changes in		
Receivables	7,222	(22,487)
Prepaid expenses	14,770	(15,323)
Deferred revenue	221,660	168,922
Payables and accruals	(7,378)	(83,891)
	355,225	149,368
Investing		
Contingency Fund income		12,573
Proceeds on the maturity and disposal of investments	15,000	271,637
Purchase of equipment	(4,964)	(9,432)
	10,036	274,778
Transfers to Building Fund from		
Operating Fund	(100,614)	(644,054)
Contingency Fund		(145,709)
	(100,614)	(789,763)
Net cash provided (used)	264,647	(365,617)
Cash and short term investments		
Beginning of year	758,064	1,123,681
End of year	$ 1,022,711	$ 758,064

Doane Raymond

The Medical Society of Nova Scotia
Operating Fund
Notes to Financial Statements
September 30, 1990

1. Office furniture and equipment

	1990			1989
	Cost	Accumulated Depreciation	Net Book Value	Net Book Value
Office furniture and equipment	$ 72,183	$ 65,132	$ 7,051	$ 6,907
Leasehold improvements	38,827	37,247	1,580	3,160
Computer	91,047	76,818	14,229	26,166
	$ 202,057	$ 179,197	$ 22,860	$ 36,233

Expenditures for fixed assets are capitalized and depreciated on the straight line basis over a five year period.

2. Deferred revenue

Annual membership dues for the next fiscal year received by the Medical Society before September 30, 1990 are recorded as deferred revenue.

3. 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 $28,000.

Doane Raymond

The Medical Society of Nova Scotia
Operating Fund
Expenses

1989 Actual		Year Ended September 30 1990 Budget	1990 Actual
	Administration		
$ 10,455	Audit fees	$ 10,000	$ 9,633
4,097	Investment trustee fees	5,000	5,416
899	Insurance, travel, bonding and property	1,900	747
4,209	Legal fees	7,500	2,625
69,966	Office rent	75,000	69,416
34,837	Office services	35,000	34,926
608	Petty cash and miscellaneous	1,000	694
11,293	Postage	11,500	7,358
2,216	Repairs and maintenance	2,200	2,443
5,261	Taxes	6,000	5,539
15,041	Telephone	16,500	19,675
18,118	Travel - secretariat	15,000	23,815
6,900	Unforseen expenses	7,500	812
	Salaries and benefits		
379,424	Salaries	397,000	399,110
4,877	Canada pension plan	6,050	5,211
56,899	C.M.A. pension plan and insurance	57,500	50,953
6,719	Unemployment insurance	8,000	7,073
6,850	Parking and Christmas bonus	7,480	6,290
	Departments		
10,545	Communication department	7,000	9,879
9,329	Economics department	5,000	5,343
39,206	Professional Support Program	45,000	25,457
	Committee expenses including travel		
12,172	Executive meetings	15,000	17,383
7,154	Officers and branch meetings	12,500	3,778
17,018	President's travel	20,000	25,573
12,020	President elect travel	10,000	8,159
437	Nominating committee	500	1,725
9,056	Other committees	10,000	7,668
7,000	Archives committee	7,000	7,000
	Miscellaneous		
18,167	Annual meeting	17,000	24,943
9,083	C.M.A. general council - travel	13,000	8,843
32,000	C.M.E. grant	34,000	34,000
	C.M.P.A. expense		1,101
19,411	Depreciation	10,000	18,337
3,610	Drugs and therapeutics bulletin	4,000	3,610
98,760	Honoraria	80,000	151,189
3,098	Staff development	5,000	1,881
5,255	Student assistance loan plan	7,000	4,961
(400)	Unpaid student loan	500	
4,102	Think tank meetings		
$ 955,692		$ 972,630	$ 1,012,566

Doane Raymond

The Medical Society of Nova Scotia
Building Fund
Balance Sheet

	September 30 1990	1989
Assets		
Current		
Cash and short term investments	$ 285,677	$ 1,005,765
Accrued interest	37,085	23,050
	322,762	1,028,815
Land and building (Note 2)	1,919,936	232,504
	$ 2,242,698	$ 1,261,319
Liabilities		
Current		
Payables and accruals	$ 347,542	$ 12,741
Deferred revenue (Note 3)	103,800	85,000
	451,342	97,741
Mortgage payable (Note 4)	300,000	
	751,342	97,741
Fund Balance		
Investment in capital assets	1,919,936	232,504
Building Fund balance (deficiency)	(428,580)	931,074
	1,491,356	1,163,578
	$ 2,242,698	$ 1,261,319

Commitments (Note 5)

On behalf of the Executive

_____ Treasurer

_____ Executive Secretary

Doane Raymond

The Medical Society of Nova Scotia
Building Fund
Statement of Revenue, Expenditures and Fund Balance

	Year Ended September 30	
	1990	1989
Revenue		
Membership dues	$ 141,700	$ 137,100
Investment income	85,464	30,904
	227,164	168,004
Expenditures		
Construction, architect fees and development costs	1,644,285	16,770
Other expenses	43,147	9,923
	1,687,432	26,693
Excess of revenue over expenditures (expenditures over revenue)	(1,460,268)	141,311
Fund balance, beginning of year	931,074	
Transfer from Contingency Fund		145,709
Transfer from Operating Fund	100,614	644,054
Fund balance, end of year	$ (428,580)	$ 931,074

Doane Raymond

The Medical Society of Nova Scotia
Building Fund
Notes to Financial Statements
September 30, 1990

1. Building Fund

The Medical Society has acquired land in Dartmouth and has nearly completed construction of a building to serve as offices for the Society. The cost of this project is being funded by a special assessment of $100 per member annually in each of the next several years.

2. Land and building

	Cost Beginning the Year	Expended During the the Year	Cost End of Year
Land	$ 183,308	$	$ 183,308
Building under construction	39,273	1,644,285	1,683,558
Other expenses	9,923	43,147	53,070
	$ 232,504	$ 1,687,432	$ 1,919,936

No depreciation has been claimed on the new building.

3. Deferred revenue

Annual relocation dues for the next fiscal year received by the Medical Society before September 30, 1990 are recorded as deferred revenue.

4. Mortgage payable

13.75% mortgage maturing December 1, 1995, payable in equal monthly instalments. As security, the Society has provided a first mortgage on land and building at 5 Spectacle Lake Drive, Dartmouth, N.S.

5. Commitments

The Society has committed to purchase approximately $145,000 of office furnishings for the new premises.

6. Comparative figures

Certain of the comparative figures have been reclassified to conform with the financial statement presentation adopted for 1990.

Doane Raymond

The Medical Society of Nova Scotia
Cogswell Library Fund
Balance Sheet

	September 30 1990	1989
Assets		
Receivable from Operating Fund	$ 390	$ 3,397
Investments, at cost	5,200	2,000
	$ 5,590	$ 5,397
Fund Balance		
Cogswell Library Fund balance	$ 5,590	$ 5,397

The Medical Society of Nova Scotia
Cogswell Library Fund
Statement of Revenue, Expenditures and Fund Balance

	Year Ended September 30 1990	1989
Revenue		
Income from investments	$ 409	$ 466
Expenditures		
Trustee expense (recovery)	(250)	250
Contributions to Dalhousie University	466	414
	216	664
Excess of revenue over expenditures (expenditures over revenue)	193	(198)
Fund Balance, beginning of year	5,397	5,595
Fund Balance, end of year	$ 5,590	$ 5,397

Doane Raymond

Presidential Valedictory Address - 1990

P.D. Jackson, M.D.

Sydney, NS

Change is the subject about which I will speak to you today.

We are living in a period of very rapid and unexpected change, as the events of the past year have clearly demonstrated.

In Eastern Europe, the Soviet Union and the Middle East political change that was beyond expectation has become an accomplished fact in little over twelve months. Nationally, the Meech Lake debate has provoked a powerful stimulus to identify those changes that will be necessary if this country is to remain intact.

Within this Province socioeconomic changes abound. The decline of the fishing industry has threatened the very existence of some of our communities. There have been significant changes within government and these can be expected to continue for some time to come.

Within this Medical Society significant change continues to be experienced following the retirement of two long-standing senior executives. Symbolically perhaps the move to our new office building will coincide with a new era of administration for this Society.

Even the understanding of the word "health" has changed in recent years — mostly through a change in its definition that has been promoted by the World Health Organization. No longer just the absence of illness or injury, health is now regarded as a "resource for living". As such it is a goal to be achieved through promotion. The Ottawa Charter for Health Promotion, released by the Canadian Public Health Association in 1986 names the following fundamental resources for health; as peace, shelter, education, food, income, a stable ecosystem, sustainable resources and social justice and equity.

