The Lung as a Mirror of Systemic Disease

PART II—A

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THE preceding section dealt with the pulmonary manifestations of diseases of metabolism. The present one will be devoted to a description of the pulmonary findings accompanying certain blood dyscrasias and allergic diseases.

Diseases of the Blood

1. Anemia
2. Pulmonary Hemosiderosis
3. Sickle-Cell Anemia
4. Polycythemia
5. Hemorrhagic Diseases
6. Leukemia

As a group, diseases affecting the blood and blood forming organs seldom involve the lungs. Occasionally pulmonary hemosiderosis and sickle-cell anemia, rarely polycythemia vera and hemorrhagic dyscrasias, are associated with pulmonary manifestations. The leukemias often involve the intrathoracic lymph nodes; seldom the lung parenchyma. In the years when hematogenous tuberculosis was encountered with greater frequency than it is at present, bizarre blood pictures of the leukemoid variety were sometimes observed. Infectious mononucleosis, although featured by hematologic findings, is caused by a virus and is not strictly speaking a blood disorder. The pulmonary manifestations of this condition resemble those encountered in primary atypical pneumonia.

Anemia: Pernicious anemia does not involve the lungs directly but it does exert a deleterious effect on any existing bacterial or viral infection. The frequent association of secondary anemia and diaphragmatic hernia is well recognized and need only be mentioned. The accompanying loss of blood is not necessarily related to gastrointestinal bleeding which may or may not be present.

Leuko-erythroblastic anemia has been reported in a patient with bronchiogenic carcinoma, an association suspected of being more than a coincidence since similar blood findings have been encountered in other malignancies. Humphreys and Southworth cite the history of a woman, aged 58, with a large anterior mediastinal tumor complicated by aplastic anemia. The patient was treated with repeated blood transfusions for almost two years without effect. Following removal of the tumor, which histologically appeared to be probably thymic in origin, there was a sharp reticulocytosis with return of the erythrocyte count to normal. The patient died one year after the operation. The authors refer to another instance, reported by Opsahl, of thymic carcinoma complicated by aplastic anemia.

Pulmonary Hemosiderosis: This disease is characterized by excessive accumulation of iron in the organs and tissues of the body. Iron particles may be deposited in the lungs as a result of inhalation of dusts or fumes in occupations in which ferrous metals are used, as well as from endogenous sources.

For the moment we are concerned with the latter, the nonoccupational form of pulmonary hemosiderosis. The condition is found in association with long-standing mitral stenosis, advanced left ventricular failure, following repeated blood transfusions, in certain forms of malnutrition encountered in African negroes as a result of absorption of iron from cooking utensils, or it may occur without apparent cause. The last mentioned is referred to as idiopathic hemosiderosis or brown induration of the lungs.

1. Long-standing mitral stenosis is the most frequent cause of pulmonary hemosiderosis. The engorgement of capillaries incident to the hypertension of the lesser circulation gives rise to small hemorrhages. Following hemolysis of the extravasated erythrocytes, the liberated iron-free globulin fraction, hematin, is absorbed; the iron-containing fraction, hemosiderin, remains in the tissues and initiates a foreign body reaction. The minute, dark-brown spots visible to the naked eye represent deposits of iron which show histologically giant cell formation and fibrous proliferation in the alveoli and adjacent stroma. The foci may undergo calcification, even ossification.

Pulmonary hemosiderosis associated with mitral stenosis manifests itself roentgenologically in miliary densities scattered in both lungs, most numerous in the midportions. The nodules resemble those of miliary tuberculosis, pneumonoconiosis and histoplasmosis. In the absence of significant edema, there is little interstitial reaction noted roentgenologically between individual nodules. In a man, age 27, under the writer's observation for the past nine years, the small nodules gave way in time to a fine reticular stippling. The patient had known of his rheumatic mitral stenosis since childhood. At the time the miliary foci were discovered, in the course of a routine chest x-ray examination, he had had a period of increased dyspnea and blood streaked sputum. In most instances pulmonary hemosiderosis, recognizable roentgenologically, is present in association with decompensated rheumatic heart disease (Fig. 9).

2. Idiopathic hemosiderosis or, so-called, brown induration of the lungs is encountered almost exclusively in infancy and childhood. The onset is insidious and is associated with hypochromic anemia possessing hemolytic features. Periodic seizures of dyspnea and cyanosis soon appear. In the late stages of the disease there is often a compensatory polycythemia. The changes in the lungs affect chiefly the pulmonary artery, especially the terminal vessels. In addition there is an increase of reticulum, collagen and muscle and a decrease of elastic fibers which reduce the distensibility of the lungs causing peripheral blood stasis. This is followed by hemorrhage and the deposition of iron deposits in the tissues. Idiopathic pulmonary hemosiderosis is characterized roentgenologically by a "smoky," "ground glass" or "mossy" appearance. The involvement is greatest in the hilar regions. The disease is associated with a minimal degree of gross nodulation of the organs, especially in the initial stages of the disease.

3. Hemosiderosis following repeated blood transfusions is the result of iron overload. The iron content of the tissues may be of a degree found in hemochromatosis, a metabolic disorder characterized by excessive absorption if iron from the alimentary tract. Hemosiderosis following repeated blood transfusions manifests itself in the lungs as a diffuse interstitial reaction. From the few chest x-rays available for study, it appears that the roentgen features resemble those of the idiopathic rather than the mitral type of disease.

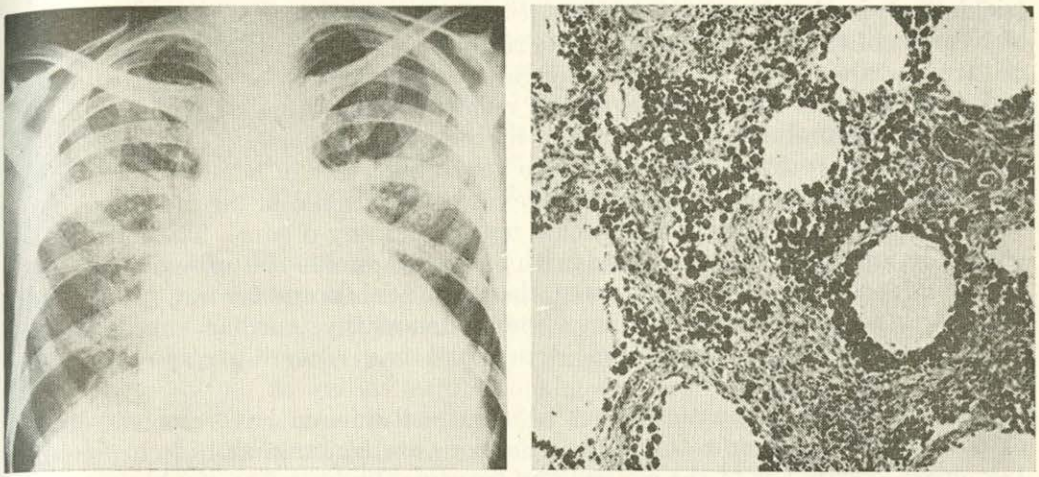

Figure 9.—Hemosiderosis of lungs in a woman of 43 with decompensated rheumatic heart disease. A. Miliary infiltrations in both lungs, especially midthirds; heart greatly enlarged. B. Microscopic section of lung showing focal deposits of dark-staining iron pigment in perivascular and interstitual tissues. (Autopsy disclosed old rheumatic valvulitis of mitral valve with stenosis and insufficiency; dilatation and hypertrophy of left auricle, right ventricle and right auricle; chronic passive congestion of lungs, liver and spleen; siderosis of lungs).

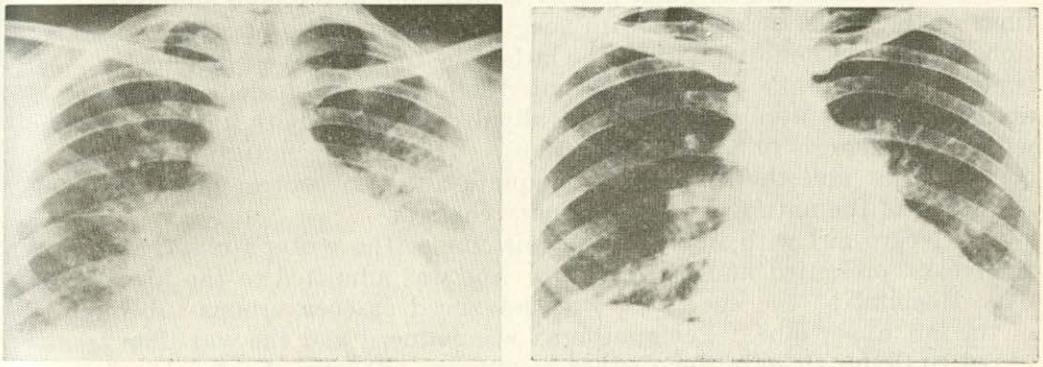

Figure 10.—Sickle-cell anemia in a Negro woman of 31, admitted to hospital late in pregnancy in acute respiratory distress and generalized edema. A. Marked congestive changes in both lungs with linear infiltrations permeating both organs, especially midthirds; irregular, triangular density in right; heart enlarged. B. After delivery of stillborn, considerable recession of infiltrations; prominent hilar markings; enlarged heart with prominence of pulmonary conus. (Coexisting rheumatic heart disease also considered).

