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Our Clouded Horoscope

By H. B. Atlee

THERE are three desperate failings to which human beings and institutions are prone (1) they will not look the facts of history in the face, (2) they refuse steadfastly to look any further into the future than the ends of their noses, and (3) they tend readily to maintain the philosophy: "Why should I bother, I'm doing all right out of it." It is because I see these unhappy traits present in the current deliberations of our profession—not only locally but across the continent—that I am constrained to bring forward the following considerations.

Whether we like it or not, it seems inevitable that we will find ourselves asked, within a relatively short time, to accept some form of socialization. We know that plans have been drawn up at Ottawa which merely await the fortuitous hour. We know that large bodies of our population, especially the wage-earning and lower-salaried, white-collar groups, would welcome this. We ourselves, in entertaining such schemes as Blue Cross and Maritime Medical Care, have taken the first step towards acceptance of some socializing scheme. Since, therefore, government, populace and profession—the three major bodies concerned—have moved so far in this direction, it requires no great prophetic gift to state that we are going to be socialized. In which event, we are destined to become a group comparable in almost every respect with the teachers in our public school system, who underwent this same process some generations ago, and whose fate is likely to become ours.

But this socialization will occur in a community that remains—apart from ourselves, the school teachers and a few other groups—unsocialized. This is a very vital fact to keep in mind, since our future—financially, socially, and professionally—will become increasingly at the disposal of the unsocialized majority—the voting public, and its representatives in parliaments. It has been the history of voting publics and parliaments that, in epochs of business recession, or when big business is strongly represented in legislatures, the first expenditures to feel the axe are those devoted to the social services—of which we shall form a part. That is one thing that history—from the study of which and its implicatons we all shy away so fearfully—teaches us.

The next thing history would—if we studied it—teach us is that, since the beginning of society, the price of those goods and services by which we live and have our being has gone steadily upwards. Admittedly, there have been periods of deflation—such as that which occurred in the 30's—but on the whole the price of goods has risen steadily since Adam was a boy. History then teaches us that there is nothing eternal about the dollar, whose tendency has been—in a world that produces more and more—to buy less and less. Only that most outrageous dupe of wishful thinking—the man who refuses to look further than the end of his nose—will refuse to agree that this trend will continue in the future.

The next thing that history teaches us is that you can't have socialization without bureaucracy, that bureaucracy breeds those two bastard children conformity and standardization, which in turn breed mediocrity. Human

nature being such as it is this is as inevitable as tomorrow. The process is something like this: under bureaucracy the sycophant and the yesman rises to the top as surely as cream on milk: on the other hand, the man of ideas and originality, who, in the very process of gaining acceptance for his ideas becomes 'difficult', tends to be relegated to the doghouse. For a bureaucracy has these characteristics (1) The democratic, or freewheeling, processes become hampered. There is a boss at a big desk—his yesmen clustered around with their suction apparatus on the qui vive—who calls the tune and who, becoming steadily more corrupted by his power and his yesmen, grows less and less ready to listen to criticis or ideas, or capable of understanding them. Until finally he takes the stand. not that his bureau is the servant of the people, but that the people are the servants of his bureau. (2) A bureaucracy has not the courage to live dangerously—which means that it will not risk trying out new ideas, many of which must fail, to find those that will succeed. If by some miracle it did, those omnipresent vested interests opposed to change, and their representatives in the oppositions in parliaments, would pounce on every failure (and refuse credit to every success) until the poor bureaucrat responsible, suffering from hotfoots and burned fingers, learned to sit on the status quo until his backside grew to it. For the fault lies not so much with the bureaucrat as the circumstances that work on him. He is human. He is often a man of great ability. But the 'circumstances' corrupt him.

I am sure you will agree that there is no need to labor further these obvious historical facts. Are the effects that they will have on our future as clear? If the way we are facing them as a profession, and the way we talk about them as individuals, are just criteria, the answer is a categorical No! So let us look, in strict conformity to the so-obvious historical facts, into the crystal ball.

A. Do we want to become a depressed profession like the school teachers? When I was a boy the small town in which I was brought up had two male teachers in the high, and one in the preparatory grades of its school. They were men of considerable consequence in the community, ranking socially and economically with the best. They lived in good-sized houses; they went to Boston or New York on the occasional trip. In short, they had prestige equal to the best in the town. Why has much of that prestige disappeared? Why is the schoolteacher of today a member of a depressed profession, generally speaking the timid servant of school boards and departments of education? Part of the answer comes under—

B. The servant may be worthy of his hire, but does he get it? In the case of the school teacher he didn't. As a result of the inflation that accompanied the first world war, the pre-1914 salary was no longer adequate. But because of the lag that accompanies all raises in salaries that are at the disposal of taxpayers and bureaucracies, this inadequate salary was not increased immediately to meet the rising costs of living. As a result, by about 1923 there were no longer any male teachers in the school of my home town, and every teacher from principal down was a woman. Why? Because only women would accept, and only single women could live on, the salaries then going. All the bright young men, even those who had used teaching as a stepping stone to the professions, sought sustenance elsewhere. With the

result that you could count on your two hands all the male teachers in all the public schools of Nova Scotia. A whole decade of boys lacked masculine leadership, in order to get which they had to be sent—where the parents could afford—to private schools.

Eventually salaries were raised. Eventually, men with college degrees found it worth while to teach again in the public schools. Today there is a fair, though not yet adequate, number of male teachers in our schools. But something is missing. The prestige that the teacher held in the community has not returned. There are no Maclellans of Pictou any more—and as a result no Pictou Academies.

Prestige is an important prize to professional men. If we search our subconscious honestly, most of us must confess that our major reason for entering medicine was a yearning for prestige. To a degree that few other vocations do, medicine lends us something of the capacity to perform miracles —to play God. Out of the prestige resulting we derive much of our satisfactions; satisfactions which amply compensate the loss of sleep and the necessity of being on the job for 24 hours a day. Add to this fact that the more hours we work and the more sleep we lose the more we get paid, and you arrive at a sum that probably constitutes 90% of our motivation. (I leave a large sop of 10% to those who may feel that they were called to practice our art through a pure love of humanity).

The moment you put men on wages and salaries, the amount of time they work per day becomes important, and the pressure is for union hours. The doctor who goes on union hours quickly becomes less than a whole man, and he as quickly loses that quality of being a guide, counsellor and friend to his practice that many hold to be so important. When he loses that quality he ceases to be a present help in time of trouble—loses much of his godlike function—and tends to become a mere technician, a sort of body plumber. This not only further lowers his prestige in the community, but also in his own eyes, so that playing God becomes an empty and cynical illusion.

C. Let us face the fact that we live on a continent on which the amount of money a man earns largely determines his position and influence in the community. We can deplore this fact (those who subscribe to the teachings of Christ certainly should) but there it is. Only the man who refuses to search his heart will deny that he is not to some degree infected by this essentially stupid contagion. While we can protest against it, we must face it and live with it. Who can say to what extent the low salary of the school teacher determines his continued lack of prestige in the North American community? It certainly is responsible for the fact that there is such a desperate lack of teachers today, and that inflation is once more doing to that profession what it did in the 20's.

Is this to be our fate also? It certainly will if we allow the same things to happen to us that have happened to the teachers. Granted the following, (1) that we are due to undergo some form of socialization, (2) that we will accept as compensation what will be considered even a fair average rate of pay as of the date of socialization, and (3) that the rest of the population will remain unsocialized—granted those three factors, then it must follow as surely as God made little apples that we will become a depressed profession like the school-

teachers. The three historical inevitables—inflation, bureaucracy, and lack of social prestige—will sink us. The man who refuses to face this is ignorant of the facts of life.

Does it not then behoove us—unless we suffer from so severe a form of masochism, that we feel that to become a depressed profession would cause a salutary deflation of our swollen egos—to consider our future seriously in the short time that remains before the governmental halter is clamped about our necks? What must we preserve in order not to deteriorate? Probably the three most important would be (1) our ability to evolve and develop with the same freedom and rapidity that we have in the last 150 years, (2) our capacity to earn enough to buy a reasonable share of this world's goods and services, educate our children to at least the same university standard we got ourselves, and save enough to look after ourselves from 65 or 70 onwards without having to depend solely on the Old Age Pension, and (3) to maintain our present prestige and social position. (I use the term 'social position' not in the sense of Who's Who but Who is Able to Do What). Of these three the first two are the most important since, if we can preserve these we are not likely to lose the third.

To preserve the first we must have a care to the nature of the compact into which we enter with governments. There will be a tendency on the part of many of us—in fact, if we follow historical precedent, the vast majority of us—to throw up our hands and yield everything in an atmosphere of defeat and rout. We'll stall off socialization as long as we can—we may actually fight desperately against it for a time, as our colleagues in the U. S. are doing —but when it becomes inevitable we will accept it as vanquished men. Vanquished men are frightened men. So the next step will be to scramble aboard the bandwagon and pick the best seat available, to vie with one another in showing governments what really good boys we are, and how amenable to the heel on the neck. In so doing we will be following, not the wild course of Atlee's imagination, but the precise path of historical precedent. We will be doing what our fellows have in similar situations since the beginning of time. And the man who thinks he is different from his fellows had better see a psychiatrist.

It is important therefore, that we try to face socialization when it comes not as a defeat, but as a more or less inevitable evolution of human affairs. Socialization may not be the best answer to man's problems; in fact, in providing an easy solution for certain of them it may—by seriously jeopardizing individual freedom—actually create more serious ones; but it appears to be the answer with which man intends in the immediate future to solve some of his difficulties. We are not perhaps fully conscious of this evolutionary trend because we are blinded by the industrial prosperity of North America. Men accept it more fully in Europe, Asia and parts of South America where large minorities—ever increasing in numbers—clamor for socialization, and clamor the more desperately as their situation worsens. Communism, with all its horrors, has come to many of these countries and, short of some miracles will come to more. It came—and will come—because the free world offers no middle way between it and the most reckless free enterprise—or rather, let us say that the free world will accept no middle way.

Is it possible that the medical profession of Canada can, in the face of approaching inevitability, show the world a middle way? We certainly cannot do so by becoming the salaried servants of government, subservient in all ways to departments of health and the vicissitudes of politics. For if you carry that process throughout the entire population, everybody is the paid servant of government and you have arrived at Communism; and if one historical fact is clearer than any other, it is that professions like ours under Communism not only fare badly as regards the individual, but the capabilities of evolving their ideas freely and without restraint is greatly hampered. Our hope therefore of a decent future lies in becoming the partner rather than the servant of departments of health and governments. In that case we must accept socialization free from any sense of defeat and with our loins still girded to battle for that freedom to evolve and develop that we have had in the past and without which we will rapidly deteriorate.

Some of us seem to feel that, if we set up our own body of control rather than be controlled by a department of health (except on terms of equal partnership), we would safeguard our freedom to evolve. This has the elements of wisdom, but it can be a snare and a delusion. A bureaucracy is a bureaucracy, whether it is composed of civil servants or doctors. What is so likely to happen is what has already happened. We elect an executive grossly overweighted with specialists, teachers in medical schools, and the more financially opulent of our brethren. They will in turn select an executive director to manage the bureau. He—and they—will more and more determine policy—which in turn will more and more follow the aspirations of the Toronto-Montreal axis. Why? Because of our fatal incapacity to endure to the end, to think out to finality, our human problems—the escape from which can be summed up in the phrase: Let George do it. Elect a premier and you don't have to worry about politics for four years: elect a city manager and you don't have to worry about civic affairs any more at all: elect an executive director—some smart, smooth character—and he will carry you through. No more problems. . .until suddenly ten, fifteen, twenty years later you wake up and realize that the powers of this bureaucracy over you have so expanded that you are caught like a asquirrel in a cage, and the only direction in which you can move is around and around.

This will be the tendency—and the peril. On the other hand, if we resolutely refuse to give any director or executive too great powers over us, if we watch and direct their actions and policy with the greatest scrutiny and care; in short, if we remain eternally vigilant—far more vigilant than we are now in our governmental and civic affairs—we may be able to show the world a middle way between its two present choices. Unless we do so, we shall inevitably lose our freedom of action, our ability to evolve, our place in the scientific sun. This is our greatest danger and, since we are human and subject to the historical frailties of humanity, we shall probably not completely escape it. We shall certainly succumb to it unless we show more wisdom and vigilance than we now are showing.

How shall we preserve under socialization our capacity to earn enough to buy a reasonable share of this world's goods and services, educate our children at university level, and save enough for our old age? Not, I am constrained

to say, by following such financial will-o-wisps as Blue Cross, Maritime Medical Care, etc. These financially illusory schemes not only commit us to an unrealistic value of our worth, but they say in effect to governments that we are prepared to be taken over at that worth.

Let us look for a moment at that phrase 'unrealistic worth.' When I began to practice as a specialist in Halifax in the '20's, the surgical and obstetrical fees I received were precisely those which in the '40's we agreed to accept from Blue Cross and Maritime Medical Care—and which we still accept. Under Maritime Medical Care we *get* about 60% of that, and the prorating seems to tend downwards rather than upwards. But what do you get with this so earned dollar when you approach the grocer, the druggist, the plumber, the carpenter, etc.? Forget about taxes, in which we all share, and that dollar gets you just half what it did in the 20's and 30's—and is getting steadily less. In other words, everybody else is charging us more than twice what they did, to pay for which we accept the now phoney prewar dollar . . . .or, if we belong to Maritime Medical Care, 60% thereof.

Furthermore, the income from these insurance schemes is static. We have no clause with any of these schemes whereby our income goes up if inflation continues. Workers in many industries have been wise enough to insert such a clause into their wage contracts, based on the government index of the cost of living. In other words, their income is tied to the cost of living so that, come inflation or deflation, they are earning a real and not a phoney dollar. As I have already pointed out, history teaches us that there has been a steady inflation throughout history. Nothing has happened, or seems likely to happen, to change this trend.

Let us suppose that inflation does continue—as a matter of fact the cost of living has gone up this very month. What will be our position in 10 years time on the basis of the fees now being paid us by the various insurance schemes? Either our standard of living will go down, or we will have to work twice as hard to preserve it—in other words, see more and more patients. I saw how that worked in England within a few years of the introduction of their type of panel practice. I did a locum for two men and this was the sort of life we endured. All three of us saw about 10 patients between 9 a.m. and a quarter to ten. Then we started our visits. I did the nearby ones on bicycle and my list was never less than 50 daily except on Sunday. The two partners used cars, and they took on upwards of 75 visits. From two to four in the afternoon we saw at the office not less than 25 patients each. Pausing then for the 30 minute sacred tea ritual, we were off again to finish our visits by 6. At 6.45 we went into the offices again until from 9.30-10, during which we saw another score or so of patients each. What sort of service could we give these 100 odd human beings we each saw every day? What proper examination had we time to undertake? What time had we left even to meditate on the stupidity of this squirrel cage in which we were chasing our tails.

Admitted that the above situation was an unusual one; it was not unique. It is the sort of thing that is bound to happen when men, working on a fee for work basis, find that the fee has become inadequate. The two men I referred to above were the sons of clergymen, and both were honorable citi-

zens trying their best to give faithful service. This is the straits to which even honest men are driven under such circumstances when the fee is inadequate, or the dollar loses its value.

What this does not only to our professional worth but to our moral integrity, must be clear to the dumbest. No man can do justice to 100 patients a day. The more we learn about the investigatory side of our art, the longer it takes us to examine and diagnose a patient. It is likely that this trend will continue, and that each individual case will require more and more time. What we require is not more patients, but more time to investigate and meditate upon those we have. The pressure of bureaucracy will have the tendency to force us to take on more patients for the same money, rather than fewer for more. The pressure of bureaucracy has forced our public school teachers on this continent to take on more and more children per class—to such an extent that in some of the big city schools teachers are so hard put to maintain discipline in their unwieldy classes, that they have little time left for actual teaching. This sort of thing has only one end.

