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THE NOVA SCOTIA MEDICAL BULLETIN

Medicine In Transition

"Ring out the old, ring in the new"

There can be no more appropriate time to discuss the changing political organisation of medicine, and to reflect on the ideals and ideas for which we are striving.

We are fortunate to publish an extremely fine oration "Medicine in Transition", given recently by Dr. Chester B. Stewart. Formerly Dean of Dalhousie Medical School and the initiator of the Tupper Medical Building, he has built up a remarkable reputation which marks him as the father figure of our medical community. His analysis of the Hall Report is lucid and shrewd and whilst you may or may not agree with all his concepts, it rings a bell of warning against the prospects of domination by bureaucrats, whether they are of Government or University domain. He carefully elicits all that is good with our present system and lists some of the services not fully covered — prosthetic services, mental care, home care programs, and the true portability of medical services.

The medical profession has enjoyed relative freedom from rancour in Canada, and it is vital to retain an environment that will allow medical practice to flourish and to stimulate the development of newer concepts and their application. The medical school plays a very vital role in this process. What sort of persons are selected to become medical students, what are their expectations and what opportunities will there be for the full development of their potential? There is not much point in carefully selecting the brightest students, subjecting them to seven years of compulsory and intensive study, if they are to be confined to a limited office practice dealing with minor ailments at the rate of one every three minutes!

Our family practice program brings practical problems to the student early in his career. Our elective research summer projects are a veritable warehouse of stimulating ideas. Yet are we sufficiently careful to stimulate original thoughts from the medical profession as a whole?

This issue of our *Bulletin* is permeated by winds of change. An excellent article by Dr. Gilles Bisson on the Pap 'smear' demonstrates the tremendous contribution made by advances in endoscopy as a result of discoveries in fibre optic physics. "No woman with an abnormal Pap smear or an abnormal cervix on palpation or visualization shall undergo destructive therapy without colposcopic examination". A tall order, but forthright and up to date.

The study on twin pregnancies by Zilbert and Gray shows how a statistical survey can produce practical recommendations. In women expecting twins, the incidence of deliveries before 37 weeks was 16% in those who rested, compared with 44% in those who did not. Early diagnosis of a twin pregnancy and the simple warning to rest would result in significantly less premature deliveries in these mothers.

The teaching of medicine remains an art. One of the most traditional methods is by the patient's bedside, much coveted by Sir William Osler, who was famous for his scholarship, his clinical acumen and his equanimity. Some of his sayings still ring true.

It is remarkable how simple ideas flourish when they hit the right target. One of the outstanding contributions to medicine was made by Dr. Enid MacLeod — a Professor Emeritus in the Department of Physiology and Biophysics at Dalhousie. She was responsibile for introducting curare as a muscle relaxant in anaesthesia. Before the days of muscle relaxants and endotracheal intubation, induction was a slow business, often punctuated by vomiting, laryngeal spasm and considerable apprehension. Literally millions of persons all over the world have benefited from the application of this agent originally used as a deadly poison.

Other remarkably simple inventions were waiting for the observant. Mouth to mouth respiration and closed cardiac massage are just two examples in use every day. Some inventions have laid in wait for many years, shelved until some new master genius dusts them off again. Penicillin, originally discovered by Alexander Fleming in 1928, was too unstable to be effective but was made a dramatically successful antibacterial weapon by Chain and his colleagues in 1941.

> Knowledge and wisdom, far from being one,
> Have oft-times no connexion. Knowledge dwells
> In heads replete with thoughts of other men;
> Wisdom in minds attentive to their own.
> Knowledge is proud that he had learned so much;
> Wisdom is humble that he knows no more.

Quinquennial brain dusting is another suggestion that is highly commendable. A sabbatical leave should not be the sole privilege of the "full-time" staff man. Every physician needs "back to the hospital for renovation and rehabilitation, and regeneration every five years", with so many developments in surgical techniques and medical knowledge. This remedy should be prescribed more readily without fear for the physician's loss of status on his return.

Osler would have approved of the 'Grand Rounds' concept which is being inaugurated in this issue. The article on Marfan's syndrome brings together the pathologist, orthopaedic surgeon, physician and the paediatrician. They highlight the unsolved problems in this genetically determined disease, as well as the philosophical dilemma as to what to tell someone who has a potentially fatal disease.

Case presentations are the 'bare bones' of any clinical problem. Apart from ectopic gestation, spontaneous haemoperitoneum is a phenomenon which may result from many different causes, including vascular or visceral conditions, but Dr. Rex Dunn describes the clinical findings in a man who developed a hepatoma complicating his cirrhosis of the liver.

How are future medical students to be chosen — by athletic prowess (Sir Alexander Fleming was selected by St. Mary's Hospital for his achievements as a water polo enthusiast), by selective examination, by interview, by computerized analysis, or by physical status? Is there another Lord Moran who can select a medical student by personal interview, arrange the affairs of a Royal College and still have time to be the personal physician to one of the most demanding Prime Ministers of all time — Sir Winston Churchill?

Personal character is something only time and circumstance can evaluate. Dr. Montague MacMillan spent only a few weeks as a locum in general practice before embarking on a lifetime career as a Cape Breton doctor. Yet is was his peculiar qualities of charm, ingenuity and determination that allowed him to use a speedometer cable successfully as an esophageal bougie, carry out thousands of deliveries in primitive conditions under chloroform anaesthesia, and drive through many a blinding snowstorm to reach the lantern hanging in the patient's doorway.

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Dr. Alan J. MacLeod

PRESIDENT
1980-1981
The Medical Society of Nova Scotia

Dr. Alan J. MacLeod was born in Caledonia, Prince Edward Island in 1919.

He studied pre-med at the Prince of Wales College and spent two years teaching in public schools on the Island after graduation. In 1941 he enlisted in the Royal Canadian Air Force and served as an air navigator in the Bomber Command with the 431st Squadron. After the war he came to Halifax to complete his medical degree at Dalhousie University. Graduating in 1950, he and wife, Catherine MacDonald of Campbellton, New Brunswick, moved to the quiet, reflective little town of Moser River, Nova Scotia, where he practised until 1956 when he returned to Dalhousie for his post-graduate training in Internal Medicine. In 1961 he joined the Dalhousie Faculty of Medicine as an Associate Professor of Medicine.

Dr. MacLeod has been in Nova Scotia since 1945 and a member of The Medical Society of Nova Scotia for thirty years. He has served as Honorary Secretary of the Provincial body; President of the Halifax Branch and President of the Nova Scotia Internal Medicine Society.

His personal stamina and energy would rival that of any sixty-five year old Swede. At a very youthful sixty-one, Dr. MacLeod still swims everyday, enjoys good food, hiking and walks almost everywhere he goes. Being a "country-boy" he likes the out of doors, but for the same reason he loves the excitement of big city life.

Dr. MacLeod is well known in the medical community for his extensive work in Renal Dialysis and is Director of that Unit at the Victoria General Hospital. His clinical interests are renal disease and allergy. Too bad, however, there aren't enough hours in the day — the new President would like to renew one or two of his old hobbies, like hunting and fishing.

□

Medicare in Transition*

C. B. Stewart**, M.D., Dr. P.H.,

Halifax, N.S.

I feel highly honored that the Dalhousie Medical Students' Society has invited me to give the Friday-at-Four Lecture. It is satisfying to the old man's ego to be taken down from the shelf and dusted off occasionally! But I was especially pleased when your President, Miss Jane Henderson, asked me to speak about the recent review by Justice Emmett M. Hall of the National-Provincial Health Programs and the reaction of The Canadian Medical Association at its meeting last month in Vancouver. It is good to know that medical students are interested in this subject. I think it is vitally important that the physicians of today — and of tomorrow — learn how our present system of medical practice evolved over the last thirty years and how they may be affected by changes that are now under consideration both by the CMA and by Governments.

I chose the title "Medicare in Transition" although I dislike the vague word "Medicare". It seems to mean just about anything that a newspaper writer or politician wants. Does it mean all services provided by a physician to his patient, or all personal health care including medical, nursing, hospital and pharmaceutical services? Or is it the system of financing either of these? Or some combination of the above. A woman recently said to me in angry tones: "I went to my doctor and he gave me a prescription, but the druggist made me pay for it. What kind of Medicare is that!"

You should at least make sure whether a speaker or writer uses "Medicare" to mean medical services — what a doctor does for his patient — or medical insurance — what a Government does to pay the patient's bill. You cannot use the same word for both without creating confusion for yourself as well as others. Mr. Hall uses the term Medicare only occasionally but does not define it. I shall try not to use it again.

Mr. Emmett M. Hall, retired Chief Justice of Saskatchewan, was appointed a Special Commissioner to review Canada's Health Services in 1979 by the Hon. David Crombie, then Minister of Health and Welfare. The report was submitted to Hon. Monique Bégin, present Minister of Health and Welfare. As you may know, the same Justice Hall was the Chairman of the Royal Commission on Health Services from 1961 to 1965. His two reports Volume 1, 1964, and Volume 2, 1965, are here on display, and there are several research reports prepared for the Commission which would equal the size of these two weighty tomes. Hall's Royal Commission was appointed by Rt. Hon. John Diefenbaker, Prime Minister of Canada in 1961, but Hall reported to Rt. Hon. Lester B. Pearson in 1964. Does history repeat itself? If so, the next Conservative Prime Minister may think twice before offering Mr. Hall a consultant position!

Mr. Justice Hall was asked to conduct a rather extensive investigation, and it is a good indication of his own health status that this vigorous man of eighty plus held hearings in every province, received a huge number of briefs, and completed a 101 page report in less than a year, in spite of a long interruption by an election campaign, during which hearings could not be held.

I do not need to spend much time telling you why the Hall Survey was undertaken. Many physicians in Prince Edward Island and Ontario, and to a lesser degree in some other provinces, had "opted out" of Medicare. The out-flow of Canadian practitioners to the United States was causing concern. Mr. Hall's report does not give these two reasons, but suggests it was time for a review because hospital insurance had been in effect for 21 years and medical insurance for 11 years. Economic changes had occurred in Canada. Health care priorities and technology were under constant development. Changes had been made in the financial arrangements between the Federal and Provincial Governments. There was growing concern that the monies provided by the Federal Government were inadequate to take care of the programs of hospital and medical insurance. At the same time there was a feeling that provincial priorities were sometimes upset because shared programs got most attention.

Hon. Mr. Crombie asked Mr. Hall to determine how well the goals enunciated in the 1964 *Health Charter for Canadians* had been met, and how effective were the medical and hospital plans from the standpoint of portability, reasonable access, universal coverage, public administration, adequate compensation and uniform terms and conditions. I will postpone comment on these and on the Health Charter and will compare Hall's 1980 recommendations with his own charter of 1964 later.

At present it is sufficient to say that Mr. Hall was *not* asked to determine whether the present plan is the best for Canadians, but how well it matches his own 1964 proposals and how closely it meets the basic principles on which hospital insurance had been established in 1959 and medical insurance in 1966.

The Hall Report indicates that most of these specific aspects, such as portability were not of great significance. The two items that eclipsed all others in public, professional and governmental perceptions were extra-billing by physicians and conflict over physicians' fees. They frequently almost monopolized many of the hearings.

By "extra-billing" Mr. Justice Hall meant billing the patient in excess of what the medical insurance system provided, whether it was an unlimited amount determined only by the doctor, or an amount sufficient to bring the charge up to the level recommended by the medical society of the province. Usually these two are differentiated. Let me explain. The Provincial Medical Society sets a *schedule of fees*, so much

*Dalhousie Friday-at-Four Lecture, October 17, 1980.

**Emeritus Professor of Epidemiology, Dalhousie University, Halifax, N.S. B3H 4H7.

for an office or home call or for a long list of diagnostic or operative procedures. The Government agency sets a *tariff*. This may be a percentage of the Medical Society fees or it may be specific for each service.

When voluntary medical insurance was organized in Nova Scotia in the early 1950's under Maritime Medical Care Incorporated, doctors agreed to accept a pro-rating of their fees. This was partly to subsidize their own insurance plan, but it was also justified at the time because of the reduction in billing and other office work, and the escape from "bad debts". The later Government plan followed the same pattern and set the tariff below the fee schedule. It might, for example, pay 85% of each charge. The term "extra-billing" may mean billing 15% up to the fee set by the Society, or it may give the doctor freedom to set a higher fee. In the latter case, the insurance regulations require that the doctor tell the patient in advance that there will be an extra charge.

Hall calls both of these "extra-billing". He does not differentiate between a fee set by a "free and self-governing profession" and, the ultimate in laissez-faire practice, the complete freedom of an individual doctor to charge all that the traffic will bear. The principles involved are very different, as is well known to those who helped plan the voluntary insurance systems or participated in negotiations as Government plans were developed.

"Opting-out" is another term with different meanings. In Quebec an opted-out or non-participating physician is completely outside the Government plan and so are his patients, who cannot obtain reimbursement for medical expenses. In most other provinces that allow opting out — and some do not — the doctor bills the patient, who can then collect the 85% or other amount approved in the provincial tariff. This amount may be paid by the Government insuring agency directly to the doctor, but in a number of provinces it is paid to the individual patient. He or she may or may not then pay the doctor — or may buy a new fur coat with the gall-bladder money!

The chief conclusions and recommendations of the Hall Review were:

1. Adequate recompence for physicians.
2. Elimination of extra-billing.
3. Compulsory arbitration, if negotiations on fee schedules are unsuccessful.
4. Elimination of premiums in Ontario, Alberta and British Columbia.

Hall believes that the medical profession and the Provincial Governments have two viewpoints in complete opposition, and which cannot co-exist. The medical profession maintains that it has the right to determine its own fee structure as a free and self-governing profession. The provinces and their paying agencies insist that, in the absence of an agreement with the profession about the fee schedule, the power rests with the province to fix the tariff *and the physicians must abide by that tariff.* Physicians do not quarrel with the Province's right to set a tariff or insurance benefit, even when it is less than the fee schedule. It is the last clause which creates the problem — no extra billing.

Hall argues that the medical profession cannot be a law unto itself in fixing fees for its services. He again quotes his own favourite reference — The Hall Royal Commission Report of 1964.

"The emphasis on the freedom to practice should not obscure the fact that the physician is not only a professional person but also a citizen. He has moral and social obligations, as well as self-interest to do well in his profession. The notion held by some that the physician has absolute right to fix his fees as he sees fit is incorrect and unrelated to the mores of our times. The nineteenth century laissez-faire concept has no validity in the twentieth century in its application to medicine, dentistry, law or to any other organized group. Organized medicine is a statutory creation of legislation and of parliament. When the state grants a monopoly to an exclusive group to render an indispensable service, it automatically becomes involved in whether those services are available and on what terms and conditions".

Hall also says:

"Nor has the state the right to conscript the services of physicians".

It should be pointed out that the above is only Hall's opinion and is not to be regarded as a court ruling. In fact, even a non-lawyer can suggest some counter-arguments or raise relevant questions. Why should the profession of medicine be the only one subjected to this level of government control? Fees of dentists and lawyers are set by the professional body, and Hall suggests no changes. Furthermore, it is not correct that Governments have granted a monopoly right to organized medicine. Governments appoint the Licensing Board or College, which is responsible to Government, not to the Provincial Medical Society. The Hall viewpoint may be a valid argument against giving each individual physician the right to set his own fee and vary it depending upon the patient's means, while at the same time accepting the standard fee from the insurance plan. But he applies the same argument against the potentially much smaller charges designed to bring the total fee to the standard level considered fair by the whole profession.

Nevertheless, the chief message of the Hall Review is clear, Governments have not financed hospital or medical insurance adequately. This message, I think, has received too little attention by the press, T.V., and even by the Canadian Medical Association. It is easy to see why Governments have not paid any attention to it.

Hall says, for example:

1. "Virtually all who opposed extra-billing (at the hearings) were equally forthright in advocating that physicians were to be adequately compensated".
2. "Criticism is justified of the exaggerated data on physicians' incomes, almost universally given out by Provincial Commissions and headlined by the media. This has created the impression that physicians' incomes are much higher than they are".
3. "The real point is the right of physicians to be adequately compensated for their services, no more, no less".
4. "I reject totally the idea that physicians must accept what any Province may decide unilaterally to pay. I reject too the concept of extra-billing".
5. "The policy throughout Canada of reducing the ratio of beds to population, which is being systematically carried out actually before alternative facilities are available to accommodate patients being discharged from acute

hospitals, present problems not envisaged in 1964."

6. "The plan (Hospital and Medical Care Acts) provides for . . . the furnishing of insured services . . . on a basis that provides for reasonable compensation for insured services provided by physicians . . ."

Hall made it quite clear that the elimination of extra-billing by physicians or hospitals and the provision of satisfactory finances by government were *both* essential. One should not be done without the other. His proposal was that, if negotiations on physicians fees fail and an impasse occurs, the issues in dispute must be sent to binding arbitration. The Arbitration Board would consist of three persons, an independent chairman to be named by the Chief Justice of the relevant province, one nominee from the profession and one from the Government. He suggested that the Provincial Governments now have the power to outlaw extra-billing and should do so. But it must be a condition that the province enacting such legislation would itself, in the Act, agree to accept binding arbitration. The two elements must be twinned. The right of the Cabinet to approve or disapprove of the arbitration award should no longer exist.

The Canadian Medical Association, at its meeting in Vancouver, expressed its disapproval of a system of compulsory arbitration. Doubt was expressed that governments would accept this reduction in their power to control the public purse. In fact, the Minister of Health for the Province of New Brunswick had already rejected it out of hand before the CMA met. Most provincial ministers followed suit, and I understand that they made this abundantly clear at a recent meeting with the Hon. Monique Bégin. It would therefore appear that the argument is not simply between the medical profession and the Hall Review. As has happened on a number of other occasions recently, it is a quarrel between the provinces and the Federal Government.

Perhaps the CMA should have let the Governments take the blame for rejecting Hall's recommendation. As it was, the medical profession caught almost all of the newspaper flak for this rejection.

It would seem logical that Governments should also reject the other half of Hall's twin recommendation. If they do not accept compulsory arbitration as a means of ensuring adequate financing of the plan, then they should not out-law extra-billing. But one can never guarantee that logic will prevail. Some provinces already refuse to allow extra-billing.

The President of The Canadian Medical Association, Dr. D. L. Wilson, said that the CMA would support several of Mr. Hall's recommendations in the Review of Health Services. Unfortunately he did not say which ones, although Dr. Thomas, the in-coming President, later did so in a letter to all CMA members. Dr. Wilson categorically rejected Hall's package of proposals to resolve what were called the dominant issues. "Mr. Hall's proposals that all direct personal responsibility for the payment of health care costs be eliminated, that all health care costs be paid by government from taxation revenues, that payment for physician services come from one source only, and if necessary be determined by compulsory arbitration, are not in the best interests of the public or the profession".

Dr. Wilson noted that one of Mr. Hall's proposals would infringe on the patient's right to select a physician of his choice. Under this proposal patients choosing an opting out physician would be denied their share of the financial benefits of the medical care insurance program for which they would have paid. "The Hall system", he said, "would, in labour relations terminology, mean that a physician would become a government-retained independent contractor — in fact, a civil servant". "In a very real sense, Mr. Hall's recommendation is that health care insurance, which the medical profession of Canada has pioneered and strongly supports, would be abandoned in favour of state medicine".

This differentiation between a Government plan to ensure payment for hospital and medical services and a Government plan to control and operate these services has already been referred to in my criticism of the vague term "Medicare". Unfortunately the term "State Medicine" — fighting words to the CMA — is equally hard to define and is probably better avoided.

Dr. Wilson said that, if the governments accept Hall's proposals, it would be inevitable that physicians would seek the protection of some form of union organization rather than the current voluntary association of self-employed professionals. He, therefore, recommended that the General Council direct the Board to explore the potential benefits of the unionization of the profession, with attention to such issues as defined hours of work, premiums for hours on call, overtime, weekend and holiday service, standardized working conditions and grievance procedures, indexed pensions, and other fringe benefits that are available to state employees.

I agree with the criticisms of the Hall Review made by the President and General Council of The Canadian Medical Association, but I think it was unfortunate that they decided to study unionization at the meeting in Vancouver. *For the first time in the last ten years a strong and independent voice had been heard, to the effect that governments had not been financing hospital and medical care insurance adequately and that they should mend their ways.* In my view, that was by far the most important message in the Hall Review. No matter how often or how loudly physicians said this, they were suspected by the public of trying to feather their own nests.

Instead of concentrating on Hall's positive support and using it to persuade the public and government, the CMA placed emphasis on organizing a union to combat compulsory arbitration. Any newspapers or magazines, that I have read, have concentrated almost totally on this threat by the doctors, and they seem almost 100% unsympathetic. *Maclean's,* with its scare cover on the Medicare Crisis, was typical. I think the timing of the study on union-organization was poor. Furthermore, the leaders conveyed the impression that they did not necessarily mean it. The new CMA President, Dr. Thomas, describes the decision as "Unionization if necessary but not necessarily unionization". Most of this audience is too young to recognize this as a parody of Prime Minister MacKenzie King's description of his plebiscite on conscription during World War II. That wily old politician formulated a question that meant one thing in Quebec, something else in the rest of Canada, and, behold when it was over, it meant something else to MacKenzie King himself. I do not think Dr. Thomas has chosen a very admirable model. However, I do not disagree with the idea of obtaining cost estimates of what it would take to finance a medicare service under civil service rules. It would probably suggest to Government that they are better off under the present plan. But the study could have been done anytime

during the last ten years and probably should have been.

I am personally opposed to union organization of the medical profession. I think it is unprofessional, and I regret that the Canadian Association of Internes and Residents has supported and even organized strikes. Younger people may think this an old-fashioned viewpoint. That is a matter of opinion. But, aside from the ethical aspect, please consider this very practical viewpoint. It seems to me that the reaction against strikes in the public services is growing steadily. I suggest that the organization of a physicians' union would do more than anything else to precipitate drastic legislation to outlaw strikes, and medicine would find itself classified as an essential public service. We would thus hasten or ensure the conversion of the present medical insurance system, with all its flaws, into a state medical service, which would be much worse. Hall did not recommend that solution either in 1964 or 1980. But Mlle. Bégin obviously favours a state or public medical service. Why play into her hands?