Sickle-Cell Anemia: This disease affects Negroes almost exclusively as a primary, hereditary blood dyscrasia. It is estimated that the sickle-cell trait (sicklemia), in the absence of hemolytic anemia, occurs in from 7 to 8 percent of Negroes of the United States. The ratio of sickle-cell anemia to the sickle-cell trait is about 1 to 40. The elongated multi-pointed erythrocytes interlock and obstruct the capillaries, the resulting stagnation of blood causing congestion, thrombosis and infarction of the affected parts. The associated destruction of erythrocytes gives rise to varying degrees of hemolytic anemia. Although the major pathological changes are encountered in the bone marrow, skeletal system and spleen, the disease may affect any organ. The most pronounced symptoms are associated with so-called sickle-cell crises which are characterized by pain in the abdomen, thorax and joints and fever. Additional symptoms and signs are jaundice, lymphadenopathy, cardiac enlargement, ulcers of extremities, hemorrhagic tendencies and recurring respiratory infections.

The pulmonary manifestations of sickle-cell anemia have received little attention although respiratory tract infections are common and often precipitate crises. A review of the clinical and roentgen findings of a sizable number of patients with sickle-cell anemia treated in recent years at the Morrisania City Hospital, where a large proportion of the patients are Negroes, revealed some interesting data. Many of the patients had been admitted repeatedly during recurring crises or for treatment of intercurrent complications, including pregnancy (Fig. 10).

There were marked variations noted in the size and configuration of the cardiac silhouette in comparative chest x-rays. Equally impressive was the frequency of labile changes in the lungs. A "normal" chest x-ray was a rarity. The pulmonary markings ranged the gamut from increased bronchovascular markings and irregular patchy infiltrations in the mid- and lower portions of the lungs, in keeping with congestive changes, to massive consolidations with or without cavitation, the latter due to ulcerative tuberculosis. At times a soft, veil-like haziness was noted following transfusions. In several, nodular densities were seen symmetrically distributed in both lungs in keeping with hemosiderosis or minute infarctions. The fleeting nature of the roentgen shadows and the absence of adequate autoptic control preclude exact definition of the nature of the pulmonary changes.

A Negro girl with sickle-cell anemia, under the writer's observation for five years, presented unusual features. She was admitted to the Morrisania City Hospital at the age of 14 with advanced caseocavernous tuberculosis of the left upper lobe. Pneumothorax was induced and she was then transferred to Seton Hospital for further treatment. Shortly she developed fluid in the pleural cavity and the pneumothorax was discontinued. When streptomycin became available she received the antibiotic for two months and eventually the disease became arrested. At the age of 19 she became pregnant and in due time delivered a live infant. This youngster with sickle-cell enemia was able to weather an advanced tuberculosis and to go through pregnancy successfully, accomplishments worth citing.

Polycythemia: Anoxia causes an increase in circulating erythrocytes to augment the oxygen-carrying capacity of the blood. The resulting polycythemia is a compensatory mechanism and is encountered at high altitudes,

in association with congenital and other forms of heart disease as well as in a variety of pulmonary conditions including advanced emphysema, fibroid tuberculosis, pneumonoconiosis and pulmonary arteriosclerosis. Quite often one is dealing with combined cardiopulmonary disease. Polycythemia vera, in contrast to compensatory polycythemia, is a hematologic disorder characterized by excessive erythropoieses due to hyperplasia of the red bone marrow. In addition to symptoms of anoxia, present in both forms, polycythemia vera is featured by enlargement of the liver and spleen, hyperglobulinemia, an elevated metabolic rate, leukocytosis and other signs pointing to a primary blood dyscrasia.

Hirsch, also Hodes and Griffith, found in patients with polycythemia caused by pulmonary arteriolosclerosis that the middle and peripheral zones of the lungs are usually within normal limits. On the other hand, in patients with polycythemia vera there may be present accentuation of the bronchovascular markings as well as infiltrations and discrete sp herical lesions in the mid-zones of the lungs. In the opinion of the writers, the nodular lesions, which are of a transient nature, represent thromboses of the pulmonary veins although stasis and infarction are possibilities. In a study of the roentgen findings in 36 patients with polycytemia vera, Hodgeson, Good and Hall also noted varying degrees of pulmonary involvement, of the type mentioned, in 25. Cardiac enlargement often coexisted but there were a sufficient number without this complication to warrant the conclusion that the pulmonary changes were probably related to the polycythemia.

Of particular interest is the occurrence of polycythemia and cyanosis in association with arteriovenous fistula of the lung, a syndrome which is receiving increasing attention as more patients with this condition are discovered as a result of routine chest x-rays. Clubbing of the fingers and symptoms of anoxia are additional features. This congenital, at times familial, malformation is closely allied to hereditary hemorrhagic telangiectasis, occasionally encountered in the skin, mucous membrane and other organs. The pulmonary defect consists of a collection of thin-walled vascular sacs, a cavernous hemangioma, which is made up of a distended afferent artery and distended efferent veins. The arteriovenous communication allows the admixture of venous and arterial blood giving rise to anoxia, the severity of the latter depending on the amount of unoxygenated blood passing through the fistula. Makoler and Zion estimated that approximately 30 percent of the blood must be shunted before cyanosis becomes manifest in otherwise healthy individuals. In addition to symptoms and signs of anoxia (dyspnea, cyanosis, weakness, dizziness, faintness, headache, etc.) other manifestations are hemoptysis, cardiac bruit and, as might be expected, a decrease in the arterial saturation of the blood.

The roentgen findings are quite characteristic providing the possibility of the existence of a pulmonary fistula is kept in mind in patients with polycythemia and cyanosis revealing atypical roentgenograms. A small fistula may be present without symptoms. The chest x-ray shows an irregular lobulated density in one of the lower lobes, rarely in an upper lobe, with coarse linear bands connecting the density to hilar structures. Angiocardiography brings the fistula into relief. Pulsations are occasionally demonstrable on fluoroscopic screening. In 1949, Yater, Finnegan and Giffin reported two

cases and tabulated the pertinent findings of 43 additional ones culled from the literature. Of the 45 cases, 26 were treated by operation; only two died postoperatively.

Hemorrhagic Diseases: Blood dyscrasias associated with an abnormal tendency to bleeding rarely affect the lungs. This is somewhat surprising in view of the vulnerability to hemorrhage of other parts of the body. However, hemorrhage in this disease does occur from the oropharynx and larynx and is apt to cause respiratory distress due to aspirated blood. A number of instances of severe dyspnea have been reported in hemophiliacs from hemorrhage in and about the larynx and adjoining structures.

Freedman, Levine and Sollis-Cohen reported one instance of hemophilia and another of thrombocytopenic purpura associated with nontraumatic hemothorax. The patient with thrombocytopenic purpura died and the postmortem examination revealed hemorrhage from the intestinal mucosa, perforation of the left diaphragm, a sanguino-purulent empyema in the left chest and necrosis of the left lower lobe of the lung. Pendergrass and Neuhauser also described a case of pleural hemorrhage in a patient with hemophilia. In a study of causes of hemorrhagic pleural effusion, Berliner did not find a single instance of blood dyscrasia in 120 cases analyzed. Scurvy, purpura and hemophilia (cited by Lauche), as well as icterus and severe anemia (cited by Kaufmann), have been reported as possible causes of hemorrhagic pleural effusions.

Leukemia: The leukemias are commonly included among the lymphomas of which Hodgkin's disease and lymphosarcoma are the most prominent members. Three major forms of leukemia are recognized: chronic lymphatic, chronic myelogenous and acute leukemia. Chronic lymphatic leukemia is the one most likely to involve intrathoracic structures. Kirklin and Hefke, also Falconer and Leonard, reported an incidence of intrathoracic involvement in 21 to 30 percent of patients with leukemia. As is true of intrathoracic lymphomas in general, physical examination of the chest gives little information. Bronchial obstructive phenomena, such as wheezing respiration and sputum retention are rare. There is seldom significant displacement of intrathoracic structures. If the mediastinal tumefaction is large, there may be evidence of pressure on the superior vena cava. The absence of signs indicative of invasion of the sympathetic, recurrent laryngeal or phrenic nerves is noteworthy. The presence of a Horner's syndrome or a paralyzed diaphragm in a patient with mediastinal mass speaks more for carcinoma rather than lymphoma.