Thus, as a resource health is in a state of equilibrium with the economy and with the environment. Health is subject to shrinkage should there be declines in the economy or deterioration in the environment. This concept is clearly exampled in Eastern Europe, the Third World, and yes even in this Country amongst the urban poor and some native people. This, then, is the backdrop of change against which I wish to speak of change as it impacts on us as physicians. Physicians remain one of the few groups in society who still carry the ultimate responsibility to an individual patient for the cure, improvement or just acceptance of those medical conditions that block that patient's shot at the goal of health.

Without doubt at this time it is the economic variable that is providing the imperative for change that we are now all obliged to confront. It is of interest to know that estimates from Judge Emmett Hall's original predictions for health care costs have remained accurate to this day. However, the boom time of the '60's is now long past and the predictions of his Commission for population and economic growth have both fallen far short of expectations. In reality therefore Medicare faces steadily rising costs without a steadily rising income to pay for it.

To compound this, political policies have been developed by the Federal Government in the face of the national debt to halt the increase of transfer payments to provinces for medical services. Furthermore, acting upon the advice of health care economists and health policy analysts the Federal Government has decided to limit further increases of expenditure for acute health care since they expect but little return for so doing in terms of population health.

The several recent provincial studies on health across this Country including the Royal Commission on Health in Nova Scotia have adopted similar policies in this regard. They have ALL also recommended decentralization and regionalization within the systems, so that local regions may rationalize services to meet local needs and requirements but all within the limits of strict financial envelopes. By such techniques it is proposed that accountability will increase and the introduction of innovative and less expensive modalities of care will be stimulated.

The Nova Scotia Provincial Royal Commission on Health identified physician manpower as a key item amongst the determinants of overall system costs. As such it recommended a marked reduction in medical student intake as a starting point to reduce the overall numbers of physicians. The Canadian Medical Association is developing a considerable expertise in the field of medical manpower and is at the present time trying to develop consensus amongst most of the players involved in the manpower issue. Manpower statistics are extremely difficult to determine with any degree of accuracy and any changes seem to provoke a domino effect over the next decade that extends to involve almost every single specialty within the profession.

Ongoing input from all the medical players involved and also all levels of government involved will be necessary before the correct changes can possibly be made regarding this issue.

I feel encouraged by today's announcement by the Minister of Health and Fitness that the implementation process for the changes suggested by the Nova Scotia Royal Commission on Health will continue to involve the active participation of various providers and user groups. In particular, I am pleased that two members of The Medical Society of Nova Scotia will sit on the Task Force that is to plan the implementation of physician distribution and remuneration — a subject of critical importance to us all. Similarly, The Society will be asked to have a member sit on similar task forces to examine and expedite change in areas of nursing, primary health care delivery, mental health services, drug utilization and ambulance services. Surely, this is very welcome evidence of the participation recommended by the Royal Commission on Health as a guiding principle in its Report.

I am relieved that the concept of REGIONAL AUTHORITIES wielding absolute financial rule for each region has not been followed at this time. The proposal to set up Regional Health Agencies to encourage sharing and co-operation within a particular region each with direct access to the Minister of Health and Fitness is surely a more realistic option for a province with such a small population as Nova Scotia.

All the changes I have mentioned — and the many that I have not — may be perceived as either a challenge or as a threat, or as both. As such we are all going to be provoked into achieving more for the same — or even less.

As our population ages, we may accurately predict that the demands for very legitimate medical services will rise at a time coincident with no increases in the financing of the acute care side of the health care system. In order to meet this expected trend we will have to apply rigorous assessment of the effectiveness of our actions.

Outcome review and quality assurance programs will have to be developed in conjunction with the appropriate personnel, to clearly demonstrate that our actions are appropriate for the delivery of quality care, with responsible use of manpower and other resources in relation to overall fiscal restraint. When such techniques are applied many ethical problems may arise that will require adequate public participation to resolve.

We must move quickly to establish peer review — not as a punitive measure — but as a further means of improving the overall efficiency, within the system of health care.

We must become more critically aware of the cost and usage of drugs, as the Pharmacare program consumes an ever larger percentage of the health care budget, doubling every 4.5 years with alarming regularity. Good systems of Quality Assurance and Peer Review could possibly have significant impact here.

We will have to learn to co-exist with impact analysis in hospitals as a further means of delivering appropriate services within a given region, within a budget.

As physicians, we must also share in the promotion of "HEALTH" -- of health in PUBLIC Policy -- of HEALTHY CITIES -- and most particularly -- "HEALTHY HOSPITALS".

The hospitals of this province should become examples of ENVIRONMENTAL Excellence, and as WORKPLACES that are stimulating and satisfying for all who perform a day's work therein. As physicians we have a responsibility to help relieve the frustrations, tensions and turf wars that so often exist within a hospital. Surely, as the volume of knowledge continues to rapidly increase, our dependency on each other and on other health professionals continues to increase.

The necessity for TEAM approach continues to grow if we are to provide excellent care to our patients.

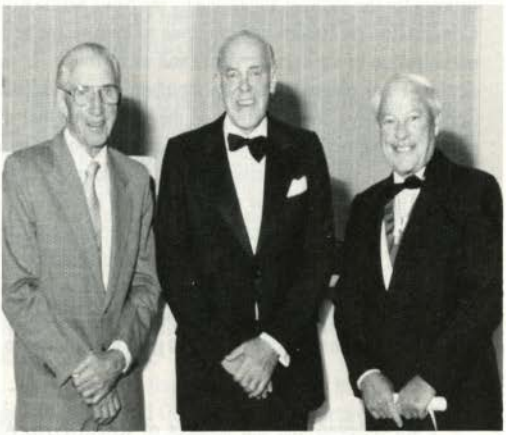
As we are clearly being called upon to demonstrate efficiency and increasing financial responsibility, as a result of these changes, I will challenge both hospital boards and administration and the Department of Health and Fitness to do likewise. To develop healthy outcomes policy, to provide more public and provider participation on Boards and committees, to develop appropriate regional co-operation, to become more publicly accountable for their use of budgets in an appropriate way. For the hospitals spend the largest share of the health care budget and even small percentage savings can lead to large dollar amounts.

In this Province at this time, change is quite clearly underway — the economic imperative has launched it and the anchor has been weighed. It might come as little surprise that after twenty years, MEDICARE is due for a REFIT and modernization. This process is now about to begin. Upon completion, in a few years a period of shakedown will occur as the crew familiarize their new roles, hopefully to once more settle into an efficient, effective and happy company.

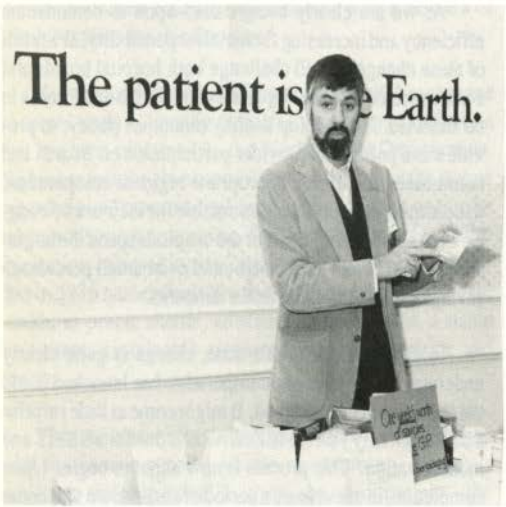
I thank you for your attention this afternoon and for having given me the opportunity to have held this office over the past year. It has been a truly wonderful experience. Thank you. □

Some Pictorial Highlights
137th Annual Meeting

Past President, Dr. Peter Jackson graciously acknowledges a silver tray, a gift from the Department of Health and Fitness.



Four distinguished Nova Scotian physicians had their names added to The Society's list of Senior Members. From left to Right: Dr. Robert Wright of Elmsdale, Dr. Arthur Shears of Halifax and Dr. Gordon Thomas of Mabou. Dr. George Angus of Yarmouth was unable to attend.



An important first. This year the Annual Meeting featured a booth that examined some environmental concerns. Dr. Graeme Bethune, chairperson of the MSNS's Environment Committee put a great deal of effort into the project.

Dr. Judy Kazirmirski, Chairperson of the CMA's Board of Directors congratulates Dr. William Canham, The Society's new President. Executive Director, Howard Epstein shares this special occasion.

Drinking Problems Among First Year University Students

Roula N. Kteily-Hawa,* BSc and Wayne R. Mitic,** EdD,

Halifax, N.S.

The purpose of this study was to examine the differences in reported alcohol-related problems among first year Dalhousie University students by gender and place of residence. Alcohol-related problems were divided into three categories: social consequences, early dependency symptoms, and vandalism or violence. Early dependency symptoms were the most often reported alcohol-related problem. A significantly higher percentage of males (χ^2=8.7, df=2, p<.05) reported three or more drinking-related problems in the year prior to the study as compared to females. A larger percentage of students who resided on-campus (55.4%) reported three or more alcohol-related problems, as compared to those living with parents (38.9%) and those residing in off-campus apartments (37.9%). Specific programs with peer-facilitated approaches are recommended to target groups at "high risk" for specific drinking-related problems. Health professionals need to become more aware of the prevalence of alcohol abuse among young adults.

