

The NOVA SCOTIA MEDICAL BULLETIN

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Editorial

Tobacco and Life-Insurance

The latest reports from the United States (sponsored by the A.M.A. and by the Department of the Surgeon General) on the effect of smoking on health would certainly have rung the death-knell of any habit less pleasant, less blessed by social acceptance and not based on habituation to an alkaloid. The relationship of bronchial carcinoma to cigarette-smoking is emphasised but the relationship between smoking and other diseases of the lungs and vascular system is better documented than in any previous studies on this continent. Indeed these reports may prove to be as complete as any to come for some time and perhaps as complete as can ever be expected from what is after all a rather crude experiment on a laboratory animal as unsatisfactory as is the human being.

The reports were unusually well covered in the mass media and were favourably commented on editorially but it seems unlikely that there will be any dramatic public reaction to them. Public opinion polls indicate that only a small fraction of the public is sufficiently impressed by the reports to consider giving up the habit, while the tobacco manufacturers openly predict that a number of the middle-aged will abandon them but that this loss will be more than compensated for by the ever-larger population of teenagers who can apparently afford to take up the habit at an earlier and earlier age. Their confidence would appear to be well-founded and their observations may be not without medical significance since, if they are correct, we can expect the age-at-death from bronchial carcinoma to be progressively lower as heavy smoking is indulged in at ever-younger ages.

Apparently unimpressed also by the accumulating statistics are those masters of statistics the life insurance actuaries. It is not so long ago that insurance companies offered lower premiums to anyone making an annual affidavit of abstinence from alcohol. Current medical journals carry advertisements purporting to offer automobile insurance at lower rates to such insurers.

Why are not the life-insurance carriers offering benefits to non-smokers who are by all accounts better risks? The indictment of tobacco as a health hazard is at least twenty years old but insurers still spread the cost of this hazard over the populations of smokers and non-smokers alike. The cost and difficulty of obtaining satisfactory affidavits would be small; secret smokers must be heavily outnumbered by secret drinkers although the insurers presumably carried the latter for many years.

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The very least that life-insurers could do would be to take adequate smoking histories from applicants for insurance. The mere implication that they thought that smoking might affect longevity would impress some members of the public and perhaps especially those who continue to smoke because they 'must die of something', ignoring the fact that bronchial carcinoma occurs at a much earlier age than the other common cancers. Data accumulating in the insurance offices would add to our knowledge and the companies might eventually find themselves justified in allotting dividends to the advantage of a group with a better life experience. It seems only a matter of time before competition between insurers makes some step in this direction desirable. Three small companies in the United States are reported as already discriminating in favour of non-smokers.

The large insurance companies of all kinds are, of course very large investors in industry and it may well be that what we are suggesting is in part that the profits of the tobacco industry be passed on to non-smokers. A twist of irony in the other direction would of course greet the non-smoker when he found himself asked to pay a higher premium than a smoker for his annuity but we believe that they could live with this, — assured by those who should know that he is going to live healthier and longer.

W.A.T.

THE FATAL DISTINCTION

Well renowned is this physician
 And none will say he isn't wise,
 Error, though, in his position,
 In patient's minds he would despise.

He quickly recognized the sense
 In each scientific study,
 But this great weight of evidence
 Leaves his thinking only muddy.

For any patient could divine,
 He'd not practice as he'd advise,
 As with his little neon sign
 He would by habit advertise.

Nor would each patient soon forget
 What this addiction would disclose,
 Myopically, *his* cigarette
 He sees end just beyond his nose.

The value of our lives we graph
 By the things we hold the closest,
 And he may write his epitaph
 In the final diagnosis:

"Here lies the difference implied
 Between knowledge and conviction;
 A man who lived his life and died,
 By the light of contradiction".

EDWARD McCARRON, M.D.

Annual Meeting 1964

The Annual Meeting of The Medical Society of Nova Scotia will take place at

KELTIC LODGE, INGONISH BEACH

Monday, September 14 to Thursday, September 17 inclusive.

The Business Sessions will be held Monday, September 14 and Tuesday, September 15. Wednesday and Thursday will have Clinical Sessions and Social events. Group Clinical Sessions will be the basis for the Scientific Sessions.

The Executive Committee will meet on September 12 and 13 (Sat. and Sunday).

Make your plans to arrive on Sunday, September 13, 1964 for the "Cielidh", Sunday evening, September 13.

Watch each issue of The Medical Society of Nova Scotia Medical Bulletin for progress reports on the Annual Meeting.

Application forms for reservations will appear in the Bulletin in plenty of time — just be sure you take advantage of these and obtain your bookings early to avoid last minute disappointments.

C.J.W.B.

FROM THE BULLETIN OF 40 YEARS AGO

Medical Society of Nova Scotia Bulletin, March, 1924
DALHOUSIE MEDICAL COLLEGE

PUBLIC HEALTH NOTES

Issued by the Department of the Public Health, Nova Scotia
Halifax, N. S., March, 1924

1. SMALLPOX. The Virulence of the smallpox infection is increasing in both the United States and Canada. This appears to be the quite general consensus of opinion among the leading health authorities. In 1922 in the countries named, the number of deaths per 100 cases of the disease was about 4 times that of the previous year. During the epidemic of the mild form of the disease which has been experienced in this Province, the number of deaths which resulted were very few. So few indeed were they, that it was in many cases extremely difficult to impress on the public the importance of adequate control measures.

Familiarity with a mild type of the disease which was comparatively easy of control should not lull us into a false security. It is conceivable that infection from a severe type of the disease may overpower the relatively feeble immunity resulting from an attack of the extremely mild form. It may be, also, that the protection which vaccination affords cannot be relied upon with so great surety against the much more virulent infection. There must be no slackening of the effort to make impossible a wide-spread outbreak, if the interests of the public are to be properly safe-guarded.