The roentgen manifestations of the leukemias do not differ significantly from those encountered in Hodgkin's disease or lymphosarcoma. The most frequent findings are enlarged hilar lymph nodes with variable degrees of extension of the process to adjacent portions of the lungs (Fig. 11). The hilar lymph nodes may be involved alone but rarely does one see isolated infiltrations of the lungs. In contradistinction to the rarity of pleural involvement in myelogenous leukemia, this complication is quite frequent in chronic lymphatic leukemia.

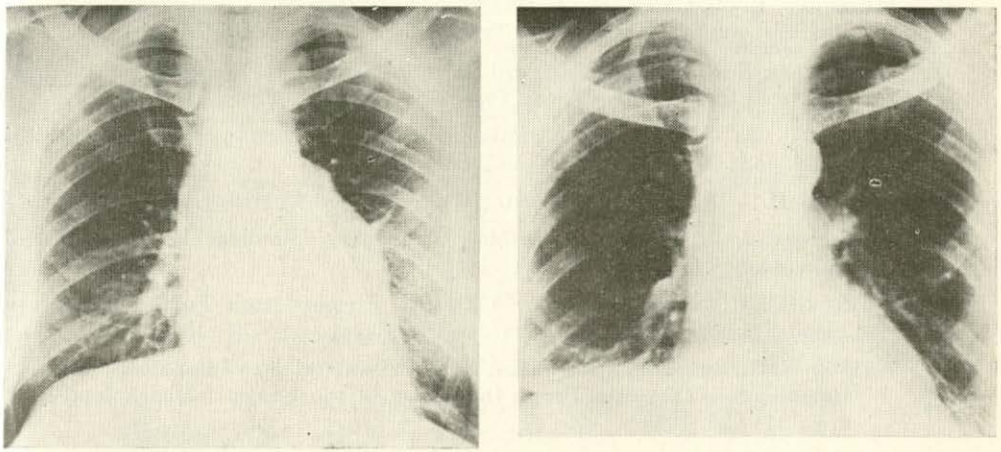

Figure 11.—Acute lymphatic leukemia in a man of 61. A. Lobulated density at left hilus; irregular infiltrations in left lower lung field. B. Following radiotherapy, recession of hilar density; linear horizontal infiltrations in both lower lung fields. (Autopsy revealed acute lymphatic leukemia involving spleen, liver and bone marrow; no evidence of leukemic infiltrations in lungs).

ANAEMIA

1. Burger, R. A.: Leuko-Erythroblastic Anemia Due to Bronchogenic Carcinoma. Dis. Chest, **18**: 57, 1950.

2. Humphreys, G. H., and Southworth, H.: Aplastic Anemia Terminated by Removal of a Mediastinal Tumor. Amer. Jour. Med. Sc., **210**: 501, 1945.

3. Leibowitz, S.: Tuberculous Sepsis with a Myeloblastic Blood Picture. Arch. Path., **25**: 365, 1938.

4. Ritchey, J. O., and Winsauer, H. J.: Anemia and Its Relation to Diaphragmatic Hernia. Amer. Jour. Med. Sc., **214**: 476, 1947.

PULMONARY HEMOSIDEROSIS

1. Gumpert, T. E.: Miliary Appearances in the Lungs in Mitral Stenosis: Endogenous Pulmonary Hemosiderosis. Brit. Med. Jour., **2**: 488, 1947.

2. Lendrum, A. C., Scott, L. D. W., and Park, S. D. S.: Pulmonary Changes Due to Cardiac Disease with Special Reference to Hemosiderosis. Quart. Jour. Med., n. s., **19**: 249, 1950.

3. McLetchie, N. G. B., and Colpitts, G.: Essential Brown Induration of the Lungs. Can. Med. Assoc. Jour., **61**: 129, 1949.

4. Muirhead, E. E., Crass, G., Jones, F., and Hill, J. M.: Iron Overload (Hemosiderosis) Aggravated by Blood Transfusions. Arch. Int. Med., **83**: 477, 1949.

5. Penderrass, E. P., Lame, E. L., and Ostrum, H. W.: Hemosiderosis of the Lung Due to Mitral Disease. Amer. Jour. Roent. & Rad. Ther., **61**: 443, 1949.

6. Pilcher, J. D., and Eitzen, O.: Pulmonary Hemosiderosis in a Six Year Old Boy. Amer. Jour. Dis. Child., **67**: 387, 1944.

7. Rubin, E. H.: Diseases of the Chest. W. B. Saunders Company, 1947, p. 61.

8. Waldenstrom, J.: Relapsing Diffuse, Pulmonary Bleedings or Hemosiderosis Pulmonum. Acta Radiol., **25**: 149, 1944.

9. Womack, C. R., and Brownlee, R. G. Jr.: Hemosiderosis Following Repeated Blood Transfusions. Amer. Prac. & Dig. Treat., **1**: 731, 1950.

10. Wyllie, W. G., Sheldon, W., Bodian, M., and Barlow, A.: Idiopathic Pulmonary Hemosiderosis (Essential Brown Induration of the Lungs). Quart. Jour. Med., n. s., **17**: 25, 1948.

SICKLE-CELL ANEMIA

1. Carrol, D. S., and Evans, J. W.: Roentgen Findings in Sickle-Cell Anemia. Radiology, **53**: 834, 1949.

2. Diggs, L. W., and Ching, R. E.: Pathology of Sickle Cell Anemia. South Med Jour., **27**: 839, 1934.

3. Henderson, A. B.: Sickle Cell Anemia. Am. Jour. Med., **9**: 757, 1950.

4. Herrick, J. B.: Peculiar Elongated and Sickle-Shaped Red Blood Corpuscles in a Case of Severe Anemia. Arch. Int. Med., **6**: 517, 1910.

5. Scott, R. B., Banks, L. O., Jenkins, M. E., and Crawford, R. P.: Studies in Sickle-Cell Anemia. II. Clinical Manifestations of Sickle-Cell Anemia in Children. Jour. Ped., **39**: 460, 1951.

6. Weiss, W., and Stecher, W.: Tuberculosis and the Sickle-Cell Trait. Arch. Int Med., **89**: 914, 1952.

POLYCYTHEMIA

1. Hirsch, I. S.: Pulmonary Changes in Polycythemia Vera. Radiology, **26**: 469, 1936.

2. Hodes, P. J., and Griffith, J. Q.: Chest Roentgenograms in Polycythemia Vera and Polycythemia Secondary to Pulmonary Arteriolosclerosis. Am. Jour. Roent., **46**: 52, 1941.

3. Hodgson, J. R., Good, C. A., and Hall, B. E.: The Roentgenographic Aspects of Polycythemia Vera. Proc. Staff Meet. Mayo Cl., **21**: 152, 1946.

4. Maklor, P. T., and Zion, D.: Multiple Pulmonary Hemangiomata. Am. Jour. Med. Sc., **211**: 261, 1946.

5. Moyer, J. H., and Ackerman, A. J.: Hereditary Hamorrhagic Telangiectases Associated with Pulmonary Arteriovenous Fistula in Two Members of a Family. Ann. Int. Med., **29**: 775, 1948.

6. Yater, W. M., Finnegan, J., and Giffin, H. M.: Pulmonary Arteriovenous Fistula (Varix). J. A. M. A., **141**: 581, 1949.

HEMMORHAGIC DISEASES

1. Berliner, K.: Hemorrhagic Pleural Effusion: An Analysis of 120 Cases. Ann. Int. Med., **14**: 2266, 1941.

2. Fox, J. R., Spencer, J. T., Jr., and Tosantins, L. M.: Dyspnea in Hemophilia from Hemorrhage into Larynx. J. A. M. A., **130**: 78, 1946.

3. Freedman, P., Levine, S., and Solis-Cohen, L.: Hemothorax in Blood Dyscrasias. Amer. Jour. Med. Sc., **205**: 692, 1943.

4. Pendergrass, E. P., and Neuhauser, E. B. D.: Pleural Lesions in Hemophilia. Amer. Jour. Roent., **48**: 147, 1942.

Leukemia

1. Falconer, E. H., and Leonard, M. E.: Pulmonary Involvement in Lymphosarcoma and Lymphatic Leukemia. Amer. Jour. Med. Sc., **195**: 294, 1938.

2. Kirklin, B. R., and Hefke, H. W.: Roentgenologic Study of Intrathoracic Lymphoblastoma. Amer. Jour. Roent., **26**: 681, 1931.

3. Vieta, J. O., and Graver, L. F.: Intrathoracic Manifestations of the Lymphomatoid Diseases. Radiology, **37**: 138, 1941.

Thirty Years Ago

"The Present Status of Medicine in Nova Scotia*

Dr. A. G. Nicholls, Halifax, N. S.