Alcohol use is part of student life on almost every college and university campus in the world. The college years are considered to be critical because they symbolize a new freedom for the students in which minimal parental control is exercised.[1] As well, drinking on campus is largely reinforced by the presence of drinking outlets such as campus bars and pubs. Shore and Rivers indicated that during the first year of college, students learn to make decisions about their drinking by looking to their peers for ". . . guidance and standards" (p.27).[2]

Alcohol abuse has been defined in different ways, one of the most common being the frequency of negative social consequences.[1] According to the Canada Health Survey, the highest rates of alcohol problems in relation to driving, the law, and accidental injury were reported by 18 to 21 year olds.[3] Engs reported that a sizeable minority of college and university students experience the harmful consequences of alcohol abuse and that this results in various health and social problems. Some of these problems include: hangovers, vomiting, blackouts, missing classes, and damaging property.[4]

Researchers concur on the presence of gender differences in drinking-related negative consequences. Wechsler and McFadden, and Ratliff and Burkhart reported that males were more likely than females to drive while intoxicated and experience alcohol-related problems.[5,6] Studies that used frequency of drinking-related problems or frequency of intoxication to measure abuse of alcohol agreed that males experienced significantly more alcohol-related problems than females.[5,7]

The literature indicates that alcohol-related behaviour problems may also be related to place of residence. Living arrangements with stronger social components are associated with higher levels of drinking-related problems. Heavy drinking students who live in peer-oriented environments report a greater number of drinking-related problems.[6]

This study was conducted during the second term of the academic year 1989-90 at Dalhousie University. The main focus of this paper is on variations in reported alcohol-related problems by gender and place of residence among university students.

METHOD

Population and Sample

The population consisted of full-time, first year, undergraduate students attending Dalhousie University. The sample was delimited to first year students because drinking during this stage is characterized by extreme variations.[8] First year students are most affected by peer pressure and hence may engage in heavy drinking in order to "gain acceptance" among their friends (p.28).[2] Thus, early detection of drinking problems among students may help to prevent future problems in college.[8]

In order to detect significant differences at the .05 level, a sample size of 233 (20% of the target population) was needed.[9] A low response rate was expected and therefore we oversampled. We obtained a random sample of 582 students (50% of the target population), proportionately stratified by gender and place of residence, by means of a table of random numbers. Students were classified into three categories by place of residence: a) those living in traditional university residences; b) those living in off-campus apartments with or without roommates; and c) those living with their parents. The selected sample had the following demographic composition: 42.8% were males and 57.2% females; 34.5% lived on-campus and 65.5% lived off-campus (in apartments and with parents).

Instrument

The Computerized Lifestyle Assessment (CLA) instrument was used for data collection.[10] The CLA querries individuals on thirteen lifestyle factors. The

* Graduate Student, Health Education Division, Dalhousie University.

** Associate Professor, Health Education Division, Dalhousie University.

Correspondence: Dr. W. R. Mitic, Associate Professor, Health Education Division, Dalhousie Unversity, Halifax, N.S. B3H 3J5

Note: The views expressed in this article are those of the authors and do not necessarily represent those of Dalhousie University.

study that we conducted, however, was delimited to collecting information on alcohol use and non-medical drug use only. For the purpose of this paper, we will include information on drinking-related problems only.

Skinner and Allen assessed the validity of the CLA by randomly assigning 150 patients who presented at the Addiction Research Foundation with alcohol and/or drug problems to one of three assessment methods: computer, interview, or questionnaire. No significant differences in consumption patterns or reported alcohol-related problems were detected. Therefore, the CLA was deemed to be as accurate as those more established methods.[11]

We pilot-tested the CLA on a sample of seven first year, undergraduate students to examine its ease of administration. Students, upon being administered the CLA, were given a series of questions to describe the instrument. Their comments included words such as "easy", "friendly" and "interesting".

Based on categories proposed by Berkowitz and Perkins, the alcohol-related negative consequences assessed by the CLA were divided into three groups: the first group includes social consequences such as trouble at work or at school, trouble with the law, major arguments in family, or spending too much money on drinking. The second group includes early dependence symptoms such as inability to stop drinking, uncontrollable shaking when sobering up, or carrying a bottle or keeping one close at hand. The third group includes vandalism or violence towards others as a result of drinking, or personal injury or injury to others caused by excessive drinking.[12,13]

Data Collection

Between February 19 and March 5, 1990 we mailed 582 letters, followed by an equal number of follow-up letters, addressed to a random stratified list of first year students. We scheduled student appointments for a period of three weeks: 194 students each week. For convenience, we chose the Student Union Building as the location for data collection.

Trained volunteer students were present during data collection to welcome subjects and provide them with necessary directions. They also explained the steps that we had taken to ensure that confidentiality and anonymity of students' responses were maintained. Each student was assigned an identification number that he or she used to complete the assessment.

All participants used one of two computers, separated by a partition for privacy, to complete the CLA. The assessment takes around 10 minutes to complete and is self-administered with minimal supervision. Graphic feedback was given during the assessment at the end of each major section. At the completion of the assessment, the students received a printout highlighting their lifestyle risk areas as well as specific recommendations for each area.

RESULTS

A total of 243 students participated in the study, of whom 48.6% were males and 51.4% females; 30.4% lived on-campus while 69.6% lived off-campus. The mean age of the students was 19 years (S.D.= ± 1.5).

Approximately 35% of the students reported no drinking-related problems (negative social consequences, violence and personal injury, and early dependency symptoms) in the past 12 months. About 21% reported one or two problems while 43.6% reported three or more drinking-related problems at least once in the past year. A significant difference (χ^2=8.7, df=2, $p<.05$) exists between males and females with respect to the number of problems experienced in the past year. A significantly higher percentage of females (43.2%) experienced no

TABLE I

Percentage of Students Reporting Alcohol Dependence Symptoms at Least Once in the Past Twelve Months by Gender and Place of Residence

	MALES				FEMALES				
PROBLEMS	On-Campus	Off-Campus	With Parents	Total	On-Campus	Off-Campus	With Parents	Total	Sample Total
Fuzzy Thinking	45.9	43.3	49.0	46.6	40.5	22.2	28.8	30.4	38.3
Physical Sickness	51.4	26.7	37.2	39.0	37.8	25.0	34.6	32.8	35.8
Passed Out	51.4	30.0	33.3	38.1	27.0	22.2	23.1	24.0	30.8
Blackouts	48.6	23.3	21.6	30.5	16.2	11.1	25.0	18.4	24.4
Shakes	27.0	20.0	23.5	23.7	24.3	11.1	15.4	16.8	20.1
Cannot Stop	13.5	23.3	9.8	14.4	24.3	16.7	11.5	16.8	15.6
Heard "Things"	2.7	16.7	11.8	10.2	5.4	8.3	3.8	5.6	7.8
Weird Sensation	8.1	10.0	11.8	10.2	8.1	2.8	5.8	5.6	7.8
Carry a Bottle	2.7	0	5.9	3.4	8.1	0	5.8	4.8	4.1
Panic When Unable to Drink	2.7	0	5.9	3.4	0	2.8	3.8	2.4	2.9

drinking-related problems in the past year as compared to males (27.1%). A higher percentage of males (52.6%) than females (35.2%) experienced three or more drinking-related problems at least once in the past year. A larger percentage of students who resided on-campus (55.4%) reported three or more alcohol-related problems, as compared to those living with parents (38.9%) and those residing in off-campus apartments (37.9%).

Among alcohol-related problems, early dependency symptoms were the most often reported, followed by social negative consequences, and violence and personal injury. Table I presents the percentage of students by gender and place of residence who reported alcohol dependence symptoms. Fuzzy or unclear thinking after heavy drinking was the most reported early dependence symptom among students (38.3%). Approximately 36% of the students reported getting physically sick (vomiting and stomach cramps) as a result of drinking in the past year. Males outnumbered females in almost all of the reported alcohol dependence symptoms. However, problems such as being unable to stop after taking one or two drinks and carrying a bottle or keeping one close at hand were reported by a greater percentage of females as compared to males. These findings may indicate that females are less capable of controlling their drinking than males. In general, students living on-campus reported the highest percentage of alcohol dependence symptoms (Table I).

Table II presents the percentage of students by gender and place of residence who reported alcohol-related negative social consequences. Spending too much money while drinking or after drinking was the most prominent problem among students. The second most reported negative social consequence was missing classes; about 17% of the students have missed two or more days of school at least once in the past year because of drinking. A higher percentage of females (3.2%) as compared to males (2.5%) reported losing friends at least once in the past twelve months.

