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The NOVA SCOTIA MEDICAL BULLETIN

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THE CANADIAN PUBLIC HEALTH ASSOCIATION

The present day membership of the Canadian Public Health Association is made up of citizens interested in the health and welfare of our nation.

Among its members one finds groups of people primarily interested in epidemiology, nutrition, health education and veterinary, mental or dental health. Particularly since the advent of paramedical services, which originated by the recommendation of the Medical profession and the Medical Schools, there has followed a much closer liaison between the practising physician and those primarily associatied with public health work.

This Association has often been looked upon as a "Branch" of the Department of Public Health. This is definitely not so, but Provincial and Federal Departments of Health invariably hold their Annual Departmental meetings at the time of the Annual National or Branch meeting of the Association in order that their personnel may take advantage of the Scientific meetings and hence keep up to date with medical progress.

The Nova Scotia Branch of the Canadian Public Health Association has since its inauguration enjoyed excellent cooperation from The Nova Scotia Medical Society, and recommendations from this Society as to standards and qualifications of public health personnel have on several occasions been the guidance at the National Branch level.

The Canadian Public Health Association is at present extremely active, and enjoys a good public relationship. Its members come in contact with a large percentage of our population and by virtue of health education give our people a better understanding of what good health means to our Nation.

The matter of Canada becoming a Welfare State is just as much of a concern to this association as to any other organization concerned with health and welfare. It is essential that whatever health service is provided, whether administered by government or by free enterprise agency, it be of a high caliber. In this respect it is of interest to study in detail, over a long period of time, countries which are looked upon as welfare states and one will find there is no comparison from reports which are based on superficial, hurried study, or brief observation. What one actually will realize is that these countries have in their national budget a terrific welfare spending in order to provide all sorts of

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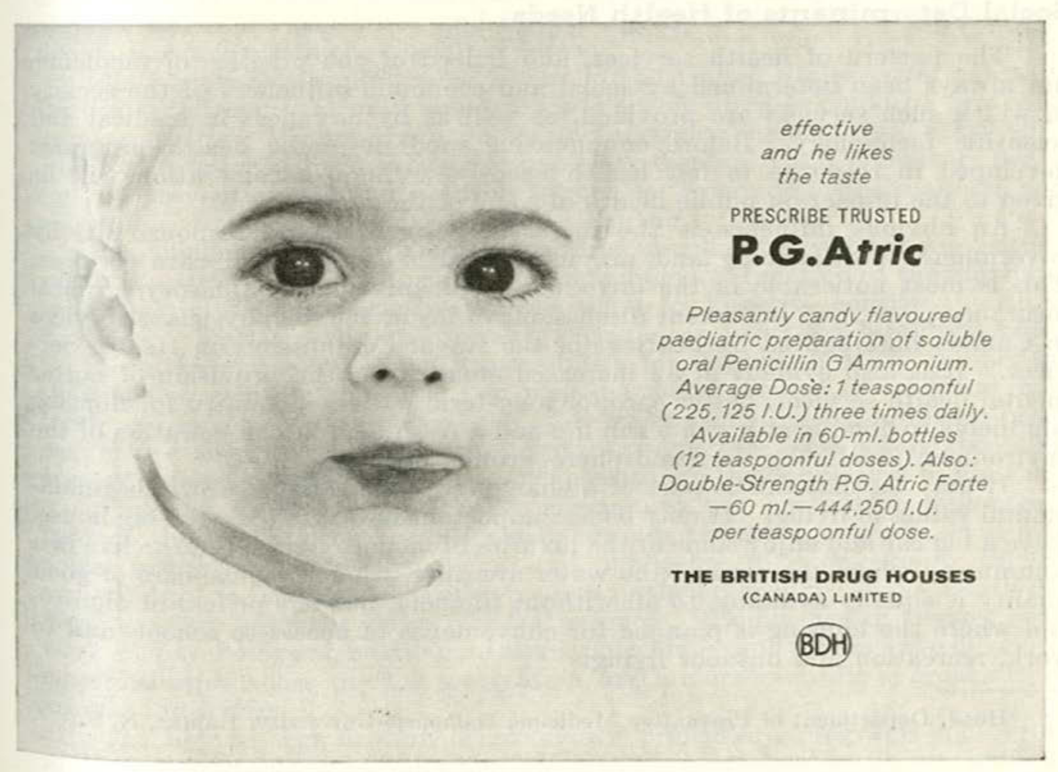
social services, but that these countries are not socialistic states, and as a matter of fact are heading away from Socialism. The Scandinavian countries, for instance have never been socialistic states to the degree that many people think, there is far less public ownership in Sweden than in Britain, West Germany or France (mining and manufacturing is 92% privately owned, and banking, insurance shipping and retail vary from 88 to 97.5%). These countries realize that welfare schemes cannot exist without a base of prosperous private industry and in fact Sweden refers to herself as a "free enterprise welfare state".

With such information and tendencies is it therefore not logical that the practise of medicine should remain a free enterprise?

D.J.T.

This month's Bulletin is devoted to selected papers from the conference on "The Unmet Needs in Public Health", held by the Nova Scotia Branch of the Canadian Public Health Association in Kentville on October 23-24, 1962. The Editorial is contributed by their President.



INTRODUCTION OF CONFERENCE THEME: "THE UNMET NEEDS IN PUBLIC HEALTH"

G. H. HATCHER, M.D., D.P.H.*

Halifax, N. S.

A major need in public health today is for closer integration of the many public and voluntary health activities. A meeting of the Nova Scotia Public Health Association that includes staff of official health departments, of voluntary agencies such as the Victorian Order of Nurses, practising physicians, university specialists and other scientists, is an example of such integration.

Complete consolidation of all public and voluntary health, hospital and welfare services into a single organization is neither possible or desirable in most Canadian communities, even though some health services that are separate today may be consolidated or integrated into a single administrative unit in the future. Health workers will continue to concentrate on co-operative relationships that will help the patient and the local community receive a balanced pattern of services, and leave jurisdictional disputes to the politicians. Of course, we have our medical politicians and our administrative politicians as well as party politicians, but if most of us concentrate on getting services to people instead of seeking power and prestige, the job will get done.

Social Determinants of Health Needs

The pattern of health services, and indeed of the practice of medicine, has always been determined by social and economic influences of the society in which such services are provided, as well as by advances in medical and scientific technology. Before enumerating modern public health programs developed in response to felt health needs elsewhere, consideration will be given to the impact on public health of some of these influences.

An obvious influence is the increasing acceptance of responsibility by government for financing and providing health and medical care services. This is most noticeable in the introduction of universal compulsory hospital insurance plans, and in current discussions of insurance for physicians services in Canada high-lighted by hearings of the Royal Commission on Health Services. It is also evident in an increased concern for the provision of better mental health services, better care for long-term patients, concern for housing conducive to good health and a full life and a fresh look at the pollution of the environment, including the atmosphere, around our large cities.

It may be that this is part of a changing public attitude towards fundamental values of living. It may be less important in future to own a big house, drive a big car and enjoy some of the luxuries of modern living, than to live in a community where the air and the water are pure, where medical care of good quality is equally available to all without financial barriers or loss of dignity, and where the housing is planned for convenience of access to schools and to work, recreation and outdoor living.

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Maintenance of health and adequate provision for care of the sick is a community wide concern to a greater extent in Canada today than ever before. Whatever new, integrated health programs are developed, public agencies will be called on to play a larger part.

The Chronic Illness Epidemic

A second trend is the much talked about aging of the population, with a larger number of persons living on into the later decades of life who formerly died in their infancy or youth.

While maternal and child health services will remain a major concern, the larger proportions of persons with long-term illness and disabilities in our aging population now demand more attention. The acute general hospital, the proprietary nursing home, the private physician trained in the medical curriculum of the last few decades, and the community public health departments as presently organized, have simply not been geared to meet the continuing care needs of the chronically ill and disabled. We suddenly find ourselves in the middle of an epidemic of chronic diseases, similar to the epidemic of cholera and dysentery in the 1830's that gave rise to the public health movement. We find ourselves almost equally as unprepared as then, for we have no real means of cure and very few specific preventive measures available for arteriosclerotic heart disease with its coronary artery occlusions, for cerebral vascular accidents with resulting hemiplegia or strokes, for most crippling arthritis, for many neurological disorders such as multiple sclerosis, muscular dystrophy, or Parkinsons disease, for malignant neoplasms in many sites, for schizophrenia and senile psychosis, and for the accidents that kill or cripple more people each year than the casualties of war.

The Commission on Chronic Illness in the United States, after extensive studies, estimated that only about 5% of chronic diseases could be prevented from occurring. With early diagnosis and adequate medical care, nearly 40% might be prevented from causing unnecessary disability and premature death: e.g., by prevention of blindness from glaucoma, gangrene in the diabetic, congestive heart failure in the cardiac and so forth.[1]

The challenge is to provide this kind of so-called "secondary prevention" within a setting in which the patient is encouraged to function at the maximum level of activity – whether at work or in caring for himself – consistent with his disability. This is really good quality chronic care with a rehabilitation goal. To those charged with official responsibility for the health of the public, this challenge presents in the same two ways as the challenges of maternal mortality and infectious disease and the other great public health problems of the past have done. First, how can we organize and pay for these needed secondary prevention services, and next how can we motivate the population to use them.

The key to motivating the population to use preventive measures is through the family group, or other social groups at school, at work, or at play. Social science research in medicine and public health is developing rapidly, and will lead to basic social science courses in the curriculum of the health professions along with the basic physical sciences. Public health nurses, social workers, psychologists, health educators, physicians, and others have developed empirical approaches to such motivation, and a more scientific approach is just around the corner.

The key to organization of secondary prevention programs for chronic illness is the establishment of appropriate teams of medical specialists and non-

medical personnel, as resources to assist the patient's personal physician. If the "generalist" personal physician continues to be supplanted by multiple specialists and institutional services, intimate knowledge by the physician of family relationships and of the home environment, and continuity of medical care over a long period of time, tend to be lost. With them we lose the best chance for early detection of chronic disease and control of its disabling sequelae.