Let us ask ourselves this question: Are we worthy of our hire? If the fee that we accept from our various insurance fees is a fair one, then the fee that the MacDougalls and Stewarts, and those old enough to have been in practice before 1940, was an unfair one. In effect, in those pre-1940 days we must have been charging twice what the traffic should have been asked to bear: we were gouging. If that is an unjust indictment, if the fees charged then were fair, then—in accepting the same fees today when everything we must buy with them has more than doubled in price, and everyone around us is getting more than twice the pre-1940 wage—we are either fools, or (having lost our wits) are hellbent for professional suicide.

As head of a teaching department I am particularly perturbed. Teaching and research require time—not only for their conduct, but for that meditation without which they cannot either be envisaged or effectively conducted. If you are the sort of teacher who slaps it at the students off the pages of a textbook,and undertakes no clinical investigation, the amount of time required needonly be minimal. But the philosophy governing the enlightened medical school today is changing. More time is being devoted to improving the techniques of education, more and more clinical investigation is becoming a sine qua non. How can I ask the younger men in my department to give up more and more of their time to teaching and research, when the dollar they are earning buys less and less of this world's goods—when it buys less than half what the dollar did when I was at their career stage?

Someone will immediately say that the answer is the fulltime teacher. The adjective 'fulltime' is a weasel word as used today on this continent. There is no such thing as a fulltime medical teacher. There are teachers who have hypothecated certain areas of their time to teaching and research, reserving other areas for private practice; but the pressure here is to accept more and more private practice as the dollar loses value and chisel further and further into the hypothecated time. We are human. Even where such teachers are paid an all-inclusive salary and what they earn at private practice goes into their department, the pressure from the university is for more private practice to be undertaken so that more and more of the departmental

cost-load will be so borne. University presidents are human, too. Furthermore, universities are finding it more and more difficult to finance the ever-increasing costs of medical education, and this tendency to capitalize on the clinical teacher will grow greater rather than less.

In any case, whether the teacher is so-called fulltime, or whether he teaches for the sheer hell of it and a small honorarium, he will have less time for it—and less time for clinical investigation—the harder he has to work in order to earn an adequate income—the term 'adequate' meaning an income comparable to that of the lawyer, engineer, or other highclass professional.

It would seem therefore, that we should set about defining a 'realistic' fee for the services we render, that we should tie it irrevocably to the cost of living, and that we should accept nothing less from insurance schemes. If we do not do this shortly, we shall find ourselves being taken over at our present valuation. Government is not going to pay us more than we ourselves are agreeing to accept. If, moreover, having defined a fee, we accept a downward prorating to 60%, government is going to say: "Why should we pay you $100.00 when you were satisfied—*under a scheme that you set up yourselves*—to accept $60.00?" We may be that crazy, but I doubt governments are. Here is where the finger of Doom points straight at us. The moment we accept from government the same sort of fees, and fees not tied to the cost of living, that we are now accepting under our own schemes, we start to become a depressed profession. The young men of initiative and enterprise who prize their individual freedom and have a sensible value of their worth, will begin to seek a career in other fields. To fill the gap, more and more women, who can afford to enter callings that no longer will support men, will crowd our ranks. This is what has happened in history: what will inevitably happen again. After that, facilis descensus Averni.

One of the saddest arguments I hear when I bring forward these jeremaic arguments is: "I'm doing all right out of Blue Cross and Maritime Medical Care." In other words, let's take the immediate cash and let the credit go. Why should we care for tomorrow, there's cash in the bank today! No thought for tomorrow when the cash in the bank or the annuity is worth a half or a third of its present value. No thought of the future of the profession—of the young men knocking at the doors of the medical schools—of the medical schools themselves, the font et origo.

Once we all looked to Germany for leadership in medical science. In those days Berlin and Vienna were Meccas: Germany was the greatest creative nation in our art. Until Hitler completed the collectivization that had started a generation before. Until the pressure of events put inferior men into high places and less and less money was available for research. Did you hear of many medical men protesting in Germany in those days? No—they were doing all right out of their insurance schemes. But the mark wasn't doing all right. And in a single generation the hegemony of German science vanished.

All too little time remains for us to face this socializing wave of the future. For men of my age it does not so much matter: we have had our innings and more or less garnered in our harvest. But you young men, who must carry the torch into the future, are you happy about what you see in the horoscope?

Are you happy about the professional and financial status it promises? Does the threat of bureaucracy to your individual and collective freedom to evolve, to continue the great gains of the past over death and disease, cause you no loss of sleep these nights? Can you hear about the desperate difficulties of the public school teachers of this continent with equanimity, in the full knowledge that they are likely to become your own? Then, you must stop saying: "I'm doing all right." You must begin to ask yourself: "Will my sons be doing all right?"

In short, you must get the lead out of your pants and some gumption into your actions. It is later than you think.

Some Problems in the Clinical Use of Antibiotics[1]

R. W. REED, M.A., M.D., C.M.[2]

THE physician who must select one of nearly a dozen antibiotics for treatment of an infectious process, is faced with several problems in addition to the often difficult choice of an antibiotic. Most physicians have undoubtedly become aware of one or more of the perplexing problems which will be discussed briefly. Three of the most important of these are, (1) the development of antibiotic resistant strains of bacteria, (2) the use or misuse of antibiotic combinations and (3) the development of complicating infections directly due to the use of antibiotics.

The problem of resistant bacteria is probably the most disturbing at the present time. Two theories have been put forward to explain why this occurs, one based on mutation, the other on adaptation. Demerec (1) and Lederberg, (2) attribute the development of resistance to rare spontaneous mutations which occur every ninth or tenth generation, whether or not the antibiotic is present. When the antibiotic is present, it acts selectively to favor the survival of these new resistant mutants. The rapidity of development of resistance varies from one antibiotic to another. In the case of penicillin, it is generally a slow step-wise affair, while with streptomycin, it is usually a very sudden increase. Demerec (1) postulates that these differences are due to varying potency of the genes which control development of resistance to various antibiotics.

There is much experimental evidence to support the mutation theory, and also some very practical evidence. For example, following the rapid development of sulfonamide-resistance by gonococci, Schmith & Reyman (3) re-examined 50 strains isolated in the presulfonamide era and found several highly resistant to sulfonamides. Alexander & Leidy (4) in carefully controlled studies have shown that in populations of *Hemophilus influenzae* one cell in every 10^{10} is naturally highly resistant to streptomycin. When terramycin was first brought into clinical use a number of resistant strains of staphylococci were isolated from patients who were receiving terramycin, but also from people who had never received terramycin.

Eagle (5) has examined the question of antibiotic resistant bacteria and on the basis of his experiments and those of others concludes that the mutation theory and the adaptation theory are not mutually exclusive. It is possible, he believes, that the slightly enhanced resistance which develops following exposure to low concentrations of antibiotic may be the result of adaptation to this environment, while the few highly resistant cells in a bacterial population represent spontaneous mutations.

However antibiotic resistance develops, it is becoming a matter of some concern, particularly in infections due to *Staphylococcus pyogenes* (6). Strange-

1. Presented in part at the Medical Staff Meeting, Victoria General Hospital, Halifax on May 22, 1953

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ly enough, some bacteria have shown little tendency to penicillin-resistance even after ten years of exposure to the drug. *Streptococcus pyogenes*, pneumococci and gonococci are notable in this respect. Most of the gram-negative bacteria commonly associated with urinary tract infections show from 20 to 50% of strains resistant to aureomycin and streptomycin, but only 10% resistant to chloromycetin. A recent survey of results from this laboratory showed little change in these figures from 1952 to 1953.

The ubiquitous *Staphylococcus pyogenes* is by far the worst offender in the number of antibiotic resistant strains which emerge. Published figures from this and other continents from 1946 onwards have shown a steady increase in the number of penicillin-resistant strains among hospital populations. These figures when plotted make an almost perfect sigmoid curve as shown in Figure 1. It is interesting to note that the number of penicillin-resistant strains has levelled off at about 70%, with no significant change since 1950. The figures for aureomycin-resistant strains of staphylococci are not so numerous, but when plotted (Figure 1) the slope of the line corresponds very closely to the slope of the penicillin line. Terramycin figures are almost identical with those for aureomycin. It would appear, then, that an equilibrium has been reached between penicillin-sensitive and penicillin-resistant strains of staphylococci. One might speculate that in another two or three years, a similar balance will exist with regard to aureomycin and terramycin. The same speculation might be applied to antibiotics still to be released or discovered.

Table I shows a summary of all antibiotic sensitivity tests done against staphylococci isolated in this laboratory from Jan. 1 to April 30, 1953. The figures speak for themselves regarding "domesticated" or hospital strains. It is interesting to note that 22% of 167 strains of staphylococci which were tested against penicillin, aureomycin, terramycin, streptomycin and chloromycetin were resistant to all five antibiotics. This finding is by no means confined to Halifax. In hospitals where a preponderance of one broad-spectrum antibiotic has been used, the greatest numbers of patients are found infected with staphylococci resistant to that antibiotic (9).

The carrier rates of staphylococci and of penicillin-resistant staphylococci differ greatly in the hospital population and in what one may call the outside population. Wilson & Crockroft (10) have published representative figures from the Vancouver General Hospital. 65% of children attending the O.P.D. were carriers but only 11% of strains were penicillin-resistant. Girls living in the Y.M.C.A. were 35% carriers and 26% of the strains they carried were resistant to penicillin. For City Health Department Personel, the figures were 27% and 18%. In the Maternity wing of the Hospital, 48% of the personnel were carriers, but 70% of their strains were resistant to penicillin. Among the Operating Room staff, 51% were carriers, but 79% of their strains were penicillin resistant. Similar figures from other centers are in agreement.

The staphylococcal carrier rate can change very rapidly when an individual moves from the outside environment into the hospital environment. This has been followed by Rountree et al (11) who cultured nasal swabs from nurses when they entered training and again six weeks later. It was found

that on entering nursing school from 30 to 50% were carriers but only about 4% were carrying penicillin-resistant strains. Six weeks later, 50 to 80% were carriers, and 50 to 60% were carrying resistant strains. That is a very rapid change in a matter of weeks. The high carrier rate of staphylococci among hospital personnel probably explains to a large extent the high incidence of superficial wound infections which occurs in most hospitals. Barber et al (12) properly emphasize that "penicillin-resistant staphylococcal infections are nearly always cases of hospital cross-infection. The prevention of both is, therefore, the same and depends on the hygiene and aseptic control of the hospital." Prissick (13) has recently published an excellent review of the literature on penicillin-resistant staphylococci.

The trend toward the development of resistant strains of bacteria probably would have occurred even with more thoughtful care in the use of antibiotics. However, there can be little doubt that their widespread and indiscriminate use has hastened the process by several years. Infections due to multiple-resistant staphylococci are becoming more and more frequent in hospitals and the problem of how to treat them is becoming serious. Consideration may well be given to the use of antitoxin, which was largely put aside in favor of antibiotic therapy, although there has never been any evidence that the toxic substances produced by staphylococci are neutralized by antibiotics. The tendency for many staphylococcal infections, particularly furunculosis, to become chronic has led to the recommendation that staphylococcus toxoid (14), vaccine or a combination of the two be used for the prevention of recurrent infections. This suggestion perhaps applies more today than seven years ago when it was made.

The question of combined antibiotic therapy is one which deserves some consideration although the answer is as yet only tentative. A single antibiotic can be used effectively in most infections due to a single organism and a single broad-spectrum antibiotic is frequently effective in mixed infections, particularly those in the peritoneum following the rupture of a viscus (15). Nevertheless, antibiotic combinations are very commonly and often indiscriminately used, although there is both experimental and clinical evidence that such combinations are not always effective. There is good experimental and clinical proof for the value of antibiotic combinations in certain infections, notably the use of streptomycin plus aureomycin, terramycin or chloromycetin in brucellosis (16, 17) and penicillin plus streptomycin (18, 19) in endocarditis due to *Streptococcus faecalis*. Apart from these two instances, however, the so-called synergistic effect of antibiotic pairs is not certain. In fact, actual antagonism has been demonstrated by Lepper and Dowling (20) in the treatment of pneumococcal meningitis with penicillin and aureomycin, and of *Hemophilus influenzae* meningitis with aureomycin, streptomycin and sulfasoxazole.

Jawetz (21) and his group have studied the antagonistic or synergistic action of paired antibiotics extensively. They find that when a pair of antibiotics acts simultaneously on a single organism either in vitro or in vivo, one of three effects may be observed:

(1) Indifference, where there is no increase or decrease in the activity of the paired antibiotics over the action of either one alone.

(2) Synergism, where the combined effect is much greater than that of the most effective of the pair alone.

(3) Antagonism, where the combined effect is much less than that of the most effective of the pair used alone.

Unfortunately, apart from brucellosis and enterococcal endocarditis, it is impossible at present to be sure that a given antibiotic pair will always show antagonism or synergism against a given organism. The same pair may show synergism against one strain of a particular species and antagonism against another strain of the same species. There is as yet no rapid and practical laboratory method of determining the situation with respect to a specific antibiotic pair and a specific organism. Based on their own work and that of others, however, Jawetz et al (22) have established a tentative classification of the commonly used antibiotics which may serve as a guide in the selection of effective combinations.

Group I contains penicillin, streptomycin, bacitracin and neomycin which are primarily bactericidal. Combinations from within Group I are frequently synergistic, occasionally indifferent and rarely, if ever, antagonistic. Group II comprises aureomycin, terramycin, chloromycetin and possibly the sulfonamides, all of which are primarily bacteriostatic. Combinations from within Group II are rarely either synergistic or antagonistic. The use of drug pairs selected from within one of these two groups will be less likely to result in antagonism, particularly if both are partially effective in vitro against the causative organism. If in vitro studies show partial effectiveness of a Group I and a Group II drug, the two may be used but only in doses which will result in a full therapeutic concentration of each at the site of infection. This scheme is a tentative one, but it does offer a guide to treatment of infections where combined therapy is considered necessary. The results are likely to be more effective in most cases if laboratory studies can be done. Spink (23) states that the widespread practice of employing two, three or even four antibiotics at the same time is inexcusable in most instances.

Another problem which has resulted from the widespread use of antibiotics is the unexpected occurrence during treatment, of secondary infections caused by bacteria resistant to the drug being administered. Many such infections are caused by bacteria usually regarded as non-pathogenic. They arise especially in the respiratory tract of children or in debilitated older people. Massive doses of penicillin will not only eliminate the pneumococci in cases of pneumonia, but also the majority of gram positive bacteria from the throat as well. In the laboratory we can amost invariably tell when a patient has received penicillin by the predominance of coliform bacteria in the sputum. This is a disturbance in the balance of nature which may sometimes result in definite symptoms, for example, when the replacing organism is *Pseudomonas aeruginosa* or *Proteus vulgaris.*

Miller and Bohnhoff (24) have demonstrated an unusually high incidence of *Monilia albicans* in the throats of patients under treatment with streptomycin or the broad-spectrum antibiotics. In the majority of such patients,

the micro-organisms did not give rise to symptoms. However, Woods et al (25) and Brown et al (26) have both reported several cases of clinical moniliasis which they feel are definitely attributable to antibiotic therapy. Wheat and associates (27) have reported several cases of infection, some fatal, due to bacteria of the Chromobacter group which are generally considered completely non-pathogenic and they too, feel that these peculiar infections can be attributed to a disturbance of the normal flora during antibiotic treatment. Dearing and Heilman (28) have recently described their findings in a series to patients who complained of diarrhea following treatment with various antibiotics. Virulent staphylococci were recovered in large numbers from stool cultures of 39 who had received terramycin, streptomycin or aureomycin. All but three strains proved resistant to the five commonly used antibiotics. When erythromycin treatment was instituted, the staphylococci disappeared and so did the diarrhea. The changes in bacterial flora of the respiratory or gastro-intestinal tract which occur during antibiotic treatment do not always produce symptoms. When the replacing organism is a pathogen or potential pathogen, however, the result may be of great importance to the patient's well-being and of considerable interest to the physician.

These, then, are some of the problems which may and frequently do occur in the age of antibiotics. As more antibiotics are made available for clinical use, it is probable that the problems associated with their use will increase rather than decrease. It has been pointed out that hospital strains of staphylococci, while they have apparently arrived at an equilibrium regarding penicillin-resistance, are rapidly developing resistance to the other commonly used antibiotics as well. Fortunately, studies to date do not indicate a corresponding increase in multiple-resistant staphylococci in non-hospitalized populations (29, 7). Much of the responsibility for maintaining this situation rests with practising physicians, who should avoid the haphazard and indiscriminate use of these very useful drugs.