While vandalism and personal injury as a result of drinking were the least reported problems stated by students of both sexes, there was a much higher percentage of males reporting these problems in the past year as compared to females (Table III).

TABLE II

Percentage of Students Reporting Alcohol-Related Social Consequences at Least Once in the Past Twelve Months by Gender and Place of Residence

	MALES				FEMALES				
PROBLEMS	On-Campus	Off-Campus	With Parents	Total	On-Campus	Off-Campus	With Parents	Total	Sample Total
Spending Money	59.5	60.0	47.1	54.2	45.9	19.4	28.8	31.2	42.4
Missing Classes	29.7	26.7	15.7	22.9	21.6	5.6	1.9	9.6	16.9
Spending Money Needed for Essentials	18.9	20.0	19.6	19.5	18.9	13.9	11.5	14.4	16.0
Family Arguments	10.8	13.3	11.8	11.9	8.1	0	5.8	4.8	8.2
Trouble at School	10.8	3.3	5.9	6.8	2.7	0	3.8	2.4	4.5
Trouble with the Law	5.4	0.1	7.8	7.6	2.7	0	0	0.8	4.1
Arrested for Drinking & Driving	8.1	6.7	2.0	5.1	2.7	0	1.9	1.6	3.3
Lost Friends	0	3.3	3.9	2.5	0	2.8	5.8	3.2	2.8
Family Separation	2.7	0	3.9	2.5	0	0	0	0	1.2

TABLE III

Percentage of Students Reporting Violence and Personal Injury as a Result of Drinking at Least Once in the Past Twelve Months by Gender and Place of Residence

	MALES				FEMALES				
PROBLEMS	On-Campus	Off-Campus	With Parents	Total	On-Campus	Off-Campus	With Parents	Total	Sample Total
Hit Someone	13.5	13.3	15.7	14.4	0	2.8	7.7	4.0	9.0
Accident Where Others Hurt	10.8	16.7	11.8	12.7	2.7	0	1.9	1.6	7.0
Personal Injury	8.1	10.0	7.8	8.5	2.7	0	0	0.8	4.5
Kept from Regular Activities	5.4	3.3	7.8	5.9	5.4	0	1.9	2.4	4.1
Hospitalized	0	0	3.9	1.7	0	0	0	0	0.8

DISCUSSION AND RECOMMENDATIONS

The results of this study must be interpreted with caution. First, the use of a self-reporting instrument that relies on the individual's own perception of level of intoxication may lead to inaccuracies.

Second, some inaccuracies in reported levels of alcohol problems may occur as a result of failure of the individuals to remember feelings of intoxication experienced in the year prior to the study.

Finally, although students originally contacted were randomly selected, participating students were self-selected. The process of self-selection may indicate that students who took part in the study were more motivated and more aware of problems related to alcohol use than those who did not. Alternatively, it may indicate that those who participated were heavier drinkers than those who did not. However, since the effect of self-selection cannot be controlled for, we assumed problematic drinkers and infrequent drinkers were equally represented.

In general, males at Dalhousie University experienced more alcohol-related problems than their female counterparts. These findings agree with those reported by Kozicki who found that males experienced significantly more drinking-related problems with their friends, family, school, health or injury, and the law as compared to females.[14] Also, Berkowitz and Perkins reported that a significantly higher percentage of males as compared to females experienced violence or personal injury, and negative social consequences as a result of drinking.[15]

Overall, students living on-campus reported the highest number of alcohol-related problems. Highly social, peer-oriented environments such as on-campus residences reinforce "social normative beliefs" (beliefs about peers' expectations) which influence the students' drinking patterns and alcohol-related behaviour (p.461).[1]

Singer and Anglin reported that few adolescents who abuse alcohol view themselves as having a problem when being treated for other related problems or injuries. Moreover, health-care professionals' estimate of the prevalence of alcohol abuse among adolescents was underestimated by more than fourfold when compared to actual rates.[16] Increased attention by health-care professionals to the recognition and appropriate referral of young adults who exhibit alcohol-related problems are essential components to successful intervention.

Special programs, with peer-facilitated approaches, should be designed to target students at risk for specific alcohol-related problems. The involvement of students in the development, implementation, and evaluation stages of a program is very essential for the success of that program.[17] However, any attempt to affect the behaviour of students should be reinforced by campus policies that are supportive of responsible use of alcohol.[18] According to the Campus Alcohol Policies and Education (CAPE) program piloted at the University of Western Ontario in 1986, campus policies should cover four major areas: a) management of licensed events such as promotion of non-alcoholic drinks and food, finding alternatives to drinking, and maintaining entertainment after the bar closes; b) operation of drinking facilities such as proper training of bar tenders and servers, promotion of light alcohol drinks, and prohibition of "doubles" or pitchers; c) pricing of beverages such that prices would be related to the alcohol content of a beverage; and d) availability of alcohol on-campus such that it is forbidden to open new drinking outlets on-campus or extend hours of operation of pubs and bars.[19] □

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References

1. Brennan AF, Walfish S, & AuBuchon P. Alcohol use and abuse in college students I. A review of individual and personal correlates. *Int J Addict 1986;* **21:** 449-474.
2. Shore ER, Rivers PC. Peer pressure to drink: Implications for university administrations planning. *J Alcohol Drug Ed* 1985; **30:** 23-31.
3. Canada. *The Health of Canadians.* Ottawa: Health and Welfare Canada and Statistics Canada, 1981.
4. Engs RC. Drinking patterns and drinking problems of college students. *J Studies Alcohol.* 1977; **38:** 2144-2156.
5. Wechsler H, McFadden M. Drinking among college students in New England: Extent, social correlates and consequences of alcohol use. *J Studies Alcohol* 1979; **40:** 969-996.
6. Ratliff K, Burkhart B. Sex differences in motivations for and effects of drinking among college students. *J Studies Alcohol* 1984; **45:** 26-32.
7. Straus R, Bacon SD. *Drinking in College.* Westport, Connecticut: Greenwood Press Publishers, 1953.
8. Cherry A. Undergraduate alcohol misuse: Suggested strategies for prevention and early detection. *J Alcohol Drug Ed* 1987; **32:** 1-6.
9. Marks RG. *Designing a Research Project.* Toronto, Ontario: Lifetime Learning Publications, 1982.
10. Allen B, Skinner HA. Lifestyle assessment using microcomputers. In J. N. Butcher (Ed). *Computerized Psychological Assessment: A Practitioner's Guide.* New York, N.Y.: Basic Books, 1987.
11. Skinner HA, Allen BA. Does the computer make a difference? Computerized versus face-to-face versus self-report assessment of alcohol, drug and tobacco use. *J Consult Clin Psychol* 1983; **51:** 267-275.
12. Berkowitz AD, Perkins HW. Problem drinking among college students: A review of recent research. *J Amer Coll Health* 1986; **35:** 21-28.
13. Mitic WR. Adolescent drinking problems: Urban versus rural differences in Nova Scotia. *Can J Community Mental Health* 1989; **8:** 5-14.
14. Kozicki ZA. The measurement of drinking problems among college students at a midwestern university. *J Alcohol Drug Ed* 1982; **27:** 61-72.
15. Berkowitz AD, Perkins HW. Recent research on gender differences in collegiate alcohol use. *J Amer Coll Health* 1987; **36:** 123-129.
16. Singer M, Anglin T. The identification of adolescent substance abuse by health care professionals. *Int J Addict* 1986; **21:** 247-254.
17. Kraft DP. The prevention and treatment of alcohol problems on a college campus. *J Alcohol Drug Ed* 1988; **34:** 37-51.
18. Gonzalez GM. The effect of a model alcohol education module on

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Pap Screening in the Over 60 Year Old Female

Donald C. Brown,* MD, CCFP, ABFP, FCFP,

Halifax, N.S.

The standard of practice for Papanicolaou smear screening for women over the age of 60 years has been to discontinue screening if previous pap tests have been negative. This critical review of the literature points out that the burden of invasive cervical cancer lies with elderly women, the majority of whom have never had a pap test or whose pap test was 5 to 10 years previously. Physicians should be aware of their older female patients' pap smear status and offer pap screening to women over the age of 60 who have not been pap tested or who have not had a pap smear in recent years.

The Walton Task Force and other authorities have recommended that cervical cancer screening using the Papanicolaou (pap) test be discontinued in a woman after age 60 years provided that she has had a number of negative pap smears before that time.[1] The objective of this paper is to examine that recommendation in light of epidemiological and other relevant and more recent evidence in the literature.

