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The NOVA SCOTIA MEDICAL BULLETIN



# Editorial

## Picking Pockets and Picking Brains

We are all too well acquainted with drives for funds. All for worthy causes, but drives none the less. Here is a new drive, worthy, we think, in its own way. A drive, not to pick pockets but to pick brains. Time and again during the Preceptorship programme in the last three years students have remarked on the many 'treatments' given by their Preceptors which are not to be found in any text.

This was confirmed by a visitor from 'Down Under' last summer, who agreed that continuing education is not alone a matter of research into more of the things learned as undergraduates, but of many matters not touched in the curriculum of the Medical Schools. The Postgraduate Committee of the College of General Practice is aware of this, hence the Brain Picking'.

Many a veteran Practitioner has tips and wrinkles, gained perhaps from his teachers in a past generation, perhaps from his father, perhaps from his senior partner, in practice, and perhaps he has developed by himself and which gives him an 'edge' in the battle against disease. These 'clues' are what we now want to pick from your brains — for who would want to keep to himself such pearls as the following:

> A child is in danger of becoming dry and you have to impress the mother that fluids should be forced. The trick — order 1 ounce of syrup of wild cherry in a dropper bottle. Tell parent to dilute this "medicine" by putting exactly 12 drops in a glass of water. Figure fluid needed (glass of water 180 cc) and prescribe the "medicine" three or four times daily as needed. Even the mother becomes an active participant in the treatment.
>
> Note in the case of "boils". There is often the tendency for certain people to have recurrent boils. Many patients have been treated with penicillin only. Isn't this treating the germ and not the patient? With the knowledge of immune processes of the body this does not suffice. Besides other investigation, as urinalysis, hygenic advice etc., it would be advisable to immunize such a patient by antigen, plus antibody. This can be done with Staph-Strep Serobacterins. In this way the patient and not the germ alone is treated.

Elementary perhaps? But not to be found in the standard texts. It is the priceless wisdom of the man who has been in practice for some years, and for whom experience has been the Professor of Continuing Education, and who has profited by his course of study.

Who has gems of like price? To any of our readers we say, let us have your experience that we may share it with those less fortunate. You too may have a part in the continuing education of us all.

W.A.C.

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OF
THE CANADIAN MEDICAL ASSOCIATION

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# The President's Page

This is the time of year for reflections. Have we as a Medical Society accomplished all that we might have in 1963? Can we do better in 1964, and if so, how can it be done?

There is sound basis for believing that the organization within The Medical Society of Nova Scotia is one of the best in Canada. We therefore should have been expected to initiate some changes for the betterment of medical practice. I think we did this, and here are some of the major achievements:

1. Sponsored projects under Federal-Provincial Grants on:
   Maternal and perinatal morbidity and mortality,
   Biochemical diseases of infancy,
   Uterine cancer,
   Erythroblastosis.
2. Recognized the need for further post-graduate education and has agreed to double the individual member financial contribution to the Dalhousie Post-graduate Department.
3. Made a grant of $10,000 to the Dalhousie Fund over five years to ensure the future of Undergaduate Medical Education.
4. Agreed to set up a Specialist Register.
5. Presented to the Government of Nova Scotia and the public a plan for voluntary Medical Services Insurance, to make it available to all.
6. Set up a joint high level study committee between The Medical Society of Nova Scotia and M.M.C. to seek solution of problems between the Society and its off-spring.
7. Reactivated discussion with other Medical Societies re single prepaid plan for Medical Services Insurance for the Atlantic Provinces.
8. Published an up to date and more equitable schedule of fees.
9. Established liaison with the N. S. Barristers Society and appointed an active Medical-Legal Committee.
10. Accepted application of eleven sections within the Society, seven of which have already been fully approved.
11. Agreed to sponsor a Nova Scotia Cancer Registry under Provincial Health Grants.
12. Initiated regular meetings of the Officers for urgent Society matters.
13. Submitted application to Federal-Provincial Grants for a Research grant "To study the distribution of physicians and facilities to fulfil the unmet needs of the population of Nova Scotia."

14. Sent a full complement of nine members to the C.M.A. Council Meeting.

15. Recognized by the C.M.A. by its selection of Dr. D. I. Rice as one of the five members on the C.M.A. Committee on Policy.

16. Had a wonderful Annual Meeting at Yarmouth, well attended, with good debates, and many accomplishments.

1964 is a brand new year. What lies ahead?

1. The Government will probably establish its committee on Medical Services Insurance. This will mean numerous meetings, with a mutually satisfactory outcome, though not without considerable infighting and a strong and united Medical Society.

2. The proposed change to a Council form of government for our Medical Society has been referred to each of the ten Branch Societies. Result?

3. The Specialist Register needs some legal aid and further negotiation will be necessary with the Provincial Medical Board, who will probably adopt it.

4. The Society will be asked to change some by-laws. In fact, it may be asked for a thorough revision of the by-laws.

5. The Medical Economics Committee will continue to negotiate with Government in order to up-date our agreement regarding "welfare patients".

6. The 1964 Annual Meeting is September 14-17 at Keltic Lodge — wonderful accommodation, new swimming pool, beautiful setting — much to discuss, many friends to see.

What else? — "Tuum est"!

The Medical Society has been wise and fortunate in its choice of committees. The effort and vigor and time, freely and sincerely given by key men of our Society in their interest for the betterment of medical practice has been inspiring to all of us.

Let us resolve for 1964 to give these men a pat on the back, to think Provincially rather than locally, to criticize wisely and constructively, with the full realization that all are working in the interest of everyone and each to the same end.

A very Merry Christmas and a Happy New Year.

Clarence L. Gosse,
President

# A Plan
# For
# Medical Services Insurance (Nova Scotia)
# Proposed By
# The Medical Society of Nova Scotia


— October, 1963 —

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Prepared by the Special Research Committee. Approved by the Annual Meeting of the Society, July, 1963. Final presentation approved by Executive Committee, September, 1963.

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# MEDICAL SERVICES INSURANCE
# NOVA SCOTIA

**A plan proposed by The Medical Society of Nova Scotia**
**(The Nova Scotia Division of the Canadian Medical Association)**

## I. Introduction.

"Health Insurance" is a subject which has received the attention of the medical profession and the public since the 1920's. It has been endorsed in principle by the medical profession of Canada since 1936. In general, there were to be two steps toward Health Insurance, the first being Hospital Insurance, the second Medical Services Insurance. "Medical Services" have traditionally meant Physicians' Services. With the phenomenal increase in knowledge and techniques, medical services now mean not only physicians' services as provided to the patient but also those ancillary to physicians' services which are under the direction of the physician. It is recognized that these services are closely inter-related; nevertheless it is the intent to deal primarily with Physicians' Services Insurance in this presentation.*

As early as the 1930's, the profession of Medicine in Canada had developed methods of making insured physicians' services available to those of the population who could afford the payment of premiums. This resulted in the development of voluntary, non-profit, physician-sponsored, prepaid plans. There are 12 such plans throughout Canada, all associated in Trans-Canada Medical Plans (T.C.M.P.). The Medical Society of Nova Scotia in 1948 established Maritime Medical Care, Incorporated. The effectiveness and popularity of these plans together with the increasing complexity and cost of Health Services have resulted in pressure to extend insurance benefits to all.