But unless the solo practitioner has more help from consultants, has better knowledge of the work environment of his patient, has assistance in early referrals, has some kind of organized follow-up service, and has good quality chronic institutional care facilities available, he is unable to meet his patient's long-term care needs adequately. Often the patient continues to seek care from his family doctor anyway. Sometimes he tries to secure these services piecemeal from various specialists, or he may cease to seek medical attention while his health continues to deteriorate. In each case, he tends to receive episodic and inadequate service for his chronic illness, and preventable disabling complications escape the attention of the attending physician until too late. The Commission on Chronic Illness showed conclusively that nearly half of the chronically ill private patients in a large, fairly representative population sample were not receiving the medical care services they needed. As a consequence they were found by a team of examining physicians to be more disabled than they would have been had they received the care we know how to provide.[2] A study of the out-patient department of a large teaching hospital in Miami showed a somewhat similar situation for public patients.[3] Lack of continuity of care and loss of chronic illness patients in public clinics from medical supervision until they have an acute episode of some preventable complication, or until their disease progresses to severe disability, is characteristic of over-crowded, super-specialized out-patient departments.

Comprehensive Care

A third major influence leading to closer integration of health services, is the increasing recognition by health professionals and the public alike that patient care must be comprehensive. Comprehensive care encompasses the social, psychological and physical aspects of care, and includes preventive measures, diagnosis, therapy, and rehabilitation to maximum social function. For the patient with severe or chronic illness, or for the patient whose illness is complicated by severe psychological or social problems, there is increasing recognition that good quality care can only be provided by a team of health professionals, organized under the leadership of the attending physician to supplement his services, and to carry the high standards of general hospital care over into the long-term care institution, and into the patient's home.[4,5]

This will represent a form of integration of traditional local public services with other voluntary health agencies, both private and public, and with medical and hospital services, which will go beyond most of the patterns of co-operation and co-ordination of the past. The local public health nurse will be a key member of most of such teams.

In the discussion groups you will consider some of the following programs of integrated health services, in which new health teams are operating in hundreds of local communities today.

1. Adult health maintenance programs, for older persons, similar to child health conferences for the young, that will detect disease early and maintain continuity of care of the chronically ill.[5]
2. Multiple screening programs for early detection of chronic illness in the general population, and return of the chronically ill patients to competent medical supervision.[6]
3. Programs for the classification, according to their care needs, of patients referred for admission to chronic care institutions, and for classification of the institutions according to the care they provide.
4. Rehabilitation evaluation programs for patients in chronic care institutions.[7]
5. Organized home care programs.[8]
6. Dental disease prevention and health maintenance programs.
7. Family centered social and medical rehabilitation programs for welfare clients.[9]
8. Industrial health maintenance programs.[10]
9. Programs to return mental patients to full participation in community life.
10. Special research and demonstration programs that will relate hospital and community health services more closely: e.g. epidemiological studies; in-patient discharge and follow-up programs; and planning for needed volume or levels of health services.

"Research or Stay Behind" is the title of a lead article in a recent issue of the American Journal of Public Health, written by a former Canadian.[11] The unique responsibility of public health workers is research in the administrative application of new medical and health knowledge, in programs that will benefit the largest number of people. Which of the above programs shall we select for a research and demonstration project to adapt these principles to Nova Scotia's special traditions and needs?

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CHRONIC DISEASES AND DISABILITIES

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It seems appropriate that public health workers should deal with chronic diseases when they consider unmet needs in public health. No group should be better able to offer the leadership in planning programs to prevent chronic diseases or their resulting disabilities. Many consider these the greatest problem facing modern medicine. It may seem strange that our major unsolved problem is, to a considerable degree, the result of former surgical, medical and public health successes. These successes have increased life expectancy but they make this greater surviving number of older persons victims of so-called degenerative diseases, such as arthritis, cancer and heart disease, for which the etiology is often obscure, and for which there is usually no known cure.

It is difficult to define the problem. There is no one solution. In one case the solution may rest with a single person such as the family physician while, in the next case, anything short of team approach is useless. The costs may be great, but an expensive 6 months program may pay its way many times over if it results in returning a man to gainful employment for 10 or 15 years rather than having him a charge on society for the rest of his life. The recruitment of personnel for this type of work poses problems different from that of therapy in more active treatment cases. The results may be less dramatic, as well as less complete; the patient's personality may make him more difficult to treat and less appreciative of what is being done for him than other patients. In general, one requires personnel with above average missionary zeal as well as good training. One may need to combine treatment with research or, in other cases, to combine work in this field with other aspects of medical work in order to allow people in chronic disease management to keep their perspective and their zeal.

In opening this symposium I am speaking as a general physician, knowing that a Psychiatrist and Physiatrist will follow, as well as a Nurse and Vocational Guidance Specialist, and they will be speaking in more detail of their special interest.

EXPERIENCE OF THE DEPARTMENT OF VETERANS AFFAIRS

As a background I would like to discuss some experience as seen in D.V.A. in the past fifteen years. The program, in some ways, is more comprehensive than for the population at large and we can learn from it, at the same time realizing that there are still great deficiencies.

For some years facilities have been available for the older veteran to obtain domiciliary care in Veterans' homes, lodges or hospitals. The late Dr. Warner was instrumental in bringing about a change in our approach to these older veterans, with the active assistance of some dedicated people, notably Dr. Wallace Wilson of Vancouver. Consequently former geriatric units or Vet-

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erans' homes where veterans merely existed for their remaining years, have been transformed into *Assessment and Rehabilitation Units.* The goal is now to help older and chronically ill veterans to live more fully, and not merely to live longer.

How does such an A and R Unit operate? First, the assessment team asks these questions about a potential candidate for such care:

What is his general medical status?

Has he correctable disease?

Can a specialist offer something that has not as yet been considered, and will this make him more mobile or more comfortable?

Has he problems that could be better handled by a psychiatrist?

Is the psychologist needed to assist in the evaluation of the overall mental picture?

What does the Social Service or Welfare Worker know about him and his family?

Is his referral to domiciliary care the result of unsatisfactory home environment?

If his urinary incontinence could be corrected or his mental status improved could he be cared for in his home community?

With an enthusiastic and dedicated team approach a new and more progressive program was possible. Patients formerly requiring institutional care were rehabilitated by the intelligent use of specialists, physiotherapists and other ancillary groups in a modern medical institution. Many of these patients were fit for restricted employment. People who had been in hospitals or homes for months or years were rehabilitated back to their home community. In some areas supervised boarding houses offered a more normal environment for older or disabled veterans who formerly would have been kept in institutions. Some centers had home medical care services and this, along with the knowldge that early hospitalization was available if the need arose, was a consolation to the patient, his family or his landlady and permitted such a person to continue as a member of his home community rather than taking up a bed in a more expensive and impersonal institution.

CHRONIC NURSING CARE OF THE SEVERELY HANDICAPPED

What about the other end of the spectrum of chronic care: the patients who are severely handicapped from chronic illness and require constant hospital care rather than domiciliary care. These form a large group which requires specialized facilities and, although needing continual and a very expert type of nursing, does not need proportionally as much physician care. However, constant supervision and availability of specialized services are required. Camp Hill Hospital's A and R Unit is an integral part of the Department of Medicine. Physicians working in such a unit become experts in this field and learn tricks and pointers that are as fundamental in improving patient care as the more sophisticated measures in other specialities.

The nursing care of these patients is crucial. In no branch of nursing is a higher degree of skill or a more complete devotion to proper care required, yet many institutions with such patients have less well-trained and less well-motivated people staffing them. Some administrative authorities do not appreciate the problems and fail to differentiate domiciliary care, where patients

are largely self-sufficient, from chronic care wards. The quality of nursing care on the chronic wards at Camp Hill is superior to that of any general hospital in my experience, and is a source of great personal satisfaction to the medical staff. The team nursing of graduate nurse, nursing aide and orderly produces results that are almost unbelievable. No excuses are made for bed sores, as actually they just do not occur. How one may recruit more such people, and how one may keep such people interested in this type of nursing, might well be a topic for group discussion.

Our experience in the last dozen years has shown a great change in our D.V.A. permanent care patient population. No longer do we have a high percentage of the truly domiciliary type patients. This group, to a great degree, is kept out of institutional life by making arrangements for them to maintain themselves in their own home community environment, with help from one or more of the A and R team members. On the other hand, those who are in hospital are largely chronic patients requiring expert nursing care.

A natural development of the A and R Unit was to assist in assessment and rehabilitation of that even larger group of veterans in the 40 to 60 year age group who have, or believe they have, a material handicap to prevent them from being gainfully employed. This group of potential or actual applicants for War Veterans' Allowance believe they are deserving of support from society ar large. They have many counterparts in non-veteran population, among the Compensation Board cases who have difficulty in adjusting to their partial disability, those seeking disability allowances from Provincial sources, or those seeking assistance from various community organizations. This rehabitation phase of A and R Unit has had less success, for various reasons, than the physical rehabilitation and return to a home or non-institutional environment of the older, veteran.

RELATION TO MEDICAL EDUCATION

Perhaps it is appropriate to mention the approach at Halifax in the development of our A and R Unit. In some of the larger metropolitan areas the A and R Units were administratively distinct units and any potential candidate for their consideration was admitted to such a unit and worked up by the team. That these units became experienced in their work and their judgment good is unquestioned. However, with our smaller volume we attempted to teach the team assessment and rehabilitation method to as many people as possible. We had these patients worked up on general medicine, for the most part, and used the psychiatrist, psychologist, and other medical and nonmedical specialists as necessary. The resident and attending staff expressed their overall opinion of the patient before he was considered by the committee of the A and R Unit consisting of physician, the welfare worker, the social service worker and the administrative member. What we lost in efficiency of handling an individual case we believe we gained by making clinical clerks, internes, residents and staff members conscious of the nature and magnitude of the problem. We trust this experience makes them better able to take their place throughout the province as practising physicians. In our own small way we hope we have helped bridge this gap in medical education. We have likewise avoided an "Empire building" group as occasionally arises, which may get this work out of perspective in the total hospital and community picture.