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A Comparative Study of Medicine in Korea and Canada

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MANY scholars have pointed out how the climate, food and mode of living influence greatly the incidence of disease, especially infectious diseases.

I have tried to make some comparative observations on the incidence of some diseases in the two countries of Korea and Canada. I have noticed great differences, even in the same disease, probably due to environmental conditions. Another big factor is the difference of race. There may be some variation in hereditary immunity, or sensitivity to some diseases. Even in the same disease the symptoms are quite different at times. It is possible that environment has affected skin colour, and the skin itself has different susceptibility in some diseases. Lately the Korean war has changed many ideas in the medical field.

Prior to World War II, some important infectious diseases in Korea, as reported by Simmons in 1944, were: typhoid fever, 5,417 to 7,954 cases yearly; paratyphoid fever, 309 to 707 cases yearly; dysentery, 1,912 to 4,548 cases yearly; cerebrospinal meningitis, 40 to 517 cases yearly.

It is obvious that the rates are tremendously high by Canadian standards. The population of Korea is approximately twenty-five million.

In August, 1945, when the Japanese surrendered to Allied forces, we had many typhoid, typhus and small-pox cases because of a vacuum of medical work for about one month. After the Allies occupied South Korea in the middle of September, 1945, they brought large stocks of vaccines, especially typhus-vaccine, and in addition D.D.T. was introduced. These saved many people. We previously had smallpox, typhoid and typhus vaccine, but the latter two were unreliable wartime preparations. In 1946 we had a big epidemic of cholera, spread by refugees from Shanghai. We did extensive work for the prevention of this disease, and have no recurrence. In 1950 the Korean war began, so we had additional problems in the medical field, particularly the lack of medical personnel, owing to many doctors being carried away to North Korea, and the shortage of equipment and medicine. The U. N. forces are doing quite all right, but still we are suffering from the shortage of doctors and medical instruments and medicine, especially for civilians. There is only one doctor for every ten thousand persons.

The percentage of the population inoculated in recent years is shown in Table I.

TABLE I

Proportion of Korean Population Immunized against Certain Diseases

Year	Typhoid Fever		Smallpox		Eruptive Typhus		Cholera	
	Number	Per cent	Number	Per cent		Per cent		Per cent
1949	6,087,460	30	6,986,980	34	305,200	1	4,438,150	21
1950	3,931,840	19	4,369,883	21	1,401,171	6	1,786,977	8
1951	15,781,306	78	18,828,653	93	19,672,031	97	1,349,122	6
1952	1,602,476	7	8,044,900	38	8,391,218	39	539,097	25

The greatest problem in Korea is tuberculosis. There are many reasons for the spread of this disease. The first is poor nutrition and overwork, both physical and mental. The shortage of houses is also a big problem; too many people living in one room and isolation of patients impossible. We have only 200 sanatorium beds in South Korea now. We only began B. C. G. vaccination last year so it is too early to know the result.

Our climate is warmer than Canada, Korea being a little further south, (34-43° latitude). It is hot in summer and cold in winter. Whether related to climate or not, Korean diet contains highly seasoned food, lots of fruits and vegetables especially in summer. The seasonings are red pepper, soy bean sauce and much salt in hot weather. The main food is rice, so we eat more carbohydrate but not as much fat as in Canada. We use more fresh foods, no canned foods, and much seaweed and fish. We do not use coca-cola or ginger ale. Children eat rice candy, but not chocolates. In the country the people drink water from wells, which often contains more mineral salts. In some places we have mineral water which Koreans call "drug-water."

In summer because of hot weather, the people wear white hemp clothes. These are very cool and porous, allowing sunshine to penetrate. We have more sunny days than you have. Over seventy per cent of the people are farmers, so they work outside. In winter time we put cotton padding inside our clothing, and the farmers particularly keep warm by this means. Housing is not good, with little sunshine and poor air circulation. This is probably one of the reasons for the high incidence of tuberculosis. However, we can keep warm with little expense as Korean houses are built with the fire and chimney extending under the floor. We sleep on the warm floor with a thick cotton mattress, so we keep the body warm and dry. It is possible that this is a factor in preventing rheumatism, which in uncommon in Korea. We sit on the floor, so we do not hang the legs down for long periods as with a chair. Whether for this reason or not, we have very few cases of thrombophlebitis or varicose veins. However we have many haemorrhoids. Some are tuberculous, but many are not. No explanation has been suggested.

Transportation is very limited. Most people walk long distances, even women carrying their children, or some times large bundles. In the country every farmer has many domestic animals, and they have many parasites. Most farmers work in the water in summer to grow rice, so they commonly have ankylostomiasis. Koreans drink strong rice wine. Perhaps for this reason many farmers have cirrhosis of the liver. Some pathologists have related this also to highly spiced foods.

In relation to the above mentioned environmental differences, there is a great variation in the incidence of various diseases. In 1949 and 1952 we had very hot summers, and there was a major epidemic of encephalitis in these two years. The variety was Japanese B-type. In some summers we have typhoid fever, and in winter we frequently have typhus and smallpox epidemics. Many farmers have malaria in summer, and in the south part of Korea, we have some leprosy cases, some elephantiasis, and much distomiasis from certain fish in the rivers.

In 1951 we had a few cases of epidemic haemorrhagic fever in Central Korea, but we have relatively little diabetes, thyrotoxicosis, or endocrine diseases, and not many blood dyscarsias. It has been frequently pointed out by Korean, Japanese and English workers that pernicious anaemia is not found, and we have very little hypertension compared to Canada. This may be related to the rice diet and low cholesterol content in food. Even in the same disease, the clinical course may be quite different in these two countries.

Diabetes. I was surprised that you have so many diabetic cases in Canada. Also I never saw such severe diabetes in Korea. We have some cases, but all of them are mild. We can control them with diet, and gangrene does not occur. We have seen no diabetes in children and find it more frequently in men than women.

Tuberculosis. We have a great many seriously ill tuberculosis patients. Their courses are always shorter than your tuberculosis cases, with high fever, and high sedimentation rate. They are complicated by spontaneous pheumothorax, intestinal tuberculosis, or sometimes miliary tuberculosis, especially in young people. The highest susceptibility is in the twenty to thirty year group.

Heart Disease. We have very little heart disease especially very few myocardial infarctions. This may be partly due to the low incidence of diabetes, rheumatic fever and phlebitis. We have much mitral stenosis in females. I presume the reason is due to puerperal infections. I wonder why there is more stenosis in females in America, as stated in current text-books. Our heart diseases are less complicated than in Canada. We do not have much congestive heart disease, perhaps due to lack of rheumatic fever. As a rule in Korea diagnosis must be made without electrocardiography. Our heart patients do not usually suffer from auricular fibrillation.

Rheumatism. We have few rheumatic fever cases, and they are mostly cured, so rheumatic heart patients are not often seen. I have never seen any rheumatoid arthritis.

Cancer. Unlike Canada, there is not much cancer. However, uterine cancer is frequent, and gastric carcinoma is often found. Bronchogenic carcinoma is not often diagnosed even though most Koreans are heavy smokers.

Blood Disease. We have much ankylostomiasis anaemia. Most of them respond to iron therapy. Other blood dyscrasias are not often found.

Infectious Diseases. We have typhoid fever, typhus, sometimes small-

pox; in children much measles, whooping cough, mumps, diphtheria and scarlet fever. There is much malaria in summer, mostly tertian. People never die from malaria; I think they have some immunity. We have some small poliomyelitis epidemics occasionally.

Venereal Disease. After the Korean war began there was an influx of many soldiers from sixteen countries. You can imagine that there was a great increase in venereal disease. There is high percentage of chancroid, gonorrhoea and syphilis, but most patients can be speedily cured by antibiotics. Some workers feel that neurosyphilis is much less common in the Orient due to the high malaria morbidity.

I have mentioned personal observation on the incidence of some diseases in the two countries. I cannot agree with three points of aetiology which are mentioned in certain medical text-books.

1. Our people smoke very much, but bronchogenic carcinoma is not often found. Possibly the form in which the tobacco or cigarettes are prepared is important.

2. It has been stated that poliomyelitis spreads near rivers or sewage disposal, but I saw many cases in Alberta far from any river.

3. It has been thought that the cause of ulcerative colitis is an autonomic nerve disorder. Koreans have many peptic ulcers, but no ulcerative colitis. Most of our colitis is amebiasis, and can be cured with anti-amebic drugs.

I saw more biliary disease in Ukrainians in Alberta, and more diabetic patients in Nova Scotia than in Korea. I think the hereditary factor in different races is of great concern in most diseases. I think the Korean people should take more fat, and the Canadian people should reduce fat in their diet.

In summary, tropical diseases, tuberculosis, infectious diseases and venereal diseases are more common in Korea. Diabetes, rheumatic fever, heart disease, cancer and blood dyscrasias are more common in Canada.

The possible effect of certain differences in environment and heredity are discussed.

Acknowledgement:—I wish to thank Doctor I. S. Robb of Camp Hill Hospital for suggestions.

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Minutes of the Executive of the Medical Society of Nova Scotia, 1953.

The reconvened meeting of the Executive was called to order by the President at 2.30 p.m.

Present: Doctor J. W. Reid, President; Doctors M. G. Tompkins, H. F. McKay, H. G. Grant, P. O. Hebb, E. F. Ross, J. A. MacCormick, H. J. Devereux, J. A. McDonald, G. D. Donaldson, A. M. MacPherson, B. J. D'Eon, C. G. Harries, P. R. Little and R. E. Price.

The report of the Legislative Committee was read by Doctor A. R. Morton who came in for that purpose.

"Your legislative committee has had a fairly active year. As reported last year at the annual meeting of the Association, the Provincial Government planned a consolidation of the Medical Act to be passed at the 1953 session of the Legislature.

"A draft copy of their proposals was obtained, and gone over, with Mr. F. Smith of Burchell, Smith, Jost, Willis and Burchell, who was employed as our Solicitor.

"Many conferences were held between our Solicitor and members of your Committee, at which the president was also present. Our suggestions of change were sent forward to the Government Counsel, as well as to the Solicitor acting for the Provincial Medical Board. Also conferences between the three Solicitors were held, and finally your committee met with the Legislative Committee of the Provincial Medical Board and the Provincial Government Legislative Counsel, and the final draft was carefully gone over, word for word, and approved by all.

"The piece of legislation did not reach the floor of the House, as it was felt very unwise to bring it forward, in view of the early introduction of a bill to legalize chiropractic in this Province.

"It is ready, and we hope will be introduced early in the next session of the Legislature.

"The committee then had to deal with the Chiropractic Bill, and Mr. Wm. Wickwire was employed as our Solicitor to oppose this Bill. Many conferences with him, the Secretary and the President laid our plans for this opposition at the Public hearing of the Bill.

"We were successful in having this Bill receive a six months hoist, but we warn the Society that it will probably be a perennial problem from now on.

"The accounts to our Solicitors were:

Mr. Smith and confreres.....$250.00

Mr. Wickwire.....$250.00

"These have been paid by the Society, but Mr. Smith, who is familiar with the consolidation of the Medical Act, should be retained to assist your new committee when this Bill is before the House next year.

"It is the feeling of the Committee that very close watch will be necessary on all legislation for the next few years."

Doctor H. F. McKay: "The work that Doctor Morton and his committee have put on this Legislative Committee is of very great value to our Society, and I am quite convinced that Doctor Morton should continue to be chairman of the Legislative Committee. I would like to thank Doctor Morton for his report and tell him that the Society appreciate it."

Doctor Grant moved that Doctor Morton's report be adopted which was seconded by Doctor P. O. Hebb. Carried.

The Secretary read the following resolution from the Cape Breton Medical Society, dated September 15th, 1953, signed by Doctor H. R. Corbett, Secretary.

"At a recent meeting of the Cape Breton County Medical Society the following Resolution was adopted:

'Resolved that the Members of the Cape Breton County Medical Society request the Nova Scotia Medical Society Executive to make an effort to terminate the Medical Reciprocity Act now in force with Great Britain.'

"I may state that our Executive Members will be in attendance at the coming Meeting and are prepared to present further details concerning the above noted Resolution."

Doctor H. F. McKay moved that the letter be received and referred to the Legislative Committee for further study and action. This was seconded by Doctor C. G. Harries. Motion carried.

The Secretary read the following letter from Doctor F. L. Whitehead, Secretary of the New Brunswick Medical Society, dated October 2nd, 1953, re Canadian Medical Association Annual Meeting—Atlantic Provinces, 1958.

"At a meeting of the Executive of our Society on October 1st, 1953, the following Resolutions were passed and are forwarded for your information and whatever action you may wish to take:

1. 'THAT the New Brunswick Medical Society is in favour of co-operating with the Medical Societies of the other Atlantic Provinces in sponsoring the 1958 Annual Meeting of the Canadian Medical Association and we suggest that a temporary combined Study Committee be set up by the four Societies to go into the preliminary details, as soon as possible.'

2. 'THAT in implementation of the above Resolution, we set up a Committee of three to meet with Committees from the other Societies at a central point, which we suggest should be Moncton, N. B.'

"The Committee of our Society consists of Dr. G. F. Skinner, Saint John; Dr. H. S. Everett, St. Stephen; Dr. D. A. Thompson, Bathurst; Dr. C. L. Gass, Sackville, N. B., as ex-officio member.

"It is our understanding that preliminary plans, with particular regard to the site of the proposed meeting, should be made in the relatively near future so that appropriate hotel reservations can be made."

Doctor M. G. Tompkins thought that all the other provinces should have the right to stipulate the particular location of the 1958 meeting provided they were able to accommodate it.

It was moved by Doctor R. E. Price that the President elect three members to meet with the New Brunswick group regarding the meeting of the Canadian Medical Association in the Atlantic Provinces in 1958. This was seconded by Doctor G. D. Donaldson. Carried.

Doctor H. F. McKay's resolution re the resolution of the Cape Breton Medical Society was replaced by a resolution moved by Doctor P. O. Hebb as follows: "That we ask our Legislative Committee to make an effort to terminate our reciprocity with Great Britain re medical licensing." This was seconded by Doctor R. E. Price . Motion carried.

The Report of the Committee on Public Health signed by Doctor G. Graham Simms, Secretary, dated September 26th, 1953, was read by Doctor H. G. Grant.

"The following is the report of your committee on Public Health:

"Again we are pleased to report that there has been steady progress in the field of Public Health. Long established programmes of proven worth have been continued while a number of new projects have been initiated which promise to be of very real value.

"Heart disease, as usual, was a leading cause of death. The number of deaths increased from 1,715 in 1951 to 1,841 in 1952. Studies carried out in recent years would indicate that by the judicious use of antibiotics and the sulphonamides, recurrences of attacks of Rheumatic Fever can be largely controlled. The serious problem of Coronary Artery Disease probably will remain in most part unsolved until research throws more light on the subject.

"Cancer increased slightly from 832 deaths in 1951 to 846 in 1952. The opening in 1952 of the Nova Scotia Tumor Clinic at the Victoria General Hospital, with its outstanding diagnostic and treatment facilities, will initiate a new front on this great killing disease. New diagnostic equipment and an additional supply of radium have already been purchased.

"There has been a further substantial decrease in the number of tuberculosis deaths. In 1942, there were 379 deaths from all forms of tuberculosis for a rate of 64.9. In 1952, just ten years later, there were only 94 deaths for a rate of 14.4. Facilities for the diagnosis of tuberculosis were augmented during 1952. An additional two miniature film X-ray units were provided to general hospitals in the Province. There is now a total of eight hospitals with a Routine Hospital Admission Chest X-ray Programme in operation.

"B. C. G. Vaccination is gradually being inaugurated in a number of training schools in the Province. It is expected that this measure will materially reduce further the incidence of tuberculosis among hospital personnel.