## II. Background.

At the Annual Meeting of the Society, 1960, resulting from discussion of the Canadian Medical Association statement on Medical Services' Insurance, the following resolution was adopted unanimously:

> "THAT The Medical Society of Nova Scotia at its General Meeting (1960) goes on record and is in accord with a plan for Medical Services' Insurance for Nova Scotia so that the highest possible quality of medical services will be available irrespective of income; and furthermore, The Medical Society of Nova Scotia believes that this can be brought about by the united efforts and co-operation of existing agencies interested in and responsible for the health of the people of Nova Scotia." CARRIED.

The implementation of this resolution resulted in the appointment of a Special Research Committee in September of 1960. The approved terms of reference for the Committee were as follows:

1. That the Committee formulate a plan or plans which would make available to all people of Nova Scotia an adequate medical care service of high quality.
2. That the Committee carry out such studies and investigations as may be necessary in the formulation of such a plan.

Such studies will include the following, but may also encompass any relevant matters necessary to fulfil the purpose stated above:

(a) A consideration of the present methods of financing and providing medical care in Nova Scotia.
(b) A study of medical and para-medical resources present and projected.
(c) An estimate of the major unmet medical needs.

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*(Part 1 of **Brief from Nova Scotia Government to Royal Commission** states in the first paragraph of the **Summary**:

> "A casual perusal of the material contained in this Brief will indicate the wide range of 'Health Services' available in varying degree to the citizens of this Province — it will also soon become clear that the major element in health service is medical care and here the major component is physicians' services. Closely associated are the nursing and ancillary medical services necessary to make a medical care programme operate successfully.")

(d) An evaluation of the factors responsible for such unmet needs.

(e) An evaluation of the effectiveness of the existing medical insurance plans, whether voluntary, non-profit, commercial or governmental, with respect to the extent of coverage for the insured individual an the extent of coverage of the population.

(f) An evaluation of the strengths and deficiencies of voluntary prepaid, commercial and government-financed medical care plans in other areas of the world.

(g) A consideration of the effect of such plan or plans on medical education and research.

Following a meeting of the Special Research Committee on December 20, 1960 a letter was sent to the Honorable Minister of Public Health informing him and the Government of what the Medical Society was undertaking. This was followed by a meeting with the Minister of Health on December 29, 1960. A reply from the Minister was received on January 18, 1961. In January a le'ter was sent to Mr. E. Urquhart, Leader of the Opposition, Nova Scotia Legislature and Mr. M. J. MacDonald, Leader of the C.C.F. Acknowledgement was received from each of these gentlemen. The Minister of Public Health offered the co-operation of his Department.

In December 1960 the Prime Minister of Canada announced his intention to appoint a Royal Commission on Health Services. This resulted from communications from the Canadian Medical Association, requesting that such a move be taken by the government. At the Executive Committee meeting on February 4, 1961 the Special Research Committee was directed to prepare a Brief to the Royal Commission which would represent the views of The Medical Society of Nova Scotia. However, it was not until June 1961 that the members of the Royal Commission were named and the terms of reference were made available.

The Chairman of the Special Research Committee and the Executive Secretary attended a Canadian Medical Association conference on terms of reference in July at which time there was an intimation that Nova Scotia might be the first province visited by the Commission, but this was not a known fact until August. The Nova Scotia Division was notified that the hearings in Nova Scotia would be on October 30 and 31 and the Commission required 25 copies of the Brief not later than October 15. This urgent situation was met by the Special Research Committee presenting to the Executive Committee at a Special Meeting on September 9, a draft of the proposed Brief and again on September 30, the final draft of the Brief.

The Special Research Committee had initiated inquiries as early as January 1961. These included solicitation of views of groups or individual physicians either directly or through Branch Societies; inquiries as to the number of "medically indigent" as well as the marginal group; a questionnaire was sent to 89 physicians throughout Nova Scotia to appraise "Medical Manpower"; a student assistant had undertaken the projection of a Community Survey covering some 3,000 members of households in various types of communities throughout Nova Scotia. A professor of economics was allotted the task of preparing an estimate of the number in Nova Scotia who would require financial assistance in meeting the costs of premiums for Physicians' Services Insurance.

The additional stimulus of an interval of six weeks in which to prepare a Brief for the Royal Commission found the Special Research Committee with a general outline of basic information which was expanded by the preparation of a Supplementary Brief to the Royal Commission in September of 1962.

Since 1960 the Special Research Committee has kept in close contact with all developments and has made a study of the conditions which pertain in Nova Scotia. The Medical Society can see no valid reason for changing the basic recommendations made to the Royal Commission in relation to a recommendation for the extension of Physicians' Services Insurance to all residents. In the Brief, the Medical Society placed Physicians' Services Insurance as the third recommendation in the listing of priorities, being preceded by the necessity for additional trained personnel and improved facilities for diagnosis, treatment, rehabilitation and prevention of mental and physical disabilities.

## III. Recommendations

The recommendations of The Medical Society of Nova Scotia are:

A. Relative to **Physicians' Services Insurance**:
   1. That physicians' Services should be made available to all residents of Nova Scotia on a prepaid basis.
   2. That any plan for prepayment should be voluntary in nature.
   3. That Physicians' Services Insurance be **comprehensive** and thus include physicians' services associated with diagnosis, treatment, rehabilitation, and prevention of disease.
   4. That financial assistance for those unable to pay for such insurance should be provided by Government.
   5. That services under comprehensive Physicians' Services Insurance be provided only by doctors licensed to practice medicine.

B. Relative to **the insuring mechanism**:
   1. That contracts for comprehensive medical care should be free of medical exclusions or waiting periods.
   2. That, to assure comprehensive coverage, a responsible accrediting body be established to examine any plan submitted by insuring agencies to determine whether it merits accreditation.
   3. That Maritime Medical Care, Incorporated is a suitable insurance agency. Its Group Comprehensive Contract without waiting periods and medical exclusions would contain the minimum requirements of a comprehensive physicians' services plan.
   4. That the medical profession should continue to subsidize with professional services those individuals identified under the Social Assistance Act (1961) providing Maritime Medical Care, Incorporated be the sole carrier. Approximately 10,000 of the 22,000 so identified already receive comprehensive medical benefits as per agreement between the Government and The Medical Society of Nova Scotia. (See page 8).

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The Medical Society of Nova Scotia agrees with the statement by the Government of Nova Scotia in their Brief to the Royal Commission on Health Services, namely:

> "That before seriously considering any scheme for medical care in this province there must be careful consideration as to its feasibility and methods of financing.,,
>
> (From Part 1, October 1961, Summary XII).

## IV. The Determination of Those for whom Financial Assistance will be Required.

The population of Nova Scotia is approximately 770,000. With the objective of making available to all residents a plan for Physicians' Services Insurance, there are three groups to be considered.