John Stewart Memorial Lecture 1963

"ART, SCIENCE, & JUDGEMENT IN MEDICINE"

IAN MACDONALD, M.D., C.M.

Toronto, Ont.

In the bead-roll of distinguished sons of this historic province some names take a special place. They recall lives devoted to the service of mankind and emphasize qualities of character which successive generations recognize to be of enduring value. Our legacy of great lives includes that of John Stewart, who is particularly in our thoughts today, and whose memory we honour in this annual commemorative ceremony in the University he served so well and to which he brought such credit.

All that we are today in medicine is dependent upon the work of our predecessors who advanced the art and science of medicine, preserved its ideals and enhanced its traditions of service and progress. John Stewart was one to whom we owe a special debt. In the thirty years since his death, scientific knowledge has doubled in each decade; social, economic, and political changes have modified the distribution of medical care; and our profession is expanding both in its interests and in its responsibilities. However, the foundations of medicine are unchanged and its fundamental principles remain constant. Thus a knowledge of past experience and of the development of the basic ideas of medicine in relation to the times in which they originated can throw light upon our own problems and sharpen our judgments about them. John Stewart lived during a period when there were great advances in medicine and in contemporary thought and he bequeathed a great example to his successors. It is particularly appropriate that the licensing authority of Nova Scotia, The Provincial Medical Board, should have taken care to keep bright the story of his life work. In proposing that the University inaugurate this lectureship with their support, they not only honour their distinguished past president but they also ensure that the "iniquity of oblivion" should not "blindly scattereth her poppy" and deal with the memory of John Stewart "without distinction to merit of perpetuity".

Any man in my profession would feel honoured to be called upon to deliver the lecture for this memorial occasion. To a student in this School during the latter years of John Stewart's tenure, with a deep respect for the generations of teachers whose devoted labours have raised it to the first rank, there could come no greater satisfaction. I am deeply grateful to those who have chosen me for this distinguished office.

Although I cannot, tonight, make extensive reference to John Stewart's life, one would hope that younger colleagues, on the threshold of their medical careers, would recognize that Nova Scotia and Dalhousie have in him an unique "hero and benefactor", as he called his master Lister and so be encouraged to search out for themselves the biographical details which are so fascinating to those of us who knew him.

His life was unique in time and circumstances. His professional life extended like a great cantilever of years between two soaring peaks of achievement in medicine. The one, Lister's development of antiseptic surgical principles which abolished the mortal tyranny of sepsis from surgical

wards and laid the scientific foundation for modern surgery. The other was the discovery of Prontosil and Domagk's successful use of it in the streptococcal infections so heralding the bright dawn of the sulphonamide era. Think of the remarkable discoveries in science and the advances in the treatment and control of disease made by a conscientious, imaginative and free profession during the six decades between these two peaks of achievement in man's unending battle against infection and disease! Think of what John Stewart and his contemporaries had to learn year by year and day by day in order to keep abreast of the tidal bore of knowledge! Equally important, think of what previously accepted knowledge they had to discard!

We too, have to keep pace with advances in science and the changes in the body of accepted knowledge while preserving and developing the skills and attitudes we have inherited. As science increases the effectiveness of medicine, I believe that it becomes more important for our profession to pay greater attention than ever before to the art of medicine; and particular attention to judgment in medicine. Without these directors and stabilizers, science could well run away with us or lead us into false paths. I have accordingly chosen for my title tonight, "Art, Science and Judgment in Medicine".

We hear and read a good deal about all three. The Editor of The Nova Scotia Medical Bulletin in November 1959 remarked on John Stewart's "excellent judgement". What does this convey to us? Do we all have the same idea of science in medicine or "scientific medicine"? What do we mean by the art of medicine? I am sure there are different interpretations and meanings; and to some extent they will be determined by our conception of that rather expansive word "medicine".

The only reason for the existence of medicine as a profession is to promote health and relieve suffering. A noble and clear conception of our duty is set out in simple words on the tomb of Pasteur, "to cure sometimes; to relieve often; to comfort always". As a consequence of the advances I have referred to, medicine today has vastly more effective means of treating disease and preserving health than existed or were even dreamed of at the time of Pasteur's death in 1895. It is our responsibility to use these diagnostic and therapeutic resources to maximum efficiency.

When patients come to us seeking relief, the fundamental questions we ask ourselves are: what is troubling this patient? ; what can I do to cure or relieve him?; how might this illness have been prevented? While the answers may sometimes be found easily, they more often require all of our art, a wide understanding of science and keen judgement. The effectiveness with which these three are used determine in large measure the quality of medical care. How they are used depends in the first instance on the individual doctor dealing with the individual patient. Like any man, he is bound to be influenced by the environment in which he works, by his background and his attitudes, by his primary education as well as his medical school training, and by his ability to profit by experience and to continue learning after entry into practice. There are less obvious, and indeed imponderable factors, which emphasize that doctors vary as much in their reactions as do the altered biological processes which they encounter in their patients. This is one of the reasons why the methods of science alone cannot be applied to human beings as individuals and why clinical medicine can never become a true science. Art is required as well.

Our ideas of the art of medicine vary and there is a good deal of misunderstanding about its place and usefulness in medicine today. Some misinterpret it as being merely a fancy phrase for "a good bedside manner". This in turn is sometimes thought of as an expression of cold insincerity or even as evidence of medical humbug so mischievously satirized by Bernard Shaw. The fact is that it is an expression of good manners and of understanding and sympathy for sick people; and as such it is part of the art of medicine. We have been reminded recently by Sir George Pickering of the belief of William of Wykeham, the founder of that School of great traditions, Winchester, "manners makyth the Man". Sir George went on to say that in "the alleviation of human suffering the conduct and character of the doctor are at least as important as, perhaps more important than, learning". "The ethos of medicine is of no less importance than the science". He warned that while the science of medicine is progressing rapidly, the ethos of medicine may be lost and incalculable damage to medicine and humanity result. Dr. Charles Gass, the distinguished Stewart lecturer in 1961, similarly spoke of the merit of medicine and of the urgent need to preserve it.