"To-day, in this Province, excluding D. V. A., there are more than eleven sanatorium beds per death. This, together with free treatment, the provisions of free streptomycin, I. N. H. etc., ensures that no one because of finances is barred from receiving the best of remedial care for tuberculosis

"The Communicable Diseases, as a whole, do not presently constitute a great public health problem. However, your committee takes this opportunity once again to recall to the minds of all members of the medical profession the basic fact that immunization, particularly in infancy, is essential if we are to maintain our present happy position.

"Poliomyelitis is one of the communicable diseases which has remained a problem. In 1952, we had 94 cases of whom four died. There was an unusually heavy and concentrated outbreak in the Tatamagouche area during March of 1952. Fortunately, the epidemic was localized. Of the 94 cases during the year, 31 were from Halifax County, 20 from Halifax City and 14 from Colchester County. Fifteen cases were aged one to four, 24 were aged five to nine and 18 were in the 15-19 age group.

"As it is fully appreciated that patients with severe acute Polio do not stand travel at all well, the Provincial Department of Health initiated in 1952 the policy of setting up Branch Polio Clinics. One was set up, with much appreciated assistance from the Polio Foundation, in Antigonish. Already this year, 1953, 20% of the cases have been handled at the Branch Clinic.

"The Venereal Diseases have been coming under control quite rapidly. The incidence rate for Syphilis, all types, dropped from 44.0 in 1951 to 27.1 in 1952. The incidence rate for Acquired Syphilis, Primary and Secondary, dropped from 4.2 to 3.4 in the same period.

"The Maternal Mortality Rate stood at 0.7 in 1951. This represented twelve maternal deaths. Preliminary figures for 1952 indicate that there will be little change for that year.

"Infant Mortality has been giving increasing concern to those engaged in the fields of Public Health, Obstetrics and Paediatrics. While the all time low rate of 34.7 for 1951 is heartening, at the same time, a loss of 594 infants plus 319 still-births is a situation which should remind us that much is still left to be done. Within recent months, a group, representing Obstetricians, Paediatricians, Psychiatrists, Nurses, and Public Health Doctors has been set up to study the whole problem of Maternal and Infant Health. It is not too much to expect that this widely representative group may lay the frame. work for a programme that in the years to come will bring forth results comparable to those now attained in the field of tuberculosis control.

"There has been continued progress in the field of Mental Health.

"The Psychiatric Out-patient Department at the Victoria General Hospital has been transferred to more spacious accommodation on the first floor of the Private Pavilion. There are six psychiatrists attached to the staff.

"At the Nova Scotia Hospital, Insulin Treatment Services have been increased and other procedures have been added.

"The Psychiatric Clinic at Sydney has been operating at full capacity.

"The programmes at Dalhousie University, for the training of psychiatrists and clinical psychologists, and at the Maritime School of Social Work, for the training of Psychiatric Social Workers, are still continuing successfully.

"The three Mobile Dental Units, operated by the Provincial Department of Health, carried on the usual educational and treatment programme in rural areas from June to December. Treatment was confined to those under the age of twelve. A total of 3,415 children, from 96 schools, were given dental examinations. In all, over 14,000 dental operations were performed. During the period January to May, the three dentists were allocated to the three provincial sanatoria.

"This year, three young ladies went away to take a two-year course of training as Dental Hygienists. On the return of these trainees, it is planned to inaugurate both an intensified educational programme and also a topical flouride programme.

"The post-graduate course in Clinical Preventive Medicine was held again last January. The papers delivered and the discussions arising thereupon were of considerable benefit to those attending this very worthwhile course.

"The Canadian Public Health Association, Atlantic Branch, met in Yarmouth during September, 1952, immediately proceeding the meeting of our Society. This meeting was very well attended; those present representing the various fields of public health, both official and voluntary. The papers were of a high calibre.

"In closing this report, your committee wish to state that they would welcome constructive criticism and comments."

Doctor H. F. McKay stated that at the meeting in Yarmouth, he had asked regarding the fluoridation of water. He moved that the report of the Canadian Medical Association Committee on Public Health relative to fluoridation of water as presented in the Canadian Medical Association Journal, September, 1953, paragraph 212, Transactions, be endorsed by this Executive and published as an addendum to this report. This was seconded by Doctor A. M. MacPherson. Motion carried.

Following is the paragraph to be added to Doctor Simms report.

"Your committee voices approval of the study of fluoridation of communal water supplied by the joint committee of our Association and the Canadian Dental Association. The very considerable amount of evidence indicating the value of fluoridation in combating the overwhelming problem of dental caries, and the failure of careful research to show hazard in the procedure under properly controlled application warrants, we believe, the positive support of our Association. If this is generally agreed, then the Canadian Medical Association and the Canadian Dental Association have the duty of giving leadership to our communities by publicizing their opinion."

Neither the Medical Museum nor the Workmens Compensation Board Committees had anything to report.

The Secretary read the report of the Cogswell Library Committee, signed by the Chairman, Doctor J. McD. Corston, dated October 5th, 1953.

"Herewith the Annual Report of the Cogswell Library Committee for 1952-53.

"The Medical Library Committee held three meetings during the year. Library appropriations were fixed for each department, and book purchases were made from recommended lists. Ninety-seven books were bought at a total cost of $554.35, The Cogswell Library Fund furnished $200 of this amount.

"The following new journals have been added to the subscription list.

Enzymologia.
Journal of Applied Microbiology.
Obstetrics and Gynaecology.
World Health Organization Bulletin.

"The Library has continued its policy of lending books and journals to physicians in the Maritimes. During the year 200 books and journals were mailed to out of town borrowers. The Committee wishes to remind the profession of the mail service offered on books and journals to members outside the city.

"Miss Allan, Librarian, has shown her usual high standard of efficiency and co-operation. In February, 1953, Mrs. J. S. Thomson joined the staff as a part time clerical worker. She is doing very efficient work in the Circulation Department."

It was moved, seconded and carried that this report be adopted.

Doctor H. F. McKay, Chairman of the Committee on Economics, then presented his report, dated October 7th, 1953.

"One meeting of the Committee was held during the year, December 8th, 1952. A letter from the Cape Breton Medical Society re fees in the case of wards of the Childrens Aid Societies was dealt with and recommendations made to the Executive at the Semi-annual Meeting the following day. Letters from two members who carry on an extensive cardiological practice, but who are not certified, were received, and their relations to Maritime Medical Care were discussed; the matter, with recommendations, was referred to the Executive. The action and recommendations in both these matters is contained in the Minutes of the Meeting as published in the Nova Scotia Medical Bulletin. The Committee also discussed the feasibility of Members in our Society becoming subscribers to Maritime Medical Care; this matter too, was reported to the Executive, and the action taken is noted in the Minutes referred to.

"The Chairman reported on the Meeting of the Committee on Economics of the Canadian Medical Association in Toronto, October 24th and 25th, 1952, and many of the items on this agenda were fully discussed. The matter of the Statement of Policy proved highly controversial, your Committee feeling the matter too important to be solved by so small a body referred the matter to the Executive whose decision was that paragraph 6-c should be deleted. This action was reported to the Chairman of the Committee on Economics of the Canadian Medical Association.

"The matter of Insurance Reports was raised by a member of your Committee, Doctor H. A. Creighton, who later prepared a letter on the matter, a copy of which was forwarded the Chairman of the Canadian Medical Association Committee on Economics. Some progress has been made in the matter under a special Committee set up by the Canadian Medical Association.

"With the co-operation of the Manager of Maritime Care your Chairman prepared a report on the Society's experience with the Provincial Welfare Medical Care Plan, covering the period March 1st, 1950 to December 31st, 1952. This report is in the hands of a Sub-committee of the Canadian Medical Association Economics Committee, together with similar reports from Ontario, Saskatchewan, Alberta and British Columbia, who have some form of Social Welfare-Pensioner Medical Care, and is being studied relative to the evolution of some form of Master Plan which might be applicable on a National Basis.

"Relative to the increase in Medical Benefits to the Welfare Group which would seem possible due to the continually mounting surplus in this account, your Chairman was asked to solicit an opinion from the Committee. This was attempted by correspondence, and was not entirely satisfactory; three suggestions were received (1) minor surgical benefits, tonsillectomies, circumcisions, etc., (2) some plan in which wards of the Childrens Aid Societies might become eligible for some treatment, (3) extension of coverage to include limited coverage in hospital. These suggestions were given the Executive at the special meeting March 26th, 1953.

"Your Chairman attended the second meeting of the Central Economics Committee in Toronto, April 10th and 11th, 1953. In addition to the Divisional members, the meeting was attended by Doctor Malcolm Taylor, who has by now assumed the post of Economics Adviser to the Association, on a part time basis. Doctor Percy Vivian, Chairman of the Department of Health and Social Medicine, McGill University, was also present for the first day. Many items on the agenda were similar to those of the previous meeting in October, and will appear on the agenda of future meetings. Probably the best method of dealing with them here is to summarize the various items as recorded in the Minutes, together with a summary of the Chairman's report to the General Council, Winnipeg, June 15th and 16th, Canadian Medical Association Journal, September, 1953, page 209, paragraphs 83 to 107.

(1) Social Welfare and Pensioners Care

Doctor J. Lloyd Brown, Chairman of the Sub-committee will probably have some concrete suggestions to make at the next meeting of the Committee.

(2) Provincial Health Survey Reports. One Province has reported its study; the matter must await the reports from the other Provinces before any over-all recommendations can be made.

(3) Statement of Policy. No change in the present form was recommended, but further study by each Provice was urged. One Province has prepared a Brief which has been placed in the hands of members of the Central Committee. It is suggested that this Brief might be used by this Division as a basis of study, and directions to your Representative prior to the next meeting of the Central Group.

(4) Sick Mariners Fund. This matter is very contentious in British Columbia, and has been taken up with the appropriate authorities in Ottawa; it is very involved, particularly as it applies to foreign ships, and its overlap in some instances with Compensation Boards. Your Chairman has made inquiries in this Province, but has not received any clear cut complaints relative to its administration. It is suggested that any pertinent criticism should be passed to the Chairman, or General Secretary.

(5) Salaried Doctors and Contract Practice. The Chairman of the Central Committee is extremely anxious that the Canadian Medical Association co-operate in every possible way with our colleagues who fall into this category, and who may feel that their services are being exploited. Your Chairman brought this matter up at the Semi-annual meeting in December, and no comment was offered. It would seem that in view of some items of

correspondence received by the Society following the increase in annual dues, that there are some among us who feel that they are not being dealt with fairly. Two Provinces, Ontario and British Columbia, are at present preparing a study of this matter, and their reports are expected shortly.

(6) D. V. A. Schedule of Fees. Several Provinces are dissatisfied with the present schedule, feeling that there is much too wide a differential between it and the prevailing Provincial schedule. The greatest discontent apparently comes from British Columbia. It was agreed in Committee that the British Columbia Division would prepare a Brief on the matter. Since this action the General Council has recommended that the Executive of the Canadian Medical Association set up a special Committee to take up the whole matter with the D. V. A.

(7) Reports for Casualty and Sickness Benefits. The special committee in this matter has had encouraging results in their representations to the Life Insurance Companies for simplification and standardization of their forms. but there is no central organization of the Casualty and Indemnity Companies. The Committee will continue the matter, but the Chairman of the Central Committee on Economics reported to the General Council in June that its might be necessary to prepare forms and submit them to these Companies with an ultimatum, that these, and only these forms would be used by members of the Canadian Medical Association. This report was adopted by the General Council.

(8) Fees. The Central Committee on Economics will continue to study the fee situation. It is recognized that a uniform fee schedule is not feasible on a National basis, but the Chairman feels that by constant study in Committee, each Province will be kept better advised of the policy of other Provinces. In order that this principle be further exploited it was passed by the General Council that—'The Executive be requested to sponsor a meeting between Chairmen of the Divisional Tariff Committees, and members of the Committee on Economics of the Canadian Medical Association looking to the study of medical fees on a rational basis.' Your Chairman has been advised that subject to the approval of the Canadian Medical Association Executive this week, this meeting will take place in Toronto, November 30th and December 1st next, which too are the dates set for the next regular meeting of the Committee on Economics.

"This report is accompanied by copies of the Minutes of the two meetings of the Committee on Economics, Canadian Medical Association.

"All of which is respectfully submitted."

Doctor McKay moved the adoption of his report which was seconded and carried.

Doctor H. G. Grant read the Report of the Committee on Pharmacy, signed by the Chairman, Doctor J. R. Macneil.

"The following is a report of the Committee on Pharmacy.

"No meeting of this committee was held during the year as no important matters arose for discussion or decision.

"At the request of Mr. L. S. McKenzie of New Glasgow, the Chairman of the Liaison Committee of the Nova Scotia Pharmaceutical Society, an

effort to hold a joint meeting was made. However, on account of distances to be travelled and that members of each committee were unable for varied reasons to attend no meeting was held.

"It is suggested that the personnel of the Committee on Pharmacy for the coming year be selected from a central locality in our province and that this recommendation if acted upon favourably by the Executive, be forwarded to the Nova Scotia Pharmaceutical Society. Thus a conference between members of two professions closely allied and hampered by much the same difficulties or obstacles of time, place, etc., might more readily be arranged."

Doctor Grant moved the adoption of this report which was seconded and carried; the last paragraph of this report to be referred to the Nominating Committee.

The next report read by the Secretary was that of the Committee on Industrial Medicine which was signed by the Chairman, Doctor G. Ritchie Douglas, dated September 19, 1953.

"The following is the report of the Committee on Industrial Medicine for the year 1952-53.

"During the year no inquiries or recommendations were brought before the Committee and no meetings were held. The Chairman has kept in touch with the members by letter and telephone.

"As far as can be ascertained the status of Industrial Medicine in this province consists of:—

(a) A committee of the Nova Scotia Medical Society which usually holds no meetings, receives no complaints or suggestions and issues no communiques.

(b) The Industrial Hygiene Division of the Nova Scotia Department of Health, with Doctor D. J. Mackenzie and R. Donald MacKay, Sanitary Engineer, as consultants. The work of this division concerns the special studies of such hazards as lead poisoning, carbon monoxide, silicosis, etc.

(c) A number of part-time and one or two full-time physicians in the Province are employed as Industrial Medical Officers. They are chiefly employed for treatment services and pre-employment medical examinations.

"The recommendations of your committee are:

1. That in future the members of the committee be drawn from those physicians in the Province actually engaged in Industrial Medicine, full or part-time and that one of the members be a Medical Health Officer of the Provincial Department of Health.

2. That the Sanitary Engineer make annual inspection visits to the larger industries employing physicians. Smaller industries to be informed by letter that inspection services are available on request."

Doctor H. J. Devereux moved the adoption of this report, which was seconded by Doctor J. A. MacCormick, and carried.

The Secretary then read the report of the Medical Advisory Board, signed by Doctor H. D. O'Brien, the Chairman, dated September 21st, 1953.

"The Medical Advisory Board to lay organizations wishes to report that it had two requests before it, one was for the appointment of medical advisors, the other a request for a speaker to the Diabetic Society. These were complied with.

"It is to be noted that it is almost impossible to get medical men to be speakers for these various lay societies and it is thought it should not be the duty of this body to obtain them."

It was moved by Doctor H. J. Devereux that this report be adopted, which was seconded and carried.

The Report of the Pension and Retirement Funds, signed by the Chairman, Doctor C. H. Reardon, dated September 20, 1953, was not read, but is given below.

"Your Committee re Pension and Retirement Funds begs to report that a year has passed with the armour of the Department of Internal Revenue barely scratched.

"I quote from the discussion of the Eighty-sixth Annual Meeting of Council of the Canadian Medical Association—'In conjunction with a number of professional organizations including the Association of Professional Engineers, the Canadian Institute of Chartered Accountants, the Law Society of Upper Canada and the Royal Architectural Institute of Canada, a determined effort was made to obtain tax deferment on pension contributions. The services of an eminent counsel were engaged and a detailed brief was presented to the Minister of Finance, together with a suggested amendment to the Income Tax Act. The inequitable position of self-employed taxpayers, when compared with the privileges afforded members of approved pension plans, was stressed and it was confidently expected that these representations would be effective. It was disappointing to learn that the Budget presentation made no reference to legislation in this field and it is only possible to report that our efforts have again been unsuccessful.'