IN the last days of September of this year there was staged in the City of Halifax an event of more than passing importance in the medical annals of this Province. For the first time in its history, the Faculty of Medicine of Dalhousie University inaugurated a course of post-graduate instruction. The idea was the outcome of a meeting of the Maritime Branch of the American College of Surgeons, held at Halifax earlier in the year, and, while it commended itself to the imagination of those interested in teaching, it was with not a little trepidation that the idea was translated into action. The Medical School was hardly out of its swaddling-clothes, and, moreover, isolated from the other and greater centres of scientific activity. In spite of the latter fact, and perhaps because of it, the experiment proved a complete success, to the gratification of all. The Course was short, lasting but one week, and was free. About thirty physicians from various points in the Maritime Provinces, and one from the United States, were in attendance. Medical and Surgical Clinics were held daily at the Victoria General, the Halifax Children's, and Grace Maternity Hospitals, which were conducted by the medical men connected with the several institutions, notably Drs. Cunningham, Alan Curry, Doull, Eagar, Hogan, Johnston, Lessel, H. K. MacDonald, P. A. Macdonald, McDougall, K. A. MacKenzie, Mack, Muir, Murphy, Silver, and Weatherbe. Lecture-demonstrations were given by Professors A. G. Nicholls on Morbid Anatomy, and John Cameron on Applied Anatomy. Special lectures were also given by Drs. Murdoch Chisholm, John Stewart, Dean of the Faculty, and W. H. Hattie, Provincial Officer of Health. A visit was paid to the Halifax-Massachusetts Health Centre No. 1, where admirable clinics were conducted by Drs. Sieniewicz on Tuberculosis; Arabella MacKenzie on Pre-School Dental Work; Donovan on Venereal and Skin Diseases; Turel on Pre-School Medical Conditions; and Wiswell on selected medical conditions of children.

The proceedings gained an additional interest from the fact that this is the Jubilee Year of the first graduating class in Medicine of Dalhousie University. It was deemed fitting to commemorate this by a banquet at the Halifax Hotel, when eighty-five covers were laid. Of this first graduating class the sole survivor is Dr. Finlay McMillan of Sheet Harbour, N. S., who attended the post-graduate course, and was the guest of honor at the banquet. Suitable addresses were delivered by, among others: Dr. McMillan, President A. S. MacKenzie, of the University, G. S. Campbell, Ll.D., Chairman of the Board of Governors, Dr. John Stewart, Dean of the Faculty of Medicine, and Dr. Kenneth MacKenzie, who presided. During the course of the proceedings, Dr. McMillan was presented with a gold-headed cane, on behalf of the Profession of the Province.

So much appreciation of the post-graduate course was expressed by the visitors, that it is practically certain that a similar venture will be made next year. Such events are of the greatest possible value to all concerned; to the

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form; to the teachers, in that they are impelled to strive after a high plane of excellence; to the University, because its attainments and its necessities make their appeal to those best able to appreciate them.

The encouraging result of the venture tempts one to review the present status of Medical Education in our Province; to "take stock," as it were, of our assets and liabilities. The writer was once asked in all seriousness, "Do you think that there is a place now-a-days for the small Medical College?" This question cannot be answered by a categorical "yes" or "No." Two considerations must be settled first. Does the small college meet a want in its local community? And, to use a colloquialism, can it "deliver the goods?" Applying these touchstones to Dalhousie Medical School, we can at once say that it meets the first condition. The call for its ministrations is clear, and becomes more insistent every year. There were never more medical and dental students in its halls than there are to-day. And this is not a accidental phenomenon. It is the result of a steady growth, a notable increase in the length of the curriculum and the amount of the fees notwithstanding. Halifax is the natural intellectual centre for Nova Scotia, Prince Edward Island, and Newfoundland. It is as convenient as Montreal for the greater part of New Brunswick. In addition to having the advantage of position, it is a seat of government, a focus of religious activity, an activating force in Public Health effort. Its very isolation seems destined to force it to the front as a Mecca for the youth of eastern Canada.

Again, the small Medical College can justify its existence if it can command sufficient clinical material and efficient laboratories. No College, big or small, can be said to do the fair thing by its students if it stints them in these two particulars. It is well known that the larger Medical Colleges have had for the past few years more students than they can possibly handle well. As a result they are restricting their matriculants by selecting the most promising. That this will redound ultimately to the benefit of the community and the Medical Profession itself can hardly be doubted. A small college may do as efficient work as a large one if it can supply enough clinical cases. It is mainly a question of the proportion between hospital beds and the number of students that are to be catered to. An honest course can be given also with a modest laboratory equipment, provided that the teachers are competent and enthusiastic. Halifax is ideally situated in the matter of clinical facilities. A happy and enlightened policy has resulted in a number of general and special hospitals being grouped together in close proximity to the Dalhousie Medical Faculty building. The Victoria General Hospital, the Halifax Children's Hospital, Grace Maternity Hospital, the Halifax Tuberculosis Hospital, the City Home (with many chronic cases of disease) are all now in active operation. An Out-Patient Department, with a Dispensary and Health Centre, is in process of erection. It is very probable an Infectious Hospital will be established in the same district, and a Psychiatric Pavilion is in contemplation. In addition, a Hospital for Insane exists at Dartmouth, not far away. In the matter of laboratories, a large modern building is now nearing completion, which will house physiology, biochemistry, pharmacology, and hygiene. The erection of this structure was made possible, as well as that of the new Health Centre, through the munificent gift of the Rockefeller and Carnegie Corporations, amounting to a million of dollars. A large, and much needed, addition to the graduates, in that they obtain useful instruction quickly and in "tabloid"

existing Pathological Building has been decided upon. Thus, there is a "lay-out" of important clinical and other auxiliary institutions such as is not readily paralleled even in larger and more important medical centres.

So soon as these laboratories are finished it becomes possible to make much needed additions to the professorial staff. A Biochemist, a Hygienist, a Pharmacologist, and a Histologist are still to be appointed, and then Dalhousie will enter the ranks of the first class Medical Colleges. With the completion of the new Health Centre and Out-Patient Dispensary, which belongs to and will be controlled by the University, a far-reaching scheme of Public Health and the prevention and limitation of disease will become part of the activities of the Medical School, and students will be brought directly into contact with problems of Preventive Medicine and Social Service in a way that hitherto has not been made possible.

This innovation seems to have been the logical development from the splendid Public Health programme of the Massachusetts-Halifax Health Commission, the Provincial Red Cross, and the active and statesmanlike co-operation of the Provincial Health Officer. Nova Scotia is the only country in the world where so comprehensive and so well thought out a scheme for the betterment of the health of the community is being worked out. Enquiries have been received from far-away Australia by Dr. B. F. Royer, the executive head of the Massachusetts-Halifax Health Commission, which shows that we are being watched with interested eyes. It may be that Nova Scotia is setting the pace for the world in this particular.

The policy of the University has been progressive and far-sighted. The medical course is now six years, and will shortly be seven. This does not mean that more medical subjects will be necessarily be taught, but the additional time is largely occupied with the study of languages, basal sciences, and other cultural subjects. Students entering upon their professional course will be more matured and have a better intellectual foundation on which to build. It is important that bed-side instruction be not restricted in this new curriculum, but it should be possible to make the final year of study a "hospital year", every one of the graduating class receiving an internship. Then we will have a well balanced course, and the quality of the product will, in my judgment at least, be greatly improved. Given the above conditions, the small college, with the close personal relationship which exists between teacher and taught, should give a good account of itself.

And what of the existing qualified medical men of the province? A University is no mean asset to any city. It constitutes a centre, a mainspring of intellectual action, a standard of comparison. The medical men that flock to a city with a medical school are usually capable, ambitious, and progressive, but they suffer from excessive competition. The Country Practitioner, perhaps not less able, while spared so great a struggle for existence, is under the handicap of isolation. He is apt, after a time, to fall short of his high ideals. The refuge for him is in his medical journal, his local medical society, and an occasional post-graduate course. The late Sir William Osler used to insist on the necessity for a "quinquennial brain-dusting." An annual brain-duster is even better. It can be obtained quickly and at low cost in Halifax.

The plan whereby the various Medical Societies of our Province become branches of the Nova Scotia Medical Society, and thereby of the Canadian

Medical Society, is an admirable one. Members have the very great privilege of receiving the Canadian Medical Association Journal, whereby they become **au courant** with things medical in the Dominion, keep in touch with things outside their little circle, and find an invaluable exponent for their scientific observations. The work of Jenner, Koch, and James MacKenzie, to mention but three that first come to mind, show us what may be accomplished by a wide-awake general practitioner, toiling away from a great medical centre.

The Medical Profession is a great Republic. It exists for the advancement of medical science and the amelioration of human suffering. We all need one another. Particularly, as we find ourselves here, a large isolated family in this Ultima Thule of Canada, as Haliburton calls it, should we aim at the exaltation of our profession and the improvement of ourselves. Let us, no matter what our College, assist our Local University. It needs our encouragement, it needs our sons and daughters. It needs money. It needs books. Whatever it receives it will repay a hundredfold, in service to the profession and the community at large, in discovery, in intellectual stimulus, in scholastic attainment. Let us improve ourselves by joining our nearest Medical Society and attending its meetings; by reading our journals, and by recording our observations. If we do not achieve the highest ends, we at least will have the satisfaction of maintaining an honorable place in the procession.