TRENDS IN CERVICAL CANCER

The epidemiology of cancer of the cervix in Canada between 1931 to 1984 indicates that the mortality rate rose from a low of 4.67 per 100,000 population in 1932 to a high of 8.66 in 1952, then started to decline until 1970 when morbidity was 15.50 and mortality was 5.76. Subsequently, both morbitity and mortality rates fell until 1980 when morbidity was 10.11 and mortality was 2.83 per 100,000 population per year. By 1984, mortality had fallen to 2.66.[2]

In the Americas, reported age standardized morbidity rates of cancer of the cervix now vary from a high of 35.7 in São Paulo, Brazil, to 8.8 in Saskatchewan, with the Maritime provinces at 15.6 per 100,000 population. Data also show that the morbidity of blacks and hispanics is twice that of non-hispanic whites in Los Angeles, with Asian rates lowest of all. Connecticut's rate is low at 8.4 and may be attributable to its longstanding screening program while Utah has the lowest American rate at 7.5 per 100,000 population which may be related to its significant Mormon population.[2]

THE VALUE OF SCREENING

One way to evaluate whether or not a pap smear screening program is effective is to compare the proportion of cervical cancer diagnosed in the cancer-in-situ (or CIN III) stage with the proportion diagnosed as invasive carcinoma.

In Nova Scotia from 1965 to 1978 inclusive, 1068 (33.3%) cases of invasive carcinoma of the cervix were registered and 2139 (66.7%) cases of in-situ carcinoma of the cervix were registered. Figure 1 shows how the incidence of invasive cancer varied by county. The three highest rates were seen in Cape Breton, Cumberland and Digby counties; these counties also had the three lowest pap screening rates of 25%, 33% and 46% respectively.[3]

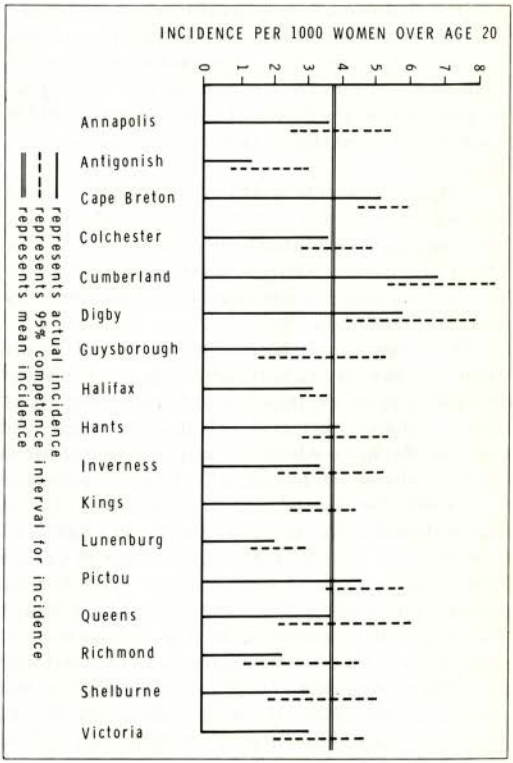

Fig. Incidence of invasive carcinoma of the cervix in eighteen counties in Nova Scotia — 1965-1978. Solid line, actual incidence; broken line, 95% confidence interval; double solid line, mean incidence.

The province of British Columbia has operated a pap smear screening program for over three decades. It has a recall system that functions through family physicians with gynecologists acting as consultants.[4]

By 1965, roughly a third of the population of women at risk had been screened yearly, and since the early 1970s about 40% to 45% have been screened each year. An increasing number of cases of CIN have been detected

*Associate Professor, Department of Family Medicine, Dalhousie University, Halifax, N.S.

Correspondence: Department of Family Medicine, 5599 Fenwick St. Halifax, NS B3H 1R2

over the decades, 1955-85. In 1985, 465,676 (44% of at-risk women) were screened and 1420 cases of CIN were detected for a rate of 133.6/100,000 screened.[4]

In British Columbia, the mean interval for screening is two years. Despite this level of screening, an average of 65 new cases of invasive cancer is found annually. Over the past ten years, of the invasive cancer diagnosed, 65% were in women over age 50 and 75% had not had one pap smear. Only 16% of the women 60 years of age and over were screened. Between 1980 and 1985, 40% of new invasive cases were in women over 65 years of age.[4]

The British Columbia figures show how mortality and incidence rates for invasive cancer have fallen while at the same time the rate for CIN rose. Evaluators of the program have concluded that the reduction in morbidity and mortality from invasive squamous cancer of the cervix in British Columbia over the past 30 years is directly attributable to the province-wide screening program and that a large potential increase in invasive cervical cancer rates among younger women is being prevented. They state that, if morbidity and mortality from cancer of the cervix is to be further reduced, the proportion that never has had a cervical smear must be reached and persuaded to participate in the screening program.[4]

Comparative data from Denmark, Sweden, Finland, Iceland and Norway support the conclusion that screening has a significant effect on mortality from cancer of the cervix. Only in Norway, where there was no screening program, had there been no decrease in the incidence of the disease.[5]

The relative risk of unscreened to screened women having invasive cancer of the cervix varies considerable depending upon the population studied. Lynge *et al.* reported relative risks for cervical cancer for women who had and who had not been screened over the past five to 10 years. They found relative risks of 2.7 in Toronto, 2.9 in Geneva, Switzerland, 3.7 in Milan, Italy, 7.7 in Maribo County, Denmark and 9.9 in Cali, Columbia.[6]

Worth *et al.* reported how mortality rates in Canada changed in relation to screening rates from 1960-72. Female populations with a screening rate of less than 24 smears per 1000 women showed a 27.5 increase in mortality rate per 100,000 population and women with a screening rate over 250 per thousand had a 38.7 decrease in mortality rate.[5] Their data clearly showed that provinces with the highest screening rates had the greatest decrease in mortality.

Graaf *et al.* presented results of a population pap screening program in the Netherlands from 1976-85.[7] Their first screening yielded three to eight severe dysplasias per 1000 with 74% attendance rate; in a second screening three years later, the yield had fallen to 1.0 per 1000 smears and 67% attendance rate. A third screening three years later yielded 0.7 severe dysplasias per 1000 smears and 63% attendance rate. All women in the age range 35-54 years had been invited for a cervical smear; they were also able to observe a decline in invasive cancer in that age group.[7]

PAP SCREENING IN OLDER WOMEN

Holmes and Hearne demonstrated a highly significant positive relationship between advancing stage and advancing age ($p < 0.001$).[8] They reported that cervical cancer incidence rates rise steadily with increasing age during adult life. This evidence provides a strong argument for cancer screening in older populations since more cases will be detected, with better cost effectiveness, and early detection will result in better cure and salvage rates.[7]

Mandelblatt and Hammond in a study of 205 patients, 37% of whom were over age 65, showed a strong linear positive relationship between age and median interval since prior pap smear (correlation coefficient $r = .93$). Overall, 64% of the elderly women screened had either never had a pap smear or had not had one within three years.[9] The prevalence rate of positive pap smears was 27 per 1000 for women 65 or older.

In a Maryland case-control study, Celentano *et al.* reported that women with invasive cancer of the cervix were less likely to have had a pap test than matched controls, especially those over 60 years of age ($p < 0.001$). In the over 65 age group, 55% of the cases had never had a pap test while only 15% of the controls had never had a pap test ($p < 0.001$).[10]

Ebeling and Nischan described the introduction of a cervical cancer screening program in the German Democratic Republic after conclusions were drawn from two pilot studies. Ten years following the implementation of their program in Berlin, mortality rates for all women were 37% lower, and for women aged 50-59, they were 57% lower.[11]

Mandelblatt and Fahs conducted a study in New York of the cost-effectiveness of a cervical cancer screening program for infrequently screened elderly women attending an urban municipal hospital clinic. The results of pap testing were abnormal (malignant or pre-malignant) in eleven of 816 (13.5%) women screened. The early detection of cervical neoplasia saved $5907 and 3.7 years of life per 1000 pap tests. When average medical costs per year of life extended by screening were included, the program costs $2874 per year of life saved.[12]

In a 1984 Nova Scotia report, 80% of the women diagnosed with invasive cancer of the cervix had never had a pap smear.[3] In Sweden, women who have never been screened had a fourfold increased risk of having invasive cancer of the cervix compared with women who had one or more prior pap smears. In Sweden, 85% of the women who had never had a pap smear were aged 60 years or more.[9] In the United States, screened elderly women had two to three times more abnormal pap smears than women under 65 years. [Forty percent of the population accounted for 62% of the invasive cancer of the cervix].[9]

CONCLUSION

Screening for cancer of the cervix has a particularly important advantage over screening for many other

malignant conditions; one can expect prevention of invasive cancer of the cervix, not merely early diagnosis. Coppleson and Brown have observed that the transition time between stages of cervical abnormalities elapses four times more rapidly in elderly women compared with younger women.[13] Previous recommendations to cease pap screening after 60 years were based on low age-specific conversation rates that were studied from British Columbia in a relatively highly screened population in which the elderly were under-represented.[9]

Women aged 65 and older account for 25% of the cases of invasive cervical cancer and 42% of the deaths due to cervical cancer in the United States.[14] Epidemiologic observations consistent with rapid disease progression in the elderly yield estimates between three to nine years for progression from normal cervical cells to advanced cancer.[15] The National Institutes of Health suggests that a woman have two negative pap smears after age 60 before screening can cease.[16] Physicians must therefore ensure that they know their older female patients' pap smear status prior to withholding screening.