"It is hoped that eventually the actions of these representative bodies shall be able to break through the do nothing wall that so often surrounds the public service.

"One group in Western Canada are presently running a trial scheme through their M. M. C. equivalent, but were unable to receive approval or otherwise from the Tax Department, but rather must first try it and then present it at which time a decision on validity might be expected.

"The Committee feels that the Association should continue to investigate and harass the Tax Department for more equitable treatment on tax matters.

"The Association on the other hand, must look forward to this day, and prepare in advance the administrative structure to handle such schemes as Pension Plans; Group Insurance (now in operation); Group Accident and Sickness; Group Automobile Insurance, etc."

Doctor M. G. Tompkins read the following.

"To the Members of the Executive Committee of the Nova Scotia Medical Society.

"I hereby present my report as Chairman of the Appeal Committee. "There has been no meeting of this Committee since it was formed last year. "We have had no cases referred to us."

Respectfully submitted,

(Sgd.) M. G. TOMPKINS.

The Secretary's report from September, 1952 to October, 1953, was not read. It was moved by Doctor P. R. Little and seconded by Doctor H. J. Devereux, that it be accepted for publication in the Nova Scotia Medical Bulletin. Motion carried.

"The year on the whole was an average one, there being nothing unusual to report.

"It began with a very successful Annual Meeting held at Yarmouth, with Doctor L. M. Morton as President. Doctor Morton and his local committee are to be commended for an excellent meeting; the scientific papers were of a very high order, and everyone expressed their delight with the social side of the gathering. We had as contributors from outside, Doctor T. A. Lebbetter, formerly of Yarmouth and now of the Winnipeg Clinic; Doctor Heinrich C. Brugsch of the New England Medical Centre, Boston; Doctor Walter. C. MacKenzie, Professor of Surgery at the University of Alberta; the late Doctor Harold Orr, President of the Canadian Medical Association; Doctor D. R. Wilson, Associate Professor of Medicine of the University of Alberta and Doctor T. C. Routley, the General Secretary of the Canadian Medical Association. The local contributors were Doctor Wallace M. Roy, Doctor B. F. Miller and Doctor R. W. Reed.

"This was the first time in our history that the Executive met the whole day previous to the annual meeting, and also the first time we met with a small executive. Everybody was pleased with the new arrangement. The smaller executive allowed business to be carried out much more quickly, and by taking the whole day we had more time to devote to the business subjects, although the whole day was occupied. At that executive meeting the following important matters were brought up. First, the treasurer's report showed a loss for the year of some $228. There were two resolutions from the Lunenburg-Queens Medical Society; one a proposal for a tax free retirement plan which was referred to a special committee; the other a resolution asking for exemption on monies spent on post-graduate education, which was tabled. There was a letter from the Cape Breton Medical Society regarding payments of accounts by the Children's Aid; this was referred to the Committee on Economics. The question again came up of a full-time secretary. The Valley Medical Society, the Cape Breton Medical Society and the Pictou County Medical Society all expressed opinions against. The Lunenburg-Queens Medical Society on the other hand were in favour of this in principle, but gave no definite statement one way or the other as to how they would vote on it. There was a letter from Doctor Fred Whitehead of the New Brunswick Medical Society regarding a Maritime meeting in 1953, but in view of the fact that this year would be our Centenary it was decided not to join in a Maritime meeting in 1953. There was considerable discussion as to whether the Society should appoint representatives to the Board of Directors of the Maritime Hospital Service Association, and this matter was referred to the general meeting. The Society agreed to give free membership to members serving in the Armed Forces outside of Canada until one year after their return to Canada. It was decided to ask the Nominating Committee to appoint a Committee to act if requested as a Medical Advisory Board to lay organizations formed for the purpose of controlling specific diseases. There was a

request from the Nova Scotia Chapter on Multiple Sclerosis asking for two representatives to their Board and this was referred to a special committee. Doctors F. E. Rice, W. A. MacLeod, C. B. Trites, A. Calder and O. B. Keddy were elected honorary members. A very excellent report was received from the Cancer Committee. The Committee on Economics reported the termination of medical services to old age pensioners and an increase of from 75c to 85c per month for the beneficiaries of mothers' allowances and blind pensioners, also a very decided improvement in the pro-rating by Maritime Medical Care.

"The Legislative Committee reported certain contemplated changes in the Medical Act dealing with doctors who are practising near the Nova Scotia New Brunswick border, and also the authority of outside doctors to examine patients as part of clinical research Our representatives to the Executive of the Canadian Medical Association, the Nominating Committee of the Canadian Medical Association and our representatives to Council were elected; as also were our representatives to the House of Delegates of Maritime Medical Care. Thirty-eight new members were admitted. It was decided that we continue to collect fees for the Canadian Medical Association.

"At the two business sessions, most of the important matters considered by the Executive were referred to or dealt with. The necessity of preparing for our Centenary was fully discussed, and it was decided that the incoming President be empowered to appoint a committee to make plans for this celebration. It was decided to appoint two representatives to Maritime Hospital Service Association. Doctor J. C. Wickwire gave a full report on Maritime Medical Care for the past year.

"The semi-annual meeting of the Executive of The Medical Society of Nova Scotia was held in the Board Room of the Dalhousie Public Health Clinic December 9, 1952. There was considerable time devoted to making arrangements for the Centenary and several visitors were present, notably Doctors C. L. Gosse, A. R. Morton, W. G. Colwell and F. J. Barton. It was agreed that a levy of $10.00 be put upon all our membersto pay for the expenses of the Centenary. It was announced by Doctor M. G. Tompkins that at the last meeting of the Executive of the Canadian Medical Association they had voted $1,000 towards the expenses of our celebration. It was also announced by Doctor Tompkins that Doctor William Taylor of the University of Toronto had been employed by the Canadian Medical Association as advisor on socialized medicine. The Statement of Policy of the Canadian Medical Association adopted in 1949 brought forth much discussion, especially that paragraph which read—'The right of every Canadian citizen to insure under these plans.' After considerable discussion it was decided that the words 'right of' be replaced by 'opportunity for.' Doctor Tompkins also spoke about the increased fee of $10.00 which it was necessary for the Canadian Medical Association to place upon its members to take care of increased expenses.

"A very good report was given by the Committee on Public Relations and they were voted $300 to be used for publicity expenses.

"On March 26th there was a special meeting of the Executive held at the Dalhousie Public Health Clinic. At this meeting there was a committee

appointed to study the health survey of the Province of Nova Scotia. There was also received the report of the Committee of Public Relations and there was considerable discussion about membership and methods of increasing it. There was some fear that the increased fee of the Canadian Medical Association from $10.00 to $20.00 would materially affect membership in The Medical Society of Nova Scotia, but so far this has not followed. Membership in The Medical Society of Nova Scotia was 492 in 1952, and in 1953 483, a falling off of 9 members. The Canadian Medical Association membership in our Division in 1952 was 485, whereas in 1953 it was 456, a falling off of 29. However, in looking at the membership in the Canadian Medical Association back for three years, one should not draw any immediate deductions, for in 1951 there were 457 members of the Canadian Medical Association in Nova Scotia, in 1950 there were 451 and in 1949 436; all of these figures being approximately close to the membership in 1953.

"For the past few months Doctor Reid and his Committee have been busy in preparations for the Centenary. We have worked in close co-operation with the Refresher Course of the Dalhousie Medical School. An excellent scientific programme has been arranged and visitors will be here from several of the medical centres of Canada and the United States and also we are having one visitor from England. The social side of this event has not been neglected, and the ladies are being well taken care of; in fact everything points to the fact that the week of October fifth will be one of the most successful in our career.

"The following members have passed away since August 1st, 1952;

Fred Thompson Densmore, M.D., Dalhousie 1915, died at Dominion, September 28, 1952, at the age of sixty-two.

William Cecil Harris, M.D., Dalhousie 1902, died at Yarmouth November 9, 1953, at the age of seventy-seven.

John Harold Leslie Simpson, M.D., McGill 1924, died at Springhill November 13, 1952, at the age of fifty-five.

George Hastings Cox, M.D., University of New York 1895, died at New Glasgow January 6, 1953, at the age of eighty-two.

Alfred Ernest Waddell, M.D., Dalhousie 1933, died at Halifax March 20, 1953, at the age of fifty-seven.

James Albert Moran Hemmeon, M.D., University of Maryland 1896, died at Annapolis April 6, 1953, at the age of eighty.

Ralph Paterson Smith, M.D., University of Glasgow, 1918, died at Newcastle-upon-Tyne, England, April 8, 1953, at the age of fifty-seven.

Victor Neil MacKay, M.D., Dalhousie 1905, died at Halifax April 9, 1953, at the age of seventy-seven.

Charles Gordon Smith, M.B., Toronto 1922, died at Halifax September 1, 1953, at the age of sixty."

The list of obituaries was read at the business session by Doctor M. G. Tompkins, when one minute's silence was observed in commemoration of departed members.

The Secretary read the report on the Health Survey signed by the Chairman, Doctor A. G. MacLeod.

"The following is submitted as an interim report of the Committee to survey the Report on Health Facilities and Services in Nova Scotia by Doctor C. B. Stewart.

"We feel that this committee is too widely dispersed geographically, and it is impossible to get together for a sufficiently full and thorough study. It is recommended that the chairman be empowered to form a nucleus committee for further study, and when such is completed, to call together the whole committee to summarize and finalize the findings.

"Consideration was also given to the referal for study of this report to the various branch Societies with a view to getting their opinions. It was felt, however, that this would be unwieldy and probably non-productive. We believe the former recommendation more practical and feasible.

"Two hundred copies of the chapters on Health Insurance and Conclusions and Recommendation (Chapters 10 and 11) from the Report have been prepared, and with the approval of the Executive will be available at the general meeting. It is hoped that interest will be aroused.

"In conclusion, we would like to commend Doctor C. B. Stewart on the excellence of the Report. In scope, in thoroughness, and in the completely objective manner in which the conclusions and recommendations are prepared, it is of exceptional quality. We feel that the Society should commend Doctor Stewart's outstanding work."

It was moved by Doctor H. F. McKay and seconded by Doctor M. G. Tompkins that this report be adopted. Carried.

The report of the Provincial Medical Board, signed by Doctor H. D. O'Brien, was next read by Doctor H. G. Grant, dated September 23rd, 1953.

"As one of your representatives on the Provincial Medical Board I beg to submit the following as items of interest to the profession dealt with during the past year;

"The Board held two general meetings in Halifax, two Executive meetings, and numerous meetings of the Legislation Committee as the need arose.

"In co-operation with representatives of our Society, representatives of the Board, with the solicitors of each body, spent a considerable portion of the past winter working on the Medical Act. The idea behind this task was to eliminate obscure terms, express ideas in more definite and direct language, and consolidate the whole, rather than the introduction of any special new legislation. It was of course inevitable that the procedure would involve minor changes, but these were fully agreed to by all parties as being for the good ordering of professional standards and conduct in this Province. The committees would like to acknowledge the great assistance of Mr. Henry Muggah of the Attorney General's Department in respect to the Medical Acts of other Canadian Provinces, and helpful suggestions on all occasions. When the work was finished, the draft was forwarded to the Minister of Health for introduction into the Legislature when expedient to do so.

"Soon after the opening of the Legislature in 1953, a Private Bill was introduced to authorize and regulate the practice of Chiropractic in Nova Scotia. The Legislative Committee and the Board's solicitor drew up a brief which was presented at the Public Hearing into the Bill. This Brief dealt specifically with the educational standards set forth for the training of these

persons to treat illness to the extent set forth in the Bill. Other aspects of the Bill were dealt with by representatives of our Society, the Society of Radiologists, and others. The Bill was rejected on Third Reading by the Legislature.

"The Board has continued to support the MacDougall Library and the Doctor John Stewart Memorial Lecture.

"The routine business of dealing with problems of education and licensure has been extensive."

It was moved by Doctor H. J. Devereux and seconded by Doctor J. A. MacCormick that this report be received.

Doctor H. J. Devereux nominated Doctor A. G. MacLeod as the representative on the Executive of the Canadian Medical Association. This was seconded by Doctor M. G. Tompkins. Carried.

Doctor H. F. McKay nominated Doctor A. A. Giffin as alternate to Doctor MacLeod. This was seconded by Doctor M. G. Tompkins. Carried.

It was moved by Doctor P. O. Hebb that the honoraria to the Treasurer and the Editorial Board and the salary of the Secretary and clerical secretary be authorized as usual. This was seconded by Doctor R. E. Price. Carried.

Doctor J. A. McDonald nominated Doctor Eric W. Macdonald as the representative on the Nominating Committee of the Canadian Medical Association. This was seconded by Doctor M. G. Tompkins. Carried.

Doctor R. E. Price nominated Doctor H. F. McKay as alternate to Doctor Eric W. Macdonald. This was seconded and carried.

The following members of Council of Canadian Medical Association were nominated: Doctors A. G. MacLeod, A. A. Giffin, Eric W. Macdonald, J. R. Macneil, S. Marcus, H. F. McKay, B. E. Goodwin and the incoming President and Secretary, ex officio.

The following were nominated to the House of Delegates of Maritime Medical Care: Doctors H. F. McKay, H. E. Christie, A. L. Murphy, R. F. Ross, R. G. A. Wood, H. B. Whitman, J. A. McDonald, G. C. Macdonald, A. G. MacLeod, H. J. Devereux, R. A. Moreash, J. C. Wickwire, D. F. Macdonald, J. A. MacCormick, E. F. Ross and C. H. Reardon.

It was moved by Doctor H. J. Devereux and seconded by Doctor E. F. Ross, that the following doctors be taken in as members of The Medical Society of Nova Scotia. Carried.

Dr. C. R. B. Auld, Halifax
Dr. R. P. Belliveau, Meteghan
Dr. A. C. Brady, Halifax
Dr. A. C. Billard, Inverness
Dr. J. F. Cantwell, Halifax
Dr. M. G. Feener, Bridgewater
Dr. J. H. Fraser, Westville
Dr. K. V. Gass, Pugwash
Dr. Alfred Gordon, Dartmouth
Dr. T. W. Gorman, Antigonish
Dr. R. S. Grant, Halifax
Dr. J. W. MacIntosh, Jr., Halifax
Dr. D. H. MacKay, Halifax
Dr. D. H. MacKenzie, Halifax
Dr. H. H. Neily, Windsor
Dr. E. L. Ramsey, Yarmouth
Dr. D. L. Roy, Halifax
Dr. A. J. Shaw, Sydney
Dr. H. L. Stewart, Halifax
Dr. N. G. Stott, Halifax
Dr. M. F. Taylor, Barrington Passage
Dr. Agnes W. Threlkeld, Halifax

Dr. S. H. Kryszek, Brooklyn, HantsCounty
Dr. W. M. Little, Dartmouth
Dr. J. B. Tompkins, Glace Bay
Dr. H. G. Quigley, Halifax
Dr. J. R. VanHorne, Shelburne

It was moved and seconded that Doctor C. S. Morton of Halifax be elected as senior member of the Canadian Medical Association. Carried.

It was moved and seconded that Doctor W. W. Patton of Glace Bay, Doctor Clarence M. Miller of New Glasgow and Doctor R. A. MacLellan of Rawdon Gold Mines be elected as honorary members of The Medical Society of Nova Scotia. Carried.

It was moved by Doctor H. J. Devereux that the Section of General Practice be asked to nominate their representative on the Executive of the Canadian Medical Association Section of General Practice. Carried.

Doctor P. O. Hebb moved the following resolution, which had been held over from the morning session—"That the Executive of the Nova Scotia Medical Society approve of the change in the By-laws of the Halifax Medical Society as outlined in Doctor Smith's letter regarding membership in the Halifax Medical Society." This was seconded by Doctor E. F. Ross.

Doctor H. F. McKay: "If we accept this we are accepting compulsory membership."

By a show of hands Doctor Hebb's resolution was defeated.

Doctor H. F. McKay moved that the letter of the Halifax Medical Society be received; that the Secretary be instructed to obtain more information in the matter, and if necessary employ legal advice to finalize the constitutionality of the matter. This was seconded by Doctor R. E. Price. Carried.