The dictionary defines art as skill — especially human skill — the result of knowledge and practice. It is the property of a lively mind and to be exercised to full advantage it requires experience, versatility and an ability to profit from the experience. In the modern sense, art implies the attainment of the beautiful; and perhaps this is one reason why the old meaning of skill and ability acquired through patient practice and directed to a definite end, has been lost sight of. Painters, musicians, writers and other artists must know a good deal about the foundations of their art and they become skillful in it through practice and experience. So it is with medicine. The study of disease involves, among other things, the study and understanding of symptoms; and these may be induced by either physical or psychological means and they may be modified by either of these reciprocal factors. Thus a doctor must study man as a whole. To practise his art successfully, he must have a sound scientific background and he must possess skill in applying his knowledge and experience to the problems of the individual patient. We know that abnormal conditions in the human body can be recognized through changes in structure and in function. In obtaining the story of the evolution of an illness, art is required, for the details given by the patient must be assessed just as thoroughly as a skilled and prepared advocate would examine a witness. The disease is the crime. The patient is one of the witnesses. Appropriate questions, based on knowledge and experience, must be put to test probabilities and possibilities relating to change in function and structure. A careful physical examination, which requires skill developed from long and careful practice, can lead to recognition of many abnormalities in structure as well as in function. There are an increasing number of scientific techniques available to apply to the study of human beings and these supplementary tests can be used to confirm or exclude hypotheses based on the history and the finding of the physical examination. All these data are recorded carefully and co-ordinated with the data from the history of the illness and the physical examination of the patient. This all seems simple and straightforward; but too often facts in the history are not uncovered, observation is incomplete or inaccurate, and through bias or inexperience the data are not assessed properly. This in turn leads to wrong diagnoses and consequently to wrong decisions. Take the example of the

experienced physician investigating a cough. He will know the various underlying possible causes and of the additional symptoms which might be overlooked by the patient or considered by him to be unimportant and so not mentioned. The doctor's skill, developed on the basis of knowledge and sharpened by experience in practice, will lead him to make an orderly diagnostic approach. If he considers tuberculosis probable he will not order a series of tests which could not possibly prove his hypothesis; but he will apply those which are most likely to lead quickly to the true diagnosis. If he has not been skillful in uncovering all the facts; if he has not been clever in applying his knowledge and experience; if he has not identified the problem and thought about the data; diagnosis may be delayed and unnecessary investigation undertaken. One sometimes sees medical records which include among the data a large number of laboratory and other special tests which to the experienced observer do not contribute either to the diagnosis or to the increasing understanding and knowledge of the particular disease; and yet to inexperienced observers this is sometimes thought to be an exemplary exercise in scientific medicine. It is really an example of a deficiency in art leading to misuse of technological procedures. It is clear that I feel strongly about this, but I hasten to assure you that I am not one of those who looks only at the heel of the medical Achilles.

The art of medicine also involves an understanding of all the complexities of mind and the many shades of human personality with which one meets. A knowledge of human nature is as essential in the equipment of a doctor as is the knowledge of physiological function and the other scientific aspects of medicine. If this knowledge is lacking, both diagnosis and treatment cannot be fully effective in many instances. In the Presidential address to the Canadian Medical Association in 1905, the Emeritus Professor of Surgery in this University said, "Our nature is threefold, and the health and character pertain to each component, the physical, the intellectual and the moral". "As practitioners of medicine we must consider the living man as body, soul and spirit" and he went to refer to some words of Maudsley's in a speech made earlier that year — "mind works in every function of the body". I am sure that the Professor of Psychiatry at Dalhousie today will commend these opinions of John Stewart spoken fifty-eight years ago.

How does one acquire the knowledge and practice which leads to skill in the art of medicine. The foundation is the attitude of mind and the experience which a doctor obtains during his formative years. It is added to during his days as a medical student when his stores of basic knowledge accumulate and he develops an understanding of scientific principles. During this time he also gains an absolutely essential experience without which no individual who treats the sick can even be reasonably successful. This is a close contact with patients. He thus absorbs the meaning of illness and develops the particular sense of responsibility — the moral philosophy if you will — that comes with intimate and continuous contact with the sick. He must learn what he can about the foundations of men's motives, their varying reactions to the trials and tribulations, the joys and sorrows, the fears and hates and the thousand and one emotional impacts of the world in which they live. He must also come to understand that men vary tremendously in intellect and in their philosophies of life. His knowledge of human nature, both in health and disease, can be deepened by turning back to the great minds of the past for I believe that human nature has altered little (if any)

for some thousands of years, though modes of thought have changed. Remembering that many of the problems which confront the doctor are ethical or moral, a young doctor will find the Bible a source of guidance and precept and of accumulated wisdom and experience. The public health measures of Moses, the rather modern reaction of Adam blaming Eve and Eve blaming the serpent, the deep understanding of conscience as evidenced by Cain being permitted to live, and different references to psychosomatic symptoms will all be of interest. In the epic story of Job's patient suffering, his doubts and protests and his clinging to faith in the face of recurring disasters, one will recognize a powerful psychological study with perhaps analogies in life today. He will find useful St. Paul's exhortation that ideas must be expressed in language capable of being understood. There is much of interest too in the classical authors. He will sense that the Greeks believed the inner life of man to be secure against all outside attacks and capable of injury only by himself. "Once an eagle wounded by a dart, said, when he saw the fashion of the shaft, by our own feathers, not by others' hands are we now smitten". These pregnant lines from Aesculus seem particularly applicable today when the conflicts of men with themselves are increasing and it is found so easy, if not convenient, to attribute any unpleasant consequences to an eccentric grandparent or over-anxious mother, or to circumstances in the environment. The list should include English and foreign novelists as well, and of course it must include history. In Shakespeare, the most human of authors, one can find references to emotional reactions as fresh and applicable today as when they were written.