Thoughts On the Implications Of National Health Insurance

By a B. C. Doctor

WITH the prospect of a Federal election in the offing, the demands for the immediate adoption of a comprehensive national health insurance plan, to be financed out of general revenue, have taken on a crescendo-like character. The clamor in this respect arises almost entirely from the ranks of the Socialists and the leaders of orgaized labor, who imply (1) that the majority of people are denied adequate medical care and (2) that, if the Government of Canada assumed the direction and costs of all matters pertaining to health, the problem would be solved.

One cannot help but feel that the first assumption is pure political rhetoric based on a false premise. A glance at the care given Social Assistance cases in this Province should satisfy anyone on this point.

The second conclusion seems to contain the naive belief that the standard of health varies in direct proportion to the amount of money spent on it. How the money is spent, or who spends it, seems to be irrelevant for the most part, except that it is tacitly understood to be more effective if some one, other than the recipient of the service, pays the bills.

The flaws in these socialist claims are too obvious to require consideration in these pages. Rather, we should be concerned with the basic aims and implications of such a philosophy, for it is of less importance what it will do to the health of the people than what it may do to the soul of the nation. It might be worthwhile, therefore, to examine briefly these Utopian theories to see what they are and where they are leading us.

Socialism offers us security against illness, against unemployment, against old age, etc. It offers us less and less work and more pay. It protects us from worries and anxieties and the necessity to 'Struggle for Existence'. It stifles those with ability but it nourishes and protects the incompetent and the shirker. It takes from us our charities and responsibilities, for it is a philosophy of selfishness and materialism. It reduces us to cogs in a bureaucratic machine, bereft of initiative or thought, and ultimately and inevitably it takes away our freedom. It is a system that appeals to the sluggard and the coward but is anathema to the ambitious, the adventurous and the creative individual. One can scarcely imagine this type of state appealing to men like Jacques Cartier, Champlain, Alexander MacKenzie, Breboeuf, Lalamont and a host of other great men, who chose the dangers and opportunitkes of a new country to the soul crushing security of an old.

It is almost unbelievable that a young country like Canada should be turning so soon to premature retirement, when her development has scarcely begun. It may be that we are too wealthy. Herodotus has said that 'Soft countries invariably breed soft men'. The Israelites of the Exodus would

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Editor's Note: This appeared with the author's name withheld in the Bulletin of the Vancouver Medical Association of May 1953. It is reprinted here at the request of a Nova Scotia doctor, name also withheld.

have returned to the 'Flesh pots of Egypt' and slavery had it not been for Moses. If they had done so the Old Testament would never have been written.

When we see our people turning to government to help them rear their children, to look after their aged parents and to insure them against every circumstance, it fills one with deep concern. This tendency to lean on a paternal government is surely a sign of a disintegrating society.

It seems paradoxical to observe that, when half the world is in chains or facing dire poverty and our soldiers are fighting on foreign soil, our chief concern should be how to avoid further involvement and how to secure more comfort and ease for ourselves.

This, then, is the emasculating trend of socialism. This, in essence, is its religion of materialism and control. It is attractive and appealing on superficial examination but this is a snare and a delusion, for ultimately it destroys the finest things we have. If we fail to meet the challenge and succumb to it, then Western Civilization will decline.

We doctors are the first line of defense. It is our duty to protect the health of the people from the ministrations of office seekers and their monotonous diatribes. As citizens our responsibilities are far greater. We must realize that government controlled health insurance is the thin edge of the wedge. If this is allowed to penetrate, the door will be wide open for a full-blown bureaucracy. If, on the other hand, we successfully ward off 'State Medicine' we will have rendered a great service toward the preservation of democracy and our cultural heritage.

Centennial Celebration Notes

1. THE SCIENTIFIC PROGRAM

THE Faculty of Medicine and the Post-Graduate Committee of Dalhousie University welcome the opportunity to combine the 27th Annual Refresher Course with the Centennial Celebrations of the Medical Society of Nova Scotia. These combined meetings will be held during the week of October 5th - 9th, 1953, inclusive. The Refresher Course Committee has responsibility for the scientific program and in keeping with the occasion we are having an exceptionally fine list of speakers which should appeal to all practitioners of the Atlantic Provinces. In another notice you will be told of the social program arranged for the week. This happy combination is augmented by the Reunion of the Dalhousie medical graduates and should result in a program that has never been excelled in Eastern Canada.

We have been most fortunate in obtaining a number of distinguished guest speakers whose contributions we welcome in addition to those of our own Faculty members.

The Annual John Stewart Memorial Lecture is to be delivered by Dr. Wilder Penfield, Professor of Neurology and Neurosurgery at McGill University and Director of the Montreal Neurological Institute. This distinguished Canadian scholar, surgeon and educator has recently been the recipient of another addition to his many honours in the bestowal of the Order of Merit by Her Majesty Queen Elizabeth. It seems most appropriate that Dr. Penfield should deliver the John Stewart Memorial Lecture on this occasion.

In general surgery we have a guest surgeon who will be with us for the whole week. Professor C. F. W. Illingworth, the Regius Professor of Surgery at Glasgow University has accepted our invitation. As the author of a number of books including Surgical Pathology, General Surgery and Operative Surgery, Professor Illingworth is one of the best known British surgeons and an outstanding teacher in the field of general surgery.

Dr. Chester S. Keefer, Professor of Medicine at Boston University School of Medicine is to be our guest physician during the latter part of the week. Dr. Keefer is acknowledged as one of the leading physicians in American medicine. His interests cover a wide range in the field of general medicine although many doctors may associate him more intimately with the field of antibiotics, as he was Chairman of a Committee on Chemotherapeutic and Other Agents for the National Research Council. We are anticipating a real treat with some bedside clinics from Dr. Keefer, a master clinician.

In the middle of the week we are to have a return visit from a popular guest physician in the person of Dr. Willard O. Thompson, Professor of Medicine, University of Illinois. He is a former Nova Scotian and an Arts graduate of Dalhousie University. Many will recall his visit a few years ago and will look forward with pleasure to his contributions which will feature endocrinological aspects of internal medicine.

The specialties are to be represented by two guest speakers in the first half of the week. Dr. William Malamud, Professor of Psychiatry at Boston, a leader in his field, has a particular appeal for our Refresher Course as, among other subjects, he is to speak on Psychotherapy in general practice.

Many doctors will be happy in the selection of our guest in Otolaryngology, Dr. Tremble of Montreal. He is known to many not only as a member of the staff of the Royal Victoria Hospital and McGill University but as an artist.

The complete program will be released shortly but in the meantime the Refresher Course Committee assures all the practitioners of the Atlantic Provinces that between the contributions of our own Faculty and the guest speakers we shall present an outstanding week that should not be missed.

When one thinks of the magnitude of the other attractions being prepared suitable to the occasion of the Centennial Celebrations of the Medical Society of Nova Scotia it is fully realized that this will be a week long to be remembered and we look forward to having the largest attendance of practitioners from the Atlantic Provinces in the history of the Refresher Course of Dalhousie University.

2. THE SOCIAL SIDE

The arrangements for the social events in connection with the Centenary of the Nova Scotia Medical Society are now nearing completion. Many and varied types of entertainment have been planned to supplement the extremely fine clinical program of the week. Dr. Clarence Gosse is in charge of the entertainment.

On Tuesday, October 6th, is the Centennial Ball at the Nova Scotian Hotel. This being capably organized by Dr. Gordon Mack. On Wednesday there will be a Luncheon for the Executive of the Nova Scotia Medical Society and in the evening there will be a Reception at 6.30 followed by a Buffet Dinner, after which the John Stewart Memorial Lecture will be delivered by Dr. Penfield of Montreal. This will take place at the Nova Scotian Hotel. Drs. Sieniewicz and Gordon Bethune will be looking after the arrangements for these events. On Thursday the Annual Golf Tournament is to be held at Ashburn, being looked after by Dr. Art Titus. Following this will be a reception at Ashburn at 6.00 o'clock, the arrangements being organized by Dr. Jack Charman. Thursday is the Dalhousie Reunion night at the Lord Nelson Hotel, being put on by the Faculty of Medicine and organized by Dr. Fraser Nicholson. Friday will see the President's Reception at 6.30 and the Annual Dinner at 7.30 at the Nova Scotian Hotel. These events are being cared for by Drs. Walter House and Gordon Bethune and promise to be such as befit the one hundredth anniversary of our Society. There will be skits and entertainment commemorating this important milestone of our organization. In addition to all these there will be luncheons arranged almost daily through the courtesy of the Victoria General Hospital and Camp Hill Hospital.

In addition, there is a crowded program for the ladies under the capable direction of the charming wife of our president, and this promises to be of a very high calibre. Further details will be in the September Bulletin.