**Group 1.** Those who do not require financial assistance to meet the costs of insurance.
**Group 2.** The "Welfare Group". The individuals in this group are identified under the Social Assistance Act 1961.
**Group 3.** Those who will require complete or partial financial assistance by Government to meet the cost of premiums for prepaid physicians' insurance, i.e., those with low or marginal incomes.

### Group 2. Welfare Group.

In 1949 the Government of Nova Scotia approached The Medical Society of Nova Scotia to propose a Plan for the provision of physicians' services to certain groups of beneficiaries under welfare legislation. An agreement signed in 1950 is, with slight change, still operative. The basis for the agreement was that the Department of Welfare would pay a predetermined

amount per month per beneficiary to a mutually agreed agent, Maritime Medical Care, Incorporated. Since this amount covered only a fraction of the cost of the necessary care, physicians shared financially with government in the responsibility of providing comprehensive physicians' services to this group. Each year the Department of Welfare receives from Maritime Medical Care, Inc. a financial statement of funds received and disbursed; also each year The Medical Society of Nova Scotia and the Department of Welfare have the opportunity to review the previous year's experience and arrive at a mutually satisfactory financial agreement for the ensuing year.

Currently there are approximately 10,000 individuals who are entitled to receive medical services under the present agreement. These are recipients of Mother's Allowances, including their dependents, and the recipients of Blind Pensions from the age of 17 to 70. In addition to the foregoing, the Social Assistance Act provides only welfare benefits to the following:

1. The disabled.
2. The Old Age Assistance Group (65 to 70).
3. The Children's Aid Group.
4. Several smaller groups such as deserted mothers, women whose husbands are in prison, etc.

These four groups comprise some 12,000 individuals already identified under existing legislation, who could be added to the present "Welfare Group", making a total of 22,000 who could receive medical benefits under the agreement between Government and the Medical Society.

It is to be noted that the Committee on Medical Economics of this Society has initiated discussions with the Department of Welfare with the intent of

(a) updating the agreement of 1950 and
(b) including these additional recipients of welfare under the agreement.

The development and operation of this plan for the Welfare Group is indicative of the belief of Nova Scotian physicians that Government financial participation in the provision of physicians' services is necessary for the Welfare Group.

### Group 3. Those with Low and Marginal Incomes.

This group includes those either without financial resources, or with only marginal resources from which to pay the cost of premiums for Physicians' Services Insurance and does not include those already identified under the Welfare Group.

There are those who doubt that Medicine should undertake to recommend methods by which these individuals would be identified. While it is recognized that Government will have its own approach to this problem, Medicine has devoted considerable study to it.

In general terms, there are two methods of approach. One is to determine the number on municipal and other forms of relief but not covered by the Social Assistance Act. This group is variable in numbers and difficult to identify. The other approach is to use income tax returns as a basis for identification; to determine a figure up to which there would be complete financial assistance and a figure beyond which there would be partial financial assistance and a figure beyond which there would be no financial assistance toward the cost of insurance.

At present there is considerable attention being given to the principle that when the exemptions result in no taxable income, such would be accepted as evidence of financial inability to pay; and that up to a certain level of taxable income partial financial assistance would be provided to pay the cost of insurance.

Those in favor of a tax supported, compulsory programme for the whole population object strenuously to a "means test". The Medical Society of Nova Scotia had given close study to this matter and has the conviction that there can be no valid objection to a "means test". (See Appendix P. 14). On the contrary, there would be no compulsion in that any individual would have the choice of making application for financial assistance to pay premiums and so would have the choice as to whether he would become a subscriber to the plan.

The following are estimates of the number requiring either full or partial governmental financial assistance based on the number currently receiving Welfare aid from either Provincial or Municipal sources and the number whose income is less than $2,500.00 per year.

Accurate figures for either of these categories are not available, with the result that different figures have been used by various investigators. Figures from three sources appear in the following table:

| Nova Scotia | Number requiring total assistance | Number requiring partial assistance | Grand Total |
|---|---|---|---|
| C. M. A. Brief | 88,000 | 176,000 | 264,000 |
| N. S. Brief | 100,000 | 138,000 | 238,000 |
| Dr. Peter Gordon | 60,000 | 176,000 | 236,000 |

The figures in the Canadian Medical Association submission entitled "Cost and Ability to Pay for Medical Services' Insurance in Canada and its Provinces" are based on federal average (page 20) "That approximately 25% of the non-taxable segment of the population might properly be considered to be potential welfare recipients" and so would require government financial assistance to the total cost of Physicians' Services Insurance.

On page 24 of the same submission, it is assumed that 50% of the non-taxable group may be eligible for partial assistance. In short, the size of the partial assistance group is estimated by doubling the Welfare figures.

The figure from the Brief of The Medical Society of Nova Scotia to the Royal Commission is not a calculation, but is the actual number who have been recipient of provincial and municipal welfare for a period of at least two weeks in the year of survey. This approach has the defect that persons may have been the recipients of welfare for separate, short periods and so have been counted more than once. This results in an over-estimate of the actual number of persons.

We estimated the number requiring partial assistance by subtracting the number of those whose income is in excess of $2,500.00 (allowing for the provincial average of four persons per family) from the total population of Nova Scotia in the year of estimation, and from the remainder, subtracting those who were recipients of welfare and applying the 50% formula. Thus:

$$684{,}717 - 308{,}520 = 376{,}197$$

$$376{,}197 - 100{,}000 = 276{,}197$$

$$\frac{276{,}197}{2} = 138{,}000$$

Because of the obvious difficulty in determining the number in this group, Dr. Peter Gordon of the Department of Preventive Medicine Dalhousie University, undertook a study of the problem. He estimates there are 60,000 requiring full financial assistance by adding to the number of recipients and dependents who benefit from public assistance each month, the estimated number of persons over seventy years of age who are needy, plus the children and people being cared for in municipal homes and institutions, thus:

$$32{,}379 + 25{,}000 + 2{,}622 = 60{,}000$$

### V. Estimated Cost for Financial Assistance to Meet Cost of Insurance or Premium Charges.

It must be recognized that the following is only an estimate. Furthermore the estimate is based on the assumption that half of those requiring partial assistance will receive a two-thirds subsidy of their premium, while the other half will receive a one-third subsidy:

**Estimated Cost of Subsidization**

| | Yearly cost of those requiring full assistance | | Yearly cost of those requiring partial assistance | | Totals |
|---|---|---|---|---|---|
| CMA Brief | 88,000 x $25.* = | $2,200,000 | 176,000/2 x 2/3 of $25. = | 1,467,000 | |
| | | | 176,000/2 x 1/3 of $25. = | 735,000 | |
| | | $2,200,000 | | $2,200,000 | $4,400,000 |
| Brief of Medical Society of N.S. | 100,000 x $25.* = | $2,500,000 | 138,000/2 x 2/3 of $25. = | 1,150,000 | |
| | | | 138,000/2 x 1/3 of $25. = | 575,000 | |
| | | $2,500,000 | | $1,725,000 | $4,225,000 |
| Dr. Peter Gordon | 60,000 x $25.* = | $1,500,000 | 176,000/2 x 2/3 of $25. = | 1,467,000 | |
| | | | 176,000/2 x 1/3 of $25. = | 733,000 | |
| | | $1,500,000 | | $2,205,000 | $3,700,000 |

*The $25.00 premium is based on calculations of 1961.