In a conversation with a colleague several years ago, he expressed an all too common misconception that the art of medicine means merely a suave bedside manner too often cloaking a dismal ignorance of science and the scientific method. After he agreed that a chemist could not analyze the bouquet of a wine or determine from his analysis of the paints on a picture, whether it had been painted by a master or by the rankest amateur; and after he admitted that many ideas cannot be caught in the nets of science, he asked me to give a short definition of the art of medicine. I defined it then as the skillful application of science to the diagnosis and treatment of the individual patient taking into account all the variables found in human beings and in their reactions to stress and disease.

Nothing has been said of the different types of technical skill which contribute so much to excellence in medicine. The outstanding example is the skillful surgeon who really practises high art both in diagnosis and in operative technique. He requires not only the aptitude of the artist but he must have also extensive knowledge, wide experience and practice together with manual dexterity and all the other attributes of art.

One of the significant dates in the history of medicine is April 17th, 1616 (six days before the death of Shakespeare) when William Harvey described his discovery of the circulation of the blood to the College of Physicians of London. From that day, early in the century which Whitehead called "the century of genius", "searching out nature by way of experiment" has been the open sesame to medical progress. In the Harveian Oration of 1961, Sir Arthur Thompson concluded that "the only sound basis for medicine is natural science and the scientific method first established by Harvey".

An understanding of method and a knowledge of natural science, chemistry, physics and biology have direct application to the study of man in health

and disease. The doctor must know how to use it effectively in his daily work and be diligent to keep abreast of advances which may be applied to the diagnosis, treatment and prevention of disease. The advances in science useful in understanding man in health and disease most commonly come to the profession through scientific workers in the field of medicine itself. They are important members of the body of medicine and it is hoped that an informed society will support them increasingly so that they may make more and more generous offerings to the main current of medical knowledge. It must be emphasized that medicine draws knowledge useful to it from every source of science and it is those men, scientifically trained and orientated, often working quietly and unknown, who are adding to our stores of knowledge and contributing to advances in medicine and the relief of suffering. They have the "prepared minds" so aptly described by Pasteur as being capable of taking advantage of new discoveries in every field of science — biology, mathematics, physics and all the rest. Dr. Alexander Primrose (who it is of interest to recall, administered his first anaesthetic under Dr. John Stewart's direction in Pictou when still a student) wrote some years ago that "man imbued with the true scientific spirit will often cull treasures of great therapeutic value from the most unpromising sources, and we have no right to discard any scientific truth as irrelevant to practical medicine". He went on to recall that Oliver Wendell Holmes had reminded us "medicine . . . appropriates everything from every source that can be of the slightest use to anybody who is ailing in any way, or like to be ailing from any cause. It learned from a monk how to use antimony, from a Jesuit how to cure agues, from a friar how to cut for stone, from a soldier how to treat gout, from a sailor how to keep off scurvy, from a port master how to sound the eustachian tube, from a dairy maid how to prevent smallpox and from an old market woman how to catch the itch insect". Although one might question the accuracy of one or two of these statements, nevertheless the list could be added to by such things as the discovery of the laryngoscope by a Spanish singing teacher and the development of muscle relaxants from South American arrow poison. Dr. Primrose went on to comment that the men "who culled scientific truth from such unlikely sources were, for the most part, fitted by special training for the work that they accomplished so well". We have examples of this in our own day in Dr. Alexander Fleming's discovery of penicillin; and there are other examples which have been carelessly labelled as "serendipity" but which really emphasize the importance of experience, the power of accurate observation, the catalytic activity of imagination and the productive power of hard thinking in the prepared mind.

In applying our art and science, we constantly exercise judgement. We think of this term as implying keenness of perception or quick insight and the possession of a critical faculty and good sense. It can be taken as synonymous with decision or making up one's mind; for much of our work in medicine involves determining the causes of illness and **deciding** upon the best course to follow. Every judgment originates in the mind; it involves the selection from alternatives and it may be influenced adversely by emotional and wishful thinking and made more acute by experience and knowledge. There is also a danger that judgements may be impaired by unquestioning belief in accepted doctrine. One of Dr. Charles H. Mayo's aphorisms was "Judgement is a great asset; it makes the diagnostician and the surgeon both super men".

It should be emphasized that while medicine, like law, searches for truth it does not demand certainty. If we were required to prove everything in medicine before taking decisive action, we would fail to help patients under many circumstances. St. Thomas Aquinas held that a man's decision may be perfectly correct though the abstract problem has not been settled satisfactorily. Thus we may not be at all certain of the cause and exact site of severe upper gastro-intestinal bleeding but by collecting all possible data about this particular individual's illness and co-ordinating this with known facts about similar problems, and with our experience with many such cases in the past we can exercise judgement and decide on a course of action best suited to the particular problem. More often than not the decision is correct. Judgement involves intense intellectual effort. One assesses the significance of a series of observations and accumulated data relating to a particular patient, correlating them with present knowledge and past experience and considering the influence of the many and variable modifying factors both in the patient and in the disease. No computer could possibly do this for even though a number of correct data could be fed into it, the variables which are inherent in living organisms and in disease could not be digested. Judgement is associated with the mind rather than the will. Rumour, prejudice, suspicion, confusion and wishful thinking, as noted above, tend to becloud issues and dull judgement. Philosophers like St. Augustine had a good deal to say about doubt, truth and certainty. "In matters of difficult decision and doubtful result it is better to incline towards doubt than bend towards certainty". "Anyone who knows himself to be in doubt knows truth and is certain about what he actually knows". "A situation presents itself in which man must take a certain risk for an uncertain gain". These are useful ideas to remember when dealing with the problems of illness.