Doctor J. W. Reid again brought up the subject of forming a Council of The Medical Society of Nova Scotia, the idea being that a small council consisting of three or four men including the President and Past President might form a nucleus committee of continuity for the activities of the Society.

It was moved by Doctor P. O. Hebb that the President appoint a committee of four. This was seconded by Doctor M. G. Tompkins. Carried.

It was moved that the meeting adjourn at 5.30 p.m.

XVIIth International Congress of Ophthalmology

CANADA will share with the United States the honor of being host to the XVIIth International Congress of Ophthalmology, which will meet in Montreal, Sept. 9-11, 1954, and in New York, from Sept. 12th to 17th, 1954. Inquiries regarding the Congress as a whole should be addressed to the Secretary-General, Dr. William L. Benedict, 100 First Avenue Building, Rochester, Minnesota, U.S.A. Inquiries relating solely to the Montreal portion of the Congress may be mailed to the Associate Secretary, Dr. G. Stuart Ramsey, Physical Sciences Center, McGill University, Montreal.

100th Annual Meeting of The Medical Society of Nova Scotia

FIRST BUSINESS MEETING

THE first general sessions was held in Room 21, Dalhousie University Arts and Administration Building, Studley Campus, Halifax, N. S., October 8th, 1953, at 3.30 p.m.

The President, Doctor J. W. Reid, called the meeting to order. He apoligized for being so tardy, but had been delayed at the luncheon at the Nova Scotian Hotel given for the Executive of the Canadian Medical Association. He stated that the meeting would be short as the room had to be vacated by 3.45 p.m., and a photographer was waiting to take pictures of the doctors present. He then read the following letter from Doctor Margaret E. B. Gosse, dated September 23rd, 1953.

"Would you be kind enough to intimate to the Nominating Committee, when it is appointed at this year's Annual Meeting, that I wish to be relieved of my responsibilities in connection with the Nova Scotia Medical Bulletin. It has come to my attention that I have already served longer than any previous Editor so it seems only proper that I should retire. The demands upon time and energy of the increasingly difficulty of publication are becoming excessive.

"Wishing the Bulletin every success in the future."

Doctor J. W. Reid said that Doctor Gosse had made a very significant contribution to The Medical Society through her job as Editor of the Bulletin, a task which is a difficult and onerous one, and that he did not think we should let this time pass without moving a vote of thanks to her.

Doctor J. A. Noble moved a very sincere vote of thanks to Mrs. Gosse for the work which she has done. This was seconded by Doctor R. A. MacLellan. Carried.

Doctor J. W. Reid stated that the names of the men who would form the new Editorial Board were in the hands of the Nominating Committee.

Doctor J. W. Reid said that the Executive had met all the day previous and went over the agenda with the exception of this matter concerning the Bulletin, and he dealt with practically all the items of any significance which had been considered by the Executive. He said that because of so little time this afternoon he was not able to go into details, or to bring up the question of any new business from the floor. He mentioned the advisability of the formation of a Council, and also an official crest for the Society. He spoke about the recommendation of Doctor E. T. Granville in using the funds of the welfare account. He named the following Nominating Committee; Doctor P. R. Little, Chairman, Doctors R. E. Price, Gordon C. Macdonald, Douglas F. Macdonald and V. D. Schaffner. Notice was given of a breakfast meeting of the General Practitioners Branch at the Nova Scotian Hotel the following day at 7.30 a.m.

It was moved that the meeting adjourn at 3.45 p.m.

SECOND BUSINESS MEETING

THE second business meeting of The Medical Society of Nova Scotia was called to order by the President, Doctor J. W. Reid, in the Ball Room of the Nova Scotian Hotel, Halifax, N. S., on Friday, October 9th, 1953, at 3.45 p.m.

Doctor J. W. Reid explained that the Ball Room had to be cleared for the night's activities, and that we had orders to be finished by five o'clock. He said that it would be difficult to deal adequately with all the matters that came up for consideration, but if unable to do so the Society would reconvene the next morning at 9.30 in the Nurses Auditorium of the Victoria General Hospital. The business session the previous afternoon had been extremely brief, not because we wish to run anything, but because there was not time available to deal with the matters taken up by the Executive on Wednesday. Very few of these things were contentious in any way. Regarding new business the first thing on the agenda was the formation of a Council of The Medical Society of Nova Scotia to be a new body, not to make policies, but to serve as a small body for the present officials of the Society, and it was decided at the Executive meeting to look into the possibility of forming such a committee. The next item of new business was the adopting of a crest for The Medical Society. The Society were somewhat embarrassed when they came to make plans for the Centennial that they had no crest. Since then it had come to their attention that if they moved instantly in this matter, and since the Society is the oldest Medical Society in Canada, he believed that if they applied to the proper authorities the Society might be called "The Royal Medical Society of Nova Scotia." He then asked if there was any new business from the floor.

Doctor Eric W. Macdonald spoke regarding general practitioners whom he stated for the last twenty-five years have been pushed out of the hierachy of the profession, and in this city had all but been eliminated from our hospitals and if the trend continues, he will have very little authority in our provincial institutions. Hospital control has passed from the profession to Trustees or Boards of Directors and they are legally and morally responsible for the standard of medical care of patients in their institutions. He thought there should be a place in our hospitals for every qualified medical man according to his abilities. This would mean that hospital privileges must be graded, and allotted according to one's skill, experience and training. It would be useless to try to bring pressure to bear on hospital boards to grant the incompetent privileges to which he is not entitled. The establishment of a Royal College might help for the elite but would only establish another class in the profession. He thought the Society could do much for the general practitioners of this province if they were willing to help themselves. He suggested that the Society establish a Chair of General Practice at Dalhousie. Say it will cost $250,000, if everyone would contribute a dollar a day for three years, that would do it, and actually they would only be paying about half this as the amount contributed could be claimed as a charitable donation, on which they could save the Income Tax they would otherwise pay. He moved that The Medical Society of Nova Scotia recognizing the desirability of a Chair of General Practice being established at Dalhousie appoint a committee to

consider and investigate the possibility, keeping in mind that the cost must be contributed by our membership. This was seconded by Doctor J. J. Carroll and carried.

It was moved by Doctor H. J. Devereux that The Medical Society of Nova Scotia recommend to the staff of the Bulletin that the fifth year medical students be given complimentary copies for the calendar year. This was seconded by Doctor F. J. Barton. Carried.

It was moved by Doctor C. H. Reardon that The Medical Society of Nova Scotia give consideration through the appropriate committees to making compulsory membership in The Medical Society of Nova Scotia for all participating Nova Scotia doctors in Maritime Medical Care. This was seconded by Doctor W. G. Colwell.

Mr. D. C. Macneill stated that according to the Act of Incorporation of Maritime Medical Care he thought that any doctors practising in Nova Scotia may become a participating physician. If Doctor Reardon's motion went through it would be necessary to change the Act. Maritime Medical Care ony make payments to doctors who are participating physicians.

Doctor W. J. MacDonald thought that in order to practise in Nova Scotia doctors should be members of The Society. He thought that a committee could be set up to bring this about; the Society should give consideration to having this done.

Doctor Reardon's motion was defeated.

Doctor F. J. Barton moved that this matter be referred to the Legislative Committee. This was seconded by Doctor H. J. Devereux. Motion carried.

President J. W. Reid stated that the Executive had had letters from Doctor J. A. McMillan re publication of information of member hospitals and appointments to Executive of Maritime Hospital Association which had been dealt with; also a letter from the Canadian Red Cross Society re closing of Eastern Shore Memorial Red Cross Hospital on which no action had been needed. Also a letter from the Halifax Medical Society and the resolution from the Cape Breton Medical Society. He mentioned the report of the Legislative Committee who had had a busy year. He stated that the honorary members elected were Doctors W. W. Patton, Clarence M. Miller and R. A. MacLellan. The reports of the Public Health and Historical Committees had been tabled. The report of the Editorial Board Committee had been read by Doctor M. E. B. Gosse and Doctor Reid read Doctor Gosse's letter of resignation. He stated they received her resignation with sincere regret, that she had done a very faithful and very excellent job and that the Society owed her a very sincere vote of gratitude. He stated that the Medical Museum had nothing to report, the Public Relations Committee and various other Committees had given their reports. He then read Doctor E. W. Macdonald's resolution re the establishment of a Chair of General Practice and asked whether the chair should appoint such a committee, and it was decided that the matter should be dealt with now, the chair to appoint such a committee.

Doctor A. W. Titus gave his report on the schedule of fees.

Doctor W. J. MacDonald stated that this Committee had done an enormous job and spent a great deal of time, and that he would be very happy to move that this revised scale of fees be adopted.

Doctor J. W. Reid stated that Doctor Titus was the one to move the adoption of the report and asked Doctor MacDonald if he would second it. Doctor MacDonald stated he would be very happy to second it, and he wanted to thank Doctor Titus and his committee who had made a splendid job of it.

Doctor C. L. Gosse did not believe that two scales of fees should be in existence and moved that the meeting adjourn and reconvene the following morning.

Dr. P. R. Little then gave a report of the Nominating Committee as follows:

President: Doctor M. G. Tompkins, Glace Bay.

First Vice-President: Doctor H. F. McKay, New Glasgow.

Treasurer: Doctor R. O. Jones, Halifax.

Assistant Treasurer: Doctor A. W. Titus, Halifax.

Secretary: Doctor H. G. Grant, Halifax.

Assistant Secretary: Doctor C. B. Stewart, Halifax.

Legislative Committee: Doctor A. G. MacLeod of Dartmouth, Doctor A. R. Morton of Halifax, Doctor H. F. Sutherland of Sydney and Doctor P. E. Belliveau of Meteghan.

Cancer Committee: Doctor V. D. Schaffner of Kentville, Doctors N. H. Gosse and S. R. Johnston of Halifax and Doctor F. J. MacLeod of Inverness.

Public Health Committee: Doctor S. G. MacKenzie, Jr. of Truro, Doctors G. G. G. Simms of Halifax, J. A. McDonald of Glace Bay, Doctor I. R. Sutherland of Annapolis Royal, and Doctor T. B. Murphy of Antigonish.

Historical Committee: Doctor K. A. MacKenzie of Halifax, Doctor W. W. Patton of Glace Bay and Doctor R. A. MacLellan of Rawdon Gold Mines.

Workmens Compensation Board Committee: Doctors E. F. Ross and C. H. Reardon of Halifax, Doctor W. A. Hewat of Lunenburg, Doctor A. L. Sutherland of Sydney and Doctor C. E. Stuart of New Glasgow.

Editorial Board Committee: Doctors C. M. Harlow, C. B. Stewart and H. L. Scammell, all of Halifax.

Medical Museum Committee: Doctor A. L. Murphy of Halifax and Doctor F. W. Morse of Lawrencetown.

Cogswell Library Committee: Doctors J. McD. Corston and A. W. Titus, both of Halifax.

Medical Economics Committee: Doctors H. J. Devereux and G. C. Macdonald of Sydney, H. J. Martin of North Sydney, B. J. D'Eon of Yarmouth and D. M. MacRae of Halifax.

Pharmaceutical Committee: Doctor H. R. Peel of Truro and Doctor A. M. Siddall of Pubnico.

Public Relations Committee: Doctor F. J. Barton of Dartmouth, Doctor L. C. Steeves of Halifax, Doctor J. A. MacCormick of Antigonish, Doctor P. R. Little of Truro, Doctor D. F. Macdonald of Yarmouth and Doctor A. W. Ormiston of Sydney.

Divisional Representative, Editorial Board of Canadian Medical Association: Doctor C. M. Harlow of Halifax.

Industrial Medicine Committee: Doctor J. G. B. Lynch of Sydney, Doctor R. M. Caldwell of Yarmouth and Doctor J. E. Park of Oxford.

Medical Advisory Board Committee to Lay Organizations: Doctors H. D. O'Brien and W. D. Stevenson of Halifax, Doctor L. M. Morton of Yarmouth, Doctor R. M. MacDonald of Halifax and Doctor G. R. Forbes of Kentville.

Member of Board of Maritime Hospital Service Association: Doctor D. M. MacRae of Halifax.

Tariff Committee: Doctors A. W. Titus and J. W. Reid of Halifax, Doctor J. J. Carroll of Antigonish and one representative appointed by each Branch Society.

Doctor Little stated that the reason the Nominating Committee had not appointed a Second Vice-President was because they did not know where the meeting would be held that year, that is in 1956.

Doctor J. W. Reid nominated Doctor D. M. Cochrane of River Hebert as Second Vice-President.

Doctor G. C. Macdonald moved the adoption of the report which was seconded by Doctor D. F. Macdonald, and carried.

It was decided that as there were no such jobs in the Society as Assistant Treasurer and Assistant Secretary that the names of Doctor A. W. Titus and Doctor C. B. Stewart be deleted.

Doctor W. L. Muir stated that Doctor H. K. MacDonald of Halifax had been twice President of The Medical Society of Nova Scotia and during his first term in that office largely instrumental in the resuscitation and placing upon a firm foundation of the Society. He had been a long-time teacher and friend of many generations of Dalhousie medical students. Now unfortunately, partly as the result of a most untimely accident, and partly due to the inevitable encroachment of old age he is prevented from taking an active part in the activities of our Association; but none the less deeply interested in its welfare.

He moved that a suitable letter be forwarded to Doctor H. K. MacDonald expressing our regret at his enforced absence from our Centennial celebrations and assuring him of our deep regard and affection.

This was seconded by Doctor J. A. McDonald. Motion carried.

It was moved that the meeting adjourn at 5.30 p.m. to meet the next morning at 9.30 in the Auditorium of the Nurses Residence at the Victoria General Hospital.

THIRD BUSINESS SESSION

THE third general business session of The Medical Society of Nova Scotia was called to order by the President, Doctor J. W. Reid, in the Auditorium of the Nurses Residence of the Victoria General Hospital, Halifax, N. S., on Saturday, October 10th, 1953, at 9.40 a.m.

It was moved by Doctor J. F. L. Woodbury that the Society move a vote of thanks to the Canadian Medical Association Executive for their presence here and for their gift of $1,000 towards our Centennial. This was seconded by Doctor D. J. Tonning. Motion carried.

Doctor J. W. Reid stated that the Society had dealt with most of the things they felt were of more than passing interest at yesterday's meeting. He thought the thing most pressing for consideration at this time was the schedule of fees, and that before that started he would turn the meeting over to the new President, Doctor M. G. Tompkins. He stated he would turn the

chair over to the new President this morning to deal with the business which had to be considered as he realized the strength of Doctor Tompkins in a scrap, and he thought it better that he should be in the chair. Doctor Tompkins comes to the Society as President with a delightful personality and with a wide background of experience. He graduated in 1914 and has practised medicine and surgery in Dominion for many, many years, and this summer was signally honoured with a degree of Ll.D. from St. Francis University, and the citation particularly mentioned he was a distinguished representative of the medical men of Nova Scotia. It might not be convenient to hand the meeting over to him at this time, but Doctor Reid said he was going to, and asked the Society to give Doctor Tompkins loyal support.

Doctor Tompkins took over Doctor Reid's place and thanked the Society for the honour which had been conferred upon him and which he appreciated very much. He trusted that the Society would live up to the standards of the past years and next year when the Society met in Cape Breton he knew they would not be able to give the Society such a celebration as had been held this year, but trusted they would do their best. He stated he could not hope to live up to the reputation of the past year of Doctor Reid, and he was sure the Society must be very proud of his work that had made the Centennial such a success. He felt that something had been put over him. He did not know just what business had to come up as the business had been covered fairly well. The main item for discussion was the schedule of fees which had been brought in by Doctor Titus.

It was moved by Doctor H. J. Devereux that the Workmen's Compensation Board Committee meet with the Board and make a vigorous effort to have the compensation fees raised to at least The Medical Society of Nova Scotia schedule of minimum fees. This was seconded by Doctor J. A. McDonald, and carried.

Doctor A. W. Titus moved the adoption of the schedule of fees, which was seconded by Doctor J. W. Reid.

After some discussion Doctor Titus asked if he could withdraw his motion. Doctor J. W. Reid stated that as the motion had been seconded he did not think it could be withdrawn.