I am sure that the arrangements for entertaining members of the society and their guests will be of the same fine quality as the excellent clinical program and will be in keeping with a Centennial Celebration. The committee hopes that there will be no additional charges to members of the Nova Scotia Medical Society either for these events or for the clinical program, over and above the levy already subscribed. The program committee is very anxious that all enjoy themselves to the fullest extent during this Centennial Celebration, which we believe is the first Centennial of any Medical Society in North America. We hope that we will be able to make your visit an enjoyable one and we aim to exhibit that hospitality which is typically Nova Scotian.

APPLICATION FOR ACCOMMODATION

CENTENNIAL MEETING, THE MEDICAL SOCIETY OF NOVA SCOTIA

HALIFAX—OCT. 5th TO 9th, 1953

Dr. R. O. Jones,
Chairman, Housing Committee
Dalhousie Public Health Clinic
Halifax, Nova Scotia.

Please reserve the following:
(Indicate a first, second, and third choice).

Room(s) for.....person(s) in.....

1. Hotel with private bath.
2. Hotel without private bath but running water in rooms.
3. Tourist Home—First Class accommodation
4. Tourist Cabins, heated, private bath. Out skirts of city. Bus transportation.
5. Private Home. Selected after inspection.

Will you notify committee if you cancel a reservation or secure accommodation with friends? .....

Any special request.....

.....

.....

Arriving Halifax..... at .....a.m
(Date) (Hour) p.m.

Leaving .....a.m.
(Date) (Hour) p.m.

Means of Transportation: Rail.....Car.....Plane.....
(Note: You will receive confirmation direct from the committee accepting the reservation when made).

Are you willing to share a double room with another member of the Association?.....

Room(s) will be occupied by:

Name	Address	City	Province
.....			
.....			
.....			
.....			
.....			

(If children, please state age)

This application is submitted by me as:

(*a*) Member of The Medical Society of Nova Scotia.
(*b*) Member of Executive of The Medical Society of Nova Scotia.
(*c*) Member of Canadian Medical Association Executive.
(*d*) Member of other Provincial Medical Society.
(*e*) Participant in Program, Speaker, etc.
(*f*) Exhibitor.

If you are an Exhibitor, please give name of Firm and Individuals to occupy room or rooms reserved.

Please send confirmation to:

Dr.....
(Please print)

.....

.....

Minutes of A Special Executive Meeting The Medical Society of Nova Scotia

A special meeting of the Executive of The Medical Society of Nova Scotia was held at the Dalhousie Public Health Clinic, Halifax, N. S., Thursday, March 26, 1953, at 2.35 p.m.

Doctor J. W. Reid presided and those attending were Doctors M. G. Tompkins, H. F. McKay, R. O. Jones, H. G. Grant, L. C. Steeves, J. S. Munro, R. E. Price, J. A. MacCormick and P. R. Little. There were also present by invitation Doctors C. L. Gosse, Chairman of the Centennial Entertainment Committee, W. G. Colwell, Chairman of the Centennial Finance Committee, A. W. Titus, Chairman of the Fee Committee, R. M. MacDonald, Chairman of the Dalhousie Refresher Course Committee and Mr. D. C. Macneill, General Manager of Maritime Care Incorporated.

President J. W. Reid called the meeting to order. The Secretary read excerpts from the semi-annual meeting of December 9th.

Doctor H. F. McKay stated that the meeting of Central Economics Committee of the Canadian Medical Association had been postponed until the latter part ofApril.

Doctor Reid advised that the special committee appointed to review the Report on Health Conditions in Nova Scotia recently issued by Doctor C. B. Stewart consisted of Doctor A. G. MacLeod, Chairman, and Doctors H. F. McKay, P. R. Little, D. F. Macdonald, S. Marcus, C. L. Gosse and M. G. Tompkins. This committee will report back in October.

Doctor L. C. Steeves stated that the Public Relations Committee has had a brief meeting at one o'clock that day. Their committee had been given $300.00 to work on and they had engaged Mr. Cyril Robertson, local representative of the Montreal Standard, and he is preparing four articles dealing with the doctor and the public. The Committee had started to work on the revision of the Code of Medical Ethics but were unable to report at this time as copies of the Code of Medical Ethics for the Canadian Medical Association had only become available about two weeks ago. Their intention is to hold further meetings and to draw up a Code for The Medical Society of Nova Scotia. A point of major importance appears to be the relationship of the individual practitioner to press and radio. Doctor Steeves moved that each Branch Society establish a panel of practitioners who could be asked to speak as representative of the Branch Society in any contact with newspaper or radio. This was seconded and passed. Doctor Barton receives bi-monthly reports from the Canadian Medical Association. Doctor Steeves advised that the publicity drafts were first seen by Doctor H. L. Scammell, then by the committee requested to read them, namely the President, the Secretary and Doctor Steeves himself. They thought that the rank and file of the Society should be made aware of this activity before it goes into print, and that it should be printed in the Nova Scotia Medical Bulletin.

Doctor H. F. McKay read a letter re insurance forms and stated he had sent a copy to Doctor R. W. Richardson, who replied that they had set up a committee and they had made good progress with life insurance companies, but the casualty companies are much more difficult to handle.

Doctor J. W. Reid: "If any members of the Centennial Committee are anxious to get away I would like to give them the opportunity to make reports before we get tangled up in detail, if the meeting will excuse alteration of the order of business."

Doctor R. M. MacDonald reported that Doctor Penfield was coming to give the John Stewart Memorial Lecture, also Doctor William Malamud, Professor of Psychiatry of Boston. Doctor Willard Thompson from the University of Minnesota will be in Nova Scotia at that time and will probably be on the programme, Doctor Edward Tremble of Montreal, Professor of Otolaryngology, Doctor Chester Keefer, Professor of Medicine of the Boston University, and with the meeting of the Canadian Medical Association they expected to have on the programme Doctor Scriver who will probably be here, Doctor Burns, the President of the Canadian Medical Association will also be on the programme, and they would like one, possibly two, representatives from the Old Country representing the British Medical Association. They should have more definite information in the next few weeks.

Doctor R. O. Jones: "How is the programme arranged?"

Doctor R. M. MacDonald: "The tentative programme arranged is for a meeting of the Executive on Wednesday and the two general meetings on Thursday and Friday. Approximately half of the time will be taken up with the business meetings of The Medical Society of Nova Scotia, and half of the time with scientific programme."

Doctor R. O. Jones: "The Canadian Medical Association Executive is coming Thursday night."

Doctor J. W. Reid: "We are trying to arrange the programme to avoid exodus the end of the week."

Doctor C. L. Gosse stated that there was always a conflict between the scientific and entertainment. They were not planning for any entertainment on Monday night; Tuesday night is to be theatre night; Wednesday night there will be a buffet dinner, the John Stewart Memorial Lecture, and at ten p.m. a ball. Luncheons Tuesday, Wednesday and Thursday at the Victoria General Hospital, Thursday afternoon golf tournament at Ashburn and a reception at Ashburn; Thursday is being left open for the Dalhousie Medical Reunion which he believed was to include a Buffet Supper. Friday a luncheon at the Nova Scotian Hotel with a special speaker. In the evening the President's reception at 6.30, and the annual dinner with a special speaker and a special programme to celebrate our 100th birthday. He asked who was to look after the Dalhousie Medical Reunion, whether it was the responsibility of the University or not.

Doctor J. W. Reid replied that the responsibility was entirely with the University.

Doctor H. G. Grant stated that they had booked the room and sent out the letters. They would appoint a chairman of that committee and have him confer with Doctor Gosse. He thought that Doctor J. C. Wickwire's entertainment went over better than anything put on to date, and that something of that nature would certainly be appreciated.

Doctor W. G. Colwell wanted to know how much money was on hand. The answer was $2,912.00 so far collected from the levies, $1,000.00 to come

from the Canadian Medical Association, $1,000.00 from the John Stewart Memorial Lecture Fund and the Dalhousie Refresher Course combined, and about $1,500.00 from the exhibitors.

Doctor R. O. Jones stated that in a month or so they would have a form in the Nova Scotia Medical Bulletin and they would like members of the Branch Societies to get their reservations in.

Doctor J. W. Reid: "Somebody spoke of a fee for the visitors coming in; no action taken on that by the Executive."

Doctor C. L. Gosse mentioned $25.00 as a fee to those attending the Dalhousie Reunion.

Dr. H. G. Grant advised that Mr. Graham Allen had been appointed publicity advisor for the Dalhousie Medical Alumni, and that notices were being sent to all medical societies on the continent. He spoke about the increased fee of $10.00 of the Canadian Medical Association this year and stated that there had been a drop in membership because of this increased fee.

Doctor M. G. Tompkins reverted to discussion of fees to be charged outside visitors, to the Centennial, and felt that they should pay no more than our own members, that it did not seem fair to charge them $25.00, and our own members $10.00.

Doctor J. W. Reid felt that we could leave this until the Centennial and decide at that time if any change will be necessary. There may be funds enough so that no extra charge will be necessary.