Now, let us test Hall's proposed solutions in 1980 against his own proposals of 1964. You will recall that Hon. David Crombie asked him to comment on the adequacy of present programs in meeting the goals of the Health Charter for Canadians proposed by the 1964 Royal Commission on Health Services. Mr. Crombie seems to have assumed that the medical insurance plan introduced in 1966 was meant to implement this recommendation of the Royal Commission. The legislation does not state this specifically, and I am not sure that Mr. Crombie was right or what the status of this so-called Charter may be.

The Health Charter for Canada reads as follows, and I shall emphasize certain phrases which I would like to discuss:

> **"The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving *individual and community responsibilities* and actions. This objective can best be achieved through a comprehensive, *universal Health Services Program* for the Canadian People.**
>
> ***Implemented* in accordance with Canada's evolving constitutional arrangements;**
>
> ***Based* upon *freedom of choice*, and upon *free and self-governing professions;***
>
> ***Financed* through *prepayment arrangements;***
>
> ***Accomplished* through the *full co-operation* of the general public, the health professions, voluntary agencies, all political parties and government, federal, provincial, and municipal;**
>
> ***Directed* towards the most effective use of the nation's health resources to attain the highest possible levels of physical and mental well-being".**

Let us consider Hall's recommendations of 1980 in the light of this Charter:

1. *Involving individual and community responsibility* — But Hall recommends removal of personal or family premiums or extra-billing for any service, the only personal contributions now left. How are unfair or unnecessary patients' demands to be curtailed and responsible use encouraged? He does not say.

2. *A Universal Health services program* was recommended in the 1964 Charter. What did Hall mean by that? Recall my professorial insistence on clear definitions in relation to "Medicare". Did Hall mean health services or health insurance? He says "health services". In any event the important point, in my view, is that the Government legislation, which had already set up hospital insurance in 1959, was an *insurance* system. It did not guarantee hospital care to you or me if we need it, and it did not take over and operate the hospitals. It only guaranteed that the insurance fund would pay the bill if we obtained hospital care — a horse of a very different color. And no matter what Hall meant in his 1964 Charter, the Federal legislation of 1966 established a medical *insurance* plan — not a medical *service* plan. The Federal legislation was *"An Act* to authorize the payment of contributions by Canada toward the cost of *insured* medical care services incurred by provinces pursuant to provincial medical care *insurance* plans".

But don't be lulled into security by this observation of mine. The Hon. Monique Bégin speaks of "publicly financed *medical services"*, not medical insurance, and she has the financial clout.

Coming back to the Health Charter:

3. *Freedom of choice* was to be upheld — But Hall now recommends that no patient may choose an opted-out physician without losing his insurance coverage. Freedom must be paid for, doubly.

4. *Free and self-governing professions* were to be guaranteed. Hall's own 1964 statement that physicians are not free agents in setting fees, was contrary to this principle. How free and self-governing? Not in fee setting, says Hall.

5. *Pre-payment arrangements* were recommended in the Charter. The essential feature of an insurance system is a pooling of all prepaid premiums and the payment from this pool for the insured services. Now Hall says no premium should be charged or no special tax on an individual or family. Hiding the cost by using general tax revenue does not improve efficiency or stimulate a sense of responsibility.

6. *Full cooperation of governments* is a basic requirement. The change in financial arrangements a few years ago was forced on the provinces by the Federal Government.

In effect, Hall's charter of 1964 seems to me to have been badly mauled by governments and by Hall's own Review in 1980.

A few comments on the other items that Hall was asked to review may be in order, but these will have to be brief and incomplete.

Portability means that any Canadian should be able to get medical and hospital services if he travels anywhere in Canada. His home province is then billed by the Governmental insuring agency in the province where he received the service. This creates some problems. Proof of eligibility is required if he is from British Columbia, Alberta or Ontario. Did he pay his last premium? Students have had many problems on transfer to a university in another province. Reimbursement to physicians and to hospitals is slow. Specialist fees are based on home province rates.

Reasonable Access: Hall says premiums in Ontario, Alberta and British Columbia limit accessibility. So do hospital charges for ward care in New Brunswick. He also

deplores the closure of hospital beds in some provinces. Hall is of the opinion that a special tax may impede some poorer persons from obtaining insured medical and hospital services. However, there are methods in the three "premium" provinces to take care of such cases and they are said to work reasonably well.

If he had presented any valid evidence that these charges did, in fact, bear unfairly on the poor, the conclusion might be justified. Extra charges to ward patients and extra billing by physicians both began to reach levels where they created concern only after governments cut hospital budgets drastically and refused to allow fee increases to match inflation. The federal bureaucrats took the lead in persuading or forcing the provinces to reduce expenditures. Bed closures, which Hall criticizes, have also been a direct result of federal actions.

Universal and Comprehensive Coverage was said to be a requirement.

The Hall Review again quotes the Hall Royal Commission of 1964 which listed essential or comprehensive services as follows:

> Physician services;
> Dental care for children, expectant mothers and public assistance cases;
> Optical services for children and public assistance;
> Prosthetic services;
> Home care;
> Mental Health Services.

If Hall's 1964 report was a charter accepted by the Government of Canada, they have done a poor job of meeting its requirements. In fact, only physicians' services are covered completely. Some other services, of those listed, are supported by some of the provinces but are not started by the Government of Canada.

Did the Hall Review point to these deficiencies? Not at all. He merely reiterated his view that extra billing reduced the availability of physician services on "uniform terms and conditions".

In my view, his 1964 prescription or charter was never adopted or applied by the Federal Government. They introduced a medical insurance plan, not a medical services plan, and they disregarded the other services he considered essential for comprehensive coverage.

Public Administration: In Hall's view this seems to have been satisfactorily achieved.

Reasonable Compensation: As already indicated this was the major problem. And it holds for hospital as well as medical insurance.

The major problem, therefore, of the health services of Nova Scotia is *underfunding,* as the Hall Review shows. The reason for underfunding, I place very firmly at the door of the Department of National Health, which has consistently argued that the services should be trimmed back within one or two years of the passing of the original legislation, beginning with the Task Force Reports of 1969.

This view can be proven from Mr. Hall's own reports of the Royal Commission on Health Services in 1964. He estimated in 1962 what the medical services insurance would cost per capita by 1966 and by 1971. The per capita figure in Nova Scotia for insured medical services in 1971 was lower than Hall's estimate, if inflation is taken into account. The figure for hospital costs in Nova Scotia on a per capita basis were significantly below the Hall estimate for 1971, in spite of the howl from Ottawa for many years that costs were excessive. They were, in fact, well within the limits that had been projected. So while Mr. Hall does not fix the blame, I place it on the shoulders of the Ottawa bureaucrats.

Much of the data presented to the Hall Review by The Canadian Medical Association, and in Nova Scotia by the Provincial Division, indicated that the financial situation of the medical profession had been eroded over the last few years. Several statements in the Hall Review, as already noted, indicate that Mr. Hall was in sympathy with this and did not feel that governments had adequately supported the insurance programs.

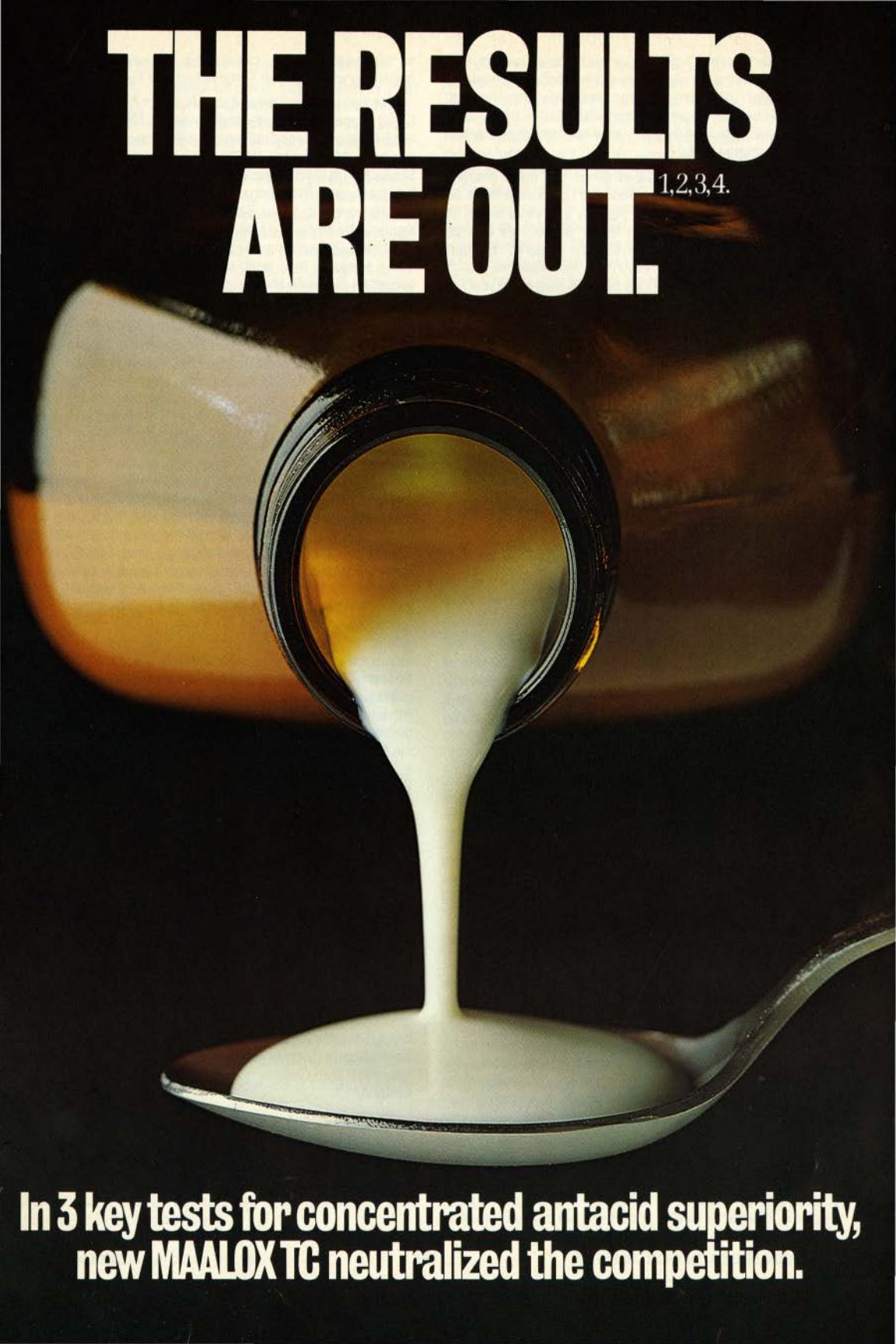
Most physicians would rather work under the medical services insurance plan, as shown by the return of many of those who opted out in Prince Edward Island last year. Most do not extra-bill when they have the right to do so, provided the provincial tariff is reasonably good. Both opting out and extra-billing are looked upon as safety valves, and should be retained. But instead of increasing the use of either extra-billing or opting out or of making a half-hearted threat of "unionization" I think that physicians should continue their efforts to convince the public and government that the insurance plans must be adequately financed. Both patients and physicians are penalized by the present budgetary restrictions. And personally I believe that the patients, who have to wait for months to get a hospital bed, are worse off than the physicians.

I hope I do not live to see the day when you, as young physicians will find yourselves under the thumb of Government bureaucrats more than you now are. But I hope equally fervently that you will not place yourselves under union bureaucrats. If you watched T.V. during some of the recent disputes, you might have judged how much freedom the union members had.

In the bad old days, unions were set up for very good reasons and they went on strike against the owner of the plant. They thus penalized the true culprit by reducing his profit. Not so today. On our return from the CMA in Vancouver my wife and I stopped off in Calgary to see her sister. We missed seeing a niece who was still in British Columbia at their summer home, so that the children could go to school. Teachers in Calgary had been on strike for 120 days. They penalized the children and their parents. Air traffic controllers in Toronto penalized us, not Air Canada, on the way back from Calgary. We spent an hour circling over Lake Ontario.

Don't penalize your patients!! □

THE RESULTS ARE OUT.[1,2,3,4.]



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Once again, Maalox TC came out on top with 3.55 mg Na/80 mEq, the lowest sodium content of all major antacid concentrates. An important consideration in the treatment of patients on sodium restricted diets.

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Concentrate D	39
Concentrate E	36

B[5], C[6], D[7] Parke-Davis; E[8] F.W. Horner.

The final test (Rossett-Rice) compared duration of neutralization while controlling pH between 3.0 and 5.0.

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PRECAUTIONS: Magnesium salts, in the presence of renal insufficiency, may cause CNS depression. Aluminum hydroxide, in the presence of low phosphorous diets, may cause phosphorous deficiency. Aluminum salts tend to cause constipation. Magnesium salts tend to cause loose stools.

Do not administer concomitantly with tetracycline antibiotics or iron preparations.

DOSAGE: 5-10 ml 4 times a day, taken 20 minutes to 1 hour after meals and at bedtime. Higher dose regimens may be employed under the direct supervision of a physician in the treatment of active peptic ulcer disease.

SUPPLIED: Each 5 ml of sugar-free peppermint flavoured suspension contains 600 mg of aluminum hydroxide (equivalent to dried gel) and 300 mg of magnesium hydroxide. Sodium content: 1.13 mg/5 ml. Available in 340 ml bottles.

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4. Independent tests conducted June, 1980. Data available on request.
5. Mg $(OH)_2$ 400 mg; $Al_2(OH)_3$ 400 mg; 30 mg simethicone/5 ml.
6. Mg $(OH)_2$ 400 mg; $Al_2(OH)_3$ 400 mg/5 ml.
7. Mg $(OH)_2$ 400 mg $Al_2(OH)_3$ 400 mg/5 ml.
8. Mg $(OH)_2$ 300 mg; $Al_2(OH)_3$ 600 mg/5 ml.
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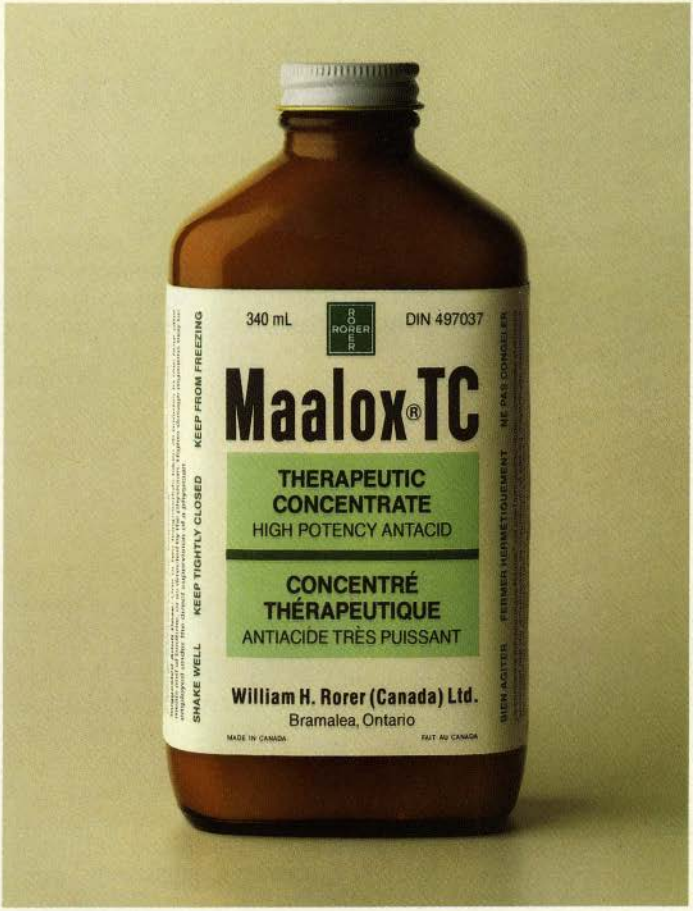

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HIGHEST POTENCY[4]
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LONGEST DURATION OF EFFECT.[4]

The Abnormal Pap Smear

Gilles E. Bisson*, F.R.C.S.(C),

Halifax, N.S.

The management of the patient with the abnormal Pap smear has changed considerably, (some would say radically) in the last few years. This has been due to the complementary use of cytology, colposcopy, target-directed biopsies and endocervical curretage when necessary, and new modalities of treatment of cervical dysplasias and carcinomas-in-situ such as cryosurgery[2,4,8,9].

Traditionally in the mangement of abnormal cytological findings suggesting intraepithelial cervical neoplasia, (which varied from a report of atypical cells through the various degrees of dysplasias to carcinoma-in-situ), the patients were followed by a series of Pap smears at various intervals of time depending on the degree of abnormality as assessed cytologically. In a small number of cases the cytological abnormality disappeared but usually it progressed to severe dysplasia or carcinoma-in-situ at which time the patient was subjected to conization or hysterectomy. Conization was used for definitive histological diagnosis and to exclude invasive cancer, and in some cases, for treatment. The final treatment was usually hysterectomy if invasive carcinoma was excluded.[7] This meant that a woman with an abnormal Pap smear was placed under considerable psychological strain for a varying period of time (which could be long), especially if she was told, or got to know through friends, that dysplasias eventually became cancers in a larger number of cases.[4]

With the new approach, in most centres, the patient with an abnormal Pap smear is sent immediately for colposcopic examination and evaluation. If any suspicious area (or areas) is detected by colposcopic examination, a punch biopsy (or multiple punch biopsies) is taken and a histological diagnosis is obtained immediately. And if the abnormality is one of the dysplasias of any degree of severity up to and including carcinoma-in-situ, the patient is treated with cryosurgery (electrocautery or with CO_2 laser beam therapy depending on the facilities of the institution). At the present time cryosurgery is favoured. Electro-cautery is used also but has the disadvantage of requiring anesthesia in most cases for good results [2,6,7]. After treatment, cytology is an excellent method of follow-up, with colposcopy as necessary[4].

Colposcopy is a technique for the in vivo stereoscopic or binocular visualization under magnification (approximately 12 times) with direct illumination, of the vulva, vagina, cervix and lower endocervical canal. Evaluation is based on the observation of surface features of the area examined such as color, topographic and architectural changes, and blood vessel configuration. The actual technique of colposcopy is adequately described in textbooks and will not be further elucidated here. An experienced colposcopist, on detecting a suspicious area, will take a target-directed biopsy. Colposcopy is simply a method of looking at the cervical epithelium under magnification and should not be over-mystified. But it does require a trained colposcopist and should not be performed by one who is unacquainted with the techniques involved. In some cases where the lesion extends into the endocervical canal, the colposcopist should be prepared to do an endocervical curretage as part of the diagnostic technique. In a small percentage of cases, conization or even hysterectomy is still necessary for a final diagnosis and for the exclusion of invasive carcinoma and for treatment [2,4,7].

All these procedures (cytology, colposcopy, endocervical curretage and cryosurgery) are carried out as office or clinic procedures and do not require hospitalization or anesthesia (with the exception of electrocautery). Cytology, colposcopy with target-directed biopsies and in some cases endocervical curretage yield accuracy rates in the diagnosis of cervical intraepithelial neoplasia of approximately 95% (in some series 99.3%). Treatment of cervical intraepithelial neoplasia with cryosurgery yield cure rates with the first "freeze" of between 50-90%. More recent series give a cure rate of up to 90%. A second "freeze" or even a third "freeze" brings the cure rate even higher and as this requires no hospitalization or anesthesia there is no great obstacle to repeated treatments [2,7,11].

This new conservative approach to the management of the abnormal Pap smear is particularly welcome as more and more young women are involved, in many cases teenagers. The reason for this phenomeon is not known; it could be that we are screening younger and younger women. Some authors speculate this may be due to the pill, the sexual emancipation of women, the new morality, etc.[5]. Conization and hysterectomy today are considered as procedures that are too drastic, and result in too many complications and too much morbidity, to be used on young women whose atypia may be transitory and of little importance [7,8,9]. Colposcopy is mandatory in the evaluation and management of the pregnant patient with the abnormal Pap smear [1,3,7,9,10,12,13]. Providing that invasive carcinoma can be excluded by colposcopy, target-directed biopsies, and endocervical curretages, these patients can be managed and brought to term with little risk to the fetus or mother [7,9,12].

Colposcopy is available at six centres in Nova Scotia in 1980. With this regional availability, no women with an abnormal Pap smear or an abnormal cervix to palpation or to visualization, should undergo any destructive therapy, that is conization or hysterectomy, without first receiving the benefit of a colposcopic examination and evaluation. □

*Director of Cytopathology, Department of Anatomical Pathology, Victoria General Hospital, Halifax, N.S.

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GUIDELINES FOR AUTHORS

In 1978, a number of American, British and Canadian editors of medical journals met in Vancouver, to establish a common format for the submission of papers, and their deliberations resulted in the "Declaration of Vancouver". The Editor and the Editorial Board of the *Bulletin* have decided to adopt this new format, beginning in 1981, and the changes are chiefly in the style used for citing references.

The entire manuscript should be typed double-spaced on one side only, with generous margins on all four sides. Tables should not be included in the text but typed on separate pages, as should the references and the legends for any figures and illustrations.

Non-metric units should not be used in scientific contributions. Parts of the SI system are controversial or unfamiliar, especially concentrations of substances, gas tensions, blood pressure and radiological units, so that authors should provide conversion factors. Abbreviations should be defined when first mentioned and, if numerous, the author should provide a glossary which will be printed separately in a prominent place in the article.