All doctors sense that their attitudes and personal philosophy may influence diagnostic judgements. William James once said that if men would change their attitudes they would change their lives. If this be true, as I believe it to be, it follows that a doctor's attitude towards his patients and their illnesses will influence his ability or inability to help them. A good example of what I mean can be found in the tendency to be more hopeful when dealing with younger or middle aged patients than when treating patients in the older age groups. The afflictions of the elderly appear intolerable enough to dampen all desire for life and if we forget the wise saying of Sophocles that "no man loves life like him that is growing old" our diagnostic energy and judgement may be weakened and the flame of therapeutic hope burn less brightly than it should. This immediately precipitates us into emotional and moral issues which we cannot debate without impairing our clinical judgement. It seems reasonable to agree with Emerson that "life is a privilege" and with Albert Schweitzer's concept of reverence for life. These are useful ideas for those of us who deal with sickness and suffering.

If illness did not involve the emotions of both patient and doctor, judgement, though still difficult, would become less so. It is thus important to be alert to the factors which may weaken judgement. It is a valuable asset to have an ingrained understanding of where one's primary responsibility lies. There can be no doubt about this; it is to the individual patient and all our art and science is directed primarily to helping him. If in accomplishing this we can, without interfering with the interests of the patient, satisfy the needs of his family and our own need to accumulate experience it is quite

proper to do so. However, if these wishes and needs conflict with the interests of the patient our judgement will be put to a severe test. One could give many examples of a situation like this. A common one is that in which early in diagnostic survey the signs, symptoms and preliminary data all point to the probability of advanced disseminated malignancy without however indicating its site of origin. Further diagnostic advance could only be made through the application of tests which at best would likely be unpleasant and at worst would be painful if not dangerous. The doctor would very much like to establish the diagnosis on a more firm basis and the patient's family are unwilling to accept the probability of a mortal illness because the diagnosis has not been established with certainty and they are well aware that doctors are human. Sound judgement would indicate that one advise against further investigation though of course explaining why. Any decision after this would not be a matter of clinical judgement but of ethical judgement. Modern technology has provided us with a number of very useful diagnostic aids; but some involve risk or discomfort to the patient. It is not good judgement to use a potentially dangerous or even an unpleasant diagnostic test when the information obtained cannot be used to help the patient. We hesitate to take big risks for small returns though there are occasions when it is proper to do so. A human life, like a ship, should not depend on one anchor. It is never proper to take even a small risk for no return whatever. There are many occasions in which discomfort and risk can be accepted because the probabilities point to a curable or a partially remedial condition which might quickly pass into an irreversible stage if not dealt with quickly. There are other situations in which the assessment of evidence may lead to some wrong conclusions; and in some of these the fault is in judgment. Judgement may be faulty in assessing the history of the illness such as when angina is misinterpreted as spondylitis or when serious structural disease is overshadowed by intense anxiety. The increasing number of powerful therapeutic agents tests our judgement very frequently for it is an axiom that anything which does good may also do harm. The constant principle upon which judgement about human illness must be based is assessing the probable risk in relation to probable and sometimes possible gains. All this implies that observations have been accurate and that there is full understanding of the mode of action of a drug, its various side effects and its long term effects, as well as the different factors which might accentuate these effects.

It is not to be understood that judgements in medicine are negative in the ordinary sense. Every judgement is really a positive decision. It is exercised constantly, as I have said, in all our work; and although I have stressed diagnosis and treatment I believe I implied that it must be used in every situation in which a doctor or a scientist finds himself, I think it is particularly important that we show judgement, good sense if you will, in teaching both undergraduates and graduates. If our objective is to graduate students with a basic store of knowledge and an understanding of the scientific method and the application of science to biological problems, together with a background which will enable them to continue learning through their professional careers, it would be bad judgement to attempt to stuff their minds so full with facts that there would be no time for them to think, let alone enjoy imaginative thinking. We should remember that the human mind can assimilate only so much and to attempt to over stuff might well lead to stifling of thought and perhaps not even leave enough room for sanity! It is not good

sense to forget this; for if we do, the student will be burdened with too much detail and too often would acquire false values. Perhaps most important of all, may be the inclination to put an inordinately high value on knowing facts and details and a correspondingly low value on the importance of accurate observation, the gathering of data about history and physical findings and the need for logical thought.

Cultivation of our art, diligent study of science and exercise of sound judgement are the foundations of high quality medical care and of steady advance in preserving health and treating disease. Let there be no misunderstanding about the relative place and importance of art and science in medicine. Modern medicine would not exist without science; but without art at the bedside, science would dehumanize medicine; and without judgment both would become ineffective, if not a menace. To the sufferer seeking relief from his afflictions, to the country interested in the health of its citizens which is the true source of wealth and power, it is of incalculable value to have in existence a professional group with wide knowledge of medicine, skilled in searching out the secrets of nature and with the ability to form sound judgements. Let us cultivate all three and so increase the beneficial power of the lever of science by placing the fulcrum of judgement and art in the proper place.

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THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
2ND ED., MACMILLAN CO. NEW YORK 1955, P. 1331.

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Dr. Perry S. Cochrane

AN APPRECIATION

I have been asked to write a tribute to my old colleague and friend Perry Cochrane.

His confrères and the community have been deeply concerned by his illness this past year and in the later days the community hospital has been very glad to ease his burdens. He had become so much a part of the hospital and community that his loss to both seems irreparable. For about forty years Perry and I worked together and our association was marked by a mutual respect and trust.

Perry Stanley Cochrane was born at Fox River, Cumberland County, sixty-three years ago, and he always carried in his heart the warmest feelings for this part of his native province. In his teens he suffered from an attack of poliomyelitis. Wisely he spent a year at sea with his father, a Nova Scotia sea captain, and gained the hoped-for remedial results. He later graduated from Sydney Academy, and in 1923 from Dalhousie Medical School where, among his classmates were his older brother Dara Cochrane, and Dr. Ronald Forbes. He then became an interne in Victoria General Hospital working with the late Dr. J. G. MacDougall who was his mentor and friend for many years. Then there was a period from 1925 to 1927 when he was house surgeon at the Inverness Hospital. In this area he enjoyed the background of the Gaelic tradition, and, always a good raconteur, his stories were embellished from that source. His patients, who have always had the warmest personal regard for him, have profited by the aptness of his little stories.