CONCLUSION

The past generation has seen a marked increase in society's acceptance of responsibility to help look after the less able, whether their handicaps are due to chronic illness from crippling arthritis, premature heart disease or some other disability. This has been good for patients but at the same time, the poorly motivated or inadequate individual with minor medical troubles is encouraged to seek the emotional and economic securities of the "Welfare State", and become more dependent. Discussion of these problems by clinicians and public health personnel may come up with some solutions which require understanding, intelligence, firmness and indeed a sense of social research; for only if we are willing to learn from actual experience can we avoid pitfalls or make changes for the better.

Some questions that might be a basis for such discussion are:

1. What measures can each of us take to induce more personal responsibility in many patients who believe that they can sit back passively and wait for "the medical team" to "fix me up". That is, how can each of us assist in improving motivation? To what extent should the inadequate person be considered mentally ill, and is it best for his family and him that he be a financial responsibility of society? Does such a ward of society have any responsibility to society in return for this financial support for most of his life? Should he be compensated additionally for each new off-spring when this is his sole evidence of productivity?

2. How can medical doctors improve their reports on disabled persons so that rehabilitation personnel may better appreciate the physical and mental capabilities of a materially handicapped person?

3. How can welfare personnel be oriented to consider rehabilitation to gainful employment, or to improved self care, the primary goal for chronically ill or disabled people seeking financial help? How can we weld the benefits of community organizations, public health authorities, the practising physician and a personnel of a modern hospital into an integrated group to produce such a needed approach to this major problem of chronic illness?

4. When will D.V.A. introduce some better methods of financial assistance for partially disabled veterans to assist them in rehabilitation rather than War Veterans' Allowance which, though so beneficial for the totally disabled, has been such a detriment to rehabilitation?

5. Is our Government considering five to ten percent of the work force unemployed as a "normal" condition of Canadian life? When and how is Canada taking a more positive action to provide sheltered employment? Are our Governments merely paying lip service to more progressive and intelligent approach to the problems of citizens with chronic illnesses and disabilities? How can this subject be better presented to the public and to the politicians in order that a more positive approach may be made?

6. Finally, are the leaders of public health and preventive medicine resting on their laurels of past accomplishments, or have they the vision to see the challenge of this present day problem in which they are so well fitted to take the lead, although many individuals and groups must work within the overall plan?

PSYCHOLOGICAL CONSIDERATIONS IN CHRONIC ILLNESS

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In most facets of medicine it is paramount to keep in mind the holism of the human organism, and nowhere is this more so than in considering chronic illness. It is so obvious as to be trite to remind you that dysfunctions of the body affect the attitudes of the sufferer and vice versa.

One of the many difficulties that beset the doctor treating chronic illness is the hangover from the Victorian era of piece-meal medicine. It would indeed be good if it were possible to divide up illness into neat little bundles affecting this organ and that tissue, and indeed many still try to do this. So often in dealing with reports for a third party, a doctor is frustrated by trying to limit the illness to the paragraphs of a medical report form. Especially is this true in the field of veterans pensions, where certain conditions carry a high pension value, but some other manifestation of the same basic conflict is not even recognized. This can lead to the ludicrous situation of a man having entitlement for free treatment of his "functional dyspepsia," but not of his "spastic colon" or his frank "anxiety state."

Psychological Illness as a Cause of Disability

In dividing up this very large field into discussable units, I feel that perhaps we could use the various degrees of "psychogenicity," at least as far as the present state of our knowledge will let us go, as arbitrary divisions.

First, illnesses considered primarily "psychogenic," like the psychoneuroses and schizophrenia. These illnesses are the cause of a great deal of chronic ill-health. With all due respect to the people with special interests in other important fields of medicine, e.g., cardiac disease, alcoholism, diabetes, etc. it can be demonstrated that the functional mental conditions are our greatest public health problem, and in proportion have received the least public attention.

Second, psychosomatic illnesses, e.g., rheumatic disease, hypertension, and many skin diseases in which psychological factors probably contribute to the aetiology but in which, at least, psychological triggering mechanisms are obvious. In these conditions a particular bout of ill health may follow a psychologically stressful period.

Third, illnesses in which the main cause does not seem to be clearly psychological, but which are complicated to a considerable degree by emotional factors, e.g., cerebro vascular accidents, diabetes, tuberculosis, etc. In these illnesses, the success or failure of treatment and rehabilitation often depends on the cooperation of the patient, and his attitudes to treatment measures may be as important as the treatment itself. Failures to accept the restrictions of a diet, the routine of drug treatment, and so forth, can thwart the efforts of the most dedicated treatment team.

Fourth, neurotic and other developments complicating the course of other illnesses, accidents, operations and procedures. In cases like this, the original

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dysfunction, which may or may not have clear-cut psychological determinants, can provide a center around which the neurotic invalidism can be focused.

It seems to me that these latter two categories are the most troublesome for the general physician and certainly complicate the treatment and rehabilitation of most chronic invalids.

The conflicts involved are those that complicate life for all of us: sick or well, and have to do with the whole gamut of human emotions; passivity, dependence, aggressiveness, hostility, sexual conflicts, guilt, competition, and the like. The mechanisms available to the chronically ill, again, are not unique but are those shared with suffering mankind; rationalization, reaction formation, isolation, repression, denial and projection. These are the ways people use to blind themselves to the true nature of their motives, to allow them to look at only one fact of a complicated reaction. At times this may lead to the refusal to recognize serious illness. This is especially true in carcinoma, but also occurs in other conditions like diabetes and cardiac disease, and may lead to delays in seeking treatment, or lapses in following it, which may prove lethal.

In passing I would like to say that in my experience out-and-out malingering is uncommon, and when it does occur is evidence of very serious personality disorder.

Having considered briefly the psychological roots of various illness patterns, let us turn our attention to the products of these mechanisms for expressing and attempting to solve the conflicts mentioned above.

Chronic Illness as a Cause of Maladjustment

The most important consideration of chronic ill health is the dislocation from ordinary life, the break with the world of work, school, social life. Perhaps the most serious consequence of this is the interruption in the feed back from the ordinary contact with people that keeps most of us oriented to life. Failing this many become mildly paranoid or worse, and this can expand the original break with the work-a-day world.

Next I would feel that the lowering of self esteen as a result of the illness and the inability to live an ordinary life is most productive of psychological mischief. Our highly materialistic society is based on work, and the material rewards of work, and anyone who cannot conform to this most important social demand is, *a priori*, out of the main stream of life. The neurotic defences employed to help combat this loss of self esteem are usually those mentioned above — repression, denial, over-compensation, reaction formation — but there may be even more serous developments such as depression, paranoid symptoms or even schizophrenia.

Questions of compensation, pensions and other allowances are obviously very important, not only because of the very necessary provision of the essentials of life for the ill person and his dependents, but for the many hidden considerations, of which the sufferer is largely unaware. In this latter category I would mention the sense of approval by society that the conferring of monies often brings the ill person. I could also point out that to some independent souls the same grant would be a disgrace and a subject for humiliation.

For some there is a safety in chronic illness, in that these individuals can retreat from the competition of everyday life, can harvest the fruits of passivity and independence, and can use their very illness as a *raison d'être*. This development, of course, depends on the neurotic superstructure providing ade-

quate degrees of self deception so that the original illness or accident bears the sole guilt of the sufferers' failure.

Should a man have for years denied an overweening dependent need, should he for years have struggled to maintain his self esteem in a highly competitive industrial job, should he have been provided with a providence-sent "blighty" of a chronic illness, and (all this and Heaven too) an adequate financial settlement – it is asking a great deal of such an one that he should get well. We are paying him to be sick.

What Do We Do About It?

Let us now consider the difficulties in combatting these complications of chronic illness. The factor of chronicity is of major importance. People who have been ill and disabled for years, and who have developed secondary neurotic mechanisms to defend themselves against the loss of esteem, loss of sense of importance, and indeed to some considerable extent loss of participation in life, very naturally are resistant to change. To expect such people to accept a psychologic diagnosis, in which along with praiseworthy motives are mixed regression to childish dependency, greed, self destructive mechanisms, and thwarting of the efforts of the treatment team, without a great deal of resistance is unrealistic.

In many instances the reality factor of the disability or disfigurement may be of such an extent as to overwhelm the resources of the sufferer. So often the working man is faced with a disability severe enough to end permanently the chance of continuing manual labour. When severe physical handicaps occur in a patient of inferior intellectual resources, and only a modest degree of emotional maturity, rehabilitation in the true sense of the word becomes impossble, and psychological adjustments to this must be made; for example, parplegia occurring in an immature man with a modest I.Q. and grade Four education.

There is a very real difficulty of finding half-way situations, either on a temporary or a permanent basis. Sheltered workshops, part time jobs, and in the field of mental illness, sheltered homes for the patient "on the way back" are just beginning to be set up, and as yet cannot meet more than a small percentage of the demand.

Lastly let us consider motivation. How much in any given case can the failure to respond to treatment and rehabilitative measures be laid to lack of real effort on the part of the patient, how much to laziness, how much to dishonesty, how much to fear of getting well, how much to sheer inadequacy to overcome the handicap. All these are value judgments, which vary considerably from doctor to doctor, and even in the same doctor from time to time in his contact with the patient. We in medicine have found no accurate way to assess and measure things like motivation, honesty and the like, and the best we can do is to try to avoid deserting the role of healer for the role of Judge. Our understanding of these matters, inadequate as it is, greatly exceeds our capacity to deal with them, and as yet few techniques for combatting them exist.

In conclusion then, it is obvious that chronic disabling conditions, which thanks to the increasing skills of public health engineering, and of surgical, medical and physical therapies are becoming ever more numerous, present a very major public health problem. It becomes increasingly evident that the

sooner rehabilitative measures are begun, the less chance there is for severe neurotic developments to complicate the picture. As in "compensation neurosis", long delays in settlement and differences of opinion about the amount of disability can affect the outcome adversely.

It behooves us to attack disability "soonest with the mostest," and to try to get rehabilitative measures in action before severe neurotic complications make them impossible.

BOOK REVIEW

RELIEF OF SYMPTOMS. By Walter Modell, (2nd Ed.) The C. V. Mosby Co. $11.50.