Doctor C. H. Reardon stated that he would like to make an amendment to the motion that the schedule of fees as presented be amended to include only one schedule of fees, a minimum scale of fees, and that the Committee have power to amend particular items where discrepancies are noted or otherwise indicated. This was seconded by Doctor H. J. Devereux.

Doctor Devereux stated that there were general practitioners who were certified, and asked whether they would charge specialist fees or general practitioner fees.

Doctor C. L. Gosse thought there should be some consideration given to the internist.

Doctor J. W. Reid thought the amendment was not an amendment, but a reversal of the fee schedule. He did not know exactly what the group had against a double scale of fees.

Doctor Eric W. Macdonald stated he understood that in Ontario and in British Columbia they had adopted the double scale of fees. He would like to move an amendment to the amendment that the proposed schedule of fees be referred back to the Committee and to the Branch Societies for reconsideration and revision. This was seconded by Doctor H. J. Martin.

Doctor Francis Whyte asked what a specialist was. His definition of a specialist was a specialist who was recognized by the profession and not by the public.

Doctor A. W. Titus stated that his Committee had been directed by the Society to draw up a double scale of fees. The classifications have been minimum. They were prepared to take out specialist's fees and leave general practitioners for the scale of fees. He thought it would be in order to put the amendment to the amendment.

Doctor J. C. Wickwire stated that if the two sets of fees were accepted it would cost Maritime Medical Care approximately $90,000; if the single fee were accepted it would cost them approximately $51,000. He would hate to see the thing thrown out. He could not see that anything would be gained if it were thrown back to the Branch Societies, as it had already been discussed.

Doctor A. W. Titus said it appeared evident that the Society did not want a double scale of fees. It was being adopted temporarily for a year.

Doctor Eric W. Macdonald said he was not concerned with the amounts on the schedule of fees, and had no intention of belittling the work of Doctor Titus, but on the other hand it was a serious state of affairs for the medical men in the province. He thought the meeting might adopt just one schedule of fees for this year and send it back to Doctor Titus and have specialist fees put in the general practitioner fees where there is a blank.

The amendment to the amendment was defeated.

Doctor Reardon's amendment carried.

It was moved by Doctor A. W. Titus that the revised minimum schedule of fees as presented be adopted with its amendments. This was seconded by Doctor J. W. Reid. Motion carried.

Doctor J. W. Reid suggested that the Secretary send a letter to Sir Lionel Whitby thanking him for his telegram and also to the Canadian Pharmaceutical Society. Agreed.

Doctor H. D. O'Brien moved that a letter of greetings and the Society's best wishes for a quick recovery be sent to Doctor R. M. Benvie of Stellarton, which was seconded and carried.

At this point Doctor M. G. Tompkins read the list of members who had passed away during the year, and one minute of silence was observed.

Doctor J. W. Reid moved that the Society send sincere thanks to the New Brunswick Medical Society for their thoughtful presentation of a guest book. This was agreed to.

Doctor H. G. Grant read the following letter from Doctor F. L. Whitehead, Executive Secretary of the New Brunswick Medical Society, dates October 2, 1953:—

"C.M.A. Annual Meeting Atlantic Provinces 1958.

"At our recent Annual Meeting, the following resolution was passed:

"THAT the New Brunswick Medical Society will co-operate with the other Atlantic Provinces in planning and carrying out an Annual Meeting of the C.M.A. in the Atlantic Provinces with the suggestion that this might be accomplished on a 'no-host' basis with all four Provinces sharing in the planning and expense.' "

President M. G. Thompkins though that it would be in order to appoint two members to attend this meeting. Doctor Grant stated that it had been suggested that the Society send three members.

It was moved by Doctor D. M. MacRae and seconded by Doctor C. L. Gosse that the President appoint the delegates.

President M. G. Tompkins nominated Doctors D. M. MacRae and C. L. Gosse and the Secretary to be the representatives at this committee meeting.

Doctor H. G. Grant said the other two representatives would like to know if this Society is willing to go in on a pooling arrangement, and also asked what the Society felt about the Presidency for that year.

Doctor H. K. Hall moved that the Society pool expenses with the other Maritime Provinces. This was seconded by Doctor J. A. McDonald. Carried.

It was moved by Doctor A. W. Titus that the following doctors be taken in as members of The Medical Society of Nova Scotia.

Doctor G. W. Bethune and Doctor H. G. Quigley of Halifax, Doctor G. D. Denton of Wolfville and Doctor N. B. Trask of Dartmouth.

This was seconded by Doctor C. L. Gosse and carried.

It was moved by Doctor C. L. Gosse and seconded by Doctor H. J. Martin that the time of the next Annual Meeting be left to the Executive. Carried.

Doctor M. G. Tompkins stated that the Society owed Doctor Titus a great debt of gratitude for the work he had done; and it would be a memorial to him in the future.

Doctor H. F. McKay said that the Society owed a great deal to the group in Halifax who had made such excellent arrangements for this past week. He moved that a vote of thanks go to Doctor C. L. Gosse and his committee, Doctor R. O. Jones and his committee, Doctor W. G. Colwell and his committee, Doctor A. R. Morton and his committee and Doctor J. W. Reid. It had been a wonderful meeting, a wonderful programme had been put on and they certainly deserved congratulations.

Doctor J. C. Wickwire stated that it was the finest meeting of its kind he had ever attended and he thought the past President had done a wonderful job. His speech last night was the finest as President he had ever heard in any organization, and he seconded the motion. Carried.

Doctor M. G. Tompkins said it had been an eye opener to the Executive of the Canadian Medical Association, and he was quite sure they would go back with excellent proof concerning our work. He thought a motion of a vote of thanks should appear on the records for the work they had done.

This was moved by Doctor A. J. McDonald and seconded by Doctor A. W. Titus. Carried.

Meeting adjourned at 11.30 a.m.

NOTE: Since this report of the Nominating Committee was received Doctor E. F. Ross has not found it convenient to act as Chairman of the Workmens Compensation Board Committee, and the President, Doctor Tompkins, has appointed Doctor J. W. Merritt to act as Chairman. Doctor Eric W. Macdonald has not found it convenient to be the representative on the Nominating Committee of the Canadian Medical Association, and Doctor Tompkins has appointed Doctor R. F. Ross of Truro.

Society Meetings

THE NOVA SCOTIA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

THE annual meeting of the Nova Scotia Society of Ophthalmology and Otolaryngology was held on Tuesday, October 6, 1953, at the Victoria General Hospital, Halifax, with the President, Dr. H. W. Kirkpatrick in the chair. A meeting of the New Brunswick Eye, Ear, Nose and Throat Society was combined with our annual meeting.

Applications for membership were received from Dr. W. T. M. MacKinnon, of Amherst and Dr. D. K. Murray of Halifax. On recommendation of the executive they were elected to membership in our society, on a motion of Dr. H. R. McKean, seconded by Dr. H. J. Davidson.

The payment of an honorarium of twenty-five dollars for secretarial services for 1951-1952 was moved by Dr. H. F. Davidson, seconded by Dr. H. F. Sutherland and passed by the meeting. Dr. A. W. Ross, of Moncton, suggested that the New Brunswick Society would like to pay fifty per cent of the honorarium.

A letter from Dr. P. E. Moore, Director of Indian Health Services, Ottawa, was read, in which he stated that the schedule of fees was in the process of revision and when available a copy would be sent to the Secretary.

A letter of acknowledgement was read from the family of the late Dr. G. H. Cox, New Glasgow.

A communication from the Secretary General of the XVII International Congress of Ophthalmology was read and filed. This letter stated that the International Congress would open with a two day session in Montreal on September 10th and 11th, 1954 and then continue in New York at the Waldorf-Astoria, September 13th to 17th, 1954. Details of these two programmes will be announced later.

The Secretary-Treasurer's report was read and showed that at present our membership consists of thirty-one active members and eight honorary members. There are no outstanding accounts and at present our balance in cash and in the bank is $545.21. It was moved by the Secretary and seconded by Dr. Keshen, that the report be referred to the auditor for examination and audit.

The president then appointed a nominating committee of Dr. Stoddard, Dr. Davidson and Dr. Smith and auditor Dr. McKean.

Dr. A. W. Ross, of Moncton suggested that the New Brunswick Society would be pleased to hold the joint meeting of our societies in 1954, if it were agreeable to both societies. It was moved by Dr. Sutherland and seconded by Dr. Keays that the executive decide the time and place of the next joint meeting in New Brunswick and notify the New Brunswick Society.

The report of the nominating committee was presented and read:

President—	Dr. E. F. J. Dunlop, Bridgewater, N. S.
Vice-President—	Dr. J. G. Cormier, Sydney, N. S.
Secretary-Treasurer—	Dr. E. I. Glenister, Halifax, N. S.

Executive—Dr. H. W. Kirkpatrick, Halifax.
Dr. H. J. Davidson, North Sydney,
Dr. C. K. Fuller, Yarmouth,
Dr. L. G. Holland, Halifax,
Dr. H. R. McKean, Truro,

This was moved by Dr. R. H. Stoddard, seconded by Dr. Smith and passed.

The auditor, Dr. H. R. McKean, reported the Secretary-Treasurer's report correct and moved its adoption. It was seconded by Dr. Schlossberg and passed.

Dr. D. M. MacRae presented a very unusual case—Malignant Granuloma of the nose—A young male patient—there have only been seventy cases reported in the literature—the diagnosis was determined by biopsy—there is no known cause and no known treatment and all cases are fatal— thus the name—Malignant Granuloma. The condition is an endarteritis, which is progressive and fatal. Recently Cortisone has been suggested as a therapeutic measure, but it does not seem to be helpful in this case.

This completed the morning session and the meeting adjourned for luncheon at the Lord Nelson Hotel, to be followed by the presentation of papers.

The afternoon session opened with Dr. G. E. Tremble, Montreal, Dept. of Otolaryngology, Royal Victoria Hospital presenting a paper "Modern Concepts of Sinus Treatment". In addition to his paper, Dr. Tremble showed an excellent color film on his presentation. He stressed the importance of conservative treatment in sinusitus, and made several excellent sketches during the presentation of his paper. Dr. Kirkpatrick opened the discussion and questions and comments were asked by Dr. Schwartz, Dr. McGrath and Dr. Desmond.

A vote of thanks and appreciation to Dr. Tremble on behalf of the members of both societies was moved by Dr. A. E. Doull Jr., and seconded by Dr. Ross.

Dr. A. W. Ross, Moncton, presented a paper "Discussion of the Use of Anti-Biotics in Acute Otitis Media and Mastoid Disease".

There was considerable discussion of the paper by Dr. Schwartz, Dr. Tremble, Dr. McGrath, Dr. Fuller, Dr. McRae and Dr. Kirkpatrick. Dr. Ross was asked to print this paper in the Nova Scotia Medical Bulletin.

Dr. D. M. MacRae, Halifax presented two case reports on Narrow Angle Glaucoma. These were cases which had been referred to Dr. Chandler of Boston for consultation, treatment and advice. In both cases there was a history of blindness in one eye, with increased tension in the remaining eye, despite the use of drug therapy. Both cases had been treated by simple iridectomy and since returning have been using pilocarpine solutions with varying degrees of tension control.

The paper was discussed by Dr. D. K. Murray, Dr. H. R. McKean and Dr. D. M. MacRae.

Dr. Kirkpatrick thanked those who had presented papers and on motion the meeting adjourned.

E. I. GLENISTER, M.D.,
Secretary-Treasurer

MINUTES OF THE ORGANIZING COMMITTEE COLLEGE OF GENERAL PRACTICE OF CANADA

Present— Chairman, Dr. M. R. Stalker
Dr. Armand Rioux
Dr. W. V. Johnston
Dr. J. H. Black
Dr. C. L. Gass
Dr. G. I. Sawyer
and by invitation, Dr. A. D. Kelly

It was announced that Dr. J. Wendell MacLeod, Dean of Medicine at the University of Saskatchewan, had been appointed as the representative from the Canadian Association of Medical Colleges, but would be unable to attend this meeting.

The Chairman expressed the hope that Dr. MacLeod would be able to attend the next meeting, as it will probably be the last meeting of this Committee.

The minutes of the previous meeting were read and accepted as true minutes of the meeting, but there were numerous suggestions for improvement in the regulations. These were thoroughly discussed and the amended provisional regulations approved as appended.

Provisional officers were appointed as follows:

1. President—Dr. M. R. Stalker, Ormstown, Quebec.
2. President-Elect—Dr. J. H. Black, Vancouver, B. C.
3. Honorary Treasurer—Dr. Glenn I. Sawyer, Toronto, Ont.
4. Chairman of Board of Representatives—Dr. C. L. Gass, Tatamagouche, N. S.

Additional members of provisional executive committee:
Dr. Armand Rioux, Quebec, P. Q.
Dr. J. Wendell MacLeod, Saskatoon, Sask.

Executive Director

It was moved by Dr. Howard Black and seconded by Dr. Armand Rioux, that Dr. Victor Johnston be appointed Executive Director at an annual salary of ten thousand dollars plus one thousand dollars expenses, to asssume office March 1st, 1954.

Provisional Board of Representatives

The executive committee plus the following representatives of the Provinces:

British Columbia	—Dr. E. C. McCoy, Vancouver
Alberta	—Dr. Pat Rose, Edmonton
Saskatchewan	—Dr. Fritz Werthenbach, Unity
Manitoba	—Dr. Jack McKenty, Winnipeg
Ontario	—Dr. William Wilford, Wiarton
	—Dr. Maurice Hobbs, Millbrook
Quebec	—Dr. Armand Rioux, Quebec
	—Dr. Hans Geggie, Wakefield

New Brunswick —Dr. Melville Rice, Campbellton
Nova Scotia —Dr. Alex MacLeod, Dartmouth
Prince Edward Island—Dr. L. G. Dewar, O'Leary
Newfoundland —Dr. John Walsh, Manuels

On motion of Drs. Black and Gass, the Honorary Treasurer was given authority to open a Bank account. The signing officers to be any two of Drs. Johnston, Kelly and Sawyer. The official banking resolution was approved.

Office space

Because of lack of space, it did not appear feasible to house the College with the Canadian Medical Associationl There was considerable discussion as to whether the office should be established in Toronto or Ottawa. The final decision was left to be made at the next meeting.

Arrangements for June meeting 1954

Tenative arrangements were made as follows:
Meeting of Board of Representatives—Wednesday, June 16th at 2 p.m.
Meeting of members of College—Wednesday, June 16th 3.30 or 4.00 p.m.
Ceremony of official launching of College—Luncheon, June 17th.

Foundation Fund

Decision to start a Foundation Fund in January 1954 was confirmed and the Secretary was instructed to insert an announcement in the January issue of the Canadian Medical Association Journal to this effect.

Founding Benefactors were to be invited to subscribe a minimum amount of $100 each. Suitable recognition will be given this list of donors.

Next Meeting

The Committee was asked to meet again at 9.30 a.m. at 244 St. George Street, Toronto, on January 15 and 16, 1954, if these dates are suitable to Dr. MacLeod.

The following are changes in the Minutes as published in the December, 1953 issue of the Bulletin.

Membership Classification.

There shall be three classes of members—

1. Honorary Members
2. Active Members
3. Associate Members

UNDER *General Qualifications for membership*, ADD THE FOLLOWING TO (B) under 2, *Members*, as GIVEN ON PAGE 351 IN THE DECEMBER ISSUE, WHICH IS NOW ACTIVE MEMBERS.

N. B. Recognizing that during the period of organization of the College, otherwise eligible physicians may have difficulty in producing evidence of having undertaken required post-graduate study, this requirement will be administered with these facts in mind until June, 1956.

UNDER THE SAME GROUP GROUP ADD (e) following (d).

(e) Doctors who have been 30 years in practice, may become members without fulfilling completely the entrance and continuing programme requirements, because of their years of experience. Yet it will be expected of them that they will show the interest in the activities of the College that their membership implies.

Active members will be elected for a period of two years. They will be eligible for re-election if so recommended by the Credentials Committee after a review of the post-graduate study accomplished in the two-year period.
Delete 4, Senior members, as given on page 352 of the December issue: and from there to the end of the Minutes substitute the following.