In general, papers reporting on studies should adhere to the following sequence:

a) **Title page** — title of article (concise but informative); first name, middle initial and surname of each author, with academic degrees; names of department or institution to which the work should be attributed; name and address of author responsible for correspondence or reprints; source of support (if any).

b) **Summary or Abstract** — not over 150 words, summarizing the purpose, basic procedures, main findings and principal conclusions.

c) **Materials and Methods** — describe the selection of subjects, the techniques and equipment employed, the types of data collected, and the statistical tests used to analyse the data.

d) **Results** — describe in logical sequence, using tables and illustrations.

e) **Discussion** — emphasize new and important aspects, and the conclusions that follow from them. Recommendations, when appropriate, may be included.

f) **Acknowledgements** — only those persons who have made substantial contributions to the study.

g) **References** — usually limited to 10 for short papers and to a maximum of 20 for review articles. Number in sequence, in the order they are first mentioned in the text, with journal titles abbreviated as in *Index Medicus*.

Examples of the new format are:

1. Journal articles — list all authors when six or less (surnames followed by initials *without* periods); when seven or more, list only the first three and add *et al.*

Epstein SW, Manning CPR, Ashley MJ, Corey PN. Survey of the clinical use of pressurized aerosol inhalers. *Can Med Assoc J* 1979; **120:** 813-816.

2. Book —

Fletcher C, Peto R, Tinker C, Speizer FE. *The Natural History of Chronic Bronchitis and Emphysema.* Oxford: Oxford University Press, 1976.

3. Chapter in book —

Deusche KW. Tuberculosis. In: Clark DW, MacMahon B, eds. *Preventive Medicine.* Boston: Little, Brown, 1967: pg 509-523.

h) **Tables** — type each on a separate sheet, number consecutively with *roman* numerals. Supply a brief title for each, give each column a short or abbreviated heading, and reserve explanatory material for footnotes.

i) **Figures and Illustrations** — professionally drawn and photographed, as glossy black and white prints, numbered consecutively with *arabic* numerals. List all legends on one page and state magnification of photomicrographs.

Atlantic Provinces Twin Study — 1977-1978*

Arthur W. Zilbert,** M.D. and Joyce H. Gray,†R.N.,

Halifax, N.S.

ABSTRACT

A survey of 261 twin pregnancies was conducted for 1977-78 at eight Atlantic Province hospitals. The twin pregnancy rate was found to be 9 per 1,000 births. Twenty-three percent of the twins were diagnosed at the time of delivery; fifty-nine percent prior to thirty weeks gestation. Delivery occurred after 37 weeks gestation in 58% of the twins; fifty-seven percent weighed less than 2500 grams at birth. The overall Cesarean section rate in twins was 23 percent. Ten percent of all the twin pregnancies were rested prophylactically prior to 30 weeks gestation. Of the non-rested pregnancies, 44% delivered before 37 weeks, while only 16% of the rested group delivered before 37 weeks gestation.

INTRODUCTION

Two hundred and sixty-one twin pregnancies were reviewed to determine the current management of twins in the Atlantic provinces. The review looked specifically for evidence of early resting either at home or in hospital, since the benefit of rest has been reported.[1,2] The study looked also at a variety of parameters to correlate the Atlantic provinces' results with past reports of twin management.

METHOD

A review of the charts of all twin pregnancies was carried out for the years 1977 and 1978 at the following Atlantic province hospitals: Saint John General, Saint John, New Brunswick; Moncton Hospital, Moncton, New Brunswick; Dr. Everett Chalmers Hospital, Fredericton, New Brunswick; Grace Hospital, St. John's, Newfoundland; St. Clare's Mercy Hospital, St. John's, Newfoundland; St. Rita Hospital, Sydney, Nova Scotia; and Charlottetown Hospital, Charlottetown, Prince Edward Island. A review of 1978 was carried out at the Grace Maternity Hospital, Halifax, Nova Scotia.

There were 28,498 deliveries in the hospitals surveyed in that period, of which 261 were twin pregnancies. Individual chart reviews were carried out by designated physicians using a data retrieval form. The individual and total hospital results were then compiled.

The study determined maternal age, gravidity, the twins' gestation at diagnosis and at delivery, the method of diagnosis, delivery method, frequency of complications, perinatal outcome, Apgar score and whether or not early resting was utilized.

RESULTS

The incidence of twin pregnancies was 1 in 109 (0.9%). The yearly incidence ranged from 0.7% to 1.2% of deliveries. (Table I)

TABLE I

TOTAL NUMBER OF TWIN AND ALL DELIVERIES IN THE ATLANTIC PROVINCE GROUP 1977 AND 1978

Center	Twin #	Deliveries %	Total Deliveries
A	54	(1.1)	5017
B	28	(0.8)	3483
C	52	(1.2)	4356
D	22	(1.1)	2078
E	38	(0.8)	4872
F	36	(0.8)	4837
G	23	(0.8)	2763
H	8	(0.7)	1092
Total	**261**	**(0.9)**	**28498**

Women aged 18-25 years delivered 44.4% of the twins, while those aged 26-35 delivered 49.4%. Women less than 18 years of age and those over 35 years delivered 3.5% and 2.7% of the twins respectively. One hundred and seven (40.9%) occurred in primigravidas and 154 (59.1%) in multigravidas.

Forty-six twins (17.6%) were diagnosed before 24 weeks gestation, 66 (23.5%) from 24-30 weeks, 97 (37.2%) from 31-36 weeks, and 52 (19.9%) were diagnosed after 37 weeks.

At the time of the study, ultrasound was available at only one of the hospitals surveyed. Forty-four (81.5%) of the fifty-four twin pregnancies at that center were diagnosed by ultrasound, with an intrapartum diagnosis rate of 9.3%. The remaining seven hospitals, without ultrasound readily available, had incidences of intrapartum twin diagnosis ranging from 21% to 50%.

One hundred fifty-three pregnancies (59.6%) were delivered at term (>37 weeks gestation); four pregnancies (1.5%) terminated prior to 24 weeks; and delivery occurred between 24-30 weeks in 17 (6.5%) and between 31 and 36 weeks gestation in 87 (33.3%) of the twins. Early rupture of membranes occurred in 0.8% before 24 weeks gestation; in 10 (3.8%) from 24 to 30 weeks; and in 33 (12.6%) of the twins from 30 to 36 weeks gestation.

The presentations of Twins A and B are shown in Table II. Data were not available for six and seven of the charts for Twins A and B respectively.

The methods of delivery for Twins A and B are shown in Table III. On three occasions, Twin B was delivered by Cesarean section after Twin A had delivered vaginally.

*Presented at the Atlantic Society of Obstetricians and Gynecologists Meeting in Charlottetown, Prince Edward Island, September 21, 1979.

**Resident, Department of Obstetrics and Gynecology, Dalhousie University, Halifax, N.S.

†Research Nurse, Division of Perinatal Medicine, Department of Obstetrics and Gynecology, Dalhousie University and the Grace Maternity Hospital, Halifax, N.S.

TABLE II

PRESENTATIONS OF TWINS A AND B

	Twin A		Twin B	
	#	%	#	%
Vertex	204	78.2	150	57.5
Breech	51	19.5	104	39.9

TABLE III

METHOD OF DELIVERY TWINS A AND B

	Twin A	Twin B
Spontaneous	137 (60.2%)	140 (53.6%)
Forceps	46 (17.6%)	38 (14.6%)
Breech Extraction	—	22 (8.4%)
Cesarean Section	58 (22.2%)	61 (23.4%)

Ten of Twin A (3.8%) and 11 of Twin B (4.2%) weighed less than 1000 grams at delivery; weights of 1000-2499 grams were recorded in Twin A and Twin B in 51.7% of the pregnancies; and weights of 2500 grams or greater were recorded in 43.4% of Twin A and 41.8% of Twin B. Twin B weighed more than Twin A in 40.2% of cases.

Eighteen of Twin A (6.9%) and 33 of Twin B (12.6%) had Apgar scores less than four at one minute. Five minute Apgar scores of 4 to 6 were recorded in 25 (9.6%) of Twin A and 51 (19.5%) of Twin B. ($p<0.005$). Twin A was stillborn in 3 (1.2%) of the pregnancies and Twin B in 6 (2.3%). There were 15 neonatal deaths (5.8%) recorded for both Twin A and Twin B.

Fifty-three twin pregnancies (20.3%) were first hospitalized before 30 weeks gestation and 115 (44.1%) were initially hospitalized after 37 weeks. Two centers noted that continual hospitalization or strict bedrest at home prior to 30 weeks had occurred in 9.5% of the pregnancies. (Table IV) Of the non-rested group, 44.1% delivered prior to 37 weeks. ($\chi^2 = 6.23$, $p<0.02$), while only 16% of the rested group delivered prior to 37 weeks.

TABLE IV

EFFECT OF REST

Center	Delivered # Rested	≤ 37 Wks	Delivered # Non-Rested	≤ 37 Wks
A	19	4	35	16
B	6	0	22	13
C	—	—	52	22
D	—	—	22	11
E	—	—	38	16
F	—	—	36	20
G	—	—	23	3
H	—	—	8	3
Total	**25**	**4 (16%)***	**236**	**104 (44.1%)***

*$p<0.02$

DISCUSSION

The frequency of twins delivering in the Atlantic Provinces continues to be about 1%, with 0.9% in the study and 1.02% in the Grace Maternity Hospital, 1965-1972.[3]

Maternal age in our study was similar in distribution to the findings of both Hendricks[4] and Robertson[5] in that the greatest number of twins occurred in the 26 to 35 year old range. Both of their studies, however, had a greater percentage of twins born to mothers over 35 years of age.

Early diagnosis of twins is stressed by many authors,[1,2,5,6] Manlan and Scott[3] advocate the use of routine ultrasound at 16-20 weeks to reduce the high percentage of perinatal mortality and growth retardation contributed by undiagnosed twin pregnancies.

Forty-nine percent of twins studies by Robertson[5] were delivered with birth weights less than 2500 grams and 56.9% of those studied by Farooqui.[7] This study agrees with Farooqui in that there is a similar percentage (20%) of breech presentations for Twin A and 40% for Twin B. Koivisto[6] reported a 22% incidence of Cesarean section which was similar to the section rate in the Atlantic Provinces.

The Atlantic Provinces survey showed a neonatal mortality rate of 5.8%. Reported perinatal mortality rates are 6.6% (Powers), 7.1% (Koivisto), and 9.0% (Farooqui).[2,6,7] Twin B was twice as likely to have a low one-minute Apgar score. Koivisto made a similar observation.[6] The Atlantic Provinces survey showed a significant increase in low five-minute Apgar scores in Twin B compared with Twin A ($p<0.005$).

Twins were diagnosed at delivery in 17.7% of Farooqui's study.[7] Twenty-five percent of the twins were diagnosed during labour or at the time of delivery at the Atlantic Province hospitals where ultrasound was not readily available. The incidence of intrapartum diagnosis was 10% at the center where ultrasound was utilized. Since 1978, ultrasound has now become available at all of the Atlantic province hospitals surveyed.

Forty-two percent of twins surveyed delivered before 37 weeks while 31% of Jouppila's study group delivered early.[1] This would probably account for the higher incidence of birth weights less than 2500 grams in the Atlantic Provinces study group. Only 41% of Jouppila's study group weighed less than 2500 grams.

Twin pregnancies contribute to an undue percentage of perinatal mortality and morbidity. To improve these results, controlled bedrest has been advocated[1,2,5,8,9] but not all agree on benefits of rest.[10] In the Swedish study, early diagnosis and bedrest was encouraged in twin pregnancies with approximately 35% of the patients staying in hospital for more than ten days; usually at 34 weeks.[1] The perinatal mortality rate was lowest in the group with over ten days in hospital. The highest perinatal mortality rates were for those twins diagnosed at delivery. Power's evaluation of Illinois statistics recommended rest between 27 and 34 weeks gestation.[2] Babies born after 34 weeks gestation in Power's study had a fifty-fold reduction in neonatal mortality compared with the group delivered prior to 34 weeks.

In our study, prophylactic bedrest prior to 30 weeks was employed at two hospitals in only 9.5% of twins although 43% of the twins had been diagnosed before 30 weeks. There was a significant difference in the incidence of deliveries prior to 37 weeks between the rested women compared with women who were not rested early.

CONCLUSION

This survey of the 1977-78 twin pregnancies in eight Atlantic Province hospitals confirms the findings of other

authors[1,6,7] on incidence, maternal age, parity, presentation, relative weights and methods of delivery. The findings of this study suggest that bedrest at an earlier stage of gestation may lead to the delivery of twins at later gestation with higher birth weights. □

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THE MEDICAL SOCIETY OF NOVA SCOTIA

PROCEEDINGS OF
16th MEETING OF COUNCIL
and
127th ANNUAL MEETING

November 21-22, 1980

INTRODUCTION: The 16th Meeting of Council began as the Medical Society Officers accompanied by Dr. W. D. S. Thomas, President of The Canadian Medical Association, paraded through Council Chambers to the head table. Following call to order by Dr. M. A. Smith, Chairman of the Executive Committee and General Council, the Officers were introduced and Dr. Thomas brought greetings from The Canadian Medical Association. Dr. Thomas wished Council well in its deliberations and indicated that he would be available to participate in the meeting as required.

Dr. Smith welcomed the Exhibitors and recognized their contribution to the Annual Meeting. He encouraged Council Members to visit the displays and discuss the products and services with the representatives. Dr. Smith extended the Medical Society's invitation to the representatives to attend the Banquet and Ball on Saturday evening.

Council began as Mr. D. D. Peacocke, Executive Secretary, read the names of Society members deceased since October 1, 1979 as follows: Dr. Gerald D. Belliveau of Yarmouth; Dr. Hugh J. Brown of Halifax; Dr. William E. Fultz of Glace Bay; Dr. Lachman Gursahani of Sydney; Dr. Gerald J. Lebrun of Bedford; Dr. J. Carson Murray of Springhill; Dr. Walter J. Payne of Sydney; Dr. Harold A. Ratchford of Agincourt, Ontario; and Dr. L. A. Skinner of North Sydney.

The Transactions of the 15th Meeting of Council and the 126th Annual Meeting 1979 as printed in the December 1979 issue of The Nova Scotia Medical Bulletin were approved.

ARCHIVES COMMITTEE REPORT: The Chairman, Dr. E. F. Ross, reported that the transfer of all Medical Archival material into and under the control of the Provincial Archives is proceeding very well because of the excellent co-operation received from Mr. Hugh Taylor, Provincial Archivist. Referring to the $15,000.00 (over three years) contribution to this project previously authorized by the Society, he reported that there will be no expense to the Medical Society beyond that expenditure for the purpose of arranging, cataloguing, recording, and displaying archival material.

The Committee is in the process of obtaining the first fluroscope ever used in Nova Scotia.

Council approved his Committee's resolution "THAT Society members make a special effort to preserve material for preservation of medical history.

CHILD HEALTH COMMITTEE REPORT: Dr. R. F. Gunn's report was presented by Dr. J. G. Seaman. Just recently formed, the Committee planned to deal with topics such as School Health in particular relation to sports activities, facilities available for psychiatrically disturbed children, broadening access to information on social agencies available to family doctors, teen-age pregnancy, and abuse of alcohol and other drugs.

BY-LAWS COMMITTEE REPORT: The Chairman, Dr. C. H. Reardon, was unable to attend Council. His report, containing the recommendation "THAT there be no change in the current criteria for the selection of Senior Members of The Medical Society of Nova Scotia," was referred to the Executive Committee for attention.

COMMUNICATIONS ADVISORY COMMITTEE REPORT: Dr. P. D. Jackson, Chairman, recommended to Council that this Committee be dissolved on the basis that its role had been assumed by the Society Officers and the Executive Secretary. His recommendation was approved.

COMMUNITY HEALTH COMMITTEE REPORT: Dr. D. C. Brown, Chairman, summarized for Council the reports of his four subcommittees — i.e. Cancer, Drug & Alcohol Abuse, Nutrition, and Physical Fitness, whose Chairmen were Drs. A. F. Pyesmany, C. W. MacNeil, C. N. Williams, and B. R. Wheeler respectively.

During the year the Cancer Committee worked extensively with the Society in relation to the Nova Scotia Cancer Treatment and Research Foundation legislation which was eventually passed and after considerable input from the Society is now consistent with the Society's views and objectives.

Dr. J. P. Savage raised the problem of drug abusers taking advantage of physicians for the purpose of obtaining drugs for use or sale and provided Council with several examples of well-travelled abusers who were able to obtain several prescriptions for large quantities of drugs in a very short space of time.

Council considered a resolution "THAT after liaison with the Nova Scotia Commission on Drug Dependency, it look into the establishment of a **Confidential** list of known drug abusers to be available to doctors throughout the Province for consultation and use".

The resolution was discussed extensively with questions regarding maintenance of confidentiality of patient information, compilation of the list, its storage, access to it, and payment for the service being asked. It was stated that these points would be looked into when the Society discussed the proposal the Nova Scotia Commission on Drug Dependency. Saskatchewan has had experience with this system. Information will be obtained from that Province to facilitate Nova Scotia endeavors.

Arising out of a suggestion from the floor, the Nutrition Committee agreed to look into the matter of increasing interest on the part of the public in ortho molecular therapy.

Dr. Savage spoke to the appalling decline in physical fitness amongst children once they reach school age, and urged Council members to take this matter up with their community school boards. He outlined for Council an experimental physical education project currently being carried out in a couple of schools in Dartmouth. Information on this is available through Dr. Savage.

Council urged the Chairman of the Child Health Committee and the Chairman of the Subcommittee on Physical Fitness to co-ordinate their efforts relating to Physical Fitness and Physical Education in schools. On this same subject, Dr. Wheeler confirmed that his Subcommittee was preparing a Brief to the Minister of Education on Physical Education in Schools and that this would be presented to the Executive Committee before presentation to the Minister.

Council then passed two motions: "THAT The Medical Society of Nova Scotia endorse PARTICIPATION'S Program entitled — Fitness,

The Facts, and recommend that physicians obtain copies of this package for the information of their patients." and "THAT The Medical Society of Nova Scotia continue to support the participation awards to Cross Country Skiing and Orienteering, by providing $500.00 for each programme."

At the conclusion of this Committee Report a recommendation "THAT the Occupational Health Committee become a Subcommittee of the Community Health Committee" was defeated. Secondly, this Committee's recommendation "THAT a representative be nominated from the Department of Preventive Medicine to the Community Health Committee" was defeated and the Chairman was informed that it was his prerogative to name his own Committee members.

EDITORIAL COMMITTEE REPORT: Dr. B. J. S. Grogono outlined for Council the activities of the Editorial Board and described a variety of proposals which they hoped would improve the quality of the Bulletin and increase member interest in it. He reported that there was an operating surplus of $623.00 but this was attributable to the fact that there were only five issues last year.

His recommendation that the Society continue financial support was approved.

ETHICS COMMITTEE REPORT: Dr. R. T. Michael's report contained no recommendations and was therefore received for information.

EXECUTIVE COMMITTEE CHAIRMAN'S REPORT: Dr. M. A. Smith presented to Council a comprehensive report on the activities of the Executive Committee over the past year. He described his report as a synoposis of the meetings of the Committee during the past year, including all the decisions take by either the Executive Committee or the Officers. He mentioned that two very productive meetings had been held outside Halifax, one being in June in Yarmouth, and the other the Summer Meeting at Keltic.

The high cost of Summer Meetings was raised and discussed. Dr. Smith reminded Council that an ad hoc committee had been struck for the purpose of investigating the continuation of Summer Meetings.

Dr. C. B. Stewart informed Council that he was a member of the C.M.A. Committee on Allied Health and asked for support. He expressed pleasure that the Society had struck the Committee on Allied Health Disciplines and stated that the Committee would be of assistance to him in dealing with this major concern of the medical profession.

FINANCE COMMITTEE REPORT: Dr. W. C. Acker, Society Treasurer, presented the Budget and Financial Statements for the Fiscal Year ending September 30, 1980. Following a question/answer period relative to the Budget, it was noted that the Budget had been approved by the Executive Committee at Keltic. Council further approved that the Financial Statements of The Medical Society of Nova Scotia for the Fiscal Year ending 1980 be approved, and that H. R. Doane and Company be retained as the Medical Society's Auditors for the year 1981.

HOSPITALS & EMERGENCY SERVICES COMMITTEE REPORT: Dr. W. G. Dixon, Chairman, reported on the wide range of activities engaged in by his Committee during the past year. These included the subject of Hospital By-Laws, the study of medical organization in nursing homes and homes for special care, physician involvement in highway crashes, and standards in hospitals.

Responding to a question, Dr. Dixon said that because of shortage of time his Committee had not had the opportunity to give consideration to the details of ambulance personnel and services.

Council approved his motion "THAT The Medical Society of Nova Scotia recommend to the Department of Health of the Province of Nova Scotia that it demand that all Hospital Boards include in their By-Laws a requirement that each hospital seek and acquire accreditation."

MATERNAL & PERINATAL HEALTH COMMITTEE: Dr. R. H. Lea, Chairman, presented a comprehensive report which appeared in four parts: (a) Perinatal Mortality for both the Province of Nova Scotia, and by regions; (b) Annual Report of the Reproductive Care Program; (c) Educational Program Activities Pertaining to Prenatal Care for Public Health Nursing; and (d) Maternal Mortalities in Nova Scotia during the Past Year (Circulated at Meeting).

Dr. Lea drew Council's attention to a point of particular pride to the Committee — i.e. Nova Scotia has the lowest mortality rate in Canada. Dr. Lea reported that Council 1979 had directed his Committee to look into Public Health Nurses' Prenatal Classes and that this had been done.

MEDICAL EDUCATION COMMITTEE REPORT: Dr. M. S. McQuigge, Chairman, complimented the C.M.A. for its efforts in getting Continuing Medical Education tax deductible. He indicated that it was not yet possible to measure the effect of this change on attendance at Continuing Medical Education programs.

He reported that the Division of Continuing Medical Education, Dalhousie University has arranged a course on the basics of physiotherapy for physicians, and that the Advanced Cardiopulmonary Resuscitation Course has proven to be extremely popular. He encouraged continuing interest by all physicians in this program. He also reported that the demand for Mandatory Continuing Medical Education is lessening, with Manitoba delaying its requirement that this be undertaken. His Committee is opposed to Mandatory Continuing Medical Education.