This book of three parts has some three hundred seventy pages in thirty-two chapters. Part 1 is on theory and begins with a plea for consideration of the Symptom as an independent integral of an illness, not merely as a neon sign directing the physician to an accurate diagnosis and which will be automatically and totally extinguished when specific therapy is instituted. Rather he would have it considered as a deleterious corollary of a disease process and to have treatment directed toward its relief and elimination.

Chapter 2 deals in an interesting philosophical way with the meaning and relationship of symptoms and complaints. Indeed the shades of meaning, emphasis and purpose of complaints are considered in fascinating detail that is different and stimulating.

Chapter 5, dealing with pain and the drugs which relieve it, is excellent and merits careful reading by all prescribers. It is interesting to note that general anaesthesia may be safer in relief of severe myocardial pain than the huge doses of morphia sometimes required.

In Part 2, devoted to Practise, is some very honest reporting on the use of many of the new drugs. The chapters on Angina, GI pain, Anxiety, Headache, and Cough will greatly help the conscience of the conservative prescriber. The chapters on Vertigo, Itch, Nausea & Vomiting and Convulsions are rewarding and the majority of new chemicals are discussed, tabulated and related as to therapeutic and toxic potential.

All in all this is a mighty handy book to have for quick reference in particular needs and for a sensible panoramic view of a wide range of modern drugs.

J.W.R.

THERE'S NO PLACE LIKE HOME

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"Organized Home Care provides co-ordinated medical and related services to selected patients at home through a formally structured group comprising at least a family physician, a public health nurse, and a social caseworker assisted by clerical service. For satisfactory functioning the patients must be formally referred and there must be an initial evaluation, monthly review of records, and a final discharge conference. There must be ready access to in-patient facilities.(1)

The philosophy, approach and methods of co-ordination differ in various home care experiments described in the literature. Home care plans may be classified according to the auspices under which they operate. They may be: 1) Hospital-based, or 2) Agency or community-based, or 3) under Medical school auspices, with a student education objective. Dorothy Percy[1] identifies only two types of program, the first being an extension of hospital services, and the second being a co-ordinated community effort, with further variations occurring on these two basic patterns.

A further insight into home care programs may come from a negative approach:

"A Home Care Plan is not a substitute for in-patient, out-patient, or nursing home care if any one of these is what the patient requires at a given point in his illness. It is **not** only for the chronically ill, although many in this group would benefit from this type of care. It is **not** to be thought of chiefly as a device for getting patients out of hospital more quickly, although this can and does happen. It is **not** "cheap", although it may well be "cheaper" (costs for a Home Care day are frequently quoted as being approximately one quarter the cost of an acute general hospital day). It is **not** alone for the medically indigent. The paying patients of many private physicians frequently, through lack of knowledge of what is available in the community, do without services which through a good Organized Home Care program would be brought to them as a matter of course, assisting materially in their rehabilitation.(1)

Whatever the type, sponsor, philosophy, approach or method, the successful organized Home Care Program depends on good team work, including a doctor, nurse, social worker, various therapists and clinical assistants.

SOME CANADIAN HOME CARE PLANS

The various programs in Canada illustrate some of the experiments, advantages, and common features, as well as the problems of this new type of service. A few will serve to indicate the variety of patterns:

1) In Montreal, the Reddy Memorial Hospital program carries on its services in the homes with the co-operation of the Victorian Order of Nurses.

2) The Winnipeg Home Care Program is based in the Out-Patient Department of the Winnipeg General Hospital. Here services are provided through the Victorian Order of Nurses and the Homemaker Service Family Bureau. They have access to the Red Cross Loan Cupboard, and physiotherapists from the Canadian Arthritis and Rheumatism Society give assistance. In this program they feel the key to their success is the good "referral system" and the "constant case-finding". Also success is dependent upon **adequate** medical and nursing attention. In this program **administratively** they ran into a bottleneck with their Homemaker Services.

3) In Vernon, B. C., the program includes convalescent home nursing care and housekeeper services.

4) In Saskatoon, Sask., the Home Care Service is concentrated on the rehabilitation of the senile patient.

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5) Some Provincial Departments of Health have already developed programs in this field, for example:

(a) In British Columbia the Department of Health Public Health Nursing staff provides nursing care in at least twelve communities.

(b) In Ontario, the Public Health Nursing staff of Northumberland-Durham gives bedside care in the rural areas.

(c) The Province of Alberta considers that a modern public health program **should** cover **total health care services.** The Canadian Red Cross and the Provincial Department are co-operating in a research and demonstration home care plan.

A full description of these and other programs is to be found in the medical literature of the last ten years. [2 3 4 5]

MAJOR FEATURES, PROS AND CONS

In reviewing the numerous programs described in the literature, several major features emerge which merit our attention. Centralization of responsibility for administration seems essential. There must be mobilization of services and resources to provide for the individual medical, nursing, social, and rehabilitation needs of each patient within the context of his home and family environment and supported by necessary inpatient facilities. The "team approach" to the patients' treatment program becomes a progressive line of integration, leading from active treatment to the functional and self-maintaining recovery of the individual. Increasing exploration of possibilities of earlier discharge from hospital, to a convalescent home or other institution where indicated, or direct to the individual's home, leads to the best possible use of a Home Care Program.[1]

A Home Care program offers advantages to the patient, to the health personnel responsible for medical and nursing services, and to the community. First, the patient is in familiar surroundings – suitable for his care and treatment. A normal setting aids the morale of patient. Secondly, the security in the knowledge that hospital care is immediately available, including readmission if needed. Thirdly, it frees hospital beds. Fourth, the home provides a special and needed teaching area for medical, social work and nursing students. Fifth, it is less costly to the patient who can pay, and there is less loss to hospital and community for indigent care. Sixth, there is no break in the medical or nursing care of patients discharged from hospital, or awaiting admission. Seventh, the Victorian Order of Nurses feels that "what the V.O.N. has always offered, **now** will be part of a more comprehensive plan for improved care of patients at home". Eighth, the city of Toronto regards this program as "extending medical and paramedical care facilities to serve patients in their own homes."

In reviewing these programs the question comes to mind: "How many practising medical men are aware of the various resources readily available at present to assist them with their patients?"

POSSIBLE PROBLEMS OF HOME CARE PLANS HAVE BEEN NOTED IN CANADA AND ELSEWHERE

First, mass publicity is essential both for interpretation to the profession and to the public, and is expensive and hard to organize. Second, the use of internes in the medical service must be carefully controlled as they are not sufficiently experienced **adequately** to assess the medical needs of the patient. This aspect must also be watched when the service is "used" by a medical school.[6] Third, how are patients without a family doctor admitted to the

Home Care Program? Where the problem has arisen the medically indigent have been admitted through the hospital clinic. Fourth, experience in the programs to date indicates that on admission to hospital the patient should be identified for Home Care, thus allowing time for the public health nurse to prepare the home for the patient's return. Fifth, emergency and necessary re-admission must be understood between the hospital and Home Care Plan authorities at the very beginning.

The case-load for Home Care programs should **not** be limited to chronically ill or elderly patients only.

An accurate assessment of costs needs to be made. Some of the figures quoted currently are based on incomplete data. Hidden costs have not been included in some of the figures so comparisons are not valid. It may well be "cheaper" than hospital services but it is still "not cheap".

The minimum personnel required for Home Care Services are doctors and nurses. Social workers, therapists, nutritionists, laboratory technicians and others may make useful contributions and should be included when and where available. Since many disciplines are involved, team work is essential, and must be planned and organized.

Regardless of the auspices under which the Home Care program might be developed, it is the responsibility of the professional personnel to devise a plan suitable to the needs of the particular area. Much information on the health needs of our Canadian communities will be included in the report of the Royal Commission on Health Services.

Since the official health agency, municipal or provincial, is the body ultimately responsible for health services in its area, it becomes the responsibility of the public health officer to see that opportunity is given for the development and extension of health services.

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BACTERIOLOGICAL ASPECTS OF FOOD-BORNE DISEASE

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One of the ways in which the bacteriologist can assist the health officer and the practising physician in the investigation of food-borne disease is in tracing the source of infection by the various species of pathogenic food borne bacteria. The principle underlying this tracing is that bacterial strains from two or more closely related sources will show identical or similar properties, while strains of different origin may show features which enable them to be distinguished in the laboratory.

Among the important organisms causing food borne disease are bacteria of the genera *Salmonella*, *Shigella*, *Staphylococcus*, and *Clostridium*. A number of different techniques are available which will enable the bacteriologist to predict whether two strains were derived from the same source. Some of these techniques will be considered, giving an indication of their scope and limitations. Some techniques are at present applicable to only one of the genera mentioned – others have a wider range of use.

Serological Typing

The first of these methods is serological, and can establish the antigenic structure of an isolated organism and relate this structure to that of previously identified strains. Establishment of antigenic structure is used most extensively in the Salmonella group.

There are several hundred different types of Salmonella organisms, but fortunately it is not necessary to test individually for each type. Somewhat over half of the serotypes fall into one of five major groups and by careful and discriminating use of sera, it is possible to narrow the field very considerably in a reasonably short time. The full identification of *Salmonella* antigens is often straightforward but may sometimes present technical difficulties, thus prolonging the time necessary for identification of the organism.

If Salmonella organisms of the same antigenic type are isolated from two different sources, for example, the faeces of a patient and the food which that patient has eaten recently, then it is often justifiable to conclude that the contaminated food was the vehicle transmitting the infection to the patient. This indicates the importance of examining samples of food which have been eaten by patients with suspected food-poisoning.

Serological methods are also applicable to the *Shigella* group of organisms which cause bacillary dysentery. By such methods *Shigella* can be divided into four groups, three of which are further subdivided into a number of individual types. *Sh. sonnei*, the cause of many dysentery infections is homogeneous serologically, therefore unfortunately the serological method is of no value in tracing transmission of these infections.

Clostridium welchii has been responsible for a number of outbreaks of "food-poisoning" and it would be desirable to have a method of epidemiological tracing for this organism. The strains involved are similar to those found in

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gas gangrene but produce less toxin and are distinguished by their unusual heat resistance. This resistance to heat depends upon the production of spores, which will germinate in food, especially meat preparations which are allowed, after cooking, to cool slowly and which are eaten the following day, either cold or reheated. Under these conditions, a large population of bacteria may develop in the food, from a small number of spores.