Continuing Programme of Post-graduate study

Active members in order to maintain their membership, and Associate members desiring to qualify for membership, will be required to carry out a continuing programme of post-graduate study as follows:

(a) One hundred hours of post-graduate study each two-year period.
(b) A minimum of 25 hours of this must be for attendance at formal medical scientific meetings, such as Canadian Medical Association, L'Association des Medecins de Langue Francaise du Canada, divisional, district or county meetings.
(c) A minimum of 25 hours of this must be for attendance at planned post-graduate courses.
(c) Credits toward the other fifty hours will be given for hospital rounds, medical papers submitted or published, planned reading courses, book reviews, case-history reports submitted for publication, community service, etc.

Membership Fees and Privileges

1. Honorary members —no fee, no vote, may not hold office.
2. Active members —Initial fee $30 for first year then $15 per year, may vote and hold office.
3. Associate members —Fee of $10 per year except for those in first or second years of practice or assistanship, when fee shall be $5 per year. The fee for internes shall be $5 per year. Associate members may not vote or hold office.

Fellowship

Fellowship qualifications will be laid down on a basis to make it comparable with other fields of practice, as one of the important aims of the College is to stimulate and recognize excellence in general practice and establish standards to this end.

Therefore, a special committee shall be set up by the first Board of Representatives to establish fellowship standards that will qualify recipients for greater responsibility in all aspects of medical practice including teaching appointments in hospitals and universities.

The following suggested regulations for qualifications for Fellowship are appended merely as a basis for further study by the Committee:

A. 1. Three years internship plus three years general practice.

OR

2. Two years internship plus five years general practice.
3. One year internship plus ten years general practice.

B. Submission of fifty case histories for review.
C. Submission of copy of medical audit report from local hospital (s)
D. Written and oral examinations of applicant.
E. Provision for continuing programme of post-graduate study.

Officers

1. Past President
2. President
3. President-Elect
4. Honorary Treasurer
5. Chairman of the Board of Representatives

These officers shall be nominated by the Nominating Committee and elected by the Board of Representatives and shall constitute the Executive Committee of the College.

The Executive Committee shall act on behalf of the Board of Representatives between meetings of the Board.

It shall appoint a Central Credentials Committee of three members and a Credentials Committee in each province which has not established a Chapter of the College.

Executive Officer

There shall be an Executive Director who shall be responsible to the Board of Representatives. He shall be a full-time employee of the College and shall carry out duties as assigned by the Board of Representatives. He shall attend all meetings of the Executive and Board of Representatives.

Board of Representatives

The Board of Representatives shall be composed of the Executive Committee plus one representatives from each province except Quebec and Ontario, which shall have two each.

The Board of Representative shall be responsible for the general conduct of the affairs of the College including the appointment of such committees (except Credentials Committee) as may be required for the proper functioning of the College.

The Board shall meet immediately preceding and following each Meeting of the College and at such other times as determined by the Executive Committee.

The provincial representatives to the Board shall be nominated by the provincial chapters, if such exist, otherwise by the Executive of the Division of the Canadian Medical Association in the province concerned.

Provisional Executive and Board of Representatives

The organizing committee shall act as a provisional executive committee and shall appoint provisional officers, an Executive Director, a Provisional Board of Representatives, establish an office, set the membership fee, collect foundation funds, receive applications for membership and do such other things as are required during the period of organization prior to the initial meeting of the College in June 1954.

Provincial Chapters

Any province having twenty-five members of the College may make application to the Board of Representatives for permission to form a provincial Chapter.

The officers of the Chapter shall be—

1. Chairman. 2. Secretary. 3. Treasurer.

These officers shall form the Executive of the Chapter. The executive shall act on behalf of the chapter between meetings of the Chapter. It shall appoint a Credentials Committee.

Function

1. Recommend members for election to the College.
2. Recommend members for re-election after assessment of post-graduate study completed each two years.
3. Nominate representatives(s) to the Board of Representatives.
4. Set up such committees (except Credentials Committee) as are required to carry on the work of the Chapter.
5. Carry out functions delegated to it by the Board, such as establishing post-graduate facilities and hospital internships suitable for training for general practice.

Members of a chapter must be members of the College.

THE following comments by Doctor Charles Gass on The College of General Practice are deserving of the earnest study and consideration of all general practitioners.

F. MURRAY FRASER,
Secretary, General Practitioners' Branch

THE COLLEGE OF GENERAL PRACTICE

THE great and rapid broadening of man's field of knowledge has brought a consequent and necessary growth of specialism. Nowhere are these changes more evident, especially to physicians, than in the field of medicine.

One of the great forward steps in Canadian medicine in the past twenty years has been the establishment of The Royal College of Physicians and Surgeons for the training and certification of competent specialists in various restricted categories. But there has been some opposite reaction to this forward action. Time is needed to find and eliminate some weaknesses. We are not concerned here, although perhaps we should be, with the adverse effect on the modern specialist who sacrifices breadth for depth. In some respects at least he suffers in comparison with the older type of specialist who worked his way to specialism through general practice. But the Canadian Medical Association has been concerned for some years with the effect which our modern advances with growth of specialism have had on the spirit and status of the general practitioner.

It is often stated that no man can keep up to date with all the new things in medicine. With the general advance the keen and hard working doctor has been struggling to keep pace and has been succeeding to a remarkable degree. He has developed in both breadth and depth in the past two or three decades, and perhaps that fact has not been sufficiently recognized. Increase in knowledge and efficiency has not been confined to the specialists' ranks in medicine. Yet there is a feeling in some quarters that the general practitioner is losing his status, not only in society but also in the ranks of the profession. One keen and forceful doctor from the West expressed this feeling rather succinctly when he said that he was tired of being told that he was the backbone of medicine and being treated as the coccyx. How well founded these ideas are is not clear, yet it is true that difficulties have arisen in some places which interfere with the practical pursuit of his calling by the general practitioner, especially in respect to hospital and teaching appointments. One reason for this is that there is no means of accrediting with high standing those general practitioners who by study and post-graduate work strive to keep up to date. They have no certificate of excellence in General Practice such as The Royal College of Physicians and Surgeons grants to qualified specialists, to recommend their appointment. Whatever we may think of the real value of extra certificates, we must face the fact that to-day they seem to be highly desirable, and, in some situations necessary. Certainly, many general practitioners deserve some mark of distinction.

Is the general practitioner—the family doctor—losing his status in society? We live in an age which is not only materialistic but unbelieving. Perhaps the family doctor is not credited with the omniscience which his predecessor enjoyed. Perhaps his halo is getting a bit thin, but the growth of specialism

is not to blame. The fault dear Brutus lies elsewhere. What the people are asking for—almost pleading for—is more well trained, progressive, ethical family doctors, not more specialists. The demand for specialists, I believe, should, and does come from the general practitioners who need and appreciate their help. The general practitioner had better face the fact that the security of his status rests with himself.

There has been a great swing towards specialism since the war. The specialist rather than the family doctor has caught the fancy of many keen young medical students. Immediately post-war the facilities for their training were strained to the limits. One hears the criticism that the medical schools and teaching hospitals are more interested in producing specialists then general practitioners, due to the influence and zeal of The Royal College of Physicians and Surgeons. In so far as this solution is real it is harmful to the profession. Certainly Canadian medicine would be much better if the general practitioner would exercise some of the influence and zeal which he undoubtedly possesses. There is evidence that the swing toward specialism has reached its peak and is in reverse. More young graduates are turning to general practice where they are needed and one of the problems of organized medicine is how can we provide incentives that these young men may grow and develop in the profession.

These are just some of the problems which the advance of our profession in a changing world has brought. Two years ago, at Banff, the Canadian Medical Association appointed a committee to study the subject and make recommendations for a solution of some difficulties. After a careful study, that committee reported to the Association at Winnipeg last year and advised the establishment of a College of General Practice within Canadian organized Medicine, with the following aims and objects:

1. To establish an academic body with broad educational aims.
2. To arrange for under-graduate teaching by and for General Practitioners.
3. To arrange for the presentation of post-graduate education for general practitioners.
4. To arrange for research in general practice.
5. To arrange for publication of original articles by general practitioners.
6. To arrange for hospital staff appointments for general practitioners.
7. To provide suitable recognition to members in the field of general practice.
8. To do all things necessary to maintain a high standard in general practice.

The report with its recommendation was adopted and an organizing committee was appointed to proceed at once with the establishment of the proposed College. The work has been going forward as indicated by a brief report by Doctor Glenn Sawyer, secretary of the founding committee in the December number of the Journal. It is expected that a constitution will be ready for publication along with details in the January issue of the Journal and that the College will be ready by March to receive applications for membership. The College will be officially started on its career at the June Meeting of the Canadian Medical Association in Vancouver.

It is early recognized that the organization must have a full time secretary if it is to succeed. An outstanding man has been secured and will begin his work in March.

When the details are published it will be seen that the qualifications for membership are modest to start with. It is hoped and expected that the infant will grow in vigor as well as in wisdom and stature with the years.

The item of finance is causing some anxiety. The cost will be about $25,000 per year. The first two years will be the most difficult until the College gets firmly established. For this reason, a Foundation Fund will be set up early in 1954, and the success of the venture will largely depend upon our financial response to the appeal. One can hardly doubt that there are many who will gladly subscribe $50 or $100 to this project which can and will mean so much to our profession.

This is a new venture in Canadian medicine. It was stated at the outset that the establishment of The Royal College of Physicians and Suregons was a great forward step. This is a second and complementary one. It is intended more particularly for the younger members of the profession. It points to the future. It reaffirms our belief that the family doctor *is* the backbone of medicine and that that backbone must grow straight and strong and not shrink and twist with the years. Let the younger men support the venture enthusiastically. Theirs is the future. As for us older ones, let us not ask "What is there in it for us?" Rather, let us see our opportunity. Years ago our profession did us the honour of numbering us among its members. What have we done in return for that great honour? Here is our opportunity! Le us support with our interest and our money The College of General Practice of Canada!

C. L. GASS.

NOVA SCOTIA GENERAL PRACTITIONERS' SOCIETY

THE third regular meeting of the newly formed Halifax Branch of Nova Scotia General Practitioners' Society was held at Dalhousie Public Health Clinic, 18th December, 1953. Considerable interest is being shown in this organization as is evidenced by the satisfactory attendance and active discussions on matters of interest to the General Practitioners of this area.

It is the aim of the Society to ensure the General Practitioner his rightfu place in the practice of medicine, and to maintain and improve the proper relation between the family physician and the patient.

It is hoped that through unification of both members and thought that opportunities will be made available whereby the General Practitioner may continue his training through closer association with hospitals and the teaching staffs of these hospitals.

Great concern is being realized by this Society over the increasing numbers of newly graduated doctors who feel that their training is too specialized, and that not sufficient emphasis is being placed on the practical aspect of medicine which would best fit them for general practice.

The Society feels that such criticism should be accepted by the General Practitioners as direct evidence of their failure to accept the responsibility of ensuring the medical student a course of study best suited to his needs.

One would like to feel that such criticisms as these may be minimized in the future.

Within the constitution of this Society a General Practitioner is defined as "one who does not limit the character of his practice to any particular field of medicine or surgical work."

If you have not already done so, the Society would welcome your membership.

DONALD I. RICE,
Secretary-Treasurer.

ASSISTANTSHIP WANTED

Dalhousie graduate 1953, now taking post-graduate training in internal medicine would like an assistantship in Halifax or immediate vicinity starting in July, 1954. For further particulars apply to the Secretary.

Personal Interest Notes

Doctor John J. Quinlan, assistant medical superintendent of the Nova Scotia Sanatorium, and his wife, Dr. Helen M. Holden Quinlan, resident physician at the Sanatorium, have successfully passed their examinations, written and oral, for specialists certification from The Royal College of Physicians and Surgeons of Canada. Doctor Roy A. Moreash of Berwick and Doctor Donald Ralph Brown of Charlottetown have been recognised by The Royal College of Physiciansand Surgeons of Canada. Doctor Moreash has been certified as a specialist in general surgery while Doctor Brown has been made a Fellow of The Royal College of Surgeons of Canada. Doctor G. J. LeBrun of Bedford has received the diploma for certfication in surgery fromThe Royal College of Physicians and Surgeons of Canada. Doctor D. S. MacKeigan of Dartmouth has been awarded certification as a specialist in general surgery after passing the examinations of The Royal College of Physicians and Surgeons of Canada. Doctor John C. Theriault of Charlottetown has passed his written and oral examinations for specialist certification in psychiatry of The Royal College of Physicians and Surgeons of Canada.

Doctor R. E. Price of Amherst received an honorary life membership in the St. John Ambulance Society at a ceremony early in December at Government House.

Doctor S. R. Johnston and Doctor H. W. Schwartz, both of Halifax, were honoured with presentations by the visiting staff of the Victoria General Hospital at a dinner meeting held at the Lord Nelson Hotel late in November.

Doctor D. F. Macdonald of Yarmouth took a course in medical civil defence at Camp Borden, Ontario, the latter part of November.

Doctor M. G. Tompkins, Jr., of Glace Bay, has been awarded a McEachern Fellowship by the Canadian Cancer Society. During the one-year term of the fellowship, valued at $3,650, he will study at the University of Minnesota. He will also visit clinics in Chicago and Seattle, Washington

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The Bulletin extends congratulations to Doctor and Mrs. A. M. MacPherson of Kentville on the birth of a daughter, Marilyn Shirley, on November 30th; to Doctor and Mrs. W. D. Stevenson of Halifax on the birth of a son, Robert William, on December 6th; to Doctor and Mrs. R. S. Grant of Halifax, on the birth of a daughter, Susan, on December 13th; to Doctor and Mrs. A. C. Billard (Hope MacMichael, R.N.) on the birth of a son on December 14th, at Albany, New York; to Doctor and Mrs. C. C. Stoddard of Halifax, on the birth of a son on December 19th; to Doctor and Mrs. S. L. Speller of Glace Bay on the birth of a daughter, Katherine Elizabeth, on January 3rd; to Doctor and Mrs. D. M. MacRae of Halifax on the birth of a daughter on December 26th, and to Doctor and Mrs. W. E. Pollett of Halifax on the birth of a daughter on January 8th.

Obituary

THE death occurred under tragic circumstances of Hugh A. Collins, M.D., C.M., Dalhousie 1935, at Pembroke, Ontario, on December 30th, 1953. Dr. Collins was enroute to spend the New Year holidays with relatives at Haileybury, Ontario, when a fire broke out on the train on which he was travelling, trapping the occupants of the last car on the train when the back door could not be opened. He was overcome by smoke and his body was not discovered until the fire had been extinguished.

Dr. Collins was born at South West Margaree, Nova Scotia, in 1892, the son of Mr. and Mrs. Angus Collins. He received his early education at home and later obtained his B.A. degree from St. Francis Xavier University in 1914. He enlisted in the Canadian Army in 1916 and served overseas as an infantryman until returned to Canada because of illness. He took up the study of medicine in later life, first at McGill University and transferring to Dalhousie University in 1932 where he completed his last three years of medical studies, graduating in 1935. His professional life was entirely spent in Government Service as he joined the Department of Pensions and National Health after graduation and was on the staff of Camp Hill Hospital until the early years of World War II, when in 1941 he was transferred to the Department's Head Office at Ottawa. At the time of his death he was Administrative Medical Officer in charge of the Veterans Pavillion at the Ottawa Civic Hospital.

Dr. Collins, who had never married, is mourned by a number of brothers and sisters throughout Canada and the United States. Burial took place from his old home at South West Margaree with interment at the Parish Church on January 4th, 1954.

C. J. MACDONALD, M.D.

The Bulletin extends sympathy to Doctor W. T. M. MacKinnon of Amherst on the death of his wife, Mrs. Elizabeth MacKinnon, which occurred recently after an illness of several months; to Doctor H. R. Peel of Truro on the death of his brother, Maxwell C. Peel, in Whittier, California, on New Year's Day, and to Doctor D. S. MacKeigan of Dartmouth on the death of his father, Rev. Dr. J. A. MacKeigan on January 2nd. To Doctor M. D. Brennon of Dartmouth on the death of his sister, Miss E. Anna Brennan, R. N., which occurred on November 26th.