MEMBERSHIP SERVICES COMMITTEE REPORT: Dr. L. A. Fried, member, presented this report on behalf of Dr. M. J. C. Thomson, Acting Chairman, who was unable to be present. The report provided Council with the details relative to the shift of the long term disability, business expense protection, and accidental death and dismemberment insurance plans to the Ontario Medical Association Plan.

The computerization of the Society's program was reported on as progressing quite satisfactorily.

The development of personal lines insurance was noted and favorable comments were made regarding these plans. Members are encouraged to inquire into the details.

It was noted that membership has increased to 1,187 from 1,143 in 1979. The grand total including students and Interne/Resident members is 1,857; total of non-members is 247 — down 13 from 1979.

OCCUPATIONAL MEDICINE & REHABILITATION COMMITTEE REPORT: Dr. A. Prossin, Chairman, stated that the combining of the committees of Occupational Medicine and Rehabilitation, with Workers' Compensation Board Liaison as a sub-committee has been effective in terms of co-ordinating work relating to workers' health and safety.

Dr. Prossin reported on the follow-up of last year's recommendations. He has met with the Workers' Compensation Board on matters relative to rehabilitation and educational programs, also with the Faculty of Medicine regarding increased reference to these topics in the undergraduate curriculum.

Council approved his recommendations (1) "THAT The Medical Society of Nova Scotia continue to support the thrust made to this date in establishing occupational heatlh services for workers: (2) "THAT it continue to recognize and support the development of rehabilitation services for workers; and (3) "THAT further educational programming in the area of occupational health and safety be encouraged at medical school level, and in continuing medical education programming."

The subject of the interrelationship between Medical Services Insurance and Workers' Compensation Board in terms of payment to physicians was raised and concerns expressed. Dr. Prossin confirmed that this was a concern of the Society and would be worked on in the year ahead.

PHARMACY COMMITTEE REPORT: The Chairman, Dr. T. J. Marrie, reported on the very favorable response received to his Committee's questionnaire on Supplementary Information on Medication (S.I.M.) and that the information would be most valuable to him in discussing the subject of S.I.M. with the Nova Scotia Pharmaceutical Society.

Dr. Marrie presented his first resolution "THAT The Medical Society of Nova Scotia endorse the principle of Product Selection provided that the prescriber has the freedom to write 'No Product Selection', if he desires." This was discussed at length and concern was expressed that the physician was abrogating his responsibility by permitting the pharmacist to make the choice of drug to be administered to the patient. It was not agreed that this proposal would represent any specific cost-savings to the consumer. The resolution was defeated, thus the policy of the Society continues to:

> "That every person who dispenses a prescription may **when** directed by the prescriber, select and dispense an interchangeable pharmaceutical product other than the one prescribed, provided that the inter-changeable pharamceutical product dispensed is listed in an Approved Comparative Drug Index and is equal to or lower in cost to the patient than the product prescribed."

Dr. Marrie introduced two resolutions: (1) "THAT 'phone-in prescriptions' only be by a physician, and that The Medical Society of Nova Scotia approach the Provincial Medical Board for further advice on this matter." and (2) "THAT The Medical Society of Nova Scotia support the Supplementary Information on Medication Program, and that an evaluation of the effectiveness of this Program be carried out." which were carried.

PRESIDENT'S REPORT: Dr. Margaret E. Churchill expressed her appreciation to the Society and Society staff for the support given her in fulfilling the role of President during the year. She reported to members on the activities which had involved her office specifically.

In particular, she discussed the subject of relations with Government and reported that these continue at a high level. The principal reason for this is the common understanding of Medicare — i.e. it is an **Insurance Program** operated by the Government, the Program pays only a portion of the doctor's fee, the physician has a legal and professional right to bill the patient for the remainder of his fee, that physicians are self-employed professionals and NOT employees of Government, and that billing above tariff — currently maintaining steady levels — is not a problem.

Dr. Churchill also discussed the subject of public relations and the modus operandi of the Society in relation to this matter. Following on Mr. Charles Lynch's speech, in which he had expressed the view that the best approach by the medical profession was not the super-hype programs that some divisions are conducting but the maintenance of an on-going, steady program which emphasizes the doctor/patient relationship. She expressed the view that the Society policy of openness with the media has been productive.

She reported that discussion of the Hall Review continues at both Government and professional level and that a series of meetings have taken place regarding action for the future. She informed the meeting that the Society would be supporting a government approach to the Minister of Finance of the Federal Government relative to the problem of underfunding of health services in the Atlantic Provinces and that this would be done on a co-ordinated Atlantic Provinces Divisions basis.

Dr. Churchill expressed the Society's deep appreciation to the Economics Committee and particularly Dr. Merv Shaw, its Chairman, for the excellent work it had done on behalf of the Society during the past year, and the tremendous amount of work which the Committee puts into this activity.

Dr. Shaw initiated his comments relative to economics by reminding the meeting that the Economics Committee is a subcommittee of the Officers, responsible and reporting to the Officers and Executive Committee. He said that during the sessions on negotiations, the Committee adhered strictly to guidelines and policy established by the Executive Committee, such policy having been adopted following consultation earlier with the Sections.

Dr. Shaw reported in some detail the nature of the difficulties experienced by his Committee and how it attempts to achieve the Society's objectives.

At this point in the meeting Council went into a closed session — i.e. press excluded, following which Dr. Shaw presented a most comprehensive and very well received presentation on the entire subject of Society negotiations. His presentation covered all facets such as attitude of the members, attitude of the Commission, details of the division of funds, and rationale behind it, the use of professional negotiators, getting approval for M.S.I. coverage of new procedures to name a few.

Following this were detailed discussions on the subject of Internes and Residents negotiations. Following lengthy discussions two resolutions passed by the Officers at their meeting on November 12, 1980 reading as follows: (a) "THAT The Medical Society of Nova Scotia supports an Interne and Resident Section contract with Government that incorporates the right to binding arbitration, and (b) "THAT The Medical Society of Nova Scotia support the graduated scale of work action as presented by Dr. B. M. Chandler ("If an Agreement for Binding Arbitration is not reached by November 26, 1980 formal notice of a work action will be given with a "limited withdrawal of services from December 1, 1980 through December 4, 1980 and going on to a 'complete withdrawal of services' immediately thereafter to continue until a satisfactory settlement is forthcoming. 'Limited withdrawal of services' refers to no provision of coverage outside of regular working hours. During any work action, coverage of critical care areas and a cardiac arrest team will be provided in consultation with Department Heads and Chief Residents.' ") to be effected by the Internes and Residents Section in the event that inclusion of Binding Arbitration in the current contract is not achieved, but only on the provision that the emergency care is not jeopardized." were approved.

Council expressed strong feeling that the Minister of Health be kept apprised of the Society's position and concerns regarding this matter. It was moved "THAT the Incoming President and whatever Officers he may select meet with the Minister of Health before any work action takes place, to let him know how strongly The Medical Society of Nova Scotia feels on this subject." This motion was carried.

Dr. Churchill continued with her report to Council and dealt specifically with the Discipline Committee, Faculty of Medicine/Medical Society Liaison Committee, and Mediation Committee. She reported that there were no cases coming before the Discipline Committee as matters in this category were normally referred to the Provincial Medical Board.

In relation to the Mediation Committee activities, she reminded the membership again of the importance that physicians recognize that the best possible public relations, to be effective, must begin at home — i.e. in the doctor's office. She said that the vast majority of complaints coming before the Society would, had this philosophy been followed, never have occurred.

She added that meetings with the Faculty of Medicine continued for the purpose of informal information exchange and discussion of topics of mutual interest. It is not a decision-making Committee.

SALARIED PHYSICIANS' COMMITTEE REPORT: Dr. J. H. Cooper, Chairman, reviewed for Council the activities in which his Committee is involved.

He reported that his Committee's attempts to take a census of Salaried Physicians in Nova Scotia had not been successful, and Council urged that this be pursued. His resolution "THAT the Medical Society continue its efforts to take a census of Salaried Physicians in Nova Scotia, and of the membership status of such physicians." was passed.

Council approved the Committee resolution "THAT the Society immediately institute an effective information-gathering program on the principles and practice of collective bargaining so that it may select strategies appropriate to its needs and medicosocial responsibilities." It was noted that The Medical Society of Nova Scotia had already adopted such a position by virtue of its participation in the passing of a similar resolution at C.M.A. in Vancouver in September.

EXECUTIVE SECRETARY'S REPORT: Mr. D. D. Peacocke informed Council that the name and application of the Garnett W. Turner Memorial Fund had been altered and expressed the hope that as a

result greater interest would be shown by members in contributing to it.

His report outlined the interests and activities of the Society in relation to Communications and Public Relations.

Mr. Peacocke expressed concern regarding non-membership in the Society and the tendency towards increasing centralization. He expressed the hope that all members would do all they could to encourage non-members to support their professional association, and that more members would volunteer for participation in Society Committee activities.

C.M.A. BUSINESS SESSION OF COUNCIL:

Dr. Churchill informed Council that this year the address of the President of The Canadian Medical Association and reports of all Nova Scotia representatives to C.M.A. were being co-ordinated into a joint presentation to encourage interest in this segment of Society business.

She then introduced Dr. W. D. S. Thomas, President of The Canadian Medical Association, whose address appears subsequent to these Transactions.

C.M.A. BOARD OF DIRECTORS — NOVA SCOTIA REPRESENTATIVE'S REPORT: Dr. G. C. Jollymore provided Council with a resume of the more important topics discussed by the C.M.A. Board of Directors and in which he participated.

C.M.A. COUNCIL ON HEALTH CARE — NOVA SCOTIA REPRESENTATIVE'S REPORT: Dr. M. A. Smith informed Council that this was the first report of this new Council which is an amalgamation of the previous Councils of Community Health and Medical Services. He added that a major subject considered by the Council was the Report of the Task Force on Periodic Health Examinations. This would be subject to continuing discussion by C.M.A. and possibly by the Divisions.

On one particular point, the question of ethics related to call-backs, there was discussion which resulted in this particular point being referred to the Medical Society Ethics Committee.

C.M.A. COUNCIL ON MEDICAL ECONOMICS — NOVA SCOTIA REPRESENTATIVE'S REPORT: Dr. A. H. Patterson reported that his Council's principal concerns had been related to dealings with Government, negotiations with Government, the Hall Report, investigation of ways and means by which physicians can improve their strength in dealing with Government, and reported specifically that the following resolution had been passed at Vancouver: "THAT The Canadian Medical Assocation assemble the information and develop the philosophy necessary to enhance physician bargaining power in all aspects of health care through any effective means, including unionization."

C.M.A. COUNCIL ON MEDICAL EDUCATION — NOVA SCOTIA REPRESENTATIVE'S REPORT: Dr. J. D. A. Henshaw provided Council with a comprehensive report on the activities of his Council on Medical Education. Subjects discussed by his Council included: Undergraduate Education, Clinical Training and Licensure, Accreditation of Canadian Medical Schools, Continuing Medical Education, Continuing Medical Education Methods, Emergency Medicine, Adolescent Medicine, Allied Medical Occupations, and Tax Deductions for Continuing Medical Education.

A matter of principal concern to the Council is portability of licensure for Canadian graduates along with the updating and standardization of programs, particularly the Clinical Clerkship, and Interneships. He said that The Canadian Medical Association has asked the Federation of Provincial Medical Licensing Authorities to convene a national meeting on medical licensure within the next year.

Problems raised by Council members included the lack of availability of positions for psychiatric training in the rotating interneship program, as well as the lack of training in Geriatrics.

Arising out of discussion on Adolescent Medicine was discussion relating to C.M.A. resolutions passed in Vancouver reading as follows: "THAT The Canadian Medical Association through its Provincial Divisions, extend an invitation to Provincial Government departments and Ministers of Education, the Canadian Teachers' Federation to participate in a joint venture to make sex education available in all schools by knowledgeable persons sensitive to the needs of students." and "THAT The Canadian Medical Association's activities in a National Sex Education Project include: (a) A public statement declaring the Association's commitment to the issue and inviting parents of school children to support the Program; (b) An appeal through the C.M.A. Journal to doctors across Canada to participate actively in the Program; and (c) An appeal to medical schools to strengthen the Sex Education and Adolescent Medicine components of their curricula." was a resolution reading "THAT The Medical Society of Nova Scotia meet with the Minister of Education, and the Department of Health, to initiate an active program of sex education within the School Systems of the Province, AND THAT the Medical Society encourage its members to lend their expertise to such a venture."

Dr. Churchill informed Council that activity in this regard is already underway; that the Society had communicated with all School Boards in Nova Scotia; as well had written the Department of Health, Education, and the School Board Association for the purpose of promoting, initiating, and organizing active programs in sex education in Nova Scotia.

M.D. MANAGEMENT LIMITED — NOVA SCOTIA REPRESENTATIVE'S REPORT: Dr. L. A. Fried reported on the activities of M. D. Management, directing attention to the C.M.A.R.S.P. as being one of the best in Canada and an excellent way to prepare for retirement. He also provided Council with a comprehensive resumé on other programs of investment and training available through M. D. Management Limited.

The Chairman brought to Council's attention that three other Nova Scotia physicians occupy important positions within The Canadian Medical Association, these being Dr. E. V. Rafuse, Chairman of the Board of Directors; Dr. A. H. Parsons, Chairman of the C.M.A. Committee on Ethics; and Dr. J. A. Myrden, member of the C.M.A. Finance Commmittee.

Dr. Parsons spoke briefly on the activities of the C.M.A. Ethics Committee, referring particularly to the establishment of a subcommittee which will be considering a new aspect, Bioethics, which requires the attention of his Committee.

SECTION FOR ANAESTHESIA REPORT: Dr. J. P. Donachie presented his report for information. He spoke briefly on the subject of C.P.R. noting that the Program had been updated and urged all physicians to become more actively involved in this most important Program.

SECTION FOR GENERAL PRACTICE REPORT: Dr. J. G. Seaman, Chiarman, submitted his report for information, speaking to the proposals his Section has for raising the level of interest within his Section.

The subject of Life Style Counselling being a benefit of M.S.I. was discussed with no specific resolution resulting.

SECTION FOR INTERNAL MEDICINE REPORT: Dr. D. F. Folkins, Chairman, report was received for information. His report contained a resume of the activities of the Section during the year.

SECTION FOR INTERNES AND RESIDENTS REPORT: This report was unavailable in time for distribution to Council and was referred to the Executive Committee.

SECTION FOR OBSTETRICS & GYNECOLOGY REPORT: There was no opportunity to present this report. It was referred to the Executive Committee.

SECTION FOR ORTHOPAEDIC SURGERY REPORT: Dr. A. B. F. Connelly submitted his Section report for information. Dr. Connelly recommended that the Committee on Occupational Medicine and Rehabilitation have representatives from Neurosurgery and Orthopaedic Surgery on the Committee. Council directed the Section to communicate with the Chairman of the Committee regarding this matter.

The subject of Workers' Compensation Board Appeal Board activities was raised and discussed with the result that the following resolution was adopted "THAT The Medical Society of Nova Scotia look into the possibility of establishment of a Medical Board of Appeal for the Workers' Compensation Board which would include a physiatrist, a neurosurgeon, and an orthopaedic surgeon in order to give a better understanding for final disability and disposal."

SECTION FOR PATHOLOGY REPORT: This report was not available in time for distribution, therefore, was referred to the Executive Committee for attention.

SECTION FOR RADIOLOGY REPORT: Dr. B. D. Byrne presented the Section report for information. There were no recommendations.

REPORTS OF REPRESENTATIVES TO OTHER ORGANIZATIONS:

DRUGS AND THERAPEUTICS COMMITTEE: Dr. J. Gray's report was referred to the Executive Committee for consideration.

MARITIME MEDICAL CARE INC. — PRESIDENT'S REPORT: Dr. A. W. Titus, Medical Director of M.M.C. Inc. presented this report on behalf of the President, Dr. E. G. Whitman who was unable to attend.

Dr. Titus drew Council's attention to the new Board structure of Maritime Medical Care which increased the Board size from twenty-two to thirty-seven and increased the Society's representation markedly.

The report also includes some interesting statistics relating to the M.S.I. Program.

MEDICAL ADVISORY COMMITTEE ON DRIVER LICENSING: This report was referred to the Executive Committee in the absence of a member to report.

NOVA SCOTIA SAFETY COUNCIL: Dr. J. P. Anderson presented this report which was received for information. Discussion by Council centered on the resolution relative to Seat Belt Legislation reading "THAT The Medical Society of Nova Scotia continue to urge the Nova Scotia Government's proclamation of the mandatory seat belt legislation and again express in writing its concern to the Premier and the Minister of Highways that such legislation is urgently needed to save lives and reduce accident-related health care costs."

A suggestion was made that a joint presentation to the Premier on this subject by representatives from the Medical Society/Nova Scotia Safety Council/Consumers Association might be productive.

NOVA SCOTIA LUNG ASSOCIATION: In the absence of a reporting member this report was referred to the Executive Committee.

PHYSICIAN MANPOWER SUBCOMMITTEE: Dr. A. J. MacLeod presented this report which was received for information. Dr. MacLeod outlined the nature of the problems dealt with by the Committee, these being: The Interne and Resident Establishment, The Problem of Physician Manpower Data, and Immigration of Physicians.

PROVINCIAL MEDICAL BOARD: Dr. H. J. Bland provided Council with a resume of Board activities and concerns. He gave Council the background on several instances of fraud which have come to the attention of the Board. He urged physicians to exercise care in their financial affairs and to conform to prescribed procedures.

He also indicated that the Board is concerned with the problem of uniform licensure in Canada, and he spoke to the difficulties involved in satisfactorily resolving this matter.

RH COMMITTEE: Dr. Leo J. Peddle, Director, presented his report which contained ten recommendations, all of which had been previously submitted and with one exception, endorsed. Council passed the following:

"THAT performance of Rh Blood testing at each patient's first prenatal visit;" "THAT recognition of Rh Negative pregnancy cases as potentially high risk;" "THAT early referral of all Rh Negative isoimmunized cases to the Rh Committee for assistance in Rh management;" "THAT performance of monthly Rh Blood testing be supported by The Medical Society of Nova Scotia"; "THAT The Medical Society of Nova Scotia support endorsation of the use of Kleihauer-Betke Test in Rh Negative patients whenever indicated to determine feto-maternal transfusions"; "THAT The Medical Society of Nova Scotia support endorsement of the 28-week antenatal administration of Rh Immune Globulin; continuation of regular monthly maternal antibody testing following antenatal injections of Rh Immune Globulin; endorsement of the use of Rh Immune Globulin in all circumstances where its use is indicated; performance of maternal antibody testing within four weeks prior to the 28-week administration of Rh Immune Globulin; and forwarding of reports of all injections of Rh Immune Globulin to the Rh Committee Office for permanent recording."

The appropriateness of presenting these resolutions to Council was discussed at some length. A strong feeling prevailed that these were matters which should be brought to the attention of practicing physicians by the Rh Committee on an on-going basis throughout the course of the year, and that the role of Council should be to endorse the work of the Rh Committee and assist in wide circulation of its recommendations.

Dr. W. D. S. Thomas, President of The Canadian Medical Association, congratulated Dr. Peddle and his Committee for their work in the Rh field, noting that Nova Scotia was far and away a leader in this activity.

REHABILITATION COMMITTEE FOR PHYSICIANS: Dr. B. J. Steele, Chairman, reported on the activities of this Committee and the difficulty of the role it was attempting to fulfill. He apologized for the lateness of the report, and went on to describe the nature of the problems facing the Committee, e.g. the means of contacting confreres who are in need of the Committee's help.

Dr. Steele encouraged all Society members to concern themselves with this problem and co-operate in dealing with it when this becomes necessary.

V.O.N. HOME CARE PROGRAM: Dr. Mark Kazimirski reported on the V.O.N. Program and submitted a resolution reading "THAT The Medical Society of Nova Scotia fully support the V.O.N. in its application to institute a co-ordinated Home Care Program in Nova Scotia." Dr. Kazimirski informed Council that the V.O.N. had presented a proposal for a Co-ordinated Home Care Program some time ago, the emphasis of which was on the Co-ordinated Home Care Program as opposed to who would actually run it.

Concern was expressed regarding the possibility of duplication of nursing services. However, it was pointed out that the role of the V.O.N. nurse and Public Health nurse were somewhat different, but in spite of this co-ordination was still very much required. The motion was ultimately carried with several dissenters.

NEW BUSINESS: It was moved "THAT The Medical Society of Nova Scotia encourage and support the Provincial Government to continue its expansion of extended care beds available to Nova Scotians, AND THAT such expansion be in consultation with the medical profession, particularly the area involved.", following which concern was expressed that although the number of extended care beds was being expanded upon by the Provincial Government, at times this was at the expense of acute care beds, and this point should be made to the Department of Health. The motion was carried.

ANNUAL MEETING

On two occasion during Council the Society was called to order in Session of the Annual Meeting to ratify the actions of Council and to hear the President's Valedictory Address which appears subsequent to these Transactions. Additionally, the membership heard and approved the Report of the Nominating Committee which reads as follows:

APPOINTMENT OF BRANCH REPRESENTATIVES TO THE 1981 EXECUTIVE COMMITTEE:

Antigonish-Guysborough — Dr. J. E. Howard; Bedford-Sackville — Dr. J. M. Fitzgerald; Cape Breton — Drs. N. L. Mason-Browne, and B. C. Trask; Colchester East Hants — Dr. G. M. Curtis; Cumberland — Dr. V. M. Hayes; Dartmouth — Drs. G. C. Pace, and G. W. Horner; Eastern Shore — Dr. P. D. Muirhead; Halifax — Drs. A. G. Cameron, J. K. Hayes, and J. W. Stewart; Inverness-Victoria — Dr. R. Stokes; Lunenburg-Queens — Dr. W. H. Lenco; Pictou — Dr. W. D. MacLean; Shelburne — Dr. J. U. MacWilliam; Valley — Drs. M. Kazimirski, and C. Prakash; and Western — Dr. C. W. MacNeil.