"Food-poisoning" strains of *Cl. welchii* have been divided into eight serological types by means of agglutination reactions. In some outbreaks (Hobbs et al, 1953), *Cl. welchii* organisms isolated from the faeces of patients and from food suspected of causing the infection have been of the same serological type, providing additional evidence that the food was responsible for the infection. However, many strains of *Cl. welchii* have proved untypable by this method, so that there is still scope for elaboration of fresh methods for tracing the path of transmission of *Cl. welchii*. *Cl. botulinum*, a cause of a rare and often fatal intoxication resulting from eating infected food (usually home-canned or pickled) may similarly by typed by antigen-antibody reactions. Five types have been differentiated. Three are known human pathogens.

Phage Typing

Bacteriophage typing has proved extremely useful in tracing the source of some enteric and staphylococcal infections. The phage may be regarded as a virus parasitic or bacteria.

The classical example of the value of phage typing is provided by *Salm. typhi*. The method was introduced by Craigie and Yen (1938). It rapidly established itself as the method of choice for the epidemiological recognition of typhoid strains and served as a model for the development of all later schemes for the typing of bacteria by phage.

The epidemiological principle involved is that if two strains of *Salm. typhi* belong to the same phage type they may have a common origin, whereas if they belong to different phage types, they do not have a common origin. Thus, in investigating the source of a patient's infection with *Salm. typhi*., it is important to determine the phage type of the organism isolated from the patient and compare it with the phage type of the organism recovered from possible sources of infection, such as the faeces of a carrier. Seventy-two phage types of *Salm. typhi* have now been reported. Most types are lysed by one phage only so that the method has a high specificity. The phage types are epidemiologically stable. Some strains of *Salm. typhi* are untypable with phage so that the tracing of their paths of transmission is much more difficult.

Phage-typing schemes have also been described for *Salm. paratyphi B.* and a few other *Salmonella* serotypes.

Phage typing of staphylococci has revealed much useful information about the spread of staphylococcal infections, particularly in hospitals. In some epidemics of staphylococcal "food-poisoning" the phage reactions of staphylococci isolated from the patients have coincided with those of strains isolated either from food or from hands of food handlers, so suggesting a probable source of the infection. A similar technique may be more familiar to those concerned with staphylococcal cross infections in hospitals. Phage typing of staphylococci is not as specific as in the case of *Salm. typhi*, as many strains of staphylococci are lysed by several phages. Interpretation of staphylococcal phage typing reactions is not always easy and demands close consultation between the health officers and the bacteriologist.

Colicine Typing

A recently developed technique shows promise in the epidemiological tracing of strains of *Shigella sonnei*, namely colicine typing. Colicines are substances produced by certain strains of *Enterobacteria* which have a lethal action on other strains of the same or related species. They have several resemblances to bacteriophages but differ mainly in that they do not reproduce themselves inside the bacterial cell. Attempts to type *Sh. sonnei* have been made by Abbott and Shannon (1958) and later by Abbott and Graham (1961), based firstly on the sensitivity of *Sh. sonnei* strains to colicines produced by E. coli and other Sh. sonnei strains, and secondly on the production of colicines by strains of *Sh. sonnei* under investigation.

The colicine sensitivity method was not useful as the sensitivity of epidemiologically related strains often differed. But typing of *Sh. sonnei* strains by their production of colicines has yielded some promising results.

The colicines produced by *Sh. sonnei* strains are detected by their action on a set of indicator strains (mostly *Sh. sonnei*). A freshly isolated strain may produce a colicine which inhibits the growth of a certain number of these indicator strains. If two strains of *Sh. sonnei* inhibit growth of the same indicator strains then those two strains may have a common origin. If the two strains inhibit growth of different indicator strains then their origin is almost certainly different. In practice, epidemiologically related strains frequently have produced colicines active against the same indicator organisms. The percentage of untypable strains varies in different areas and is sometimes disconcertingly high, but the method of colicine typing seems the most promising approach to epidemiological tracing of *Sh. sonnei* yet devised.

The method of colicine typing is a recent one and so far has not been used in Canada. But in the future, it may well reinforce the serological and phage typing techniques in the epidemiological tracing of food-borne infection. For the satisfactory control of food-borne disease it is necessary to know the incidence and type of infection in different areas, and this requires the submission of appropriate specimens to the laboratories as early as possible in the course of infections. The interpretation of laboratory findings should be made by the epidemiologist and the bacteriologist in consultation.

The practising physician may often hold the key to community protection against food-borne disease, as he sees the patient in the acute illness. A high index of suspicion, a specimen bottle in his bag, a question or two about possible sources of infection, a food sample obtained wherever possible, and every family doctor can become a Sherlock Holmes!

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FLUORINE AND DENTAL HEALTH

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It may seem incongrous for a prosthodontist to be speaking about fluoridation but it really is not. We, who are primarily concerned with repairing the ravages of ruined dentitions, are perhaps even more aware of the desirability and value of preserving the masticatory apparatus that Nature has provided, imperfect though it may be.

During the development and growth of the dentition there are many influences upon it, some beneficial and some harmful. A good diet, for example, can have a beneficial influence in the development of sound teeth, but a poor diet can have the opposite effect. Little understood body defences help protect the teeth from attack, presumably by decalcifying bacterial substances produced in carbohydrate food plaques around the teeth. In spite of them, dental caries (or tooth decay) is today the most wide-spread and universal of all diseases. Across the continent, around the world, nearly 100% of all adults have been affected by tooth decay.

"Dental caries is a complex disease. Unlike disease of soft tissue, caries in the hard dental structures exhibits none of the cardinal signs of inflammation. There is no self repair or regeneration of enamel or dentine. There is no atrophy or hypertrophy of these tissues. Dental Caries is an unique pathological process in which biochemical, bacteriologic and metabolic factors are involved".(1)

This being so, it is rightly the concern of public health groups to consider, and endeavour to promote, any measures that will reduce or minimize the terrible toll this disease exacts in pain, discomfort, and expense and even death. Although time and other contributing factors may obscure the fact, I believe there are deaths from oral malignancies that would not have occurred, had it not been for the initial carious lesion.

There have been many plans in the past to control dental caries, some of which have been excellent in theory but failed in practise. It is only within the past two decades that a method of control has been developed that promises to provide a good measure of prevention. The use of fluorides has been proven to be the one hope we have at present of substantially reducing the costly attack upon the dentition by dental caries.

There has been great publicity in recent months in an effort to sell fluoridated dentifrices, and most of the major tooth-paste manufacturers are offering such a product. Such a dentifrice may have some beneficial effect, as indicated by well-controlled studies. However, recent information suggests that the benefits are not as great as advertised, due to the relatively short shelf-life of fluorides in tooth-paste. Further, absorption of fluroride and its incorporation into the enamal of the developing tooth is believed to be more effective than local application. Reliance on fluoridated tooth-paste may encourage a false sense of security, to the detriment of more effective measures. It is well known that any measure of prevention or treatment that depends upon self-application by the patient results in mediocre results at best.

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A recent publication, (2) expresses this thought very aptly, viz: "It is probably true to say that any method of control which will be really effective must involve some action taken *for* the individual rather than *by* the individual. Most people are conspicuous in their indifference to hygienic practises that require the sacrifice of pleasure and the use of rigid self discipline."

There are methods of caries control in use now that are more effective, and that can be more effective still if used to their utmost potential. These are the fluoridation of communal water supplies, and the topical application of fluorides to the teeth of children in all areas where there is not a communal water supply. This method of topical application provided by the Nova Scotia Department of Public Health, Division of Dental Health is doing extremely valuable work in many communities where water fluoridation is not possible (and is a useful adjunct where there is water fluoridation). Reports that have been published in this journal recently, have shown that a significant reduction in tooth decay has resulted from this method of prevention in Halifax. To be of the maximum benefit this service must be provided in all rural areas.

Urban areas with communal water supply provide the greatest opportunity for the use of fluorides in preventing tooth decay, and it is an effective method. Convincing proof of this is contained in a recent report on the Brantford fluoridation study.(3) After 15½ years of fluoridation, of the native 14 and 15 year old children in Brantford, 16% were caries free as compares with 1% of children of the same group in Sarnia where the water has no fluoride content. Per 100 children in Sarnia there was a loss of just under 82 permanent teeth. In Brantford with artificially added fluorine the loss per 100 children was just over 30 permanent teeth. In Stratford where there is fluoride in the water from a natural deposit, the loss was 25 permanent teeth per 100 children. The children of Sarnia averaged about 8 permanent teeth attacked by caries, in Brantford just under 4 and in Stratford about 3. From this report and previous surveys of the native child population of Sarnia, Brantford and Stratford we have indisputable evidence of the effectiveness of this method of prevention. This is paralleled by studies in many parts of the United States.

In Halifax after only five years of fluoridation Dr. Allan R. Morton, Commissioner of Health and Welfare reports a marked improvement in dental health in the 6-8 year group who have had the benefit of fluoridated water for the most part of their lives.(4) The percentage of those who were entirely free from caries increased to 54% in 1961 as compares with 36% in 1956. As might be expected a lesser improvement in older children was evident.

If we accept the evidence that fluoridation of water is an effective means of preventing tooth decay, is it a safe method? Opponents to fluoridation have cited more than 100 disorders that are supposedly caused in humans and animals by fluoride. According to all present medical and scientific knowledge the only disorder that can be caused by ingesting fluoridated water in amounts many times the levels used for preventing caries is mottling of the tooth enamel. This may occur also in areas where water naturally contains too much fluoride. It never occurs where the fluoride content is controlled at 0.8 to 1.2 parts per million as it is in all town and city fluoridation programs.

If we concede that fluoridation is effective and safe, we may then ask - is it expensive? The cost of fluoridating communal water supplies varies from community to community, but it is doubtful if it exceeds a rate of 20 cents per person per year, in any community. When that is compared with the hundreds of millions of dollars that it is costing Canadians annually for dental treatment, one could hardly call fluoridation an expensive preventive measure.