In 1927 Perry came to Wolfville and was soon engaged in the founding and growth of Eastern Kings Memorial Hospital. His predilection was always for surgery, and as a good student he spared no effort to expand his knowledge by extensive reading and study. In 1933 he was married to Constance Collins of Advocate Harbor, and from that union two sons were born, John, and Thomas, who with his wife survive him.

In the winter of 1935 he went to England and became a part of Grey-Turner's clinic at the Hammersmith Post Graduate Hospital for a period of six months. On his return to Wolfville he engaged in an expanded general and surgical practice which continued uninterrupted until his illness.

Perry made outstanding contributions to Masonry, church, and community life. He was a member of St. George's Lodge, Wolfville, a 33rd degree Mason in the Scottish Rite, and held many notable positions in the Order. He was twice president of the Valley Medical Society and at one time president of The Nova Scotia Medical Society. He has been Chief of Staff of Eastern Kings Memorial Hospital for a number of years, and his influence in its professional work and its reputation has been incalculable. His life both personal and professional was exemplary, and his religious conviction, strong and courageous, served to give him support during his long illness. The imprint of his life will be recognized for many years to come.

M.R.E.

Elbow Injuries In Children

M. ERDOGAN, M.D., F.R.C.S. (C)

Halifax, N.S.

The purpose of this article is to discuss some diagnostic features and the principles of management of the different injuries of the elbow in a condensed manner. First the different type of fractures and dislocations will be listed, then the early and late complications which might occur will be discussed.

1. Supracondylar fracture of humerus:

In this type the humerus is fractured above its epicondyles. In the great majority a fall on an outstretched arm causes it, displacing the distal fragment posteriorly. Rarely it occurs following a fall on the flexed elbow, then the displacement of the fragment is anterior to the shaft of humerus. When the child is first seen it is very important that the radial pulse, peripheral sensation and movements of the fingers should be checked along with general and local examination. The radiographs of both elbows should be taken insisting on true A.P. and lateral views of the humerus, otherwise the pictures may be confusing and one could miss certain fractures. Reduction, if necessary, should be done before marked swelling develops. 300 to 500 units of hyaluronidase injected into the fracture hematoma is helpful to reduce the swelling.

If swelling is so marked that the elbow can not be flexed enough to hold the reduction without compromising the circulation, then the reduction should be delayed for 3-4 days. The elbow is elevated and skin traction after Dunlop is applied. The reduction is done by steady traction on the child's hand with the elbow in about 60° of flexion, molding lateral displacement first, then pressing the distal fragment with the thumb against the counter pressure of the fingers. The elbow should never be flexed without preceding traction, otherwise the nerves and vessels may be caught in between fragments. The posteriorly displaced fracture is held with the elbow in as much flexion as is possible without obliterating the radial pulse. If the fragment was displaced anteriorly it is held with the elbow in extension. A posterior plaster slab is applied holding the forearm in pronation if the distal fragment was displaced medially, in supination if it was displaced laterally to prevent malunion. It is very important that no circular cast or tight bandage should be applied. The child is admitted to the hospital for 24 hours to watch the circulation, keeping the arm elevated. If it is an unstable type of fracture, it is treated by traction. The skin traction as recommended by Dunlop is preferable to skeletal traction through a Kirschner wire in the olecranon process. As long as alignment is normal, some overlapping of the fragments is acceptable. The elbow is immobilized for 4-6 weeks according to the age of the child.

2. Transcondylar fracture of humerus:

In this type the fracture is at the level of the epicondyles, going through the olecranon fossa. On the A.P. radiograph the proximal fragment looks like a fish tail. It is an intra-articular fracture, therefore an accurate re-

duction is necessary to preserve the congruity of the elbow joint. The management is essentially the same as the supracondylar fracture of humerus.

3. Fracture of lateral condyle of humerus:

This is an epiphyseal fracture of the lateral condyle (capitellum), carrying with it a metaphyseal flake of bone. In infants, before the development of the capitellar osseous center, it may be missed. The displacement may be slight, when either no reduction is needed or external pressure on the fragment may close the gap, but sometimes it is rotated almost to 90° , so that the articular cartilage of the fragment lies against the raw surface of the metaphysis requiring manipulative reduction. It is believed that lateral dislocation of the elbow precedes this rotation. Therefore to reduce it by closed manipulation the elbow should be laterally dislocated first, the fragment is allowed to settle without applying any pressure over it, then the dislocation is reduced and the elbow is immobilised in flexion. If the manipulation is not successful open reduction is a must, otherwise nonunion of the fragment causes incongruity of the elbow joint and later on cubitus valgus deformity.

4. Fracture of medial epicondyle of humerus:

The medial epicondyle is not an epiphysis but an apophysis like the greater trochanter of the femur. Therefore it does not contribute to the longitudinal growth of the humerus. If displacement is less than a few millimeters no reduction is needed and the elbow is kept in flexion for 3-4 weeks; if it is more than that, an open reduction is necessary especially in boys. The fragment may be caught in the joint following a temporary lateral dislocation. Then if it cannot be released by angulating the elbow into valgus and extending the wrist as well as the fingers, an open reduction will have to be done.

5. Fracture of the radial neck:

A longitudinal thrust on the radius causes fracture of the radial head in an adult, epiphyseal fracture of the radial neck with a flake of metaphysis in children. The displacement, if present, is usually lateral. Angulation of up to 45° does not need to be reduced, but if more one should attempt to reduce it by direct finger pressure. If angulation is marked or the fragment is completely off, then open reduction is needed to preserve the longitudinal growth of the radius. The radial neck in a child should never be excised even if it is dislocated, otherwise comparative overgrowth of the ulna results, with radial deviation of the hand and dislocation of the distal radioulnar joint.