Doctor H. G. Grant read a letter from Doctor J. E. Hiltz complaining of the increased membership fee, and stated that juniors and those on salary would find it difficult to pay the total fee. He asked if at this time the Executive would care to make special provision for members of hospital staffs and salaried members.

Doctor R. O. Jones stated that very few on salary were getting less than $4,800.00 a year, that is those on permanent staff.

Doctor J. W. Reid: "There seems to be a decrease in membership; may be we have not been selling the Association to the young fry as well as we might. We could have a committee to study it and see if there is anything we can do; should there not be a standing membership committee? We got a little lax during the war. I think perhaps we now have to go out and sell our Society."

Doctor H. G. Grant: "I would like to move that on account of the fee increase and the decrease in membership this year that the Chair appoint a committee to look into the situation and report at the October meeting of the Executive." This was seconded by Doctor J. S. Munro and passed.

Doctor H. F. McKay: "Re contract personnel. If the fact that the Canadian Medical Association dues have been raised $10.00, and the levy is $10.00, which can be only levied in one hundred years, and if we get such a letter from Doctor Hiltz, something is wrong in the salaried contract group."

Doctor R. O. Jones stated that the Nova Scotia salaries were far below any other.

Doctor H. G. Grant advised that the Canadian Public Health had made a study of salaries across Canada, and the salaries of Provincial Health Departments of Canada.

Doctor H. E. McKay stated that it was on the agenda of the Council of the Canadian Medical Association, but nobody was able to speak to it.

Doctor J. W. Reid: "I think we should find some way of letting it be known those who are members and those who are not members of our Society. Has anybody any suggestions? Should it go to the Secretaries of the Branch Societies?"

Doctor H. G. Grant: "We have done that before."

Doctor J. W. Reid: "We might provide the various Secretaries with a list and have them approach the delinquents individually."

Doctor M. G. Tompkins: "The members of the Executive could go back to their local Branch meetings and say we have twenty or twenty-five men who are not members, what are we going to do about it, and we could provide that executive member with a list."

It was decided that a list be sent to each Secretary.

Doctor H. G. Grant read a letter from Doctor A. D. Kelly giving the definitions of the terms branch and affiliated societies as follows:

December 23rd, 1952

Doctor H. G. Grant,
Dalhousie Public Health Centre,
Halifax, N. S.

Dear Pat:

Clarence has passed to me your letter of December 17th in which you ask for definitions of Division, Branch and Affiliated Society.

Division In C. M. A. terminology a Division is a "Provincial Medical Association (or the body representing organized medicine in a Province and enjoying all the rights and privileges of a medical association)".

Branch This term is not used in any official terminology of the C. M. A. Several of our Divisions, however, refer to their constituent county or district medical societies as "branches" of the Division.

Affiliated Society From the C. M. A. viewpoint an affiliated society is "Any nationally or internationally organized medical, scientific or sociological body may, subject to the approval of the General Council, become affiliated with the Canadian Medical Association. Affiliation shall be understood to imply the establishment of a friendly relationship with the affiliated organization. There shall be no obligation on the part of either party to the affiliation to sponsor policies or movements on the part of the other."

That's enough homework for the Christmas season.

Regards,
(Sgd.) Art,
Deputy General Secretary

Doctor J. W. Reid: "We should have to make some change in our By-laws if we were to take in affiliated societies."

Doctor J. A. MacCormick: "Affiliated according to that letter has no value any way."

Doctor H. G. Grant read the meaning of affiliated from the present by-laws:

"ARTICLE XII, AFFILIATION.

Affiliations with other medical organizations may be made from time to time, upon such conditions as may be determined, provided that such affiliation be made upon an equitable basis, and that at the next preceding meeting, notice of motion of such affiliation shall have been given."

Doctor J. W. Reid: "It is a question whether we want an organized body of medical men to be affiliated with this Society and not members of it. We do not feel that qualified men working in the Province should want affiliation and not membership. The feeling was that they should be members of the Society."

Doctor R. O. Jones: "Eighty per cent should be members if the Society is to be affiliated is a rule in most societies."

Doctor J. W. Reid: "If members wish to be in a special group they would only need to write a letter to the Society requesting that that group be organized as a branch."

Doctor A. W. Titus: "Re Fees. We wrote to the various branches asking for a representative to be appointed on the fee committee, and I have only heard from three, Antigonish, Colchester and Pictou. We also decided to ask the various branches to send us their schedule of fees, and they have all been contacted to send us a list of the fees as they would want them. In addition to that I wrote to every Province in Canada and have copies of their fees schedules, and I was amazed. The one from Manitoba is the most comprehensive. Our average fees compare with most of them; British Columbia has the highest. We also decided to try and do something about Workmen's Compensation Board fees. It is going to demand a lot of work. Saskatchewan has had two sets of fees, but it has not worked out. We have also asked Maritime Medical Care to prepare a list."

Mr. D. C. Macneill: "We have asked Doctor A. L. Murphy who is on your committee to do that."

Doctor Titus stated that Doctor Murphy was not on his committee, but was advised that he had been appointed as the representative of the Halifax Medical Society.

Doctor J. W. Reid: "You have made a good start. I hope the members of the Executive will get their Branches to appoint their representatives, and that you will write to the Secretaries and ask them to appoint their representatives."

Doctor A. W. Titus asked if they could be appointed as soon as possible.

Doctor J. W. Reid stated they would like a feeling of support of the way they are doing in preparing a minimum schedule of fees; first a preparation of a complete detailed schedule of fees as prepared by various departments with the assistance of the various society members, and secondly support of the idea of a dual fee scale, that is general practitioners and specialists.

Doctor A. W. Titus: "Do you want a double scale of fees, or just one?"

Doctor H. G. Grant: "I would like to ask Doctor Titus how this committee is going to arrive at specialists' fees. Are they going to consult with the radiologist and accept the fee suggested by radiologists?"

Doctor A. W. Titus: "The neurological scale is in, radiologist scale is in, psychiatric fee is in. We intend to take all the fee schedules in Canada and compare them."

Doctor H. G. Grant: "It might be just as advisable if they made up a scale of fees for one purpose, and a second scale of fees for Maritime Medical Care, raise the general practitioner's fee and lower that for surgery."

Doctor J. W. Reid: "Would the meeting care to express an opinion? That is the second thing, proposed fee for general practitioners and specialists."

Doctor H. F. McKay: "I am against it."

Mr. D. C. Macneill: "I must do one thing or another. I only give one fee, I cannot give both."

Doctor H. F. McKay: "The one important thing is the comprehensiveness of it. Actual figures will be revised from time to time."

It was finally moved by Doctor R. O. Jones that the Committee on Fees be requested to prepare the fee schedule in detail for general practitioners and specialists. This was seconded by Doctor R. E. Price and passed.

Doctor H. G. Grant read a letter from Mr. D. C. Macneill re money paid out to general practitioners and specialists as follows:

March 25, 1953

Dr. H. G. Grant,
Secretary,
The Medical Society of Nova Scotia,
Dalhousie Public Health Clinic,
Halifax, N. S.

Dear Dr. Grant:

In compliance with your request a few days ago, we show on the attached sheet a breakdown of the allowed fees for professional services by the specialist and general practitioner.

The specialists' allowed accounts amounted to $418,753.00 and the general practitioners allowed fees were $412,365.00. These figures, to be properly interpreted, must be broken down still further as a large number of physicians who are certified as specialists do more general practice than anything, and a few of the specialists do not practise their specialty at all although they are carried on our files as specialists for the reasons that they have a certificate by the Canadian College of Physicians and Surgeons. A further breakdown of fees allowed for the period show that actually a proper breakdown of allowed fees by pay-fees allowed for the period show that actually a proper breakdown of allowed fees by payments for services show that $251,251.00 was paid to specialists for specialists' services; the remainder of $579,867 was paid to doctors for general practice services. Also included in this figure is a sum of $53,942.00 which was paid to non-participating physicians or to hospitals, for X-ray services.

We trust that the information herewith answers your query, but if we can be of any further assistance to you please do not hesitate to contact us again.

Yours very truly,
Maritime Medical Care Incorporated
(Sgd.) D. C. Macneill,
General Manager.

DOCTORS' ALLOWED FEES
1952
MARITIME MEDICAL CARE INSORPORATED

Specialists*	$418,753.00
General Practitioners	412,365.00

*this figure includes $251,251.00 paid to specialists *for specialists' services*; the remaining $167,502.00 was paid to the same specialists on a G. P. basis for general practice procedures.

Total allowed for General Practice services	$579,867.00

Mr. Macneill advised that there were 356 general practitioners and 157 specialists. He thought there should be some definite reference to contract practitioners in the new schedule.

Doctor A. W. Titus: "Will there be another meeting of the Executive before the next October meeting?"

Doctor J. A. MacCormick stated he would like to have the Department of Indian Affairs' fees investigated and those of the Canadian National Railway Benefits.

Doctor H. G. Grant advised that the Department of Indian Affairs is a Federal matter and that a few years ago the Canadian National Railway Benefits had been taken up and Doctor J. G. B. Lynch attended the session; no agreement had been reached.