A further question might be asked - are the benefits of fluoridation lasting? While it has not been shown that adults benefit from fluoridation, and results indicate that older children beginning consumption of fluorides for the first time do not benefit as much as do infants or younger children, recent investigations do show that the increased resistance to tooth decay developed in the child is carried over into adulthood, so we can say positively that the results are lasting.

What then are we doing with the safe, effective and inexpensive weapon in the fight against mankind's most prevalent and persistent disease? As of January 1962, 8.4% of Canadians lived in municipalities with controlled fluoridation, a total of 1.5 million people. Compare these figures with the United States where 50 million or nearly 30% live in areas with fluoridated water. In the Netherlands nearly 30% of the 11½ million population will be receiving fluoridated water in the very near future. In the Atlantic Provinces only Nova Scotia has made any progress, and here there are 160,000 people residing in fluoridated areas - of which nearly 95% are in the Halifax-Dartmouth Community and the remainder in Kentville and Wolfville. In Nova Scotia there are still more than half a million people who are being deprived of this great benefit along with a million more in the remaining Atlantic Provinces. Community leadership and medical leadership are required.

In 1961 there were no plebiscites on fluoridation east of Ontario, but in Ontario and Western Provinces there were 36 plebiscites held. Only in 14 were there favorable votes for fluoridation. Would we be so indifferent if these votes had been cast against pasteurization of milk, chlorination of water, or immunization against communicable disease? Fluoridation has come of age and has taken its place in preventive medicine alongside these other great practical and effective measures. It is our duty as members of a scientific profession, as citizens, as parents, to initiate, promote and support a fluoridation program in every community where it is practical and where it does not, at present, exist.

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THE DOCTOR OF TO-DAY
IN
THE REGISTER OF SPECIALISTS

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(1) This article is designed to stimulate and enlighten those members of The Medical Society of Nova Scotia who, at present, may be unconcerned or unfamiliar with the situation.

(2) Also it is designed to bring into sharper focus those concerned and interested in its successful launching.

(3) Since the status of the Surgeon, "The Glamour Boy of Medicine", is presently more involved, this field is used as an example. The plight of the comparatively underpaid Specialist in Internal Medicine and other fields, however, is constantly in mind.

(4) This article should thus serve two purposes:

1. To familiarize the members of The Medical Society of Nova Scotia with the problem.
2. To prepare the ground for an intelligent and reasoned acceptance or rejection of the plan.

(5) It does not necessarily reflect the thinking of the committee,* (of which I am a member) under the chairmanship of Dr. Fred Barton as it is just my own thinking as a member of our Society. The other active members of the committee are Dr. Thomas Gorman, a Surgical Specialist, practising as such, and Dr. F. Murray Fraser, a General Practitioner.

(6) The first fact is that *there is on "Certified Specialist" in Nova Scotia to-day.* Many have earned, by written and oral examinations of the Royal College of Physicians and Surgeons of Canada, either by Certification or Fellowship, the right and privilege to practise as Specialists, if they wish, but the Royal College *does not certify them as Specialists*, nor will it attempt to define a Specialist.

(7) Another fact is that the "setting up" of a "Register of Specialists" is the responsibility of the Province, which, in N. S., would be the Provincial Medical Board.

(8) Still another fact is that, until the "Register" is in operation, the only degree in Surgery that now exists here is the C.M. part of our M.D., C.M., formerly granted by Dalhousie University. The F.R.C.S.(C) is *not* a degree from a University, but a higher qualification recognized by the Royal College.

(9) In order to start the Register on a sound foundation I think:

1) That each applicant should have Certification or Fellowship from the Royal College of Physicians and Surgeons of Canada. Abolition of its Certification in favour of Fellowship alone will be a forward step. With the prescribed number of years of study and training gradually increasing to qualify for writing Certification examinations, one might as well now go for Fellowship.

2) The Register should be started on a modest scale with a suitable Director or Board, whichever the Provincial Medical Board in consultation with the Medical Society decides would be more efficient and effective.

3) The Director or Board should prepare a budget providing for secretarial services, stationery and sundry expenses, so that the Director or Board would receive a remuneration commensurate with the amount of work that would likely be involved.

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*Special Committee on Specialist Register

4) There should be only one fee, that for Registration, not an annual fee. This would serve two purposes:

(a) To help pay the cost of administration.
(b) To allow those who do not feel they can afford to practice as a Specialist at the present time, to decide how they would prefer to practise medicine, before making application to be registered as a Specialist.

5) A review of the Register would only be necessary as situations arise. For example, one applying to be registered as a Surgical Specialist, who has the necessary qualifications, would be entitled to do all branches of Surgery he felt capable of doing; e.g. Ortho-paedics, gynaecology, etc. When one with qualifications in one branch of Surgery arrives in a community to practice the branch of Surgery he has chosen, he may seek to be registered as a Specialist in this branch of Surgery. Dr. Atlee was the first I know of to invade the general Surgical field, in order to practice as a Specialist in Obs. & Gyn. In the beginning he sold many stories to magazines, no doubt in order to eat more regularly, but the position of eminence and fame he achieved is well known to all. What his financial reward was we have no way of knowing.

We have in the Province, generally outside the Halifax area, many doctors, who enjoy Surgical privileges, granted by the Board of Directors of their hospital on the recommendation of their Medical Staffs, after they are screened by the Credentials Committee of the Medical Staff.

Most of them are the older men, who are gradually reducing their range of Surgery to the procedures they like to do and usually do well. They do so without Certification, as they go down their twilight years to eventual retirement, one way or the other.

They pose no problem, nor would they seek to be registered as Surgical Specialists for obvious reasons. They can, with confidence match their years of experience in nearly all branches of Surgery, as well as years of experience in treating the *whole person of all ages* with the one who has an earned Certification or Fellowship but is only beginning his career in Surgery.

I recall attending a medico-legal trial about a "left in" sponge. The lawyer for the defence chose as an expert witness, one with an earned F.R.C.S.(C). When called to the witness stand, the astute prosecuting attorney asked the chosen expert witness how long he practiced as a Surgical Specialist. The chosen expert witness answered "One Year". As Perry Mason would, this lawyer said "No more questions". The chosen expert witness was then requested to "step down", as the defending attorney also had no questions to ask him.

I think the granting of Surgical privileges in all branches of Surgery, by virtue of the basic Surgical study and training, prerequisite to study and training in one particular branch, with earned Certification in this particular branch, is ridiculous. Such basic training and study is as necessary as is an M.D. degree.

There are those with Honorary Fellowships, granted by virtue of their earned Certification or Fellowship from the Royal College of Canada, such as F.A.C.S. and F.I.C.S.

Individuals in these two classes might seek to have their names registered as Specialists, even though, for financial or other reasons, they do General Practice as well. I think they should not seek to register as Specialists, until they decide to practice as Specialists.

In the long run, the Specialist, who has put in the prescribed number of years or more, who has successfully passed the strict Fellowship examinations of the Royal College of Canada, who possesses the ability, tempered by years of experience, which augments his inborn good judgment, whose integrity and character are beyond reproach will have the appeal to attract more referred work to him.

I realize that the proposals I have tried to outline will not win any "Popularity Contest", but are *original*, different, based on sound principles, and peculiarly suitable to our Province, one of the few remaining as the "Land of the General Practitioner".

Whether we like it or not, the legendary type of General Practitioner is gradually fading from the medical scene.

A short editorial recently in a daily newspaper of some stature read as follows: -

"When you are ill, call a Specialist. You may not be any better off, but you will likely be more sure of what you died of."

The disappearance of the old fashioned General Practitioner is a natural evolution in "the law of growth", so that the "Doctor of Yesterday" is scarcely recognized by the "Doctor of To-day", the Specialist. As the "Doctor of to-day" grows older he will scarcely recognize the "Doctor of Tomorrow", in whatever form he may take, e.g., teams of doctors trained and working together in all phases of special fields.

If the proposals I have tried to outline are adopted, *then and only then will a register of Specialists have any meaning or value.*

Then and only then would a dual schedule of fees be justified.

Naturally the general public and some doctors, most of them of the older class, do not like the changes they *see* coming in the ever changing Medical World.

They do not like to see their Angels go. They do not *see* that their Angels go out only so that Archangels may come in.

They do not see any force in the "To-day" to rival or recreate that "Beautiful Yesterday".

There are many, such as I, among our membership in the Society, who are not gifted with the art of expressing our thoughts well, either in the written or spoken word.

There are many among our membership with splendid thoughts, the products of the mind, who hesitate to express themselves for this reason. It is this group from which we would like to hear expressions of opinion, even though they might need help, in the form of ghost writers, to clothe their thinking in an attractive package.

There are many gifted writers and speakers, the products of whose minds are not necessarily of the highest quality, but always remember that, in the final analysis, it is the product and not the package it is in, that is the more valuable.

Finally, I think we should have a section of the Bulletin, such as "Letters to the Editor" or "Brickbats & Bouquets", to encourage expressions of opinion from the general membership. It would help our Executive to gauge the feeling of the membership at large.

SPECIALIST REGISTER – PHYSICIANS' SERVICES INDEX

Progress Report

F. J. Barton. M.D., F.A.C.S.
Dartmouth N.S.

The idea of forming a Specialist Register tool hold in 1954, following a request from Maritime Medical Care and other medical insurance carriers that such a listing be made available. The idea was shortly laid to rest because of the difficulty in defining the term "Specialist."

Following further urging from Maritime Medical Care and in the knowledge that Specialist Registers have been found necessary and useful, and are successfully operating in all provinces of Canada except three, including Nova Scotia, a Committee chaired by Dr. Hugh Martin was appointed in April, 1962, to make a renewed attempt to have the Register set up.

The Committee polled the Branch Societies in early 1962 with respect to the proposal, and received replies from 7 out of 9 inquiries – indicating general approval of the Register in principle – but in the main objecting to any restrictive clause as to the amount of general practice a Specialist would be allowed to do.

When the Chairman of this Committee, was obliged to resign because of illness in August, 1962, the undersigned, who had been a member of the Committee from the beginning, was asked to take on the Chairmanship, and Dr. Martin became a corresponding member.