6. Comminuted fracture of distal end of humerus:

This type of fracture is rare in children. The treatment of choice is continuous traction for 4-5 weeks. An open reduction is not justified in a child for it causes more permanent limitation of movement than treatment with traction.

7. Dislocations of the elbow joint:

Most frequently the elbow is dislocated posteriorly, and may be accompanied by fracture of the coronoid process, lateral condyle or radial head. Less frequently it may dislocate laterally, with or without fracture of the lateral

condyle or avulsion of the medial epicondyle. Anterior dislocation of the elbow is rare. Anterior dislocation of the radial head alone is rare and occurs only in children. If anterior dislocation of the radial head is accompanied with fracture of the shaft of the ulna it is called Monteggia's fracture which is a forced pronation injury; this is reduced by steady traction, followed by bringing the forearm into full supination. Internal fixation of the ulna in a child often is not needed, as it is in an adult. The so called posterior Monteggia fracture (fracture of upper end of ulna with posterior dislocation of radius) is probably a posterior dislocation of the elbow, at which the posterior capsule of the joint proves to be stronger than the bone. This is rare in children. In general dislocations are reduced by traction and local manipulation. If no accompanying fracture was present 3 weeks of immobilization is adequate. If the dislocation was complicated with a fracture, then, after the reduction of the dislocation, the fracture is treated as if no dislocation has occurred.

The so called pulled elbow represents a subluxation of the radial head under the annular ligament, following a pull on an upraised arm. The elbow is held in pronation and some flexion. All movements are painful and supination is limited. It is seen most frequently in 2-6 year olds. The radiographs are normal. After a warning for a sharp pain, the elbow is quickly moved into full supination and flexion. An audible click accompanies the reduction. To prevent recurrence the elbow is immobilised in flexion and supination for a week with a collar and cuff or a plaster slab.

COMPLICATIONS OF INJURIES AROUND THE ELBOW

1. Volkmann's ischemic contracture:

This is the most serious complication which might occur following injuries of the elbow. The brachial artery may be injured at the time of accident or the ischemia may develop secondarily if elbow is flexed too much following the reduction or if it is encased in a circular or tight bandage. The following 6 P's are the warning signals of the ischemia of forearm and hand: Pain, Pallor, Paresthesias, Paralysis, Pulselessness and Puffiness. Early reduction before swelling develops, as well as the injection of hyaluronidase into the fracture hematoma are of value to prevent it. If any sign of ischemia develops it is a must that all bandages to the last thread be removed at once, and that the elbow be extended. If good color returns and the symptoms subside, the elbow is held in a semi-flexed position and Dunlop type skin traction is applied. If not, a stellate ganglion block may be of value. If this does not improve the circulation either, the patient is taken to the operating room to split the deep fascia and explore the brachial artery. No time should be wasted for irreversible changes may take place in as little as 4 hours.

2. Nerve injuries:

In order of frequency, median, radial or ulnar nerves may be injured. Usually interruption is not complete and they recover well. Later on ulnar nerve palsy may occur if cubitus valgus deformity develops. A corrective osteotomy of the humerus should be done, transferring the ulnar nerve anteriorly if symptoms of irritation were present.

3. Malunion:

Children have a great capacity to overcome the deformity by growth process, the younger the age the better. In bayonet apposition the anterior block to flexion gradually subsides with time.

4. Myositis ossificans:

This is prevented if the reduction is done early with gentle manipulation, the elbow is immobilised an adequate length of time and forceful massage and passive movements of the elbow are avoided.

5. Cubitus valgus:

This may develop if the lateral condylar epiphysis is damaged or if a lateral condylar fracture is left ununited. It may also develop if an early fusion of the radial head epiphysis occurs following injury or adverse treatment. A corrective osteotomy of the humerus should be done to prevent the delayed ulnar palsy.

6. Cubitus varus (gun stock deformity):

The cause often is that the medially displaced fragment is not adequately reduced. If so the forearm should be put in pronation when the first plaster slab is applied. It may develop following overgrowth of the lateral condylar epiphysis as following an operative reduction. Rarely damage to the medial condylar epiphysis is the cause. A corrective osteotomy to overcome the deformity of the humerus is needed after full range of elbow motion is regained. These corrective osteotomies in a growing child may need to be repeated.

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Torts - Doctrine of Professional Negligence Standard of Professional Care.*

It is well settled in English law that whenever the safe performance of an act depends on the professional knowledge and skill of the actor, he is required to possess such knowledge and to exercise such skill. He must possess a reasonable degree of skill and ability which a member of his profession, trade or calling would reasonably be expected to display in the particular circumstances of the case.

The doctrine is of a very ancient and respectable ancestry. Its foundations reach deep into the Roman era where it was first formulated. With the systemization of Roman law, it found its way in the Digest and the Institutes. There, the matter was put rather laconically in the form of a maxim — "*Imperita culpa adnumeratur*". Inexperience was thus equated with negligence. Although the Digest mentions medical practitioners, midwives, artificers, assessors, building inspectors, and drivers, who would be bound to act with professional skill, it provides in quite general terms that lack of skill amounts to negligence. By negligence, in these circumstances, Roman law distinguished between intent and negligence which in the time of the Digest was again subdivided in slight and gross negligence. But the Roman doctrine of degrees of negligence has not been carried over to the English law. English law developed its own concept, that of duty of care, the breach of which would amount to negligence. There are no degrees of negligence but a proper — higher or lower — standard of care is required of the actor according to the particular circumstances of the case.

The different method of approach used in English law does not, however, detract from the basic proposition that inexperience or lack of skill amounts to negligence. On the contrary, the validity of the doctrine has never been doubted and it is firmly established in the law.