## VI. Summary

1. This plan incorporates the position of the Canadian Medical Association and The Medical Society of Nova Scotia as presented in their respective Briefs to the Royal Commission on Health Services.

2. The Medical Society wishes to emphasize that it deals primarily with Physicians' Services Insurance which is an integral component of Medical Services Insurance and which in turn is part of the broadest term Health Insurance.* (Appendix p. 15).

3. The plan is a portrayal of principles, any one of which we are prepared to expand into detail with the objective of a plan for Medical Services Insurance in Nova Scotia. Our studies of this subject are to continue.

## Appendix
## Means Test

The application of a "means test" or equivalent method of identification for those who require complete (including Welfare Group) or partial financial assistance does not in our view conflict with the principle that good health services should be available to all. Even socialistic governments use a means test for the other necessities of life such as food, shelter and clothing. Indeed, the Saskatchewan Government has used a means test since 1947 in its Hospital Insurance Plan and similarly in the 1962 Medicare Plan, although the label has been studiously avoided.

There is no inconsistency in the use of a similar means test method in the provision of financial assistance for Physicians' Services Insurance. Indeed, the very structure of income tax levels is based on the recognition by Government that there are families and individuals whose incomes are so low that they are not required to contribute taxes out of their income directly to the cost of government services in spite of the fact that they are in the main able to support themselves.

Helmut Schoeck in his work, "Financing Medical Care, an Appraisal of Foreign Programmes" expands this thought in the following terms:

Page 18. **"The Means Test Versus the Needs Test."**

If a government health plan tenderly avoids asking questions about financial circumstances (although many other government agencies do not), it must inevitably start asking questions about physical circumstances: the means test is thus replaced by a needs test. It is difficult to see why a discussion of mortgages, obligations and assets should be more painful than a discussion of whether or not a certain piece of surgery is necessary or just convenient and cosmetic.

"Those who deplore welfare measures requiring a means test miss a significant point. All we can ever do is to replace a means test by a needs test. This has been abundantly demonstrated in all nations which have introduced compulsory government systems catering to specific human requirements".

Page 32. **"The Means Test After All".**

"Even the National Health Service provides for a means test although the original intent of the Health Act was to make medical care as free as the air. This, in practice, turned out to be a sure scheme to bankrupt any government. Therefore, more and more charges for specific services had to be introduced although violently protested by the Labour Party.

"The significant point is this: All of these required charges which every patient must pay before using the National Health Service, are reimbursable to anyone 'who convinces the proper authorities that payment would entail undue hardship'. In other words, the means test again, but this time lack of means has to be shown before money paid can be refunded by the government. Anyone who has tried to get a refund from a tight-fisted bureaucrat would agree that the means test would be much less painful if those without means did not have to pay in the first place. Have Britons refused to seek refunding under a means test? From 1952 to 1958, over three million pounds, about $9 million, of prescription charges were refunded to 'needy persons'. Not even such a comprehensive scheme as the National Health Service can exist without a cost-sharing feature which in turn makes it mandatory to reinstate a means test".

## Appendix
## Health Insurance

Under Health Insurance should be included the provision of home nursing services, prosthetic appliances, drugs, etc. Drugs will be a very expensive item if all are included; however, there is justification in considering coverage for continuation in the home of those drugs related to mental health, cancer and possibly one or two other diseases.

Currently, diabetic preparations are provided without charge on the basis of a means test as are the tuberculostatic preparations for treatment of tuberculosis without a means test.

We consider these to be Extended Health Benefits.

Dental services should also be included and it is our understanding that the dental profession is studying this.

# A Plan For Medical Services Insurance (Nova Scotia)

This plan recognizes that it is but one facet of the broad objective of Health Insurance and that within the scope of Medical Services Insurance are (a) physicians' services, (b) services ancillary to and under the direction of physicians (physiotherapy, etc). The plan deals primarily with Physicians' Services Insurance. In an additional attempt to clarify the approach of the Society, factors such as provision of selected drugs on an insured basis are identified as Extended Health Benefits.

In the Brief to the Royal Commission on Health Services, the Medical Society placed Medical Services Insurance as No. 3 in the listing of priorities and the Government of Nova Scotia Brief as No. 5.

## COMMENTARY*

In summary the Plan states:

1. That The Medical Society of Nova Scotia is in favour of prepaid Medical Services and that the proposed plan has the support of the medical profession.
2. That physicians' services should be available to all on a prepaid voluntary basis.
3. That it should be comprehensive with no medical exclusions or waiting periods, and thus include physicians' services associated with prevention, diagnosis and treatment of disease, and rehabilitation.
4. That financial assistance in varying degree be provided by government to those unable to provide completely for themselves.
5. That services be provided only by doctors licensed to practise medicine.
6. That an accrediting body be established to examine any plan for physicians' services insurance submitted by insuring agencies to see that it meets minimum requirements, which might well be those of the Group Comprehensive Contract of M.M.C.I. without exclusions and waiting periods.
7. That "providing M.M.C.I. be the sole carrier" the government and Medical Society continue the arrangement begun in 1950, and reviewed annually, whereby those included in the "Welfare Group" receive physicians' services at a markedly reduced fee.

It is also proposed that consideration be given to provision of medical benefits to those identified under the Social Assistance Act (1961). This would increase from approximately 10,000 to approximately 22,000 the number receiving medical benefits in the "Welfare Group".

The President of The Medical Society of Nova Scotia in the Newsletter Vol. III, No. 2, November 1963, paid a justifiable tribute to the members of the Special Research Committee — a tribute to which every member of the Medical profession in Nova Scotia must subscribe — for the time and thought and energy they have put into the production of this Plan. He states "our Plan for Medical Services Insurance was presented to Government on Monday October 21st. From the Nova Scotian press, reports across the country, and from personal communications it would appear that the Plan has received fairly general approval. There is little doubt that the stature of our Medical Society has been enhanced in the eyes of other Medical Societies in the country, and that we as a profession have created a favourable impression among the people of Nova Scotia."

The opening paragraph of the President's comment is, to this reviewer, somewhat premature since the press editorials reviewed to date have studiously avoided showing opinion for or against the Plan as such. They have contented themselves with a review of the principles involved, and have pointed out the obvious complexity of the whole subject, dependent as it must be upon Federal aid, and perhaps the findings of the enquiry by the Royal Commission on Health Services, which has still to be heard from, and on the importance of the details of any such Plan, details of which can be highly controversial.

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*We are indebted to Dr. F. Murray Fraser for these comments and the summary of reaction across the Province and across the country.

The Chronicle-Herald Ltd., Halifax, October 24th is cautiously favourable, saying " . . . In sum, the plan is of the sort which should commend itself to the majority of Nova Scotians . . . "

While the press is mostly non-committal on the Plan itself it is unanimously congratulatory on the **presentation** of the Plan for two reasons:

(1) It is the first time a provincial Medical Society has taken the initiative and presented to a government, which up to the present has taken little **active** interest in the subject, a plan for Medical Services Insurance, and

(2) by so doing at this time the Medical Society has attempted to remove the subject from the political arena, so that a workable plan, satisfactory to all concerned, may be developed in a calm, thoughtful, non-political atmosphere, which the importance of such an endeavour certainly merits.