It is evident from a number of sources and from this review that older women who have never had a pap smear must be encouraged to do so if we are to decrease the death rate from cancer of the cervix. An editorial on early detection of cancer in women puts this in context: No woman should die from carcinoma of the cervix. The means of preventing these deaths are available and the key to the matter is early diagnosis by cytologic methods.[17] □

References

1. Walton RJ: Cervical Cancer Screening Programs — Summary of the 1982 Canadian Task Force Report. *Can Med Assoc J* 1982;**127**:581-9.

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Current Topics in Community Health

Selected by: Dr. Lynn McIntyre
Department of Community Health & Epidemiology
Dalhousie University, Halifax N.S.

HEALTHY OUTCOMES: BEYOND THE RHETORIC

Drs. Richard Goldbloom and Robert Lawrence's recent book *Preventing Disease: Beyond the Rhetoric* discusses that:[1]

> "It has become fashionable among some health-related organizations, communications media and even government departments — to suggest that if more money and effort were to be spent on disease prevention and health promotion less would be required for treatment, particularly "high-tech" medical treatment. In fact, with the exception of a few specific instances — newborn screening for PKU and hypothyrodism, routine child immunization and smoking cessation are examples — more preventive interventions can be shown to incur additional costs rather than savings.[2]

Goldbloom and Lawrence also argue that poor quality screening tests are not only costly but they can actually lead to harm. The book presents a rigorous and scientific review of numerous preventive manoeuvres in clinical practice that truly does go "beyond the rhetoric".

The Report of the Nova Scotia Royal Commission on Health Care: Towards a New Strategy presented five guiding principles that it believed formed the basis of a revitalized health care system.[3] One of the principles was that health policies should be oriented to healthy outcomes. The report also stressed the matching of resources to local health need, and suggested that the health status of Nova Scotians was poor compared with other provinces despite our high expenditures on health care and particularly on institutional care.

The inevitable conclusions were that there should be a shift of resources towards health promotion, prevention and community-based care and that the province needed a comprehensive health policy. The Report argued that the objective of a health care system should be to improve the health of its people. Evaluation of health care activities was critical so that money could be used efficiently and directed to areas where health status would be improved. The emphasis of this reorientation was on achieving healthy outcomes.

The Medical Society of Nova Scotia's response to the Report of the Royal Commission on Health Care began with a discussion of healthy outcomes.[4] This guiding principle was considered the most important of the five (the other four principles included participation of citizens, decentralization and regionalization, accountability, and matching resources to local health needs). The Provincial Health Council was lauded as a policy-setting body that would direct policies towards healthy outcomes.

The Medical Society suggested that an outcome orientation for the health care system would do much to improve the health of Nova Scotians. It pointed to our mortality statistics, our high incidence of accidents, of smoking and obesity, and to our high disease rates in the population. The Medical Society recommended that health promotion target those with low levels of income and limitations in education and address environmental degradation as well as the usual lifestyle issues.

And now we have the Minister of Health & Fitness' report, *Health Strategy for the Nineties: Managing Better Health.*[4] The Minister's Implementation Committee, responsible for development of the document, has reaffirmed that fundamental changes to the health system are to be based on the guiding principles (except for decentralization) outlined in the Report of the Royal Commission on Health Care. The Health Strategy presents a blueprint intended to achieve optimal health outcomes, and more efficient management of health care resources.

It is believed that healthy outcomes will be achieved by adhering to five precepts which underlie the new health strategy: accessibility to the full continuum of care; an emphasis on primary health care; a health system that is community-based, flexible, and responsive to users' needs; comprehensive, integrated and coordinated services and programmes; and the controlled growth of expenditures.

The Health Goals, developed as a mandate of the Provincial Health Council, will provide the global vision to direct change. Outcomes which are sought should be in concert with achieving health goals and objectives. The review of the health professions, through the development of a comprehensive human resource plan, will require health outcome measures.

So we all agree: Healthy Outcomes *are* the way to improved health and to better health management. The difficulty begins when we try to use the Healthy Outcomes orientation to plan and to act. Are Healthy Outcomes goals, process indicators, or impact measures? Do Healthy Outcomes refer to the prevention of smoking and unwanted pregnancies in teenagers, to the reduction of disability and premature death, or do healthy outcomes imply that the work we do clinically has the best achievable outcome using measurable standards and within available resources?

The answer probably is that all of these are healthy outcomes. The scope enlarges if we add environmental preservation, economic development and social justice to our list of outcomes. The task then becomes overwhelming and beyond the reach of even the most passionate public health ideologue. And that's when healthy outcomes become rhetoric.

"Healthy Outcomes" need not be rhetoric, though. We need to look for implementation strategies to identify what outcomes are healthy, whose health should be targetted, and what can be done to make health achievable. This approach is helpful at the individual, community, regional and provincial levels.

Certainly there is a role for optimizing the preventive manoeuvres which are known to be effective and efficient. It's a national tragedy that women continue to die of cervical cancer because they haven't been PAP-tested. Current stroke morbidity and mortality is partially related to the non-detection of hypertension and to poor compliance and management of hypertensive patients. Missed opportunities exist every day in physician offices to counsel patients on smoking cessation and to identify women who have been abused. These examples suggest that we should enhance our preventive and identification efforts in order to achieve healthier outcomes.

The challenge for hospitals is to see that standards are in place for the management of all admissions in terms of physical care, communication and support and to evaluate practices towards achieving the healthiest outcomes possible for patients and their families. This may be accomplished through program reviews in institutions which address multi-disciplinary aspects of care and through medical peer review.

The challenge to Nova Scotia physicians is to reorient their practices towards healthier outcomes for their patients and for the institutions in which they have privileges. As role models in the community, they can practice a healthy lifestyle and as a key influencing group, they can advocate for healthy changes throughout the province. □

References

1. Goldbloom RB, Lawrence RS (ed): *Preventing Disease: Beyond the Rhetoric.* New York: Springer-Verlag, 1990. p.xiv.
2. Russell LB: *Is Prevention Better Than Cure?* Washington, D.C.: The Brookings Institution, 1986 (cited in ref 1).
3. *The Report of the Nova Scotia Royal Commission on Health Care: Towards a New Strategy,* Halifax: Dec. 1989.
4. *Health Strategy for the Nineties: Managing Better Health.* Halifax: Department of Health & Fitness, Nov., 1990.

WOMEN (AND MEN) IN MEDICINE

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many men stayed at home to mind the children while the women went to the conference. Most frightening however was that the female physicians presumed that males were not interested in dialogue. Among their professional difficulties, they listed a lack of understanding of their problems they face, patient expectations, and even lack of physical facilities such as changing rooms for female physicians. Locker room lockout does not occur only to female sports reporters. Females not present in the changing rooms often miss pertinent clinical discussions.

The CMA has approved the creation of an ad hoc committee to assess the Association's response to womens' health care issues and the needs of women physicians. Both the Ontario and the Alberta Medical Associations already have committees that deal with women's issues. Dalhousie Medical School is to be congratulated for sponsoring "Women in Medicine, a Celebration". Considering the issues, it seems a shame that more men were not at the party. □

J.F. O'C.

Personal Interest Notes

SENIOR MEMBERSHIP CITATIONS
THE MEDICAL SOCIETY OF NOVA SCOTIA

Dr. George Archibald Watson Angus

Dr. George Archibald of Yarmouth was born February 23, 1916 in Paisley, Scotland. He was educated locally and in 1940 graduated from the University of Edinburgh with a Bachelor of Medicine and Surgery. In 1945 he obtained his Diploma in Psychological Medicine from the University of London, England. At a later date he obtained the Degree of membership in the Royal College of Psychiatrists of the United Kingdom.

Following graduation from Edinburgh he did a compulsory year of Internship in Paisley and them served as a Regimental Medical Officer with the 24th Field Regiment of the Royal Artillery in the British Army. On return to civilian life he then accepted a position as a tutor to the Professor of Clinical Surgery at the Royal Infirmary of Edinburgh. After a year he changed to the study of Psychiatry because, primarily during his spell in the Forces, he had been impressed by the quality of the psychiatric services in the British Army. He undertook his psychiatric training first of all in Inverness, Scotland, then in Canterbury, England and then in 1946-47 a year of research study in Amsterdam in the Netherlands. In succession he became Deputy Medical Superintendent at a mental hospital in York, England and them Director of the Medical Department of the British Council in London, County Psychiatrist for the County of Ayr, Scotland and in 1953 he moved to Western Australia where he was eventually Medical Superintendent at the Claremont Mental Hospital in Perth, Western Australia from 1954 to 1957.