APPOINTMENT OF BRANCH REPRESENTATIVES TO THE 1981 NOMINATING COMMITTEE:

Antigonish-Guysborough — Dr. J. E. MacDonell; Bedford-Sackville — Dr. R. A. Taylor; Cape Breton — Drs. M. R. Rajani, and F. B. MacDonald; Colchester East Hants — Dr. K. B. Shephard; Cumberland — Dr. R. A. Burden; Dartmouth — Drs. H. P. Poulos, and J. W. MacDonald; Eastern Shore — Dr. A. C. Marshall; Halifax — Drs. A. G. Cameron, J. K. Hayes, and J. W. Stewart; Inverness-Victoria — Dr. C. B. Boucher; Lunenburg-Queens — Dr. G. C. Jollymore; Pictou — Dr. C. R. Elliott; Shelburne — Dr. S. M. Woolf; Valley — Drs. D. L. Davison, and P. D. MacLean: and Western — Dr. C. W. MacNeil.

The following nominations were confirmed: President-Elect — Dr. M. A. Smith of Sydney; Chairman, Executive Committee — Dr. G. H. Ross of New Minas; Vice-Chairman, Executive Committee — Dr. James Fraser of Bedford; Treasurer — Dr. W. C. Acker of Halifax; and Honorary Secretary — Dr. R. D. Saxon, of Antigonish.

The 127th Annual Meeting of The Medical Society of Nova Scotia adjourned at 4:00 p.m., Saturday, November 22, 1980.

The record of the 127th Annual Meeting of The Medical Society and the 16th Meeting of Council is held in considerably greater detail in the Society office and is available to any persons wishing to see or discuss it. The foregoing is an abbreviated version intended to highlight the significant aspects of the meeting.

ANNUAL MEETING EXHIBITS

The Medical Society of Nova Scotia wishes to express its sincere appreciation to those firms who exhibited at its Annual Meeting in November 1980 at the Hotel Nova Scotian.

EXHIBITORS

Anca Laboratories
Boehringer Ingelheim (Canada) Ltd.
Can-Med. Surgical Supplies Limited
Connaught Laboratories Limited
Dalhousie University, Division of C.M.E.
McNeil Laboratories (Canada) Limited
Miles Laboratories Ltd. (Ames Co. Division)
Norwich-Eaton Limited
Organon Canada Limited
Ortho Pharmaceutical (Canada) Limited
Pennwalt of Canada Limited
Pfizer Canada Inc.
Reed & Carnick, Div. of Block Drug Co. (Canada) Ltd.
Robins (A. H.) Canada Limited
Rorer (William H.) Canada Limited
Saunders (W. B.) Company Canada Limited
Schering Corporation Limited
Syntex Limited
Winthrop Laboratories

NOTE: Contributions towards the Society's Annual Meeting were received from Frank W. Horner Limited (binders), and Winthrop Clinical Education Programs (binders); as well, Winthrop underwrote the printing costs of the Annual Meeting Program.

Medical Society members appreciate the extensive financial contributions that exhibitors make toward defraying the costs of conducting an Annual Meeting. As well, the additional expense of preparing exhibits and arranging for the displays are also recognized. Most important, however, is the opportunity the exhibitors have given to members of the profession to meet with representatives of the various firms for discussion of new products and services available to them.

Members of the Society are encouraged to convey their gratitude by giving the exhibitors' representatives an extra expression of appreciation on their next encounter.

Presidential Valedictory Address 1980

Margaret E. Churchill, M.D.

Thank you for the trust you have given me by allowing me to represent you for the past year. I hope I have upheld our honorable record. I always comforted myself by feeling that with Bernie Steele on one side of the year, and Alan MacLeod on the other, surely a 127 year old institution could survive the year.

As President I have gained a better perspective of the profession by means of the Officers, Executive Committee meetings, Branch Meetings, and, this year, helping to prepare and present our brief to Mr. Justice Hall. I have also met with my counterparts across Canada, and have enjoyed representing you at the Annual Meetings of the other Atlantic Provinces and Quebec.

The unstinting help of Doug Peacocke, Mr. Schellinck and the rest of the 10th floor staff has been invaluable, and I thank them.

After this almost total immersion in medical-political affairs, I will be most happy to return to my office, and devote myself to such weighty affairs as thumb-sucking and colic!

There are many unresolved issues facing organized medicine, and threats to our autonomy, but today I thought I would devote my remarks to a few areas where I think doctors do a largely superb job, but are not always perceived as doing so.

A great deal is said and written these days about medical audit, quality assurance and quality of care. There is almost an implication at times that our profession is lacking in such introspective pursuits, or that this is something new. Surely the review of patient care by the attending physician and his peers has been the core of good care since earliest times. No other profession, I am sure, has as many ways of monitoring case management, and outcome, as we do — e.g. pathology rounds, tissue, and infection committees, death reviews, etc. . . Many of us utilize the services of medical audit in carrying out these duties, but monitoting quality of care is not new.

We are sometimes accused of spending most of our time concerned with incomes. This is an honest pursuit. There is nothing wrong with seeking a reasonable fee for a service rendered. What isn't so visible is the amount of time we spend in active committee work largely unpaid, addressing such problems as maternal and perinatal health, community health, drugs and alcohol abuse, etc. etc. These are Society committees, and of course, there are endless hours to spend in hospital committee work ensuring quality of care in this Province.

I doubt if any other profession spends as much time, and money, as we do trying to maintain our expertise by continuing medical education, and until recently we couldn't even claim continuing medical education as an expense for income tax purposes.

We are sometimes perceived as turning a blind eye when a colleague practices bad medicine. There are Credential Committees in all hospitals, monitoring our professional care, and the Provincial Medical Board reviews reported mismanagement and limits privileges when necessary.

Most physicians are concerned, kind individuals, who may be a bit terse with those who overuse the system, but who will uncomplainingly work all night to put people back together again after an accident, or patiently await a birth. It is one of the great benefits of the practice of medicine that we can be comforters and sustainers in a rather cold and impersonal world. This ability to empathize, or sympathize with the sick is what is meant by "Bedside Manner". Not all physicians are good at this, though they may be excellent clinicians. Mind you, I would prefer ability to bedside manner, if I could have only one! But I suspect patients put bedside manner ahead of everything. Some of the complaints dealt with this year were a result of a lack of this quality, and often a transient lack.

I hope that the changes threatening our Medicare System and the continuing underfunding to health care which is resulting in overworked, understaffed offices, will not further erode the patient/doctor relationship, which is often a very significant factor in regaining health.

Doctors are often blamed by Government, and the Public for not spending more of their energies in prevention, rather than in treating established diseases. Well, I ask, when will we see seat belt legislation enacted; when will we have sex education properly presented in our schools with a lot of stress on the responsibilities of parenting; and when will we see more emphasis on physical fitness in our schools? We have tried to get these changes and others, and will continue to do so. They have all been discussed this year. All would result in considerable improvement in the quality of life in this Province.

I recently heard the statement that to the public, good quality of care means it is available, affable, and of course, able.

Well, in Nova Scotia it is available in offices, excellent local and regional hospitals, and in the fine tertiary care hospitals in Halifax. It isn't always instantly available, and that is where a problem is often perceived. I hope the profession will continue to make sure that within the bounds of the possible, true emergencies will get rapid, caring, and expert attention. When we fail to do this, our profession is diminished in our own eyes, and in those of the public.

Affability, I believe, means what I called "Bedside Manner", but it includes taking the time to explain a patient's symptoms, what investigations will be done, and whether a consultation is necessary. A physician who does this will also be heeded when he explains why billing above tariff is necessary, and our concerns about Medicare.

Finally, ability, the patient's third criteria of good care, is one which is clearly being taken very seriously by the profession of the Province.

There are serious problems facing us in the coming year, problems which require a united, well-informed profession. We must then increase interest in the Society's business — Branch Meetings, Committees, and Canadian Medical Association affairs. Judging by the attendance at the Annual Meeting, we are improving. As individuals, we cannot handle all the problems the 80's will bring, but as a united voice we are formidable. It is our good fortune that Alan MacLeod will represent us in the coming year. I wish him well, and know that the support I received will continue.

Thank you. □

ADDRESS

Dr. W. D. S. Thomas, President The Canadian Medical Association

1980 Annual Meeting
of the
Medical Society of Nova Scotia

Mr. Chairman, Honoured Guests, Ladies and Gentlemen.

First of all may I say what a distinct pleasure it is for my wife, Carolyn, and I to visit Nova Scotia and to attend this Annual Meeting of the Medical Society of Nova Scotia.

It is one of the very real privileges of the CMA President to attend the Annual Meetings of most, if not all, of the provincial medical associations. True, there is a considerable degree of repetition — many of the problems and solutions, or lack of solutions, are identical. But there are always very significant differences. The diversity of our country and our medical organizations and their operation is truly amazing. Each provincial division is different and each division has and continues to play a different role at the National level. For example, Nova Scotia and Nova Scotians have always played a major leading role in the CMA. . . but almost always in specific areas. Currently Dr. Ed Rafuse serves as Chairman of the CMA Board of Directors — not an unusual post for a Nova Scotian in the 113 year history of the CMA. To name just one of his distinguished predecessors I offer the name of Dr. Norman Gosse. Dr. Gosse was of course the father of another distinguished Nova Scotia physician who played an active role in CMA affairs for many years. . . Dr. Clarrie Gosse who later went on to serve as Lieutenant-Governor of the province.

Nova Scotia has of course provided several of my predecessors as President of the National Association, including Dr. Norman Goss, Dr. Bob Jones and the first CMA President Sir Charles Tupper. Having mentioned Dr. Tupper I want to take this opportunity to correct a shortcoming on our part at CMA House. In the President's office in Ottawa there is a very nice cast statue of the first CMA President, and Canada's 7th Prime Minister, Dr. Tupper — a statue donated by the medical faculty at Dalhousie University. I'm informed that through an oversight the CMA has never publicly expressed its appreciation for this very thoughtful gift. On behalf of the CMA I want to apologize for the oversight and ask that Dr. Hatcher and his current colleagues, and Dr. Chester Stewart who was Dean at the time of the gift accept our belated thank-yous.

This morning I plan to address myself to two subjects — two complex, difficult, and to some considerable degree controversial subjects. Medical manpower and therapeutic abortion. I appreciate the fact that the most topical question on health care in Canada today is the Hall Review by Saskatchewan's eminent jurist the Honourable Emmett Hall — and Government action related thereto. However, I would like to leave my discussion of that subject for the panel on CMA activities and your own formal Nova Scotia Medical Society business meeting.

Medical Manpower. There is a tendency for the average practitioner to dismiss the subject as a problem for the medical educators — a problem of the future and not of direct concern or importance to the physician in the trenches. That is a mistake, because Ladies and Gentlemen what we are really talking about when we talk about the medical manpower supply of today and plans for tomorrow is the quality of medical care. There is a growing consensus that we have, or soon will have, a surplus of physicians. Without doubt we have a physician distribution problem. It is a very complex subject that too many people, including the Minister of National Health and Welfare, are prone to over-simplify. On a recent CBC-TV program she was asked, "What about the 600 doctors leaving Canada every year — doctors that cost us about a quarter of a million dollars to train?" Her answer — "Oh that's no problem we have a surplus of physicians anyway."

We may be producing too many physicians, but we don't know for sure, and for sure we don't know if we are producing the right number of the right types of physicians that we will require in the future.

The World Health Organization figure of 1 per 650 was a world-wide requirements estimate — an estimate that was made some years ago and on very flimsy evidence. Who is to say, certainly W.H.O. did not say that high quality, sophisticated medical service programs such as exist in Canada should have one MD per 650 population. . . or one per 500 population. Furthermore, it is meaningless to quote gross doctor/population ratios. We have to know how many physicians of what type, of what discipline — of what specialty or sub-specialty are available to provide what level of service. We must know their age and sex composition, how many hours a week and how many weeks a year do they work and. . . that they are prepared to work, how much time do they devote to teaching — research — administration or clinical practice. Before we can make any meaningful comment on medical manpower supply we need a host of information that, at the moment, we do not have. That's why it is essential that the CMA Medical Manpower Data Bank be successful. That's why every physician must contribute the information requested on this questionnaire. . . but more of that later.

First let me deal with a number of questions that I am asked everywhere I go.

What's the story about Canadian physicians migrating to the United States.

Classically we have had a net loss of about 300 physicians per year to the USA since WWII. In 1974 that figure was down to 282 — to 242 in 1975. . . remember, that was during the Vietnam War and related military conscription period. That figure jumped to 425 in 1976, 555 in 1977, 663 in 1978. . . and then started to drop to 605 in 1979. During the first six months of this year the number was 214, down considerably from the 395 in a comparable six-month period in 1978 or 418 in 1979. The 1980 figure will probably be something less than 500. . . about 465. There is no question that opportunities in the USA are decreasing. At the same

time the number of available Canadian physicians interested in migrating to the USA is declining. As a result, our political friends are inclined to believe there's no problem.

I'm afraid I cannot agree.

I have never been impressed with the gross numbers migrating to the USA — other than as an indication that physicians, and in recent years that means Canadian medical school graduates, were obviously pretty unhappy. They were unhappy enough, as former CMA President Staff Barootes put it, "to vote with their feet". I am not concerned with the number that emigrate but with the who and what they are. For example, we have a shortage of anaesthetists, ophthalmologists, physiatrists, otolaryngologists and oncologists from coast to coast. You have close to 50 anaesthetists in Nova Scotia. . . a rather abundant supply of a specialty that is in short supply not only all across Canada but throughout the world. . . but what happens if say 8 or 10 of them decide to emigrate, or 3 or 4 of your ophthalmologists or otolaryngologists? The answer, of course, is disaster. These people are not readily replaced. What happens if the single neurosurgeon in Newfoundland emigrates, or the single dermatologist in New Brunswick? And in case anyone is thinking it won't or can't happen — it has. Prior to the 1979 government/medical profession confrontation in Prince Edward Island there were 4 paediatricians practising in that province. When all the dust had settled down, there was 1, Scoop O'Hanley, a man approaching 60 who was looking forward to reducing his already too-heavy practice. . . not to seeing it multiplied several fold.

There are a host of factors that must be taken into consideration when you plan for future medical manpower requirements. The number of workaholics in interns and residents is dropping. . . and that's a good thing. They are not going to put in the 55 or 60-hour work-weeks that are common today. An increasing percentage of medical students are female. Indeed, the figure has risen to 40% in 1980 first-year students. It will reach 50% by 1990. They may work as many hours or even years, with periodic maternity leaves, as we mere males but they're not going to produce a large number of orthopods or urologists. . . in short their increasing numbers will have an impact on future medical manpower that must be taken into account.

We have something like 105 Canadians graduating in medicine outside of Canada, every year. . . most of them having every intention of returning to Canada in the future. At the same time we have an increasing number of Canadian Medical school graduates who if they don't have definite plans to migrate to the United States are making sure that they are able to do so. In 1976, 411 Canadian medical school graduates sat their U.S. National Board Examinations. By 1979 that figure had more than doubled to 837. Incidentally, that figure includes 94 Dalhousie graduates — an increase of 25 over 1978. In 1979 Dal graduated 87 medical students. Obviously the graduates from more than one year were involved in the 1979 U.S. National Board Exams — but the bottom line message is very clear. I don't know about you, but I'm seriously disturbed to learn that over 50% of our medical school graduates are, in essence, buying emigration insurance. They may not be voting with their feet, but they sure are registering to be eligible to vote.

We are very close to having a classical Alice in Wonderland situation. Health Ministers are talking about reducing the number of Canadian Medical school students — when we are turning away hundreds of well-qualified applicants. Large numbers of Canadian Medical School graduates — of high international standards — are indicating they may leave the country. Large numbers of the unsuccessful candidates, many of who are unable to qualify for Canadian medical schools, wander off to other parts of the world to get a medical education — to the USA, Ireland, Italy, Poland, Belgium, Nigeria, Jamaica, Mexico, Granada or the Dominican Republic. In some cases they are receiving a good education — in others it leaves considerable to be desired. Most of them plan, or at least hope, to return to Canada.

And just in case you thought I was exaggerating when I described the situation as coming close to Alice in Wonderland let me tell you that in 1979 246 of these students, studying medicine abroad, received financial support from the Government of Canada's student loans program. Such loans are approved or endorsed by provincial governments and guaranteed by the federal government. Maybe there is something that I don't understand — I certainly would appreciate it if somebody could make some sense out of it for me, but, in the meantime, I think it's the stuff of Alice in Wonderland. I think the federal Secretary of State who provides the money to help students to "study medicine" in Granada, the Dominican Republic, or some of the schools in Italy has qualified to wear the hat of the Mad Hatter.

My major point in all of this is to underscore the relative useless purpose of quoting gross doctor/patient ratios. To paraphrase an old saying, the day has long since past when a doctor is a doctor. We need data breakdown even within disciplines and specialties. Within general practice we have subsets. The family practice teaching units were evolved to meet definite needs. The classical family physician graduate with a major emphasis on treating the family as a unit — with a heavy concentration on preventive medicine and counselling, meets a modern need in much of our country. At the same time many parts of this country need, and will need for years to come, the services of the classical GP with appropriate levels of training and skills in surgery, anaesthesia, obstetrics and so on.

An accurate, comprehensive inventory of Canadian physicians is essential. For some months we have been attempting to realize a comprehensive, computerized CMA medical manpower data bank. The response to completing the manpower questionnaire in Nova Scotia has been far from complete — in all honesty, it has been far from satisfactory. In round figures there are 1300 physicians registered in Nova Scotia. We have received completed questionnaires from about 900 — leaving about 400 physicians in the province unaccounted for. With the cooperation of the Nova Scotia Medical Board, those 400 physicians will receive a request, with their renewal notice that they complete a copy of this manpower questionnaire. I ask those who have not yet done so to please take the 4 minutes required, complete the form and return it. It is important.

Therapeutic Abortion — A Second Look

Almost ten years ago in this city of Halifax the CMA General Council adopted a series of resolutions which form the basis for the Association's policy on therapeutic abortion. The 1971 debate was perhaps the most heated and

emotional debate ever witnessed by observers of General Council.

It is important to remember that as far back as 1966 the Association had asked the government of Canada:

"That legislation be enacted to ensure that an operation for the termination of pregnancy was lawful:

(A) where it is performed by a duly qualified licensed medical practitioner after consultation with and approval of a hospital-appointed therapeutic abortion committee (Yes, I regret to say that the original suggestion for the establishment of such committees was a CMA proposal);

(B) if performed in an active public treatment hospital;

(C) if performed with the written consent of the patient and with the consent of the spouse or guardian where the committee deems necessary (it wasn't until 1980 that CMA General Council got around to eliminating its policy of requiring the spouse's approval);

(D) where the continuance of the pregnancy may endanger the life or the physical or mental health of the mother.

In 1967 part (D) of that recommendation was amended to read

"If continuation of the pregnancy will endanger the life or health of the pregnant female or there is substantial risk that the child may be born with a grave mental or physical disability... or where there are reasonable grounds to believe that a sexual offence has been committed from which pregnancy has resulted".

That advice was provided to the government by the CMA in good faith, in keeping with the feelings of the profession at the time — and in keeping with what we anticipated might be publicly and politically acceptable in desired changes to the Criminal Code, The CMA recommendations did form the basis of the change in the Criminal Code making the conduct of therapeutic abortions legal in Canada. Not all of our recommendations were accepted — "substantial risk that the child may be born with a grave mental or physical disability... or where there are reasonable grounds to believe that a sexual offense has been committed from which pregnancy has resulted" was never accepted as legal grounds for therapeutic abortion. However, the government of the day, did follow the advice provided by the profession.

CMA policy of course is an ever-evolving situation. Certainly it was subjected to major change during the Marathon Debate 1971 Halifax. When the debate was over the following major conclusions had been reached:

— The CMA recognized that there was justification for the voluntary termination of pregnancy on non-medical/social grounds.

— Abortion should be an elective surgical procedure to be decided upon by the patient and her physician and should be subject to the same control as all surgical procedures conducted in hospitals, i.e. that approval by a therapeutic abortion committee as outlined in the Criminal Code, should be eliminated.

— No hospital, physician or other health worker should be compelled to participate if it is contrary to their own personal morality.

— The CMA voiced its complete opposition to abortion on demand and abortion as a means of family planning.

— A series of resolutions on family planning were passed:

That provision of advice and information on family planning is a responsibility of the practising physicians of Canada. Within the community this responsibility should be shared with other educational and health agencies.

That facilities in addition to physician's offices for dissemination of advice on family planning be established throughout the country.

That in the event of an unplanned pregnancy the patient should be provided with the opportunity to have full immediate counselling services.

I do not wish to engage in any discussion of the moral, religious or ethical aspects of therapeutic abortion other than to say that I strongly support the CMA policy that every physician, every nurse and, more importantly, every patient should be entitled to their personal viewoint and should be free to express it without fear of harrassment by those of the opposite persuasion.

More specifically I would like to look at some of the other issues in the light of nearly 10 years experience with legalized therapeutic abortion in Canada. After 10 years it is glaringly apparent that the abortion committee structure has not only failed to serve any useful purpose, but has created problems that nobody anticipated when the legislation was passed.

Time and again the CMA and other medical organizations have recommended that the requirement for abortion committee approval be eliminated. But to no avail. The Ministers of Justice and governments of Canada have refused to revise the legislation — even when a special study commissioned by the government of Canada came to the same conclusion. Failure to revise the Criminal Code has been nothing less than a political "copout". The federal government has been unfairly placing responsibility for the legal approval of therapeutic abortion on the shoulders of physicians and hospital boards. Everyone knows of the disparity in the existence of abortion committees from one part of the country to another. We all know that most of these committees do nothing more than rubger-stamp abortion certificate applications. How else can a committee of three physicians deal with upwards of a 100 applications received each week in some of our larger hospitals. I would be willing to bet that in many of our more liberal hospitals no application for therapeutic abortion has ever been refused for other than incomplete documentation or a pregnancy which exceeded the legal limit of 20 weeks. In fact, I am firmly convinced that, with a slight alteration of the age and marital status information, I could get an application for a therapeutic abortion approved for my cat.