Several commentators have emphasized the fact that the Minister of Health, while welcoming the plan of the Medical Society, proposes to proceed with the appointment of his committee of enquiry into **all** aspects of Medical Care.

The Cape Breton Post points out the importance of the selection of the members of this committee:

"in character and ideals the committee should be the most objective and impartial obtainable for this important purpose — their identities will get close scrutiny by people having the public interest at heart".

The Globe and Mail, Toronto, October 26 and 29 feels that the Medical Society has:

"tossed a hot potato into the lap of the Stanfield Government, since the cost of the proposed plan is estimated to be roughly between 3½ - 4½ million dollars, and Mr. Stanfield during the recent election, which his party won overwhelmingly, promised not to raise taxes until the fiscal year ending in 1965."

However, it should be obvious that the potato will have grown nicely cold before implementation of such a plan becomes possible.

The Globe and Mail goes on to ask whether the plan will meet the needs of the people of Nova Scotia.

"In many respects it is similar to the one now in operation in Alberta, a plan which has so far won the support of only about a fifth of the Province's population, and must therefore be viewed with some doubt."

It goes on to say that:

"If the initiative and spirit of compromise exhibited by the N. S. Medical doctors can be communicated to their fellows across the country, it should be possible to avoid a repetition of Saskatchewan's unhappy experience."

Mr. W. E. Fulton broadcasting on C.B.C. in "Maritime Magazine" states: -

"The basic problem causing friction (in any Medicare Plan) is the doctors' view of the position of the government of the province in administering a scheme and the authority it should have in the field. This involves the question: whose responsibility is it to see that every person can obtain adequate medical care? Is it the sole responsibility of the medical profession, of government alone, or a combination of the two? The Government of Saskatchewan was the first in Canada to come to a conclusion — it felt the Government had the basic responsibility . . . the province of Alberta . . . seems to have concluded that the basic responsibility for running the plan is that of the doctor."

"The N. S. Medical Society proposals do not make clear the function of the Provincial Government other than that of subsidizing physicians services insurance. It probably deliberately avoided spelling out the function. . . . The Medical Society has wisely recognized that a provincial Medicare plan is inevitable and has put forward a scheme whereby it would have the real control of administration, with an assist by the Provincial Government in subsidizing premiums for those unable to pay in whole or in part. This plan may well be the one which will be accepted to a large degree by the Government. The Medical Society may win the **short-term battle** in controlling the administration of a Medicare plan in Nova Scotia, but in the long run it will have to resign itself to a greater and greater role by the Government in this field".

Compare this with an article in the Financial Post November 16, 1963 describing how a book dealer, the largest in Alberta, had to close out its school-book section owing to Government competition.

"Ironically, the firm's founder was largely responsible for giving the Government its start in life. Like an unwitting Frankenstein, forty years ago it injected life into a now monopolistic monster by voluntarily instructing the branch's staff on how to set up and operate a text-book supply business. He, who thought he was performing a public service, was actually paving the way for the destruction of the competitive text-book business in the Province."

Is the Government of Nova Scotia correct in its attitude that a medical care program is not yet of urgency in this province?

From the lack of comments appearing in the local press it would appear that such is the case. True, there have been many individual requests for copies of the Plan, but almost entirely from those interested in politics and medicine.

Of the only two comments appearing in the local press under "Letters to the Editor" one is from an obvious advocate of a more and more comprehensive form of "Welfare Statism" and the other from an out-and-out "Apostle of compulsion" where all things medical are concerned.

It should have a sobering effect on all those vitally interested in providing a high quality of medical care for the people of this province to realize that the publication of this plan has brought forth such a paucity of comment, indicating a complete lack of interest. It is on such a fertile field that the seeds of political propaganda are sown, often with such unpalatable results

Let us not delude ourselves. By inviting the Government to participate in a plan of subsidization of medical care of such a nature and financial scope, we are inviting eventual Government control.

Unlike our colleagues in Saskatchewan who saw their professional liberties suddenly and violently snatched from them for purely political purposes, and instinctively reacted against such peace-time compulsion, **our** servitude will be of our own making — slow but sure — a painless process — accepted with resignation by the next generation of physicians and with equanimity by the succeeding one!

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# Dr. Grace Rice

AN APPRECIATION

Dr. Grace Rice, who had been a prominent medical practitioner in Halifax, died at her home in Halifax on November 19, 1963.

Dr. Rice graduated from Dalhousie University in 1903. After two years of medical practice in Northampton, Massachusetts, she took two years of post-graduate work in obstetrics at the Rotunda Hospital in Ireland. Following this, after the usual delay in establishing herself in her new environment, she built up a very successful medical practice in Halifax.

In June, 1954, she was awarded a well-deserved life membership in the Federation of Medical Women of Canada. She was a member of, and a faithful attendant at the various local medical societies. With tolerance and understanding toward all other creeds, she was a loyal church member, who adhered to the tenets of her faith and she passed from life's transitory existence to the state of eternal duration in the repose and comfort of its full communion

Dr. Rice was in retirement for the past twelve years and thus she was not well known to younger members of our profession. Those of us who have trodden life's pathway beyond the time when the shadows are falling toward the west knew her as a good doctor, of fine ethical conduct and an outstanding Christian humanitarian. She helped, by inspiration and other means, to establish younger doctors in the community. Financially and otherwise, she helped many men and women to obtain a better goal in life.

Leaving behind her a life spent in the betterment of humanity, she had the full qualifications and was indeed worthy of one of the finest tributes ever paid to our profession, that of Robert Louis Stevenson:

"Generosity such as is possible to those who practise an art, never to those who drive a trade, discretion tested by a hundred secrets, tact tried in a thousand embarrassments, and, what are more important, Heraclean cheerfulness and courage."

J. W. MacI.

J. MacD. L - Writes:

This past month there passed away in Halifax a member of the medical profession who deserves special recognition and praise. Dr. Grace Rice served the city of Halifax as a general practitioner for more than 50 years. We honour her, not for the length of her service only, but for its quality. Dr. Rice was a woman of exceptional character.

She had good medical training, excellent judgment, a strong vigorous constitution, and a shrewd estimate of others. These together with a wonderful sense of humour made her the pivot around which countless Halifax families and individuals centred for their medical care and advice. She never let them down. Her attentiveness to each patient was one of the things that impressed me most; with her head slightly at an angle she listened carefully to all that

was said, and if the complaint only warranted a laugh and quick reassurance, that was what the patient got. If not, she was very thorough. She never seemed to hurry, but after taking over her practice for her at holiday time, I know something of the volume of work that she accomplished. It was terrific. I also learned the high regard in which she was held by her patients, and to this day I see patients who are recalling their association with Dr. Rice and what she meant to them.