When the Committee met in November last to prepare a proposal for The Medical Society of Nova Scotia Executive, the members were not unanimous in their decision on one basic principle – that principle dealing with the amount of practice outside of his specialty a member of a Register would be permitted. However, a report was submitted to the Executive in December, 1962, recommending that eligibility for the Specialist Register would require that the registrant should confine himself entirely to his specialty. The Executive amended this proposal to "in excess of 75% of work in his specialty" – and directed the Committee to proceed with implementation on that basis.

It was believed from the outset that the Provincial Medical Board was the logical agency to administer a Specialist Register. The Board was asked if it would take on this responsibility, with the stipulation that eligibility for the Register would be as follows:

(a) All those holding certificates or fellowship in the Royal College of Canada or its equivalent and a licence to practise in Nova Scotia

(b) All those who restrict themselves to their specialty and are recognized by their colleagues as specialists, and who graduated prior to 1948. (This is referred to as the "Grandfather Clause" and provides recognition of those men who, while not holding certificates, might qualify in every other way.)

(c) That all registrants are required to do in excess of 75% of their practice in their specialty.

The Provincial Medical Board, in consideration of this proposal, felt that the restrictive clause limiting the amount of general practice a specialist may do, provided real difficulties in the nature of "policing" which would make the administration of the register very difficult. The decision of the Board with respect to the proposal is:—

"That if and when The Medical Society of Nova Scotia prepares and submits a list of specialists, in the various fields of medical practice, the Provincial Medical Board will agree to undertake the maintenance of such a list or Specialist Register and will publish and make the same available to indemnity companies or other interested parties, at no cost to same. All future additions or deletions necessary to keep the Register up to date are to be supplied by The Medical Society of Nova Scotia."*

In reviewing the decision of the Provincial Medical Board, it was then apparent to the Committee that while the restrictive clause limiting a man to his specialty was an ideal provision, it was probably not adaptable to the Nova Scotia scene at this time and that, perhaps more important, the application of this provision would be very difficult.

At a meeting early in February, 1963, the Committee took a rather different view of the Specialist Register requirements and decided that perhaps it was not so much a Specialist Register that was wanted, as a **Physicians' Services Index.** First of all, it was agreed that any percentage restriction of a specialist to his work was impractical at this time and that accordingly that particular provision should be abandoned. The **Physicians' Services, Index** idea provides for the following:

1. That such an Index would list all registered medical doctors in the Province of Nova Scotia according to the specialty or discipline in which they practise. The Index would set forth, in alphabetical order, all doctors and opposite their names would appear the practice they are engaged in. In the same reference manual would also be listed the various disciplines and specialties setting forth those who practise under those particular headings.
2. The reason for the Physicians' Services Index would be to make available to the Profession, Public, Insurance Carriers and Government Agencies the names of those physicians who qualify for the various disciplines recognized by The Medical Society of Nova Scotia.

In considering the format of the Physicians' Services Index, the following requisites determine the section to which any doctor belongs:

A. Those who practise a specialty fall into two groups:

(a) Those certified by or Fellows of the Royal College. (It has been suggested that those who limit themselves to referral work only, should be referred to as "consultants" and be so designated in the Physicians' Services Index.)

(b) Those practising specialists who qualify for the specialist column by recognition of their fellow physicians and in the opinion of the registering body by virtue of their knowledge and quality of performance.

B. All those who do not qualify under section (A) would be included as follows: General Practice or other branches of Medicine requiring a medical degree, such as Public Health, Medical Administration, etc.

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*Letter to the Executive Secretary of the M.S. of N. S. dated December 12th, 1962.

MECHANISM OF APPLICATION

The following steps are envisioned in the creation of the Physicians' Services Index:

1. A registering body for the Physicians' Services Index would be created by The Medical Society of Nova Scotia, either within its ranks or in collaboration with the Provincial Medical Board.
2. The duties of the registering body would be (a) to have entered into the Medical Act recognition of this Register, and (b) to circularize application forms and information to each licensed practitioner in Nova Scotia, setting forth the questions and endorsations that will be required by the registering body in order to place the applicant in the appropriate category.
3. The final decision on eligibility to qualify for a given section must be reserved by the registering body with powers vested in it by The Medical Society of Nova Scotia.

This outline deliberately avoids the stipulation that those who practise a specialty must do a certain percentage of it in order to qualify for the index. It was felt that this matter will look after itself in the course of time, but the insistence on a percentage is apt to militate against initiating the Index in the first place, and, assuming that the membership of this Society would agree to it, its application would be very difficult with necessary "policing" and creation of ill feeling.

The concept outlined in the above proposal does not single out any group particularly, but indeed recognizes that everyone with an M.D. degree belongs in a given section or area in a Register and that no special prominence is given to any one group of doctors.

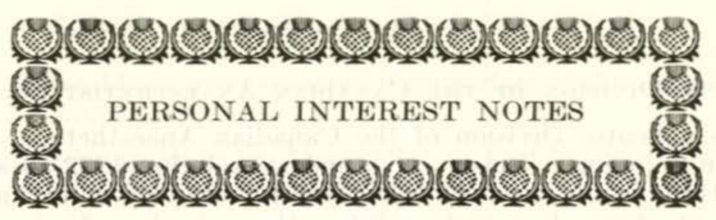
The proposals set forth in this summary are at variance with the views of the former Chairman of this Committee, although he is at present a corresponding member. The undersigned has shared with the former Chairman a wholesome difference of opinion all through our deliberations on this proposal and our opposite views still obtain at the time of writing. In another section of this bulletin there appear the views of the corresponding member.

As it stands now, the Executive of The Medical Society of Nova Scotia, at its meeting on Sunday, February 24th, endorsed the principles of the above submission and instructed the Committee to resume negotiations with the Provincial Medical Board and report at the next meeting.

FOR SALE

Well established general medical and surgical practice in town of 9000 population, Nova Scotia. Two open Hospitals within 10 minutes drive. Annual gross $30,000.00 - Introductions if required - terms acceptable - house included.

Apply Box No. 125, Medical Society of Nova Scotia.



Cape Breton Medical Society

"There is always something happening in Cape Breton". That is what the covering letter said:

1. Dr. Brian Burke, associate anaesthetist, City of Sydney and St. Rita's Hospitals has moved to Dartmouth, New Hampshire where he is now associated with a group Clinic.
2. Dr. S. Gregory MacIsaac, of the New Waterford Clinic is now a Resident in Urology at the Victoria General Hospital, Halifax.
3. Dr. Robert M. Read, a graduate of Dalhousie, and recently with the Dept. of Immigration, London, England, is now associated with Dr. Patrick Kelly, of the Department of Marine and Indian Affairs, Sydney.
4. Drs. Cornelius Donovan of Regina, Sask., and Dr. Eileen McDonagh of Moose Jaw, Sask., specializing in Psychiatry, are now associated with the local Mental Health Division.
5. Dr. H. R. Corbett of Sydney, who has been Consultant in Radiological Services, Hospital Insurance Commission, for the past three years has been succeeded by Dr. C. M. Jones, Chief, Department of Radiology, Halifax Infirmary.

New Waterford

The new medical care plan for employees of No. 12 colliery became effective February 23rd, 1963.

Colchester-East Hants Medical Society

Dr. R. A. MacLellan, an active practitioner and former member of the N. S. Legislature celebrated his 81st birthday at a surprise party attended by 150 friends and relatives. It was held in the Rawdon Gold Mines Community Hall. He was presented with a Hi-Fi set and records and Mrs. MacLellan received a bouquet, while an original poem was read in his honour. Dr. MacLellan was a member of the legislature from 1945-49. He is still district health officer and former past president of the Hants County Childrens' Aid Society and former president of the Hants Municipal School Board. In 1953 he was given an honorary LL.D from Dalhousie University.

The Bulletin extends congratulations and best wishes for many more years of activity.

Cumberland Medical Society

The Annual Meeting was held at the Fort Cumberland Hotel, Amherst, on Feb. 6th. Dr. Clarence L. Gosse of Halifax, a member of The Executive of The Medical Society of Nova Scotia was present. Dr. D. C. C. Brown, Amherst, was elected President, and Dr. J. A. Y. McCully, Secretary-Treasurer. A banquet followed the business meeting to which the wives were invited. The guest speaker was Dr. J. G. Aldous, Head of the Department of Pharmacology, Dalhousie Medical School.

N. S. Division of the Canadian Anaesthetist Society

The Nova Scotia Division of the Canadian Anaesthetists' Society has, to date, been enjoying a constructive and stimulating 1962-63 season. The regular monthly meetings, on the third Monday of every month, are attracting a good turnout of members and an interesting selection of papers have been presented to date.

Dr. Gordon Robson, of Montreal, addressed the opening meeting in October last, his subject being the "Neurogenic Control of Respiration". This proved to be a most excellent presentation and Dr. Robson suggested some very new and stimulating thoughts on the mechanism of respiration.

An original plan has been introduced this season with presentation of papers, at the monthly meetings, by the Residents in Anaesthesia at the Victoria General Hospital. It is felt that the Residents' training benefits from the presentation and preparation of such papers and the audience certainly gains in knowledge since the productions in question are invariably of high calibre, and certainly worthy of attention. So far Dr. W. MacJannet has discussed "Cardiac Arrest" and Dr. W. Turner presented "Shock in Anaesthesia", both topical and highly practical subjects.

Preparation for the combined meeting of the Atlantic Division of the Canadian Anaesthetists' Society, to be held in Moncton, N. B., on the 18-19-20 of April, 1963, is forging ahead and a first rate gathering should be in prospect. Dr. Alan Noble, Montreal, Dr. R. A. Gordon, Toronto, and Dr. Code Smith, Toronto, have accepted invitations to attend as guest speakers and each Division is also planning presentations to augment the programme.

The meeting is being tailored for both General Practitioner and Specialist Anaesthetists and should be well worth a visit from any Doctor interested in the subject. It is hoped that a definitive programme will be available for publication by the end of this month.

Finally, congratulations are in order to Drs. A. H. Hetherington of the Canadian Forces Hospital and Dr. Gordon L. Goulding of the Halifax Infirmary, who gained their Certification in Anaesthesia last fall.