In British Columbia the therapeutic abortion committee has given rise to a new and perhaps even bigger problem — political power struggles for control of hospital boards. Not too many years ago hospital societies elected board members who had a broad interest, were publicly spirited and had some expertise in overall hospital affairs. Today too frequently members of the board are elected solely on their

attitude toward one single issue — therapeutic abortion.

We now have the ridiculous situation where the annual meeting of many hospital associations has become a "circus" attended by thousands of recently signed-up members of the society representing either "pro-choice" or "pro-life" interest groups. The winner — the group with the most signees. The loser — the hospitals and ultimately the quality of patient care.

I feel very strongly that we must remove therapeutic abortion from the political arena and make it a matter to be decided upon by the patient in consultation with her personal physician. This is the policy of the Canadian Medical Association — one which I regret to say that our federal politicians have not adopted.

Ten years ago the CMA contended that the key to the solution of the problems of therapeutic abortion lay in the area of public education, sexual responsibility and the effective use of contraception. We have been preaching the gospel of prevention — but obviously not with very much success. Therepeutic abortion rates have increased steadily over the past ten years and the incidence of teenage pregnancy in particular has reached alarming levels.

We the physicians of Canada must assume a major share of the responsibility for the failure to control unplanned pregnancies in this country. We have agreed that the physicians office should provide much of the needed counselling and contraceptive advice and services. — but at the same time we have acknowledged that we need help from both Federal and Provincial Health authorities.

In 1975 Dr. Betty Stephenson, then President of C.M.A., now the Minister education for the province of Ontario made a strong plea to government for the establishment of a comprehensive National family planning program. Her pleas fell on deaf ears. In fact in recent years the Federal Government has seen fit to reduce its funding for the planned parenthood federation, an organization which in the past has struggled valiantly to provide much needed contraceptive advice particularlily to young women who for one reason or another would not or could not seek the advice of a family physician.

I am pleased to report that C.M.A. general council recently supported another resolution to actively promote a program of family life education for school children in this country. For years we have allowed a few very vocal red necked parents and school board officials to stifle attempts to reach our school children with information to aid them in handling the problems of adolesence.

I openly confess that as an obstetrician by training, by experience and by inclination I have a built-in bias. But I think this is an extremely important subject.

If the Nova Scotia Medical Society has not already pressed this issue with your provincial Minister of Education and teaching authorities, I urge you to do so. If you have already made representations — do it again. Do everything in your power to make an effective, successful sex education program a reality from St. John's to Victoria.

I know that the best sex education program in the world will not eliminate unwanted pregnancies — it will not eliminate the need for therapeutic abortion, but it will help. We need an educational program that will not only transmit the necessary information to teenagers but one that will alter the basic value structure of our society. If we talk about conception control in isolation — isolated from other basic issues and values of society our advice will fall on deaf ears. We have to deal with feelings and emotions. We have to talk to them about relationships, about decision making, about short-term and long-term effects on decisions. We have to talk to them about respect. What it is, how you get it, how you show it. We have to be honest and open with them about sexual exploitation, about peer pressure for sexual gratification and its effects on a person's behaviour. We have to help them to clarify, and adhere to, their own personal values. We have to teach them that they have the right — and how to say no — not just to sexual advances but to other things as well. We have to teach them about the different ways of showing affection and the advantages and disadvantages involved. Most importantly, we must do a better job of teaching them how to build personal relationships — to understand the mental and emotional needs of both themselves and others. With these foundations in place — with the proper attitudes, if teenagers are sexually active, they'll use birth control because of selfrespect and a sense of responsibility.

The profession is aware that the problem of teenaged pregnancy is real. We have a responsibility to help the general public to accept and come to grips with the realities of the problem. The problem is large and it is getting larger.

There are about 65,000 abortions every year in Canada, nearly 20,000 of them in teenagers, over 2,000 in girls under 15, about 10 in children under 13 years of age.

There are over 1,000 teenage pregnancies every week in Canada.

Forty percent of teenagers who get pregnant are under 17 years of age. Those under 17 years of age account for 34% of all teenage births and 50% of all teenage abortions.

In case you think I am talking about a problem that exists in Upper Canada, or promiscuous B.C. — where I grant the situation is somewhat more serious, let me give you a few figures for Nova Scotia. During 1973, there were 1,931 live births in Nova Scotia teenagers. . . During the same year there were 549 therapeutic abortions. The therapeutic abortion rate for Nova Scotia has increased steadily from 5.1 per 1,000 females in the child-bearing years in 1972 to 7.7 in 1973. In 1972 there were 6.2 abortions for every 100 live births in Nova Scotia. . . By 1973 that figure had almost doubled to 11.9. There were 837 abortions conducted in Nova Scotia in 1972 — 1,454 in 1973. I won't bore you with any more statistics — but I trust you get the message. This is a Nova Scotia problem too. Obstetricians are frequently asked why the dramatic increase in teenage pregnancies.

Some suggest the exploitation of sex in advertising on T.V. and in movies has made premarital sexual intercourse a more acceptable form of behaviour or, could it be that children are simply adopting the more liberal attitudes toward sexuality exhibited by adults? Some studies have suggested that as many as 55% of our teenagers are engaged in premarital sexual intercourse. Surely there can be no question of the need for a suitable program of sexual counselling.

But to counsel properly requires people who are properly trained. Too frequently counselling is done by embarrassed, ill-informed and somewhat reluctant teachers, or worse. . . by physicians who are equally unqualified and incompetent.

What we have to do is not only teach our children, but teach their counsellors. This, of course, will take time and money and dedication on the part of the teachers but I believe it can be done.

One suggestion which I think is an excellent one came from one of our family practice residents. She suggested that young doctors in family practice training would make excellent sex educators for our young people. . . provided they themselves were properly trained in counselling methods. Such a program would serve to upgrade the standard of sex counselling practised by our young family physicians while providing a valuable service to the community. That brings me to a second resolution passed on this subject at this year's meeting of General Council:

> THAT THE CANADIAN MEDICAL ASSOCATION'S ACTIVITIES IN A NATIONAL SEX EDUCATION PROJECT INCLUDE:
>
> (A) A PUBLIC STATEMENT DECLARING THE ASSOCIATION'S COMMITMENT TO THIS ISSUE AND INVITING PARENTS OF SCHOOL CHILDREN TO SUPPORT THE PROGRAM:
>
> (B) AN APPEAL THROUGH THE CMAJ TO DOCTORS ACROSS CANADA TO PARTICIPATE ACTIVELY IN A PROGRAM: AND
>
> (C) AN APPEAL TO MEDICAL SCHOOLS TO STRENGTHEN THE SEX EDUCATION AND ADOLESCENT MEDICINE COMPONENTS OF THEIR CURRICULA.

We cannot afford to continue with our present laissez-faire attitude regarding sex education in schools and in our communities. Teenage pregnancy must be considered "high risk". The risk of complications such as anemia, abnormal bleeding and difficult labour due to cephalo pelvic disproportion is perhaps as much as 60% higher in teenagers than in women in their 20's. For adolescents under 15 the prematurity rate more than doubles. The perinatal mortality rate for newborn of teenagers is greater than for any other age group except for mothers over 40 years of age.

If the teenager comes to therapeutic abortion, and a good many do — in 1977 20% of teenage pregnancies in Nova Scotia, 48% in my Province of B.C., there is an increased risk because significant numbers of these youngsters do not reveal their condition until late in the first trimester or frequently well into the second trimester.

For the teenager who decides to carry her pregnancy to term, the long-term outlook is equally gloomy. As high as 85% of 15 to 19 year old mothers do not complete high school. Fifty percent or more of these mothers end up on welfare. Their lack of education precludes them from obtaining rewarding employment and life becomes an economic struggle.

If the pregnant teenager marries the incidence of divorce is two to three times higher than it is among those who marry at an older age.

In summary, Ladies and Gentlemen, you will see that I have gone from a harsh and deserved criticism of our abortion law to a strong plea for a national program of family life and sex education in our schools and in our communities. The emphasis should be on prevention and on a change in attitudes.

> An attitude the CMA tried to promote 10 years ago.
>
> An attitude Dr. Stephenson tried to re-emphasize 5 years ago.
>
> An attitude I beg you to adopt today.
>
> Tomorrow will be too late. . . for by tomorrow three more teenagers will be pregnant.

Mr. Chairman, Honoured Guests, Ladies and Gentlemen, on behalf of my wife, Carolyn, Woody and Lily Freamo and all of the CMA contingency participating in this meeting, I thank you for your hospitality. . . and I thank you for your very kind attention. □

GRAND ROUNDS

Marfan's Syndrome*

John Finley, M.D., F.R.C.P. (C); Ann Hawkins, M.D.;
V. Krause, M.D.; V. Audain, M.D.; J. Hyndman, M.D.;
J. P. Welch, M.D., F.R.C.P. (C) and R. B. Goldbloom, M.D., F.R.C.P. (C), F.A.A.P.

Dr. A. Hawkins
(Resident in Pediatrics, I.W.K. Hospital for Children)

This morning's presentation is of 3 children, two sisters and a cousin, with features of Marfan's Syndrome.

The first patient, H.D., is 10 years old. Her main complaint was of aching joints, which had been a problem for several months. The rest of the history revealed that she has myopia and "tilted lenses", i.e. subluxated lenses.

Physical examination showed a height of 152 cm., in the 90th percentile for age; weight was in the 80th percentile. An upper/lower segment ratio, an important figure in Marfan's Syndrome, was 0.7 — in a normal 10 year old it would be about 0.95. Arm span was greater than height, which was abnormal. She also had bilateral upward subluxation of lenses, long extremities, tapered digits and bilateral pes planus. Cardiac examination was normal.

Chest X-ray showed a slight increase in thoracic kyphosis, a slight increase in lumbar lordosis, and a mild scoliosis. The heart and great vessels were normal. The ECG was normal, but the echocardiogram showed dilatation of the aorta.

Treatment of her kyphosis and lordosis consisted of exercise and physiotherapy. Because her scoliosis is relatively mild, she will be followed at 3-monthly intervals, to decide whether she needs a brace or any surgical intervention. She already had glasses and no active treatment was recommended for her eye problems, although she will be reassessed regularly. For her cardiovascular abnormality she was placed on propranolol 10 mg., q.i.d., and she will have a yearly reassessment with an echo each time.

The second patient D.N., is 21 and is a cousin of H.D. She has always been short of breath on exercise, but had no other cardiovascular symptoms. She has worn glasses for myopia for a long time. In 1961-62 she underwent surgical correction of a pectus excavatum, a skeletal abnormality commonly seen in Marfan's Syndrome. She had severe scoliosis and had been admitted several times between 1969 and 1973 for correction of this problem. Her father had died suddenly at age 42. A brother died suddenly this year at age 18 years, and she has a sister who has similar physical features, who will be described later.

This girl was 164 cm. in height (50th percentile). Her upper/lower segment was 0.74, again low. Her arm span exceeded her height, she had a corrected pectus excavatum, long extremities, long tapered fingers and toes, lax tendons, a high arched palate, pes planus bilaterally, severe scoliosis and a positive "wrist sign". This sign indicates that when the index finger and thumb of one hand are clasped around the opposite wrist, the distal phalanges overlap (Fig 1). Also present was a positive Steinberg Sign, i.e. the apposed thumb extends past the ulnar border. The lenses were normal.

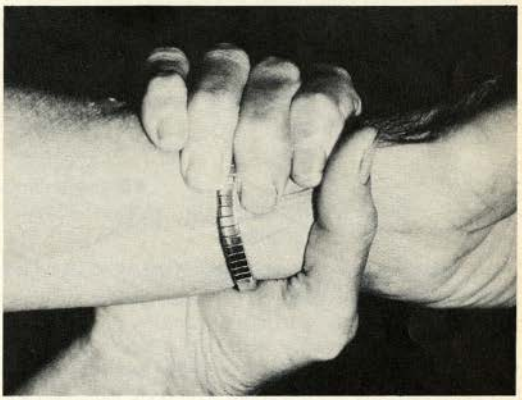

FIGURE 1

Illustration of Steinberg's sign in an older patient with Marfan's Syndrome showing the overlap of the thumb and the distal phalanges of several fingers.

On cardiovascular examination, there was a mid-systolic click and a mid-late apical systolic murmur, which was interpreted as mild mitral insufficiency. Chest X-ray was normal. The ECG showed left atrial enlargement, and border-line left ventricular enlargement. Echocardiogram showed dilatation of the aorta.

Her management included yearly cardiologic assessment, avoidance of strenuous activity, and she was advised strongly against becoming pregnant owing to the risk of aortic dissection in patients with marked aortic wall involvement. We have considered prescribing propranolol, but no decision has yet been made.

The sister of the girl just described (W.N.) is asymptomatic, but is not a particularly active person. Her height is in the 90th percentile, upper/lower segment is 0.81, and her arm span is greater than her height. The heart action is moderately increased, there is an aortic ejection click, a short systolic murmur, and apical mid-systolic clicks. And she also has obviously long legs, a long body, long arms, long fingers, a positive wrist sign and a positive Steinberg Sign. The eyes were normal.

*As presented at Grand Rounds, I.W.K. Hospital for Children, Halifax, Nova Scotia, May 14, 1980.

Correspondence to Dr. John Finley, c/o The Izaak Walton Killam Hospital for Children, 5850 University Avenue, Halifax, N.S. B3J 3G9.

Her chest X-ray was normal. Her ECG showed borderline left atrial dilation, and slightly elevated left ventricular potentials. The echocardiogram showed that the aorta was dilated and there was a pan-systolic prolapse of the mitral valve. This patient will be reassessed yearly by a cardiologist and by echocardiography to detect any further aortic dilation, and will probably be placed on propranolol with caution against pregnancy.

The family tree (Fig. 2) shows 13 members with the features of the syndrome, 3 of whom died suddenly.

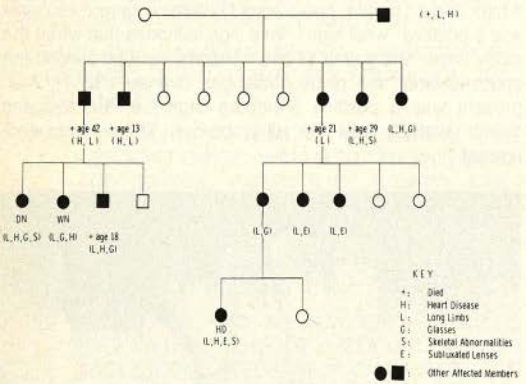

FIGURE 2

Family tree of the three patients decribed in this report. These are indicated by the initials DN, WN, and HD.

Dr. J. Finley
(Pediatric Cardiologist, I.W.K. Hospital for Children)

I'd like to speak for a few minutes about some general aspects of Marfan's Syndrome. I should explain that the main reason we felt it was useful to present this topic of a rather unusual disorder is because we have the impression that the condition may be more common in this province than one might expect. Hence the importance of bringing to the attention of all physicians — family physicians and those in various specialties — the importance of all manifestations of the syndrome. It may be that, for example, an orthopedic surgeon might be the first physician to identify an index case, and it is important that certain follow-up procedures and investigations be carried out on the non-orthopedic problems of these patients.

Marfan's Syndrome is a connective tissue disorder[1], but it is an unusual one, in that the principal connective tissue involved is in the cardiovascular system, the eyes and the joints. The trachea, the spinal discs and ligaments are unaffected. It is an autosomal dominant condition, so that it is important to counsel families where children are affected — in other words, potential parents whose children have a 50% risk of the syndrome.

The importance of cardiovascular involvement in this disease is that about 90% of these individuals have abnormal hearts at autopsy. In most cases it appears it is involvement of the heart or aorta that causes death and the abnormalities are generally limited to the aorta, pulmonary artery and the valves.

The most severely-affected patients may be identified soon after birth. Usually it is the eye findings that are noticed earliest, particularly in the toddler. Scoliosis or failure to thrive are two other abnormalities that may cause the individual to come to medical attention. The latter two are often investigated at school age, especially through screening programs for back disorders. Some children with congestive failure might appear in the early school years, but usually this is not a feature until adulthood.

If there is congestive failure, the symptoms will be those of left heart failure related to the valve disorders. Mitral valve involvement may cause mitral regurgitation, or aortic dilatation may cause aortic regurgitation.

The signs that one should look for on examination are outlined in the diagram (Fig. 3). A bounding pulse would indicate aortic regurgitation and a quick diastolic runoff. Listening over the aortic area, one might hear a systolic murmur of low pitch (not high pitch as in stenosis), suggesting that the valve is somewhat deformed, causing a flow murmur. A prominent early diastolic murmur accompanies this and can be heard at the left sternal border. It indicates the presence of aortic regurgitation due to a dilated aortic root. An apical pan-systolic murmur would indicate mitral regurgitation. On the other hand, there might only be systolic clicks, as we heard in one patient. These, when multiple, could be confused with the rub of pericarditis. They indicate mitral valve prolapse which can, of course, lead to mitral regurgitation.

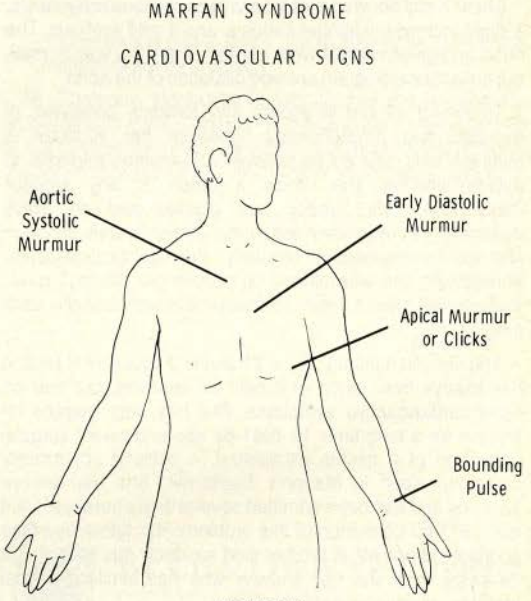

FIGURE 3

Signs of cardiovascular abnormalities which may be present in Marfan's Syndrome.

It must be realized that the absence of the above signs does not exclude severe involvement of the aorta. Several basic investigations are essential. The first is the chest X-ray and the thing to look for here is a dilated ascending aorta (Fig. 4). One would wonder perhaps about aortic stenosis, with post-stenotic dilatation. However, the findings on

auscultation should allow one to differentiate. The electrocardiogram usually is not of particular diagnostic help but may show left ventricular hypertrophy.

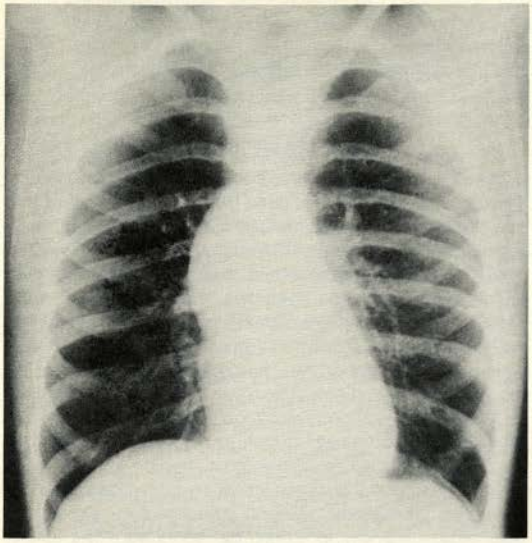

FIGURE 4

Chest x-ray of patient with Marfan's Syndrome and markedly dilated aortic root.

The echocardiogram is probably the most important and one of the easiest diagnostic tests available. The aortic root diameter is easily visualized and dilatation can be readily seen. Abnormalities of the mitral valve can also be detected with confidence.

In the differential diagnosis of this condition, the main condition to consider is homocystinuria, in which the main phenotypic features closely resemble those of Marfan's Syndrome. The cardiovascular aspects just mentioned are, however, largely absent in homocystinuria. Mental retardation is a common feature of homocystinuria whereas it is not typical in Marfan's Syndrome.

Other connective tissue diseases may also be considered, but will not be discussed here.

Now to consider treatment and follow-up. The following is a rough guide summarizing our approach in the Cardiology Department. If there are no eye or cardiovascular signs but merely the typical body habitus, no special follow-up other than the normal periodic physical examination would be recommended. If the complete syndrome is present, with eye involvement and definite heart findings but the patient is asymptomatic and the abnormal signs are stable — then we would suggest the following: between 0-16 years, yearly physical examination and chest X-ray. After 16 years, chest X-ray, physical and if possible an echocardiogram annually to detect progressive aortic dilation early.

If the signs are changing or if the individual becomes symptomatic then the approach should be more aggressive. If the aorta is very dilated, then one school of thought is to prescribe propranolol to decrease the force of contraction of the heart and reduce the pulsatile effect on the aorta. This concept is not entirely theoretical, because propranolol has been shown to prolong the life of a certain breed of turkeys affected by a condition similar to Marfan's Syndrome[2]. If the aorta is increasing in size, then there is no question that the situation is an emergency. Catheterization should be done to show the aortic root anatomy, and some form of surgery may be indicated, in an attempt to prevent dissection. If mitral regurgitation is severe, some centers recommend plication of the mitral valve to make the leaflets more competent. If aortic regurgitation is severe, the aorta may be replaced with a graft[2]. Another approach is to wrap the aorta with a type of fabric to try to preserve its integrity. This has been done successfully at the V.G. Hospital in Halifax in several adult patients.

The prognosis of an untreated population is well illustrated by McKusick's data[3]. Life expectancy curves of this population start to fall off in the teens and 20's. There is a significant mortality by age 40, and well over half have died by the age of 50. Thus life expectancy is much reduced and there is a real urgency about patients who show changing signs. The most common cause of death is dissecting aortic aneurysm, but occasionally death may occur with heart failure from mitral insufficiency.