When she started out as a woman practitioner in this city, I am sure she must have met many obstacles and discouragements. Women in Medicine were a novelty, but she set her standards and persevered steadily until she gradually made for herself a position of honour and esteem, not only in the eyes of the public, but, more difficult to achieve, in the eyes of the medical profession of this city. As a woman in medicine, I should like to pay sincere tribute to Dr. Grace Rice for the quiet unswerving type of medical service she rendered in this community. She laid a foundation here for women in medicine, which has made for us an easier road. We must build very carefully upon that foundation so that we do not dim the public image that she created.

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## FROM THE BULLETIN OF 40 YEARS AGO

Medical Society of Nova Scotia Bulletin, December 1923

### DALHOUSIE MEDICAL COLLEGE

The classes in Medicine at Dalhousie University were resumed September 12th. Several additions to the staff of the Faculty of Medicine have been made recently. Dr. Clyde Holland, who won distinction at Dalhousie in both Arts and Medicine, and Dr. Margaret Chase, B.A. Acadia and M.D. Dal., have been appointed to full time positions in the departments of Anatomy and Pathology respectively. Mr. R. J. Bean, formerly of the staff of the Western Reserve University, has been appointed Associate Professor of Histology and Embryology. Dr. E. Gordon Young, Associate Professor of Bio-Chemistry at the Western Ontario University, has been selected as the head of the Department of Bio-Chemistry, but will not assume duty at Dalhousie until the first of the new year. The vacancy in the department of Biology, created by the resignation of Professor J. A. Dawson, has been filled by the appointment of Professor J. N. Gowanloch, recently of the Wabash College staff. The affiliation of Kings' and Dalhousie, which has happily been accomplished, has combined the teaching force of the two universities, and Professor N. J. Symons of the King's foundation, is now giving the instruction in Psychology to the medical classes, while Professor A. S. Walker, also of the King's foundation, is lecturing to the first year students in Medicine on the History of Thought — a new subject which replaces the option formerly allowed.

A new six year course has been instituted, of which the first year only is being given this session. There are classes in the second, third and fourth years of the old six year course, and in the fourth and fifth of the five year course. There are approximately 175 medical students at the University this year.

## BOOK REVIEW

CLINICAL HEMATOLOGY. By Maxwell Wintrobe, M.D., Ph.D., D.Sc. (Hon.), Professor and Head, Department of Medicine and Director Laboratory for the Study of Hereditary and Metabolic Disorders, University of Utah, College of Medicine, Salt Lake City, Utah. Fifth Edition, 1961. Lea & Febiger, Philadelphia.

This hematology text has been built around the skeleton of the previous four editions with certain notable additions and a few 'amputations'. The author has, as before, prepared this book for "the beginning student, the discerning technician, the advanced post-graduate, the clinician, the teacher, and even the biochemist and sophisticated hematologist." This is accomplished in 1,186 pages, divided into 21 chapters each documented by numerous references which total 3256. Each chapter deals with a specific or related topic and all are subdivided in a concise manner — chiefly on clinical grounds.

The book is bedecked with 265 illustrations of which 50 are in color on 19 plates. Numerous tables are used to clarify and underscore facts. Most current advances in the physiology and biochemistry of the hemopoietic system, the hemoglobinopathies and bleeding disorders are discussed. Emphasis is placed on the importance of accurate diagnosis as a prerequisite to good therapy. "Shotgun" therapeutics is condemned. The management of all disorders of the blood are fully described.

As stated by the author, this book is not a laboratory manual although many procedures are briefly discussed. Rather, the principles of procedures and the interpretation of results are emphasized.

The clinical genius of Wintrobe shines through each chapter as physiology, biochemistry, pathology and histology are interwoven with the aid of this book. The practitioner can easily work from the patient to the laboratory test; almost as important, the scientist or laboratory technician can correlate his findings with clinical date.

One has thumbed, perused and studied this text for almost a year and would not be without it. It is recommended especially for the clinician interested in hematology, the student of medicine and laboratory medicine and of course the teacher.

Unfortunately, the Canadian list price of $19.50 puts it out of reach of most students.

V. W. K.

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## OBSTETRICAL EMERGENCY TEAM

The Maternal & Child Welfare Committee of The Medical Society of Nova Scotia wishes to again bring to the attention of the profession the "Obstetrical Emergency Team".

This Team is available to any doctor in Nova Scotia in any obstetric emergency, providing consultation or actual treatment services. We urge the wider and **earlier** use of this service, especially in areas where ordinary consultation services are not readily available. An early telephone consultation does not in any way obligate the physician but does help to anticipate difficulties and hazards. It may also make possible earlier planning for blood transfusion and for transportation arrangements should these become necessary.

Since the inception of the service 3½ years ago, the majority of the calls on the Team have been in relation to antepartum hemorrhage, obstructed labor, postpartum hemorrhage. Other possible situations where the Team might be used are:

Premature labor, the premature newborn, Rh isoimmunization, severe anemia, multiple pregnancies or malpresentations, the seriously ill abortion case, and infections.

The service of the Team is obtained as follows:

Any doctor who wishes to have the services of the Emergency Obstetrical Team is requested to call 422-6501, the Grace Maternity Hospital in Halifax and request "The Obstetrical Emergency Team". The call will be transferred to the Case Room Section where Supervisors are on 24 hour service. The Supervisor will take the calling doctor's name and telephone number and will immediately notify the Chairman of the Maternal and Child Welfare Committee or another member of the Team. This physician will then telephone the doctor concerned to discuss the type of emergency existing. It may only be necessary to consult by telephone. Sometimes arrangements for blood can be made or tentative arrangements for transportation of the Team members or the patient. In some cases, the decision will be made to have members of the Team proceed to the area concerned. The speediest possible transportation will be arranged — either armed services aircraft or by car.

The members of the Team are volunteers from the Departments of Obstetrics and Gynaecology and Anaesthesia of Dalhousie University.

Further inquiries concerning the program should be directed to:

Dr. D. F. Smith, Chairman,
The Maternal & Child Welfare Committee,
Grace Maternity Hospital,
HALIFAX, N. S.

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# Fatal Chronic Bronchitis*

In the United States chronic bronchitis is usually thought to precede emphysema in fatal cases, but a correlation between clinical observation and morphological findings in four patients showed death can be caused by chronic bronchitis.

Chronic bronchitis has been recognized as a pathologic and clinical entity in Great Britain and is widely regarded there as the principal cause of diffuse pulmonary emphysema. In the United States, chronic bronchitis has until recently been regarded as a "wastebasket diagnosis," made when the cause of a chronic cough was not clear. Furthermore, physicians in the United States commonly assume that when British patients die of chronic bronchitis it is the associated emphysema or loss of alveolar walls, which kills them that is, that chronic bronchitis *per se* is a nonfatal disease.

In the present study, for three years the lungs of persons who died from various causes in two hospitals were examined to establish the morphologic basis for the clinical ad physiologic signs and symptoms of pulmonary disease. The studies were initially confined to examination of one lung from each patient by the formalin fume-fixation method in the hope that stereoscopic estimations of parenchymal damage would correlate well with the severity of disease in life.