In 1957 he came to Canada and took over the post of Executive Director of the Western Nova Scotia Clinic covering Digby and Yarmouth counties. Subsequently he was the sole psychiatrist covering Digby, Yarmouth and Shelburne counties until 1977 and at that time he continued in practice at the Yarmouth Regional Hospital with private offices in Pubnico and Barrington. He is still in private practice as a psychiatrist despite handicaps with diabetes and failing eye sight.

In early years he served on the Yarmouth Regional Hospital Board and also was a member of the Yarmouth Rotary Club. In 1983 he was recipient of the Citizen of the Year Award given by the Yarmouth Lions Club.

Being a bachelor, during these 50 years in practice, his kindness and generosity to people cannot be over stressed. His financial aid to young adults helped many to obtain University Degrees and similarly, to many destitute people it meant not losing their homes or not going hungry.

One of his favorite sayings is of how he made his will: "I have nothing, I owe much, and the rest I give to the poor".

Dr. Shelagh M.T. Leahey
Representing Western Branch Society

Dr. Arthur Howard Shears

Dr. Arthur Shears is a native of Glace Bay, Nova Scotia, educated at Acadia and Dalhousie University where he received his M.D., C.M. in 1950. He did general and industrial medical practice in the busy mining town of Glace Bay for a few years. He then specialized in Physical Medicine and Rehabilitation. He was the pioneer who established the speciality of Physical Medicine and Rehabilitation in the Atlantic Province. He has been instrumental in the establishment of the Nova Scotia Rehab Centre. He also founded the school of physiotherapy at Dalhousie University in 1963. He was Medical Director of that School from 1963 to 1975. He has done excellent clinical and teaching work at Dalhousie for more than a quarter of a century.

He has been a member of The Medical Society of Nova Scotia since 1950. He has actively worked for The Society over the years. He was chairman of the Standing Committee on Rehabilitation of The Medical Society of Nova Scotia for several years during the 1950's and 1960's. He was chairman of The Medical Society of Nova Scotia Workers' Compensation Board liaison committee for several years in 1950's and 1960's. Dr. Shears has also been a member for the general council of the Canadian Medical Association between 1977 and 1986. He was chairman and member of the Allied Health Disciplines Committee of The Medical Society of Nova Scotia since 1981. He is also a member of the CMA Committee on Health Disciplines. In 1984, he was chairman of the Task Force on Health Resource Allocation of The Medical Society of Nova Scotia. Since 1986, to present time, he is chairman of the Task Force of Allied Health for personnel legislation in this province.

In summary, Dr. Shears has been an outstanding member of The Medical Society of Nova Scotia working tiredlessly for more than a quarter of a century in the area of teaching, patient care, administration and the activities of The Medical Society of Nova Scotia.

Dr. Doug C.S. Brown, President
Halifax Branch Medical Society

Dr. Gordon Waddell Thomas

The medical career of Dr. Gordon Thomas began at McGill but reached fruition in the operating rooms and classrooms of Eastern Canada. In fact, apart from wartime service, periods of postgraduate training that took him as far away as Sweden, and a brief stint as a teacher in Toronto, his entire career was spent as a surgeon and teacher in Newfoundland and Nova Scotia.

Gordon Waddell Thomas was born in Ottawa, Ontario, on December 28, 1919, but he was educated in Montreal. He completed his Bachelor of Arts degree, in honours economics and sociology, at McGill before graduating with his medical degree in 1943. Dr. Thomas served in the Royal Canadian Army Medical Corps during the Second World War, and upon his release from the service in 1946 he joined the International Grenfell Association as a medical officer and surgeon in St. Anthony on the northern tip of of Newfoundland.

He became surgeon-in-charge at St. Anthony Hospital in 1950 and took on the added duties of acting superintendent at the hospital in 1959. From 1962 to 1979 he was surgeon-in-chief and executive director of the International Grenfell Association, which delivered medical services to isolated parts of Newfoundland and Labrador.

His teaching career began in 1961, when he was appointed a teaching fellow in cardiovascular surgery at the University of Toronto. He returned to Newfoundland in 1962, and began a lengthy association with Dalhousie University in Halifax, Nova Scotia, in 1966-67, when he held the appointment of clinical assistant to paediatric surgery. From 1968 to 1979 he was a lecturer in Dalhousie's Medical School for Outpost Nursing. Dr. Thomas was also well known to medical students at Memorial University in St. John's, Newfoundland, where he was a clinical professor of surgery from 1972 to 1979. He is currently a staff surgeon at Nova Scotia's Inverness Consolidated Memorial Hospital and a consulting surgeon at Sacret Heart Hospital in Cheticamp, Nova Scotia.

He became a member of the Council of Royal College of Physicians and Surgeons in Canada in 1974 and served on its executive from 1978 to 1980. He also served as chairman of the college's Ethics Committee. He was governor of the American College of Surgeons from 1972 to 1987 and has served on the executive of The Medical Society of Nova Scotia since 1984. He became a member of the Provincial Medical Board of Nova Scotia the same year.

The authors of numerous papers, mainly on surgery for pulmonary tuberculosis in CMAJ and the New England Journal of Medicine, and of a book From Sled to Satellite, Dr. Thomas has received numerous honours and awards. He was appointed an officer of the Order of Canada in 1970, and the high esteem in which he is held by the medical profession was shown when he received the Canadian Medical Association's F.N.G. Starr Award, which is presented for an "outstanding contribution" to science, fine arts or nonmedical literature or for, among other things, improving medical service in Canada. He has also been awarded honorary degrees by Memorial and Dalhousie universities and received the Royal Bank Award in 1977.

Dr. Thomas, who maintains an interest in flying, fishing and beekeeping, married in 1944. He and his wife, Thora, have two daughters and a son.

Dr. Ken R. Murray, President
Inverness/Victoria Branch Society

Dr. Robert Gordon Wright

Dr. Robert Gordon Wright has provided very significant services to the area, continuously, for over fifty years.

Much of his youth was spent in Cape Breton, Here he developed a keen interest and high level of expertise in fishing and hunting. After High School in Inverness, he completed Pre Medical training at Acadia University and entered Dalhousie Medical School, graduating in 1940.

In that year he established practice in Noel. This was still the era of acute hardship fo those attempting to deliver up to date medical care in areas remote from sophisticated medical facilities. Transport was an acute problem both for the physician and for the patients. The road remained blocked by snow during the winter and by mud in the spring. It was difficult to access the sick and to evacuate the critically ill.

Dr. Wright met these challenges not only with dedication but also with a high level of innovation. Stories still abound in the area of the incidences of illness and accidents requiring extraordinary efforts of transportation. For example this included a propeller driven snow machine which long preceded the common snowmobile of recent years.

After two years of strenuous hardship in Noel, Dr. Wright moved to Elmsdale. Here he established a large practice where he still continues to work. Over the years he appreciated the necessity of recreational break and of the necessity to share the load. After many years of unrelieved "solo practice" he foresaw the extensive future development of the area and became instrumental in the establishment of the Elmsdale Medical Centre, now a facility of six family physicians serving the area.

Dr. Wright has many interests outside of medicine. He was very active for many years in community and church affairs. As alluded to, he is an avid sportsman, enjoying hunting and being an expert fly fisherman. He has enjoyed recreational flying and owned his own plane for years. He enjoyed camping with the family in his locally made innovative travel trailer years before trailers were commonly available. He enjoys gardening, bridge, golf and travel.

Dr. Wright is married and he and Rita have shared many of the responsibilities of practice, especially during those years when the practice was in the home and problems had to be dealt with when "the doctor" was out on calls or at the hospital. They have four children and nine grandchildren. They recently enjoyed a family reunion attended by all their children and grandchildren on the occasion of their fiftieth wedding anniversary. The time also coincided with the completion of fifty years of medical practice.

Dr. Graham A. Corbett
President, Colchester East Hants Branch Society

SENIOR MEMBERSHIP CITATIONS THE CANADIAN MEDICAL ASSOCIATION

Dr. Neil Kenneth MacLennan

Obstetrician and gynaecologist Dr. Neil MacLennan was born May 21, 1923, in St. Peters, Nova Scotia. He obtained his Bachelor of Arts degree from Mount Allison University in 1944 and his medical degree from Dalhousie University, four years later. In 1952, he was awarded a fellowship in obstetrics and gynaecology from the Royal College of Physicians and Surgeons of Canada.

Now a resident of Marion Bridge, Nova Scotia, Dr. MacLennan has practices obstetrics and gynaecology in Sydney since 1952. His medical obligations have included terms as President of Staff at City Hospital as well as St. Rita Hospital, where he also served as chief of staff. Dr. MacLennan currently holds an appointment as a lecturer at Dalhousie University in Halifax.