Dr. Krause will now discuss the cardiovascular pathology of a boy in one of these families, who died suddenly after several days of intense chest pain.

Dr. V. Krause
(Chief of Pathology, I.W.K. Hospital for Children)

The pathology of the cardiovascular system in Marfan's Syndrome is exemplified in the autopsy findings in one of the family members. The ascending aorta was greatly enlarged because of a fusiform aneurysm. There was dissection of the aortic wall with a fresh blood clot extending from the aortic ring to the upper portions of the aortic arch. Interestingly in this disease, it is the ascending aorta that seems to be exclusively affected: the descending, thoracic and abdominal aorta showing insignificant changes.

Histological sections of the ascending aorta show depletion and fragmentation of elastic laminae of the media (Fig. 5). Areas devoid of elastic fibres have a cystic appearance and are filled with mucopolysaccharide ground substance giving the appearance of cystic medial necrosis (Fig. 6). Muscle fibres are distorted and disoriented. The weakened wall predisposes to intimal tears leading to an intramural hematomata. Focal increase in branches of the vasa vasorum are seen in the adventitia and the smaller branches in the outer layer of the media show perivascular hemorrhages (Fig. 6). Extension of the vasa vasorum into the media is said to be a feature of Marfan's Syndrome and their rupture may initiate the dissecting aneurysm. The vasa vasorum show no evidence of perivascular inflammation or other features suggestive of luetic or other infection. Ultra-structural studies showed "cystic collections" of mucopolysaccharide-like material separating collagen and connective tissue and elastic fibres. No specific abnormality of the collagen fibres was detected.

The heart was greatly enlarged and weighed 400 gm. — 30% more than normal. The branches of the coronary arteries were normal although one of the coronary ostia was small, having a diameter of 1 mm. The aortic valve ring was

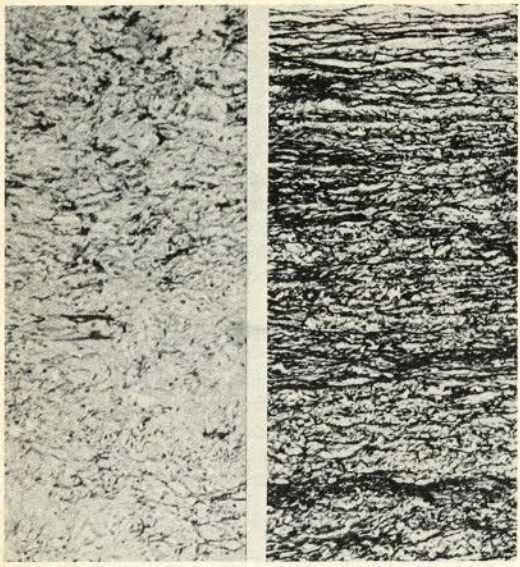

FIGURE 5

Left — elastic stain of section of ascending aorta in a patient who died of aortic dissection related to Marfan's Syndrome. The section shows a generalized depletion of elastic fibres, the remaining ones being very scattered, disorganized and disoriented. There is also a widespread vacuolar appearance typical of the disorder. *Right* — elastic stain of section of normal aorta for comparison.

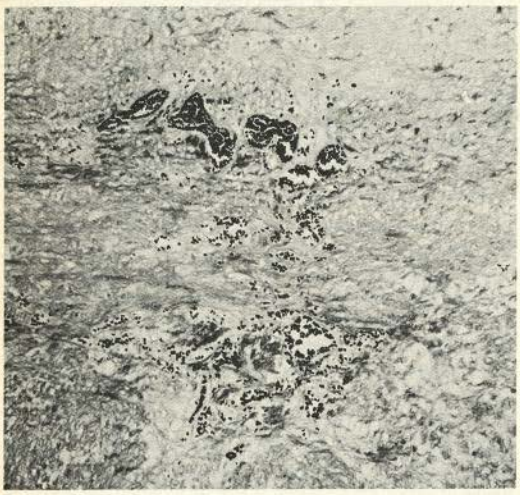

FIGURE 6

Trichrome stain of section of ascending aorta in the same patient as Fig. 5. The section shows widespread vacuolar changes, the so-called "medial cystic degeneration"' as well as peri-vascular hemorrhages. See text for details.

markedly dilated and the valve leaflets were slightly thickened and incomplete. Papillary muscles were significantly hypertrophied and the myocardium was thickened. As reported, the mitral valve may be abnormal and in this instance the leaflets appear somewhat redundant. Their respective chordae tendineae are longer than normal.

The cause of death was thus rupture of a large fusiform aortic aneurysm, although important cardiac abnormalities were present.

Dr. V. Audain
(Ophthalmologist, I.W.K. Hospital for Children, V.G.H. and H.I.)

My role is to point out some of the eye findings that are commonly found in Marfan's Syndrome and to explain why they occur. These patients often have a dislocated lens and myopia. However, this syndrome affects many structures in the eye besides the lens. There is a disorder of connective tissue which is of mesodermal origin. Thus, the condition affects those structures that are of mesodermal derivation. Ptosis may occur in these patients indicating that the levator papebral muscle is affected. Strabismus may result from weakness of extra-ocular muscles. The cornea too is involved in some patients. The cornea is made up of collagen and there may be abnormal collagen deposition. Patients can develop "megalocornea", which is a very enlarged cornea which can impair vision. The anterior chamber may be much deeper than normal because the ciliary body and the iris are recessed backwards. These patients can experience glaucoma. The iris too may be abnormal. The dilator muscles, also mesodermal tissue, are often hypoplastic, in which case the pupils will not dilate properly in response to mydriatic drugs.

Moving further back in the eye, the lens may be dislocated or subluxed. The problem here is that the fibers which normally keep the lens capsule taut and maintain the normal shape of the lens become disrupted. The lens is allowed to float, resulting in dislocation upwards and usually temporally (Fig. 7).

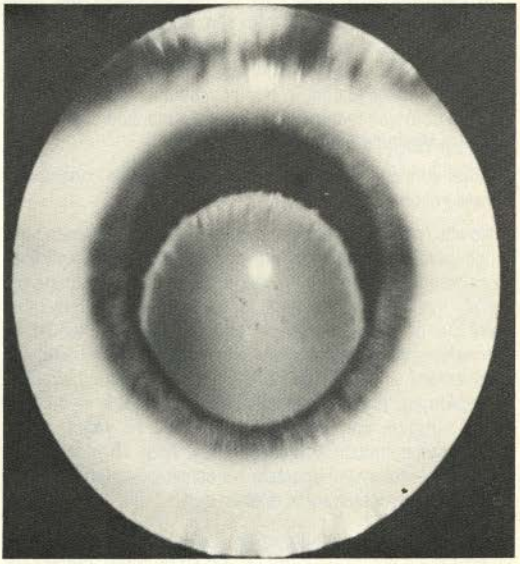

FIGURE 7

Subluxation of the lens of a patient with Marfan's Syndrome. The pupil has been dilated with a mydriatic drug in order to see this clearly. The lens is dislocated inferiorly in this case.

As the lens becomes dislocated, the tensing effect of these ligaments is lost so that the shape of the lens is altered. The lens develops a much wider anterior/posterior diameter which will cause myopia, with the result that rays of light that enter the eye now come to focus at a point anterior to the retina. We also find that some patients develop blue sclerae. The sclera, which is collagen tissue, becomes thin, allowing the underlying blue choroid to show through. These patients also develop a staphyloma, which is a weakening of the sclera and a bulging of the underlying choroid.

The glaucoma mentioned earlier arises from the development of a recessed angle, allowing little strands of tissue to develop across the iris root and attach to the cornea. This blocks the trabecular meshwork through which the aqueous drains, thereby increasing the intraocular pressure. Another type of glaucoma may arise, which is called pupillary block glaucoma. The dislocated lens obstructs the pupil opening so that the aqueous cannot flow through in the normal fashion.

A rare problem encountered in these patients occurs when a dislocated lens impinges against the posterior surface of the cornea, damaging the corneal endothelium. The patient's vision may be compromised, so an attempt has to be made to correct this by means of an operation to remove the lens. This is technically difficult in young patients because in young individuals the lens is firmly adherent to the vitreous face. The complications of vitreous loss, retinal detachment, etc., that can occur in patients who have lens extractions are exaggerated in Marfan's Syndrome. Cataracts also occur frequently in these patients.

In summary, the two major problems that require prompt attention are glaucoma and dislocated lenses. The ptosis is a relatively minor problem and can be easily corrected. This is only done in individuals in whom the lid obstructs the pupillary margin and compromises the development of vision. It can be done at a very young age, if necessary. The strabismus can be corrected depending upon the severity of the cosmetic disturbance.

Dr. J. Hyndman
(Orthopedic Surgeon, I.W.K. Hospital for Children)

The orthopedic manifestations are as important as any in this syndrome. It is important to realize that the treatment of Marfan's Syndrome is not reassessment. The treatment is unknown for Marfan's Syndrome. It is a biochemical disorder and the treatment awaits the proper biochemical management.

We are, however, left with a number of problems to contend with in some way. Collagen is of course a major component of the structural system and as a result there are skeletal manifestations as well. The major problem is scoliosis, for the incidence in Marfan's Syndrome is probably between 50-70%. These people have a shortened life span, but it's not that short. The spinal deformities can affect the quality of life, and therefore they should be treated.

The management consists of correction of the deformity and fusion of the spine to maintain the correction. I would say that the non-operative treatments, because of this intrinsic biochemical disorder, are less effective than they are in the usual idiopathic varieties of scoliosis.

Many patients will complain of foot problems. Because of the very lax ligaments they can have dislocations in their feet with marked planovalgus deformities. These are treated according to symptoms.

I would make one other comment about the use of various physical parameters in the diagnosis of this condition. It is important to recognize that since the incidence of scoliosis is 50% approximately, that many segment measurements are useless. An upper/lower body segment measurement cannot be used in the presence of scoliosis because of course, unless the correction is made for the scoliotic deformity, the upper segment is smaller by measurement rather than by any actual growth disturbance. The same is true for arm span measurements as compared to total height.

One final comment about the management of scoliosis. Occasionally in patients who are destined to be very tall and who have scoliosis, we may consider producing premature onset of maturity with estrogen therapy. This can reduce the ultimate height and may also arrest progression of the spinal deformity.

Dr. J. P. Welch
(Medical Geneticist, I.W.K. Hospital for Children)

I would like to comment first on the differential diagnosis of the Marfan Syndrome. Although homocystinuria should be included in the differential diagnosis, a distinction between the two is usually quite easy, since potential confusion is based largely on the occurrence of ectopia lentis and homocystinuria is readily identified by the presence of excess homocystine in the urine, either by urinary aminoacid spot testing or by the simple nitroprusside test. It is equally important, and usually much more difficult, to distinguish Marfan Syndrome from some of the primary muscular dystrophies and from the Marfanoid hypermobility syndrome. Distinction between these various conditions is, of course, most important from the viewpoint of prognosis and for the implication of the diagnosis for other close relatives.

We have thus far not considered the implications of a diagnosis of Marfan's Syndrome on other close relatives of the primary patient. Marfan Syndrome is well known to be an autosomal dominant disorder with high penetrance but quite variable expression. One would thus anticipate that one or other parent would have this condition, one of the four grandparents, and that each sibling would have a 50% chance of also carrying the gene. These potential affected relatives should be screened, by physical examination at least, with further investigations and special counselling of members of the family found to be affected.

There is considerable current interest in the nature of the basic defect in this condition. The weight of evidence presently suggests a defect in collagen, perhaps one which interferes with cross linkage. There has already been one report suggesting a defect in α_2 chain collagen synthesis in some patients with phenotypic Marfan Syndrome.[4]

It seems likely that the new DNA technology of restiction enzyme analysis and mapping with the use of collagen "probes" will be applied to the study of this condition. The prospects for elucidation of the basic defect in this condition within the next few years seem promising.

Dr. R. B. Goldbloom
(Physician-in-Chief, I.W.K. Hospital for Children)

I'm sure that in the final analysis one of the toughest judgments is how often to see these patients and how much to do. After all, the measure of efficacy of any medical intervention, whether it involves treatment or simply examining a patient periodically, is that the intervention must do more good than harm. This must be a pretty tough experience for the families and individuals affected by this disease in which we have so little to offer therapeutically. It may sound harmless to say to a patient "Well, let's see you once a year". To the patient I suppose, that may serve as a regular reminder of his early expectancy of mortality. It's like phoning him up and saying "how are you feeling?" which the patient interprets subconsciously as saying "are you still alive?". I don't have any ready answers — but I think it's a question that one must consider. □

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MEDICINE IN TRANSITION

Continued from page 142.

Whatever the demands of tomorrow, at least we must provide the right environment, without constant political, financial or academic harassment. Sir William Osler was a great supporter of a well-organized medical society, and a hater of quarrels and prejudice, favouring cooperative effort, however difficult the circumstances. It is hoped that Dr. Stewart's fine oration will distil some of this felicitous philosophy.

B.J.S.G.

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Massive Spontaneous Hemoperitoneum In a 49 Year Old Chinese Male

R. S. Dunn*, M.D., F.R.C.S.(C),

Sydney, N.S.

INTRODUCTION

Hemoperitoneum is a fairly common condition to confront a general surgeon throughout North America. The vast majority of these are secondary to trauma, particularly blunt or penetrating abdominal trauma, with post-surgical bleeding as another important cause. Cases thought to be spontaneous are usually secondary to splenic injury to a pathological spleen. In these cases the trauma may be very minimal, and easily missed during history taking. Truly spontaneous hemoperitoneum as a presenting clinical problem for diagnosis and treatment is, then, quite uncommon in our country. The following is the presentation of such a case, with consideration of differential diagnosis and pertinent literature review.

CASE HISTORY

Presenting Complaint and History

In early January 1980, a 46 year old Chinese male was referred to our hospital because of a sudden onset of weakness and fainting. He had been well until about a week prior to admission, when an episode of dizziness had occurred. He attributed this to fatigue as he worked quite a long day as a routine, as a busy restauranteur. Episodes of postural dizziness increased over the next few days and he sought the advice of his family physician. He was being worked up as an outpatient for this symptom when, early in the morning of the admission to the hospital, he had sudden complete loss of consciousness after having gone to the bathroom to void. Assessment by the family physician found him to be pale and hypotensive. In the supine position he rapidly regained consciousness. Intravenous therapy in the form of crystalloid replacement was begun and he was transferred to our hospital.

Direct inquiry revealed that he had minimal GI symptomatology with mild nausea for about a week. However, his bowels had continued to move and there was no melena and no hematemesis. His weight had been stable for a long period of time. There was no history of excessive alcoholic intake and he was not a smoker. He had no significant surgery in the past. He denied a history of jaundice.

Social history revealed that he was a busy entrepreneur running a restaurant in a small Nova Scotian town for the past twenty years or so. As a child he had been brought up in China and had immigrated to Canada about 25 years ago.

Physical Examination

Assessment in our emergency department revealed that he had a blood pressure of 70/40 mm. Hg. and a sinus tachycardia of 120. He was pale, well oriented, co-operative and was having no chest pain. Head and neck exam was unremarkable. The chest was clear. Examination of the abdomen revealed modest distention in this slim male without any evidence of peritonitis, masses or localizing tenderness. There was shifting dullness; bowel sounds were reduced but present. The rectal was unremarkable, with no melena stool.

Laboratory Investigations

Stat blood work revealed a hemaglobin of 7.3, WBC of 17,400. Electrolytes were normal. a PT was 15 seconds with a normal of 12, PTT was normal. The platelet count was 78,000 and EKG was unremarkable. A chest x-ray was negative. Abdominal films were done which revealed a generalized haziness but no evidence of free air masses or intestinal dilatation. An abdominal tap was done which was grossly positive for large amounts of dark red blood.

The diagnosis, then, was hemorrhagic shock secondary to hemoperitoneum NYD.

Course In Hospital

Rapid resuscitation was carried out, using infusion of Ringer's lactate through large bore IV's to stabilize blood pressure. Urine output was monitored with an indwelling foley catheter. Vitamin K and fresh frozen plasma were given, and 4 units of blood were given over the next two hours. At this point the blood pressure had returned to 120/70 mm. Hg. Heart rate was 98.

The patient was then taken to the operating room where the abdomen was explored through a midline incision in the epigastric area. A large amount of dark red blood, some clotted and some unclotted was found free within the abdominal cavity. When this was cleared away, exploration revealed that the spleen was pathologically enlarged but was not the source of any bleeding. The liver was extensively involved with macro-nodular cirrhosis. The bleeding was found to be coming from the posterior aspect of the right lobe. Palpation revealed a firm tumor here, about 10 cm. in diameter with a soft necrotic centre. The edge of the tumor was adjacent to the inferior vena cava.

No other pathology was noted within the abdomen. The bleeding continued at a fairly brisk ooze of dark red blood from this tumor. The incision was extended through the seventh innerspace into the right chest. The diaphragm was divided over the dome of the liver. The right triangular ligament was taken down and this part of the liver mobilized. Dissection in the region of the porta was carried out to enable ligation of the right hepatic artery and the right lobar branch of the portal vein. The gallbladder was removed and a lobectomy of the right lobe was then carried out through the substance of the liver using finger fracture technique, clips, cautery, and large hemostatic sutures to control bleeding, (after Starzl, *et al*)[5] The porta hepatis was temporarily clamped with a straight Pott's clamp during part of the procedure to aid in bleeding control.

*General Surgeon, Sydney City Hospital, Sydney, N.S.

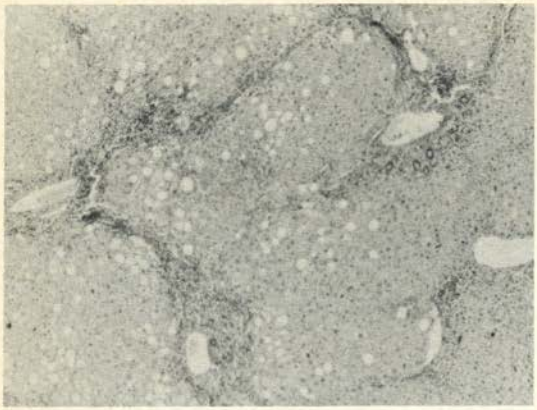

FIGURE 1

Section of the cirrhotic liver showing coarse bridging scars, and disorganization resulting from hepatic necrosis.

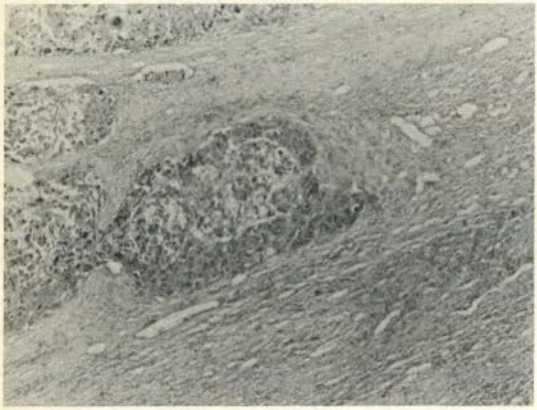

FIGURE 2

Section from tumor edge showing hepatoma, neighbouring compressed tissue and frank blood vessel invasion by tumor. (lower right)

Post Operative Course

The pathologist confirmed the diagnosis of primary hepatoma of the liver with macro-nodular cirrhosis. The etiology of the cirrhosis could not definitely be ascertained from this specimen. Resection margins were clear.

Because of the extent of the cirrhosis, we anticipated considerable hepatic insufficiency after lobectomy. The patient did develop pronounced hyperbilirubinemia but never any encephalopathy. He improved steadily. On the fourteenth post-op day, an undulating fever, a persistent effusion at the right lung base suggested a subphrenic abcess in this area. This was drained through a small incision on the fourteenth day and was found to be due to *Streptococcus faecalis*. After this the patient gradually improved and he was able to tolerate normal diet without protein restriction. Ascites was controlled with low salt diet, Aldactone, and a short course of Lasix.

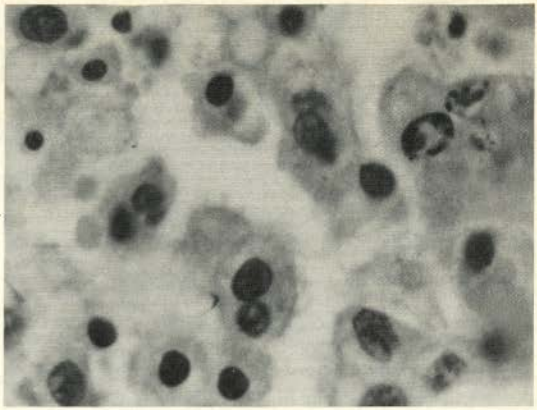

FIGURE 3

400 X magnification of tumor, showing hyper-chromatic nuclei, pleomorphism, mitotic figures, and complete loss of hepatic cell morphology.

At about the second week, a blood report was returned indicating that the patient's blood was positive for hepatitis B antigen, suggesting a likely etiology for his macro nodular cirrhosis.

The patient was discharged on the twenty-sixth post operative day. Arrangements were made for follow-up and a base line serum alpha feta protein was done with a value of 383.3 ng. (January 1980). At the time of his discharge he had a mild hyperbilirubinemia at about 2 mg.% His PT was still 15 seconds and he continued to manifest mild hypersplenism with platelet counts of about 80,000 and a modest leukopenia at 5,000 with normal differential.

He was seen in follow-up with repeated office visits and also by his family physician. Ascites continued to improve. His energy level continued to improve and he was back to work within six weeks. Follow-up chest x-rays at three and six months indicated good resolution of changes at the base. There was no physical finding at six months to suggest any recurrence. However, a serum alpha feta protein done at that time revealed distinct increase and was 2,665 ng. (as of May 1980). Because of this, a liver/spleen scan was done to see if any local recurrence could be demonstrated but the test was negative.