Early in these studies one case was found in the material from each hospital which clinically was diagnosed as severe emphysema with cor pulmonale and right heart failure, but which showed only mild emphysema morphologically plus hypertrophy and dilation of the right heart. Such apparent discrepancies between the clinical and morphologic findings led to additional detailed studies of the bronchi using conventional staining and fixation of sections from the contralateral lung. Since then, a total of four cases of death due to chronic bronchitis and its complications without severe emphysema have been found.

Pulmonary emphysema is most appropriately defined on the basis of morphologic changes in the lungs. Chronic bronchitis, although now a well-defined morphologic entity, is most commonly defined in clinical terms. However, these two diseases frequently give rise to the same manifestations and often occur in the same patient, making their distinction and diagnosis on clinical grounds alone exceedingly difficult. As for the value of pulmonary function tests to aid in differential diagnosis, there is general agreement on the physiologic manifestations of emphysema, but the value of such testing in bronchitis is not clear because few patients with chronic bronchitis without other diseases, as established at autopsy, have had complete studies of respiratory function.

The revival of methods for studying the lung in the inflated state has recently revived hope of clarifying structure-function relationships in these diseases and, thus, of providing an answer to whether tissue changes are related to symptoms.

No morphologic studies have explained the nature of the process by which cyanosis, pulmonary hypertension, and heart failure occur in these diseases. Cases have been recognized recently with marked cyanosis, pulmonary hypertension, and right heart failure, yet with minimal postmortem evidence of alveolar wall destruction. It has been shown, too, that histologic changes in the small pulmonary vessels in emphysema cannot be regarded as the morphologic basis for the pulmonary hypertension.

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*Reprinted from the Abstracts of the National Tuberculosis Association, May 1963. Printed through co-operation Nova Scotia Tuberculosis Association.

## History of Chronic Abnormality

If neither reduction in the total number of alveolar capillaries nor changes in the pulmonary arteries can account for the pulmonary hypertension of chronic bronchitis and/or emphysema, it would appear that other factors must be considered. Perhaps the most acceptable explanation today depends upon the fact that patients with fatal chronic bronchitis often have a long history consistent with chronic hypoxia and probably hypercapnia; chronic hypoxia has been shown capable of inducing pulmonary hypertension both under natural and experimental conditions.

Careful study of the air spaces and airways in chronic bronchitis gives the impression that chronic bronchitis is, at least in part, a reversible process, especially if rational therapy could be started before the onset of hypertensive changes in the pulmonary arterioles. The bronchial and bronchiolar walls are thickened and inflamed. The epithelium has undergone metaplasia and may no longer have a normal complement of cilia. The bronchial glands are markedly hypertrophied. However, areas of necrosis, that is, bronchiectasis, are infrequent and limited in extent. Fibrosis and alveolar wall destruction were not severe in the four fatal cases and were localized mostly to the peribronchial areas. Judging from the morphology in these cases, therefore, a favorable effect upon the course of this disease might be expected from early intensive therapy, especially if applied before the onset of irreversible changes. This therapy would include the use of appropriate antimicrobials, postural drainage, tracheal fenestration, and avoidance of repeated infections. Such persons obviously should cease smoking altogether and avoid exposure to other sources of irritating air pollutants. Parenthetically, since many cigarette-smoking bronchitics are virtual cigarette addicts, an almost insoluble therapeutic problem is posed.

The clinical identification of chronic bronchitis in a still treatable phase should be possible. The diagnostic features in the four fatal cases included the following:

(1) Severe chronic cough, especially in the morning when a period of strangling over a small amount of sticky mucus was a fairly regular occurrence.

(2) Repeated deep respiratory infections, slow to improve.

(3) Physiologic manifestations suggestive of diffuse emphysema but with slight differences and with slight to moderate rather than marked increase in total lung capacity, and hypoxia and hypercapnia usually out of proportion to the other findings.

(4) The chest roentgenogram, especially the tomogram, often failed to show the paucity of bronchovascular markings seen in classic diffuse emphysema.

Observers in the United States appear not to have given the attention to this disease which its severity, frequency, treatability, and possible preventability merit. Patients and even physicians are too apt to accept and even foster the common label of "smoker's cough," which is given to the early symptom of the disease. A severe chronic cough should be evaluated carefully, well before any disability has been noticed by the patient. By the time most patients notice any disability, the pulmonary functional loss may well have reached 50 per cent or more.

# Personal Interest Notes

To add to our list cited last month of doctors who are active in Civic Affairs we have the following:

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| Shelburne: | Dr. Robert Campbell, elected Mayor |
| Digby: | Dr. D. E. Lewis offering as Councillor |
| Windsor: | Dr. John A. Smith elected as Councillor |
| North Sydney: | Dr. J. S. Munroe, re-elected Mayor |
| Lunenburg: | Dr. R. G. A. Wood, re-elected Mayor |
| Wolfville: | Dr. D. L. Davison, re-offering as Councillor. |

In Dartmouth, City Council approved the appointment of Dr. M. Donald Harlow as a member of the Dartmouth Regional Library for the remainder of 1963. The appointment of Dr. Harlow as a citizen at large on the board was recommended by the Finance and Executive committee to fill a vacancy created by a resignation earlier in the year.

### Congratulations

To the following members of the profession who have been honoured in various ways, we offer our congratulations.

To Dr. A. B. Campbell who was elected president of the Halifax North British Society at the 195th annual meeting on November 5.

To Surgeon Captain C. M. "Bud" Harlow on his retirement after 18 years service as principal medical officer of HMCS Scotian. Following inspection of the ship's company at ceremonial divisions, he was paid a tribute by Commander Bruce Oland and presented with the traditional pewter mug and an engraved silver tray. After active service during the war years, he became director of laboratories at Camp Hill Hospital, a position he still holds, assistant professor of pathology at Dalhousie and consultant pathologist to the Royal Canadian Navy. During the past two years, Dr. Harlow was awarded an honorary doctor of science by Acadia, and was made a serving brother of the St. John Ambulance Corps. He is Vice-President of the N. S. Cancer Society and a national Grand Councillor.

At the investiture of the Order of St. John (St. John Ambulance) held on Nov. 20th, Dr. Charles Lorway MacLellan, Sydney, was made an Officer Brother of the Order. Drs. Joseph Cairns, Halifax, Dewi Robert Davis. Oxford, J. E. H. Miller, Halifax, and James Timothy Snow, Kennetcook, received Priory Votes of Thanks.

To Dr. A. S. Wenning, Halifax, Anaesthetist of the Children's Hospital who has been elected an affiliate fellow of the American Academy of Pediatrics. This is the professional society of specialists for infants, children and adolescents in the Western Hemisphere and has Fellows in the United States, Canada and Latin America.

To Dr. Denis Howell on his election as Vice-President of the Canadian Association of Retarded Children.

Dr. William Cochrane has accepted an invitation to become a member of the Advisory Board of the above association and will take part in a meeting on Dec. 12th in Toronto, called to organize "centennial projects in mental retardation". As a contribution to the Centennial Year, the association has proposed the initiation of 10 major demonstration projects in mental retardation to be in operation by 1967. This proposal calls for development in each province of one or more pilot projects.