Regarding the surplus in the Provincial Welfare Fund Doctor H. F. McKay advised that he circularized the members of the Economics Committee, and to date had had only one reply. Four suggestions had been made as to the disposal of this surplus, that it might include tonsillectomies, that The Medical Society of Nova Scotia might offer hospital cases a week or ten days in hospital, and it might be possible to work out some method whereby thewards of the Children's Aid might benefit.

Doctor J. A. MacCormick: "How did the surplus occur?"

Doctor J. W. Reid: "It came about when the mileage disappeared.

Mr. D. C. Macneill advised that most of the old age pensioners were in the rural areas and the mother's allowance and blind were in the urban areas, and the Government took a very dim view of Maritime Medical Care paying one dollar a mile. The surplus started when the old age pensioners were dropped.

Doctor J. W. Reid: "What we can charge is the amount of service we give them."

Doctor H. G. Grant: "I was talking this matter over with Mr. Macneill. He could supply the data and he could do that now. I think a committee should work with him; they might include tonsillectomies."

Doctor H. F. McKay: "I think the Society should increase the benefit to the pensioners and not to the doctors."

Mr. Macneill: "It is imperative that this meeting make some recommendation for the taking up of some of that surplus."

Doctor R. E. Price: "I would move that the President appoint a committee of three to deal with this matter, with authority to make recommendations to Maritime Medical Care for the enlargement of the services."

Doctor M. G. Tompkins: "We do not allow services for tonsillectomies, circumcision, etc., to the children of those who are receiving mother's allow-

ance. I would move an amendment that in future we would include services for the dependents of mother's allowance to receive treatment in hospital for tonsillectomy and circumcision."

Doctor R. E. Price thought it should include minor surgery for the dependents of mother's allowance. He added to his motion that the committee consider the enlarging of services to the Government Welfare Group with a view to taking up the surplus and preventing future surplus, considering first of all the advisability of minor surgical procedures and hospitalization procedures. This was seconded by Doctor J. S. Munro and carried.

Doctor H. F. McKay stated that at the meeting in Yarmouth Doctor J. C. Wickwire had spoken about the surgical cases going from Halifax and he had suggested that certain considerations should be given to the men, that is the general practitoners, who complete the post-operative care.

Doctor H. G. Grant: 'I would like to suggest that our Society should request Maritime Medical Care for the privilege of a listener-in at their meetings. If there were a liaison officer he would always keep our Society appraised of what is going on in Maritime Medical Care affecting the members of The Medical Society of Nova Scotia."

Doctor J. W. Reid: "The constitution of these plans is so skilfully drawn up that the parent body has little control over the corporation. We could have a sitting-in member but the delegates presumably are Maritime Medical delegates once they are in."

Doctor J. W. Reid asked if the meeting would reconvene that evening at eight o'clock.

Doctor P. R. Little thought that the Medical Society had full power over Maritime Medical Care and that the delegates were very good, and that they had all the power when it came to a meeting.

Doctor J. W. Reid: "They meet very rarely."

Doctor H. F. McKay: "I do not know that there is anything that makes their meetings secret. I think they might have a copy of their minutes."

Doctor H. G. Grant: "I am not criticising their actions."

Mr. D. C. Macneill: "The Medical Society appoint the delegates and they report back to the Branches."

It was moved that the meeting adjourn at 6.15 p.m.

The reconvened meeting of the Executive of The Medical Society of Nova Scotia met in the Board Room of the Dalhousie Public Health Clinic, Halifax, N. S., at 8.00 p.m. the same evening.

There were present: Doctor J. W. Reid, President, Doctors H. F. McKay, H. G. Grant, P. R. Little, M. C. Tompkins and J. A. MacCormick.

The first item was discussion of nominations for honorary degrees.

It was moved by Doctor M. G. Tompkins that Mrs. M. G. Currie receive an increase in salary. This was seconded by Doctor H. F. McKay and passed.

It was also agreed that Mrs. M. G. Currie visit the office of the Canadian Medical Association for information regarding office procedure.

It was moved that the meeting adjourn at 9.10 p.m.

THIRTY-TWO PHYSICIANS WIN AWARDS AT NINTH ANNUAL ART SALON, WINNIPEG

The North Lobby of the Royal Elexandra Hotel, in Winnipeg, became a temporary art gallery during the recent C.M.A. Convention, June 15 to 19. There, more than 800 paintings, photographs, and colour transparencies attracted a throng of delegates and the Winnipeg public throughout convention week. The entries, all created by Canadian physicians and medical undergraduates, made up the largest salon in the nine year history of this unusual competition. Paintings and photographs were displayed on interlocking wooden panels while colour slides were projected almost continually on a large screen.

The Salon was again organized and sponsored by the Physicians' Art Salon Committee and Frank W. Horner Limited.

Judging Arduous

The Jury of Selection, assembled by Doctors Harold Popham and A. M. Goodwin, comprised three discerning Winnipeg critics,—Mr. Alvan C. Eastman, Mr. Newton Brett, and Mr. J. M. Duncan who spent a painstaking seven hours judging the three sections. The Fine Art Section was subdivided into Modern and Traditional works and awards presented in each category. Engraved plaques and award of merit certificates are supplied by Frank W. Horner Limited.

Reproductions Planned

A selection of award winning work will appear in the 1954 Physicians' Art Salon Calendar and in a blotter series. The calendar will be mailed to all Canadian physicians in late November. Anyone not receiving a copy can obtain one by writing Frank W. Horner Limited, P. O. Box 6139, Montreal. Art Salon Blotters will be sent out through early 1954.

Both calendar and blotters will also feature paintings and photographs from the Palette Club, composed of previous first prize winners, and the Popularity Prizes determined by balloting visitors to the Salon.

Prize and Award Winners

Traditional Fine Arts		
1st. "Lakefield Rocks"	H. E. Hopkins, M.D.	Toronto, Ont.
2nd. "Still Life"	Howard I. Goldberg, M.D.	Halifax, N. S.
Awards:		
"Nogel Pass"	Evelyn A. Gee	Tranquille, B. C.
Portrait	W. J. Hart, M.D.	East Kildonan, Man.
"Fallis Hill"	M. F. Newell, M.D.	Edmonton, Alta.
"The Stones which the Builders Rejected"	E. R. Rafuse, M.D.	St. James, Man.
"Deserted Cove"	R. F. Ross	Truro, N. S.
"Road-Lake of Bays"	W. D. S. Cross, M.D.	London, Ont.
"Still Life"	Ronald Elliott, M.D.	Collingwood, Ont.
MODERN FINE ARTS		
1st. "Baigneuse"	Paul La Riviere	Montreal, P. Q.
2nd. "Random Thoughts"	L. J. Notkin, M.D.	Montreal, P. Q.
Awards:		
"Still Life"	Dr. A. E. Robertson	Tranquille, B. C.
"The Warrior"	Paul La Riviere	Montreal, P. Q.

MONOCHROMES

1st.	"Matins"	W. K. Blair, M.D.	Oshawa, Ont.
2nd.	"Seba Solitude"	P. Shragge, M.D.	Edmonton, Alta.
3rd.	"Contact Print"	H. M. Spiro, M.D.	Vancouver, B. C.

Awards:

No Title	Dr. S. Janowsky	Victoria, B. C.
Architectural Abstraction	W. P. Goldman, M.D.	Vancouver, B. C.
"Smelt Fishing by Moonlight"	F. T. Dennis, M.D.	Port Arthur, Ont.
"Reflets dans la Neige"	Jean Brisson, M.D.	Hull, Que.

COLOR TRANSPARENCIES

1st.	**"Breakwater"**	**Dr. H. W. Schwartz**	**Halifax, N. S.**
2nd.	"Night Night!"	D. A. Boyes, M.D.	Ganges, B. C.
3rd.	"When You Come to the End of a Perfect Day"	C. A. Cleland	West Toronto, Ont.

Awards:

"Spring in Butchart's Gardens"	D. A. Boyes, M.D.	Ganges, B. C.
"Winter's Stillness"	G. W. Hankins, M.D.	Calgary, Alta.
"Pastoral"	C. B. Hatfield, M.D.	Edmonton, Alta.
"Fisherman's Harbour"	**L. R. Hirtle, M.D.**	**Halifax, N.S.**
"Winter's Sunlight"	W. B. Leach, M.D.	Montreal, P. Q.
"C. N. E. Beckons"	Dr. R. E. Ives	Stayner, Ont.
"Getting Up Steam"	R. E. Turner, M.D.	Hamilton, Ont.
"Mine Eyes Have Seen"	W. R. Read, M.D.	Drumheller, Alta.
"Autumn's Gold"	Mary A. Murphy, M.D.	Hedley, B. C.

POPULARITY AWARDS

Fine Art

"My Wife"	Dr. E. V. Currie	Shelbourne, Ont.

Monochrome

"Child's World"	Charles Scriver	Montreal, P. Q.

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