The patient continued to do well. In the ninth month post-operatively he complained of some right leg pain in the region of great adductor muscles of the leg. This was initially considered to be due to a strain of these muscles. However in 6 weeks, a large mass had developed here and, when this was recognized, the patient was hospitalized with a view to doing a biopsy. An admission chest x-ray revealed massive metastatic disease throughout both lung fields.

At present, the patient is being maintained on chemotherapy which is consisting of a combination of Adriamycin and 5 FU. He has been stable clinically apart from an increase in the size of the mass in his right leg, which accounts for all of his symptoms. A course of local radiotherapy has been arranged for this particular lesion. There is still no evidence of any intra-abdominal recurrence of the disease.

CIRRHOSIS AND HEPATOMA

Primary cancer of the liver is a rare tumor in our country, being found in less than 0.2% of autopsies and accounting for less than 0.5% of cancer deaths. It has a significant association with all types of cirrhosis and, in North America, is most commonly associated with alcohol abuse. However on a world wide basis, viral induced hepatitis and cirrhosis are more commonly associated with this cancer. In China, our patient's native country, cirrhosis induced by the parasite *Clonorchis sinensis* is a major factor related to primary hepatoma of the liver. This was originally considered to be possible in our patient; however, parasitological studies were negative and the finding of positive HB antigenemia makes viral hepatitis the most likely cause.

All available evidence supports a causal relationship of a viral induced hepatitis and primary hepatoma of the liver[2,6]. A history of clinical hepatitis is present in less than 2% of patients that present later with cirrhosis due to viral infection, indicating a large number of subclinical cases. The patients with chronic liver disease have long been suspected to be subject to increased risk of developing primary hepatoma of the liver. In one study such a group was followed with serum alpha feto-protein levels.[1] 2-5% per year of this group showed a distinct increase and most of these turned out to have hepatoma. Unfortunately this has yet to be translated into any increase in survival.

In China the HBS carrier state is around 30 times higher than it is in our country and the death rate due to primary cancer of the liver is about five times higher.[2] It would appear that the relative risk of developing this cancer due to antigenicity with HB, asymptomatic or not, is higher than the equivalent figures for cigarette smoking and lung cancer.[2] World wide data are difficult to interpret in this regard because of the very high incidence of carcinoma of the liver in certain countries such as Mozambique where the ingestion of a powerful carcinogen (aflatoxin) occurs combined with the increased incidence of antigenicity.

HEPATOMA AND HEMOPERITONEUM

Typically, this tumor presents as right upper quadrant pain or mass with weight loss and liver failure, and rarely is the diagnosis made on clinical findings alone. There are many bizarre presentations: acute cholecystitis, fever NYD, Budd-Chiari syndrome, hematobilia, pathological fractures, hepatitis, para-neo plastic syndromes.

Massive intra-peritoneal bleeding has also been reported as a presenting symptom and this particular mode has been reviewed by Chamiza.[3] He reviewed the world literature and points out that 5 to 10% of hepatomas may present in this way and are often misdiagnosed as a perforated duodenal ulcer, as they often begin with right upper quadrant pain and spreading peritonitis, followed shortly by clinical shock. The immediate cause for the bleeding is presumed to be local obstruction of veins, direct erosion of blood vessels, or minor trauma to a very friable lesion. Prognosis of the patients that present in this way is usually poor. Eighteen of twenty such patients, as reported by Ong *et al.* died in six months.[4] The fulminating appearance of metastatic disease in our patient, despite apparent removal of all tumor at the initial operation, bears grim testimony to the accuracy of Ong's observations.

SUMMARY

A case is described in which the patient presented with massive intra-peritoneal bleeding, with no antecedent history or clinical findings to suggest the definitive diagnosis. He was found to have a bleeding primary hepatoma of the liver associated with macronodular cirrhosis. He had hepatitis B antigenemia. He has survived 10 months but is now undergoing chemotherapy for pulmonary metastases. Relevant literature is reviewed. Although this presentation of hepatoma is rare in our country, it has been well described in those populations where hepatoma is more prominent. The patient was an immigrant from a country with a high incidence of cirrhosis and hepatoma. Such bleeding may account for initial diagnosis in 10% of these patients. Associated conditions and causal factors for this cancer are being investigated but current treatment is ineffective and the prognosis is dismal, particularly for the type presenting with hemorrhage intraperitoneally. It seems unlikely, then, that the low rate of correct pre-operative diagnosis affects immediate or long term survival of these unfortunate patients in any significant manner. □

Since the submission of this paper for publication, the patient has succumbed to his disease and expired in early November, 1980.

ACKNOWLEDGEMENTS

I wish to acknowledge the help of Dr. R. Mathieson, Pathologist, Sydney City Hospital for his help in preparation of tissue slides and photographs. Dr. A. Laycock of the Halifax Infirmary, gave valuable assistance in selecting relevant references and thanks to Mrs. A. Reardon, for help in organizing and typing the material.

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ERRATUM

In the paper entitled: "The Clinical Prediction of Ovulation", which appeared in the October 1980 issue of the *Bulletin*, Ismail I. Zayid, M.B., B.S., F.R.C.P.(C) was inadvertently omitted as a co-author. The Editorial Board sincerely regrets this oversight.

YULETIDE
Nova Scotia Rhapsody

B. J. S. Grogono,* M.B.,
Halifax, N.S.

With my heart
I'll always yearn
for Nova Scotia's magic mystery

With my dreams
I'll always weave
the fabric of a favorite memory

With my love
I'll gather moments
fragments of a melody

The sauntering echoes
with the stars
touched all my world
with tender sympathy

Through the clouds
the mountains gleam
snow capped and glistening with pride

Through the woods
the rivers stream
to give a sparkling song to every tide

Through the vales
the orchards throng
to fashion blossoms
for each spring bride

The shining glory
when the glow of May
shines to the world
with one anthem

By the shores
the oceans rage
and swell with unremitting phantasy

By the wharves
the lobster pots
await in lonely synchrony

By their huts
sailors a tune
and swear by Neptune's harmony

The haunting hours
when the sea and sky
combine in one grand symphony

Nova Scotia
smiling in sun and shade
where friendships never fade

Nova Scotia
shrouded in mist and fog
soul of the sailors log

Remain forever
our guardian of treasure
charming us
eternally □

*Chief of Orthopaedics, The Halifax Infirmary, Halifax, N.S.

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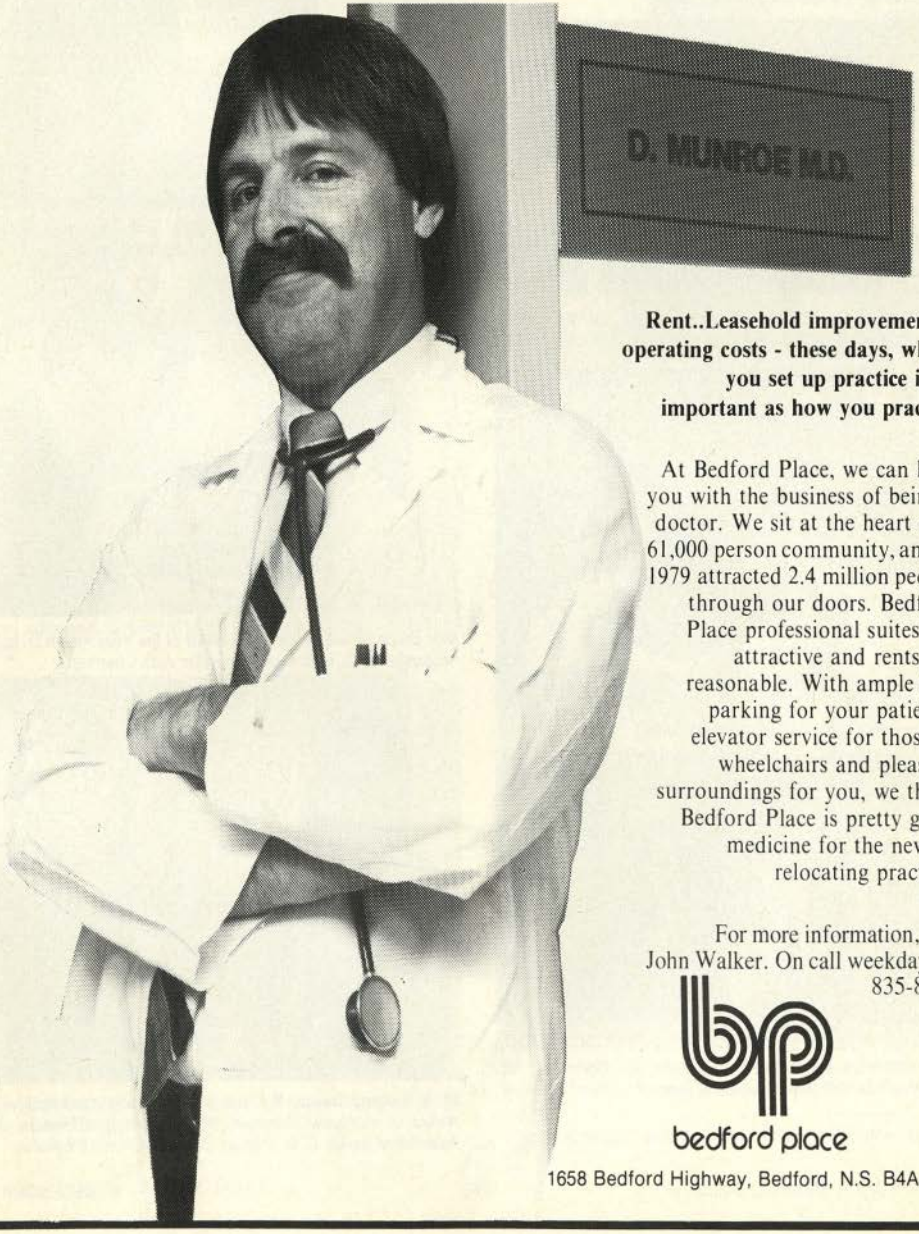

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Pictorial Highlights

127th Annual Meeting

Opening ceremony for 127th Annual Meeting.

Dr. Alan MacLeod, Dr. Margaret Churchill and Dr. Gerald Sheehy shown following the Minister's address to the Medical Society.

Tove and Marion check in Dr. Allan S. MacDonald

Dr. Bill Thomas, President of CMA and Dr. Gerald Sheehy, Minister of Health exchange views as Dr. Malcolm, Dr. MacAulay, Dr. MacLeod, Mr. Peacocke and Dr. Churchill look on.

Photographs by Vern Ferguson and Audio Visual, Tupper Building.

Dr. Bill Thomas, President of CMA, emphasizes necessity for physicians to comply with P.M.B. request for information.

Mrs. Bruce Crowe receiving Alumnus of the Year Award on behalf of her husband, Dr. J. B. Crowe, from Dr. Jack Charman.

Dr. L. George Dewar of O'Leary P.E.I. being presented with the Award of Honorary President of the Dalhousie Medical Alumni Association, by Dr. C. B. Stewart. Dr. M. E. Churchill looks on.

Catherine MacLeod, Al MacLeod, Carolyn Thomas, Bill Thomas and Margaret Churchill greet Society members and guests attending the Society's Annual Reception, Banquet and Ball.

The Turnover.

Mr. Charles Lynch, prominent journalist and Chief, Southam News Services addresses Society at lunch on first day of the 1980 Annual Meeting.

Following his installation as President of The Medical Society of Nova Scotia, Dr. Alan J. MacLeod looks to all members for support during his coming year in office.

Dr. Margaret Churchill presents a token of appreciation to Carolyn Thomas, wife of Dr. Bill Thomas, President of CMA.

Dr. Alan MacLeod, newly installed President, congratulates Dr. Murdock Smith of Sydney, as he assumes office of President-Elect. □

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Personal Interest Notes

SENIOR MEMBERSHIP CITATIONS
THE MEDICAL SOCIETY OF NOVA SCOTIA

Dr. Harold Joseph Devereux

Dr. Margaret Churchill congratulates Dr. Harold Devereux as she confers upon him Senior Membership in The Medical Society of Nova Scotia.

Dr. Harold Joseph Devereux, the youngest of 13 children, was born on a farm at Kelly's Cross, PEI in 1910. He obtained part of his secondary education at St. Dunstan's University and completed both pre-med and a BA degree at Tuft's College in Medford, Mass. before he entered Dalhousie Medical School, earning his degree in 1936. To further his career in general practice, he sought post-graduate studies in Cardiology at the Royal Victoria Hospital in Montreal and Obstetrics at the Boston Lying-in Hospital.

Dr. Devereux's first post was at Sterling Mines where he was employed for $125. per month, plus room and board. He soon moved to Dominion, N.S., where he practised with the late Dr. M. G. Tompkins and in 1942, moved to Sydney to become the thirteenth doctor in that community.

Harold and Marg Devereux were married in 1940. Diane Devereux MacDonald is the only one to follow a career in Medicine and has now completed a psychiatry residency at Dalhousie University. The boys, Greg, Brian, Dennis, and Bruce are scattered around the world, Sydney, Toronto, Alberta and New Zealand. Their careers include business, banking, oil exploration, and teaching.

Dr. Devereux has spent his professional life in Sydney where he is still in General Practice. His contribution has been recognized by his appointment at various times as president and chief of staff of both Sydney City and St. Rita's Hospital. He has served as president of the Cape Breton Medical Society.

His influence has been felt in both the Provincial and National Medical professional organizations. He is a past president of The Medical Society of Nova Scotia and can boast of having missed not one annual meeting of the Medical Society. He has represented The Medical Society of Nova Scotia on the Executive Committee of The Canadian Medical Association. For seven years, he served on the N.S. Hospital Insurance Commission and has been a director for a number of years in the recent past of the Provincial Blue Cross Insurance Commission and the Blue Shield. Dr. Devereux was honored for his participation in these various organizations in 1976 by senior membership citation in The Canadian Medical Association.

All of Dr. Devereux's energies were not directed to Medicine as he was active in municipal, provincial, and federal politics, in the Home and School Association, United Appeal, and Kiwanias Club. Recently, his hobbies include bird watching, gardening, and building his retirement home on his beloved Mira River.

Madam President, I am pleased to present Dr. Harold Joseph Devereux to you for senior membership in The Medical Society of Nova Sctoia.

Dr. Mary E. Lynk
Cape Breton Medical Society

Dr. Gordon Kent Smith

Dr. G. K. Smith receives a warm welcome from Dr. Margaret Churchill as she confers upon him Senior Membership in The Medical Society of Nova Scotia.

Gordon Kent Smith of Hantsport was born of staunch Presbyterian, Scots-Irish parents in Windsor, Nova Scotia on May 8th 1896.

He received his early education at Windsor Academy, where his father was Principal for nearly 30 years. Gordon Smith did not get a Grade XI certificate, however, as his father saw fit to expel him from school for being unruly. Rejected for military service during World War I because of chronic otitis media (a souvenir of scarlet fever), he worked as a grocery clerk, drug store clerk, night telephone operator, and accountant for about two years.

He then decided on further education, enrolled at Kings College, which was then in Windsor, and matriculated with the help of his father's tutoring. In September 1917, with

$300.00 in his pocket, he took the train to Halifax. If the $300.00 was enough, he was going to enrol in Medicine; if not, he was going to enrol in Law. Fortunately, it was enough and he began his medical studies. In such ways, sometimes, careers are decided!

On December 7, 1917, the Halifax Explosion occurred. At that moment he was in the Histology Laboratory at his desk, and the blast blew in windows, sashes and all, with glass flying everywhere. Fortunately, other than minor cuts and bruises, no one was injured. After a trip to the devastated shore-line of the harbour, and on hearing a warning of a second explosion, he and a class-mate went cross country to the Bay Road, then to the Windsor Junction railway station and home for the Christmas holidays.

Gordon Smith was a good athlete, playing varsity hockey and rugby at Kings College and Dalhousie where his teams won several Maritime championships.

He graduated on his birthday May 8, 1922 and started a country practice at Grand Pre in Kings County. After three years he moved to Hantsport where he still practises. He can recall many stories of those early days, especially since he continued to provide much of the medical service for Grand Pre, Gaspereaux and Wallbrook from his new location at Hantsport. (In those days winter house calls were made by horse and sleigh, distances of 6-10 miles!)

In 1922 he was appointed to the staff of the Payzant Memorial Hospital in Windsor and was President of the Medical Staff from 1938-1960. He is still the Honorary President of the Medical Staff and the Board of the Hospital gave him an engraved silver tray to acknowledge 50 years service to the Hospital.

Gordon Smith was married to Mabel Rand Ells of Sheffield Mills in Kings County in 1927 and has one son, John, who is also a medical doctor.

In 1929 he joined the Masonic Lodge and received his 50 year jewel in 1979. In 1929 also, he became a Councillor of the Town of Hantsport and in 1930 its Mayor, a position he held for 16 years.

Gordon Smith has always had an abiding interest in the out-of-doors, being an avid hunter and salmon fisherman. A fractured hip in 1942 curtailed his hunting activities, but he still manages to spend a week a year salmon fishing with continuing success. He considers that his life has been well spent and looks forward to the future — fishing, reading, relaxing and above all, continuing to serve his patients.

The art and science of medicine in Nova Scotia, has been enhanced by Dr. Smith's distinguished career. It is an honor to present Dr. Gordon Kent Smith for Senior Membership in The Medical Society of Nova Scotia.

Dr. A. F. B. Connelly
Valley Medical Society

SENIOR MEMBERSHIP CITATIONS
THE CANADIAN MEDICAL ASSOCIATION

Dr. Norman Barrie Coward

Doctor Norman Barrie Coward is a native of St. Thomas in the West Indian Islands, where he was born on August 14, 1905. After being educated privately as a boy he attended the Colchester County Academy at Truro, Nova Scotia. In 1922 he became a student in the faculty of medicine of Dalhousie University and graduated in 1928.

Dr. N. B. Coward is shown following his installation as Senior Member, Canadian Medical Association by Dr. W. D. S. Thomas, President, C.M.A.

From the outset of his medical career Dr. Coward evinced a particular interest in pediatrics and undertook extensive postgraduate training to qualify as a specialist in that subject. He served a two-year internship at The Hospital for Sick Children in Toronto and a further year as resident at the Riverdale Infectious Diseases Hospital in the same city. Subsequently he was chief resident for over a year in the department of pediatrics of Bellevue Medical Centre in New York. Finally he went to Britain and for twelve months visited at the children's hospitals in London, Edinburgh, Glasgow and Birmingham.

Dr. Coward has long been a member of the faculty of Dalhousie University. From his initial post as lecturer and clinical instructor in pediatrics he was promoted to successively higher rank until in 1958 he was appointed professor and head of the department of pediatrics. In this position he served also as physician-in-chief to Grace Maternity Hospital and the Halifax Infirmary. Five years later he became pediatrician-in-chief at the Children's Hospital. He retired from these posts in 1971 but continues to serve as medical director of the Hearing and Speech Clinic he helped to found.

Dr. Coward takes pleasure in philately and gardening and he enjoys the game of bridge. He and Mrs. Coward have one son.

Dr. Chester B. Stewart has been appointed by the Board of the Canadian Medical Association to a newly established Committee on Allied Health. The six man committee will deal with the inter-relations between the medical profession and the fifty or more other health disciplines or technologies involved in patient care or health protection.

Dr. Stewart was chairman of a Committee of the N.S. Health Council which reported in 1976 on Health Professional Licensing.

Dr. Dennis W. Johnston of Dartmouth has been named Chairman of the Atlantic Provinces Section of the American College of Obstetrics and Gynecologist. **Dr. Edwin R. Luther** is the new Vice-Chairman of this organization. The American College of Obstetrics and Gynecologists represents 22,000 Obstetricians and Gynecologists throughout North America.

Dr. R. O. Jones, Professor of Psychiatry, Dalhousie University gave a lecture at the Institute of Psychiatry, Denmark Hill, London on November 17th during a visit to England.

Dr. Enid MacLeod was recently honored in a ceremony to recognize her achievements. Together with Dr. D. R. Griffiths, now Professor Emeritus of Anaesthesia at McGill University, she wrote the first paper on the use of Curare as a muscle relaxant during the administration of an anesthetic in 1941.

"Hers was a real Canadian contribution to medical research" said Dr. G. A. Klassen, head of the department in which she was a demonstrator, lecturer and associate professor. Dr. MacLeod taught physiology to nursing, pharmacology, physiotherapy, dental hygiene and medical students, after her graduation at Dalhousie in 1937.

The use of relaxants such as Curare in the induction of anaesthesia can be regarded as almost a valuable discovery as the use of chloroform and ether in the previous century. Dr. MacLeod was appointed as Professor Emeritus to the Department of Physiology and Biophysics at Dalhousie University.

Dr. David Murphy of Halifax was made a life member of the Writers Federation of Nova Scotia at its annual meeting at Dalhousie University. He was presented with a scroll by Dr. Helen Creighton.

Dr. J. E. Harris Miller has been awarded the Health Service Executive of the year by the Nova Scotia chapter of the Canadian College of Health Services Executives.

An endowment fund has recently been established in honour of **Dr. Mendel E. Burnstein,** a prominent Nova Scotia physician, by his friends and patients in support of the IWK Hospital for Children. The fund, known as the Dr. Mendel E. Burnstein Research Fund, has been named to sponsor a Fellowship, awarded on a competitive basis, to a young medical graduate of outstanding promise who is preparing for a career in the care of children or in research in diseases of childhood. The fund is expected to grow over the next few years and when it reaches an appropriate level a Burnstein Fellow will be named.

Dr. Burnstein continues an active medical practice in the Halifax community. He was born and raised in Glace Bay, Cape Breton, graduating from Mount Allison University and from Dalhousie Medical School in 1952. He began his medical practice in Glace Bay and, in 1954, he moved to Halifax where he established his present practice. Dr. Burnstein and his wife, Shirley, have three children, Marcus, Milo and Matthew.

Interested contributors can donate directly to the fund and specify if the donation is made in memory or in honour of a friend or relative. Cheques should be made payable to The IWK Hospital for Children — Dr. J. Mendel E. Burnstein Research Fund. All donations are tax deductable.

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