A neuro-chemistry centre is being developed in Halifax for detailed study of metabolism in patients with mental disorders (including retardation and emotional troubles) muscular dystrophy, diabetes, etc. Dalhousie University has made space available in the Public Health Building and Dr. Cochrane is coordinator of the plans which must be delayed because of lack of funds.

To Dr. Derek H. Spark, Dr. Alan Frecker, and Dr. Douglas Paulse, recent residents in the Department of Psychiatry, Dalhousie, who have received their certification in the examinations just held.

Dr. Spark will return to work at the Nova Scotia Hospital, and Drs. Frecker and Paulse will return to the Hospital for Mental and Nervous Diseases in St. John's, Newfoundland.

To Dr. Anne Hammerling who was honoured for her work in the Israel Bond Drive at a dinner held recently, attended by the Hon. John Diefenbaker. Dr. Hammerling and her husband Dr. James Hammerling are to be congratulated on the honour won by their daughter, Victoria, in the awarding of a $1000 scholarship for English made by the Beta Sigma Phi for the Eastern Canadian Division of the Fraternity.

"Halifax Losing Top Researcher" is the caption announcing the resignation of Dr. Joseph Stapleton as head of the Victoria General Hospital Radiation Therapy Department, — a department which he has seen develop so tremendously since 1955. A native of Queensland, Australia, he leaves Halifax in January for a new position with the leading American Tumor Institute at the Swedish Hospital in Seattle, Washington. There he will set up a large isotope department and head the postgraduate training school at the University of Washington. He is presently chairman of the Cancer Committee, N. S. Medical Society and Director of the N. S. Division of the Cancer Society. We are sorry to lose him but wish him all the best.

Dr. J. C. Wickwire, Liverpool, N. S., has been attending a course "A Week in Cardiology", sponsored by the College of General Practice held at the Royal Victoria, Montreal, early in November.

Drs. B. Fullerton, Ian MacGregor, and Donald Rice were in Montreal during the latter part of the month to participate in a conference on Undergraduate Medical Education called conjointly by the College of General Practice and the Association of Medical Colleges of Canada. This was a three day conference, the second of its kind to be held.

At the annual meeting of the local branch of the Canadian Cancer Society held recently in Halifax, Dr. A. McCarter of Dalhousie was the guest speaker. Dr. Gordon Bethune was elected vice-president and Drs. John Filbee, J. A. Myrden, Norman Gosse, Jean Lawson, J. K. Hayes, and S. C. Robinson were appointed directors.

The Atlantic Provinces Orthopaedic Society held a Clinical Session and Symposium on Trauma on Saturday, Nov. 2, with Dr. D. L. MacIntosh of Toronto as guest speaker. A conference on psychiatry with Dr. H. Lehman, clinical director of the Verdun Protestant Hospital, Montreal, as guest speaker was also held during the week of the annual Dalhousie Refresher Course which took place during the first week of November. The various clinics were well attended. The Annual Meeting of the Dalhousie Medical Alumni Society was held with over 200 in attendance. Dr. F. Murray Fraser was elected president and Dr. Daniel Murray of Tatamagouche, Honorary President. Dr. Ian Macdonald, an Arts graduate of Dalhousie and presently Professor of Medicine and Director of Postgraduate Medical Education, University of Toronto, chief of service of medicine, Sunnybrook Hospital and D.V.A. advisor in medicine, etc., etc., delivered the John Stewart Memorial Lecture on the subject "The Art of Medicine."

## Births

To Dr. and Mrs. Charles Brennan, (Maura Jamieson) on Nov. 7, 1963, a daughter, at the Niagara Falls General Hospital.

To Dr. and Mrs. G. Ross Langley, (Jean Ballantyne), on Nov. 24, 1963, a son, Richard Graham Ballantine, at the Halifax Infirmary.

To Dr. and Mrs. James Robbins, (Ruth Turner), on Oct. 31, 1963, a son. Jonathan James, at the Grace Maternity Hospital, Halifax.

## Obituaries

We regret to record the death on Nov. 19 at her home, of Dr. Grace Rice, an outstanding general practitioner in Halifax for many years. Dr. Rice graduated from Dalhousie University in 1903 and after practising in Northampton, Mass., for two years, she did postgraduate work in gynecology and obstetrics at Rotunda Hospital, Dublin. Later she resumed practice in Halifax where she continued until her retirement 12 years ago.

She is remembered by many for services when the Maternity section of the Halifax Infirmary was situated on Coburg Rd.

In June of 1954 she was awarded a life membership in the Federation of Medical Women of Canada. The award, one of three at the time, was the first to be awarded since the association was organized in 1924. She is survived by her cousin, Dr. J. H. Rice, dentist of Halifax.

We regret to record the death on Nov. 28th, of Dr. John Cedric Ballem at his home in New Glasgow. For over 50 years he has practised medicine in New Glasgow and was chief of staff of the Aberdeen hospital for many years

and introduced shock treatment at the Pictou Co. Mental Hospital. He served on a number of provincial boards and for some years was on the Provincial Medical Examining Board. We extend sympathy to the immediate members of his family, especially his son, Dr. C. Miller Ballem of Montreal.

### News of Dalhousie University Medical School

The Dean of the Medical School, Dr. C. B. Stewart, gave a paper recently at the annual meeting of the Association of American Medical Colleges, held in Chicago. "With the volume of medical knowledge doubling every ten years the family physician must now face up to a lifetime of continuing study just to keep up with the latest advances in his field".

To aid the embryo doctors now in medical school the following appointments have been made.

Full-time staff: Kinley, C. Edwin, M.D.C.M. '56, M.Sc. (man.), F.R.C.S. (c.) Assistant Professor of Surgery
Hameed, Khalid, M.B., Ch.B. (Pakistan) — Assistant Professor of Pathology

Part-time staff: Graham, Charles, H.M.D.C. '54, F.R.C.S. (C) — Instructor in Surgery
Steele, Bernard Joseph, B.A. (St. F.X.), M.D. (Ottawa), — Instructor in Surgery
Buhr, Alvin J., B.A. (Man.), M.D. (West.Ont), — Instructor in Surgery
Fraser, George MacD., M.D.C.M. '50 — Lecturer in Pathology
Erdogan, Manfred Hermann, M.D. (Istanbul) j Instructor in Surgery (Orthopedics).

(N.B.—Addition)

It should be stated that the money raised by the auction among members of the N. S. Branch of the Federation of Medical Women of Canada reported last month, was in aid of the Mission for Lepers in Korea to which one of our members Dr. Florence Murray is attached, — and not for personal use.

# GENERAL INDEX

## Vol. 42 - 1963

ABBREVIATIONS USED:—Ab. - Abstracts; AWT - Around the Willow Tree; Corr. - Correspondence; Ed. - Editorials; Rev. - Review; 1000 - Thousand Word Series.


## ADVERTISER'S INDEX

NEW

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# What intramuscular iron!

- is absorbed directly into the blood stream as well as the lymph?
- did not cause precancerous tumors?
- causes few and fast fading stains?

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# Answer: Jectofer

- From Astra Research, the originators of Xylocaine, now another product with an internationally proven record of effectiveness and safety.

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