Over the years, in addition to a considerable medical practice, Dr. MacLennan has shouldered a host of responsibilities within his community. He had a hand in directing the affairs of University College, Cape Breton, during a five-year tenure as chairman of the institution's Board of Governors. He contributed to the work of the Young Men's Christian Association, as well as the Victorian Order of Nurses, as a member of their respective Board of Directors. For a nine-year period, he sat as a member of the Health Services and Insurance Commission. Dr. MacLennan also spent four years a a member of the Royal College of Physicians and Surgeons of Canada council, in addition to tackling the presidency of both the Sydney Rotary Club and the Clan MacLennan, Atlantic Region.

Dr. MacLennan and his wife, Freda, have ten children.

Dr. Harold Burgess Sabean

Now retired and living in Truro, Nova Scotia, Dr. Harold Burgess Sabean (better known as "B" to his friends and colleagues) can look back on a career as a member of an elite corps of Canadian pioneers — those medical professionals who had the vision, courage, and endurance to provide the medical services so vital in the 50's to Canada's isolated northern communities.

Born in Digby, Nova Scotia in 1924, Dr. Sabean received his early education Riverdale, as well as the communities of New Tusket and Weymouth. His first foray into the world was as a school teacher on Seal Island, where he developed an interest in marine communications. He subsequently joined the Radio Division of the Department of Transport, working in communications and spending four of the next six years in isolated outposts of the Hudson's Bay Strait area.

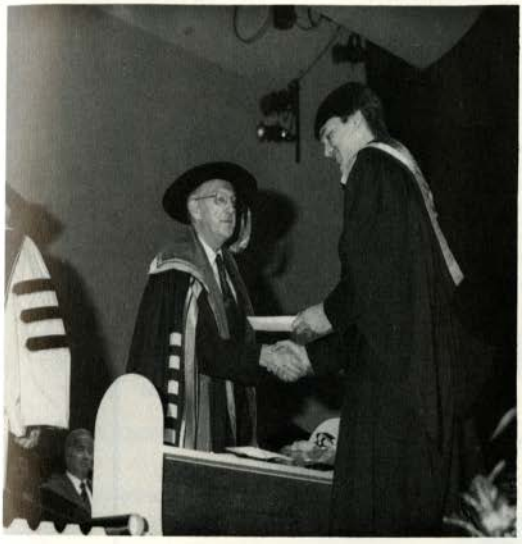
An interest in the health problems of the Inuits led him to enroll in Dalhousie University's medical program in the fall of 1949, from whence he graduated in 1956 with Doctor of Medicine and Master of Surgery degrees, as well as the University Gold Medal of Medicine. He accepted a posting as a medical officer with the Department of Health and Welfare, spending one winter on the active medical staff of Hamilton's Mountain Sanatorium (home of the largest single Inuit community in Eastern Canada) and two years as resident physician and medical officer for the Eastern Arctic at Pangnirtung's St. Luke's Hospital, Baffin Island. Usually travelling by dog team, boat or airplane, he visited all of the Eastern Arctic communities, immunizing inhabitants, providing general health care treatments, and giving physical and radiological examinations.

Dr. Sabean returned to Halifax in 1959 to pursue post-graduate studies in diagnostic radiology at the Victoria General Hospital. From there, he went to the Armed Forces Institute of Pathology in Washington, D.C. for a year of further study. He returned to Canada in 1963 to join the medical staff at the Halifax Infirmary, accepting a simultaneous teaching appointment with the Faculty of Medicine at Dalhousie University where, in 1967, he was head Head of the Department of Diagnostic Radiology. By 1974 Dr. Sabean was on the move again, this time joining the active medical staff at Colchester Regional Hospital in Truro.

With retirement from active practice in 1987, Dr. Sabean turned his attention to his many hobbies — amateur radio, reading, photography and computers — and his volunteer work with the Canadian Cancer Society's CANSURMOUNT program. He still speaks Inuit — he put together an Inuit/English grammar during his early northern communications posting — and still hears from many of his Inuit friends.

1990 CONVOCATION DALHOUSIE UNIVERSITY FACULTY OF MEDICINE

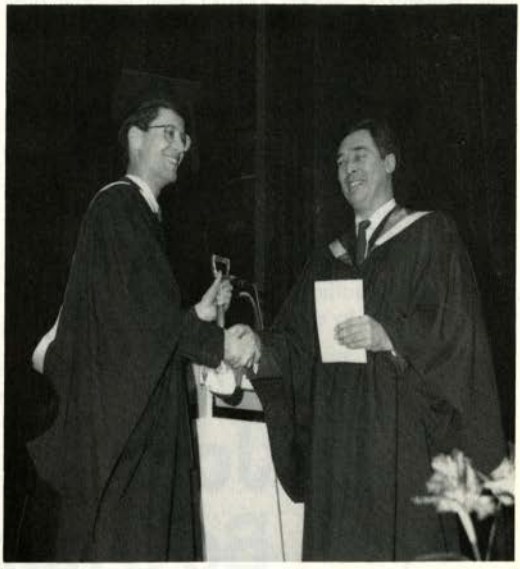
The Dalhousie University Faculty of Medicine Convocation was held on May 18, 1990, when 90 M.D. degrees were conferred [included one granted by Memorial University, St. John's, Newfoundland]. By place of residence, the 89 Dalhousie University graduates were from: Nova Scotia — 61; New Brunswick — 16; Prince Edward Island — 3; Ontario — 5; Québec — 3; and São Paulo, Brazil — 1.



Dr. Simon Jackson receiving the Dr. C.B. Stewart Medal from President Howard C. Clark.

Dr. Agnes Bishop addressing Convocation.

Dr. Simon Douglas Jackson, Sydney River, N.S., was awarded the Dr. C. B. Stewart Medal for the student with the highest standing in the regular medical course. An honorary degree was conferred on Dr. Agnes Joyce Bishop (Dal. '64), Professor and Head, Department of Paediatrics & Child Health, University of Manitoba, Winnipeg, who also delivered the Convocation Address.



Dr. William Wrixon receiving the Professor of the Year award.

Dr. William Wrixon, Professor of Obstetrics and Gynecology, Dalhousie University, was once again named Professor of the Year by the graduating class. This award, which is a trophy in the form of a small shovel with an inscribed silver blade, was presented during the Convocation exercises. □

OBITUARIES

Dr. Noel J. Jackson, (71) of West Middle Sable, Shelburne County died October 19, 1990. He graduated from Durham University in England receiving his medical degree. He joined the RAF for the duration of the Second World War, holding the rank of Flight Lieutenant. He also flew with the Eagle Squadron in the post war years. He was awarded the Queens Commendation for Bravery in 1958 for a rescue at sea. He is survived by his wife, two daughters, a son and a brother and sister. The *Journal* wishes to extend sincere sympathy to the wife and family.

Dr. Margaret E. B. Gosse, (87), of Halifax, N.S. died Monday October 22, 1990. Born in Montreal, she graduated from McGill University. She was associated with the Royal Victoria Hospital for several years. She

married Dr. Norman Gosse in 1940. She was the editor of *The Nova Scotia Medical Bulletin* from 1946 to 1949. In 1982 the University of Kings College bestowed on her an Honorary Doctorate of Civil Laws Degree. She is survived by her sister-in-law, two stepsons, and a niece, to whom the *Journal* extends sincere sympathy.

Dr. William E. Pollett, (83) of Halifax, N.S. died October 27, 1990. He graduated in medicine from Dalhousie University in 1934. He did post graduate work in Edinburgh, Scotland, receiving his FRCS (Ed.) in 1943. During the Second World War he was a surgeon in the British Army, holding the rank of Major. He was the past president of the Childrens Hospital and Halifax Medical Society. He was the editor of *The Nova Scotia Medical Bulletin* from 1961 to 1963. He was elected to senior membership of the Canadian Medical Association in 1979. He is survived by a son, two daughters, two sisters and two brothers. The *Journal* wishes to extend its deepest sympathy to the family.

Dr. Peter D. Ferguson, (75), of Dartmouth, N.S. died November 3, 1990. Born in Cleveland, Richmond County, He was the son of the late Mr. and Mrs. Alexander H. Ferguson. He was the retired chief of medicine at the Nova Scotia Hospital. He was a medical officer during the Second World War, serving with the Lake Superior Regiment. He is survived by his wife and three sons. The *Journal* expresses sincere sympathy to his family.

Dr. William A. Taylor, (69) of Bridgewater died November 11, 1990. He had a long career in medicine, starting at Glasgow University, in Scotland. He was appointed Provincial Pathologist, Professor of Pathology at Dalhousie University and Head of the Pathology institute. He was influencial in introducing the Breathalyser in Nova Scotia. He retired in 1983. He is survived by his wife, a daughter, four sons, and 12 grandchildren. The *Journal* wishes to express sincere sympathy to his family. □

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