Atlantic Society of Obstetricians and Gynecologists

The third ANNUAL MEETING of this Society is to be held at the Admiral Beatty Hotel, Saint John, N. B. on May 25th, 1963.

Doctors' Doings

Noted in the newspapers this month were the names of: Dr. Robert Belliveau, Meteghan, N. S. 1st prize K. of C. Sweepstake Contest. Dr. H. I. Goldberg entertained for Mr. Arnold Smith, Canadian Ambassador to the U.S.S.R., after Mr. Smith's lecture to the Society of International Affairs. Dr. Peter Gordon, Chairman of the Health Committee of the Welfare Council for Halifax outlined the "Problems of Lengthy Illness" to the February meeting of the Halifax Council of Women.

Dr. Kenneth Hall, Associate Professor of Psychiatry, Dalhousie, spoke to 70 motor vehicle inspectors and examiners at their annual conference held recently in Halifax. "The car serves as an 'ego extension or ego fortified' ". We tend to see the car as part of ourselves.

Dr. F. Gordon Mack was re-elected Commodore of the Royal N. S. Yacht Squadron at its annual meeting.

Dr. Lea Steeves spoke to the Mens' Club of Fort Massey Church on Heart Research from the earliest times up to the present.

Dr. Arthur Murphy in speaking to the Mount St. Vincent Alumni said that Halifax along with the rest of Canada is experiencing a wave of cultural growth.

Congratulations

To the following who have completed the requirements of the Royal College of Physicians and Surgeons of Canada in the recent examinations.

Anaesthesia:	Mary E. Hunter, Dal '57 - Fellowship and Certification - Toronto.
	A. E. Johnston, Dal '56 - Fellowship. Saint John, N.B.
	L. M. Brown, Dal '52 – Certification – Victoria, B.C.
	G. L. Goulding, Dal '54 – Certification – Halifax, N.S.
General Medicine:	D. S. Beanlands, Dal '58 (Certified – Internal Medicine) – Toronto. He goes now to London to study Cardiology.
	P. L. Landrigan, Dal '54 – (Certified – Internal Medicine) now in London, England.
	W. C. Nicholas, Dal '58, (Certified – Internal Medicine). Dr. Nicholas has received a R. Samuel McLaughlin Foundation travelling scholarship which allows him to study Endocrinology for a year in London under Prof. A. Kekwick at Central Middlesex Hospital. He is the youngest Fellow of the Royal College.
Psychiatry:	M. O. Vincent, Dal '55 – Fellowship – Guelph, Ont.
	P. Flynn, Dub. '57, (Resident – V.G.H.) – now Ed. Director, Hospital for Mental and Nervous Diseases, St. John's, Nfld.
	J. L. Frazee, Dal '49 – Certification – Vancouver, B.C.
	Eamon Moore, former Resident V.G.H. – Certification – now with Dr. Flynn, St. John's, Nfld.
Diagnostic Radiology:	W. B. Stewart, Dal '52 – Fellowship – Moncton, N.B.
	J. E. Campbell, Dal '58 – Certification – Montreal, P.Q.
Paediatrics:	A. J. Davis, Dal '55 – Certification – Corner Brook, Nfld.
Neurosurgery:	W. S. Huestis, Dal '56 – Fellowship, Certification – now doing post-graduate work in Toronto.

Orthopaedic Surgery: Antoni Trias, Barcelona '52 – Fellowship, Certification – Halifax.
(Dr. Trias was formerly with the Anatomy Dept. and is now with Dalhousie, and the V.G.H.

Internal Medicine: W. S. Totten, Dal '54 – Certification – Belleville, Ont.

Our **CONGRATULATIONS** are also extended to the following doctors who have been elected to: – *American College of Physicians*, Drs. Cudkowicz, Associate Professor of Physiology and Medicine, Harold Read, Associate Professor of Medicine, and Dr. Lea C. Steeves, Director of Post Graduate Division of Dalhousie Medical School. Drs. Robert N. Anderson, G. Ross Langley and A. J. MacLeod were named Associates of the college. Dr. Langley has been awarded a $30,000 medical grant, payable over five years, by the John and Mary R. Markle Foundation of New York. His postgraduate training has included work at the University of Rochester, and that of Melbourne, Australia. His field of study in Haematology is the metabolism of the erythrocyte. He is now on the staff of Dalhousie and the Victoria General Hospital.

The U. S. Academy of Dermatology has elected to membership Dr. Nicholas I. E. Nemethy, Associate Professor of the Dept. of Anatomy. Dr. Nemethy has been with the Dept. of Anatomy for the last ten years and is the author of a number of papers.

The American College of Radiology has granted the degree of Fellow to Dr. J. S. Manchester. This degree is given to certified Radiologists who have given distinguished service to their specialty over a period of years. Dr. Manchester is a member of the staff of the Victoria General and Childrens' Hospitals, Halifax.

A CANCER RESEARCH FELLOWSHIP at the University of Texas, M. D. Anderson Hospital and Tumor Institute has been awarded to Dr. Charles M. McBride, who has been a Research Fellow at Dalhousie and Two such fellowships are awarded annually in memory of William Heurmann. Dr. McBride has recently been attending the annual symposium on fundamental cancer research in Houston, Texas where more than 60 scientists from 12 different countries took part. His specialty is surgical research and clinical surgery.

Dr. Thane R. Cody, Dal '57 who was a Fellow in Otolaryngology and Rhinology at the Mayo Foundation in 1958 and a recipient of an E. J. Noble Foundation Award in June 1961, has been appointed as assistant to the staff of the Mayo Clinic as of Jan. 1962.

Dr. J. J. Siderov who was on the staff of the Dept. of Anatomy for some years and after certification in Internal Medicine by the Royal College of Physicians and Surgeons of Canada spent the last year in London, at Central Middlesex Hospital working with Dr. E. Avery Jones, is welcomed back to the staffs of Camp Hill and Victoria General Hospitals and the Medical Faculty of Dalhousie.

Dr. N. B. Epstein of McGill University, and the Allan Memorial Institute of Psychiatry, a graduate of Dalhousie was here Feb. 18, 19 and 20th under the

auspices of the Department of Psychiatry, Dalhousie, lecturing on family therapy, psychosomatic medicine, psychoanalysis in Canada, etc.

Dr. R. B. O'Brien of Windsor was honoured with a presentation at the recent annual meeting of the N. S. Division of the Canadian Cancer Society for his many years of devoted service in promoting the interests of the Society.

Births

To Dr. and Mrs. Brian Chandler (née Joan Miller), a daughter, Susan Andrea, at the Halifax Infirmary, on February 16, 1963.

To Dr. and Mrs. Juan Embil, Jr., (née Lourdes Rodriguez), a son, John Manuel Anthony at the Halifax Infirmary, on February 22, 1963.

To Dr. and Mrs. MacKenzie King, (née Loudelle MacLellan), a son, Stuart Arthur MacKenzie, at the Grace Maternity Hospital, on February 23, 1963.

To Dr. and Mrs. Graham Pace, (née Roxie Steven, R.N.), a son Kenneth Graham at the Grace Maternity Hospital, on February 3, 1963.

To Dr. and Mrs. Robert K. Shapter (née Maureen Currie, R.N.), a daughter Anne Patricia, at St. Clare's Hospital, St. John's, Newfoundland on Jan. 21, 1963.

To Dr. and Mrs. E. B. Skinner, (née Joan MacLaren), a son, Peter Stuart, at the Sutherland Memorial Hospital, Pictou, N. S., on February 4, 1963.

To Dr. and Mrs. William G. Tucker (née Edith Bogle, R.N.), a daughter Janet Edith, at the Henry Ford Hospital, Detroit, Michigan, on Jan. 15, 1963.

PLEASE REMEMBER THE FOLLOWING MEETINGS:

PROGRAM FOR APRIL — VICTORIA GENERAL HOSPITAL

WEDNESDAYS, 5 p.m.

April 3	Renal Hypertension	Dr. R. W. Anderson
April 10	Cancer of Cervix	Dr. S. C. Robertson
April 17	Radioactive Iodine	Dr. J. E. Stapleton

OTHER MEETINGS

April 15-17 Sheraton Hotel, Philadelphia
"The Theory and Practice of Auscultation."
April 1-5 Denver, Colorado American College of Physicians.

Last month we reported that The N. S. Medical Bulletin was on file with the Index Medicus, Academy of Sciences, Moscow. We now report that we are exchanging the Bulletin with the "Rumanian Medical Review," Bucharest.

HOUSING APPLICATION FORM

110th Annual Meeting
BRAEMAR LODGE, Yarmouth Co., N. S.
July 2 - 5, 1963
Tues., Wed., Thurs. and Fri.

Dr. C. J. W. Beckwith,
Executive Secretary,
The Medical Society of Nova Scotia,
Dalhousie Public Health Clinic,
Halifax, Nova Scotia.

Please reserve for me the following accommodation: –

A. IN MAIN LODGE:

Double Room with bath - twin beds - including meals.

( ) Lakefront view – $12.00 per person, per day.
( ) Woodland view – $10.00 per person, per day.

B. IN LAKE LODGES:

Double Room with bath - twin beds - including meals.

( ) Lakefront view – $12.00 per person, per day.
( ) Woodland view – $10.00 per person, per day.

C. IN COTTAGE:

Cottage with sitting-room and two or three twin-bedded bed-rooms, including meals $11.00 per person, per day.

I expect to arrive July.............................A.M.......................P.M...................

I expect to depart..

Name of persons to occupy the above accommodations:

Name: ....

Address: ....

....

In view of the attendance expected, no single rooms will be available at BRAEMAR LODGE, unless cancellations permit. If coming alone please check here............if you are willing to share a room. If you have a preference for some party to share a double room with (or couple(s) to share cottage with) please insert name(s) below:

I would prefer to share accommodation with: –

Name: ....

Address: ....

Name: ....

Address: ....

Please check if you are interested in any or some of the following: –

( ) Water Skiing ( ) Deep Sea Fishing
( ) Skeet shooting ( ) Sail Boating ( ) Golf

Signed: .... Date: ....