As in Roman law, it holds good in English law that any one who engages in the performance of an act which can only safely be done by an experienced or skilled man must possess the necessary experience or skill. This principle covers all imaginable transactions and activities. It is elaborated to more detail in the case of professional men exercising professions currently exercised in the Roman era with the necessary addition of all the other professions, trades and callings that are carried on in the modern time. So the standard of care displayed by medical practitioners, dentists, nurses, barbers and hairdressers, lawyers, accountants, valuers, bankers and so on in the exercise of their profession attracted special attention of the law.

The standard of care is objective, that of the hypothetical reasonable man. And it is a question of fact in every case whether the actor did or did not exercise the measure of care that a reasonable man would have exercised in the particular circumstances.

*Reprinted from the March 1963 Edition of The Canadian Bar Review Vol. XLI, No. 1.

One of the earliest recorded instances of the problem occurs in Fitz-Herbert. The reference is to the duty of artificers to exercise their callings properly, and it sums up the law as it then stood. In *Best v. Yates*, the standard of care required of a tailor was discussed, in *Coggs v. Bernard*, that of a carrier, and in *Slater v. Baker and Stapleton*, in *Seare v. Prentice*, and in *Pippin and wife v. Sheppard*, that required of surgeons was considered. The problem was also adverted to in *Blackstone* and in *Buller*.

As the standard of care required of a professional man is not simply to exercise reasonable care, but to display such care and skill that is possessed by a man of average competence exercising a particular calling, the standard may vary from calling to calling depending on the degree of knowledge and perfection attained in the particular calling. The fundamental requirement, however, is common to all professions, trades and callings. Professional men are expected and bound to exercise that degree of care and skill which is displayed by the average practitioner in that particular profession. A fair and reasonable standard of care and competence is thus required. The practitioner possessing the average skill and competence in the exercise of his profession is looked upon by the law as the standard giving entity.

The care and attention due to patients by medical practitioners being of utmost importance to the public, it is not surprising that the degree of competence required of medical men is well settled. In *Lamphier v. Phipos*, Tindal C.J. said: "Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill. There may be persons who have higher educations and greater advantages than he has, but he undertakes to bring a fair, reasonable, and competent degree of skill. Again in *Everett v. Griffiths*, Scrutton L.J. held that a medical man practising his profession undertakes that he has the ordinary skill and knowledge necessary to perform the duty towards those resorting to him in that character.

The duty imposed on medical men in English law is thus to bring to the exercise of their profession a fair and reasonable degree of care and skill. The standard of care required by American California Supreme Court, held that the standard of care required of a physician was not the highest skill medical science knows, but only that degree of skill, knowledge and care ordinarily possessed and exercised by members of his profession under similar circumstances. It was the opinion of the court that in order to determine the standard of ordinary care and skill required of a medical practitioner, the court was not permitted to aggregate into a common class the quacks, the young men who have no practice, the old ones who have dropped out of the practice, the good and the very best, and then strike an average between them. This method would place the standard too low. A higher degree of skill is, however, required from a specialist than from a general medical practitioner. Due regard must also be had for the advanced state of medical knowledge at the time of treatment of any human malady, and refuge may not be found in the practices of the medical dark ages.

A medical practitioner is free from liability on the ground of negligence if he can show that he acted in accordance with the recognized practice. As *McNair J.* has put it, a medical man is not guilty of negligence if he has acted

in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, and this is so even if there is a body of opinion who would take a contrary view. A physician is not liable for an error of judgment unless the course pursued is clearly against the course recognized as correct by his profession. A medical man is bound to use reasonable skill and he fulfils his obligation if he uses methods approved by others of the profession who are reasonably skilled. He will, however, be liable if he is proved guilty of such failure, as no medical practitioner of ordinary skill would be guilty of had he acted with ordinary care.

Similarly to medical practitioners, dentists owe their patients the duty to exercise due care and skill. They are not guarantors of good results but are obliged to exercise reasonable care and skill in the treatment of patients. The same rule applies also to nurses. They must meet the standard of learning, skill and care to which nurses practising the profession are held.

The other profession, the careless exercise of which may have considerable injurious consequences to human health is that of barbers and hair-dressers and possibly jewellers. The standard of care required is that which a reasonably prudent and skillful person engaged in the exercise of the profession would take in the same or similar circumstances. It is that degree of care normally possessed by persons of ordinary skill, ability and prudence engaged in the performance of the same transaction. In the exercise of their profession, the duty of care does not extend only to the actual rendering of professional services but includes also a duty to keep all the necessary appliances in good and clean condition.

The degree of professional competence expected of lawyers is similar to that expected of medical practitioners. It is the care and skill of a reasonably competent and careful solicitor. He is not bound to know all the law, but he must be familiar with the well-settled principles of law and rules of practice which are of frequent application in the ordinary business of the profession. He will, however, be liable on proof of "gross negligence" which implies the absence of reasonable care and skill. In case of difficulty or doubt, he should take counsel's opinion. As to barristers, they cannot be sued for damages in negligence for historical reasons, but they are subject to the rules of conduct of their Inns of Court.

The standard of care applicable to the conduct of auditors and public accountants is the same as that applied to lawyers, medical practitioners, architects and other professional men engaged in furnishing skilled services for compensation, and that standard requires reasonable care and competence. They are liable in tort for a failure to perform such services in an accurate and skillful manner. They are liable in damages to their clients if the performance of their work indicates lack of reasonable care, but to third parties they are liable only for fraud. The position of valuers is similar to that of the other professional men. They are expected to possess the skill and care an ordinary competent valuer would show in the exercise of his profession. They answer in negligence to their clients: but to third parties they are liable only for fraud.

Also bankers are under the obligation to bring in the exercise of their profession a due degree of care and skill. The applicable standard is derived from the ordinary practice of bankers. It is ascertained by reference to the practice of reasonable men carrying on the business of bankers, and endeavouring to do so in such a manner as may be calculated to protect themselves

and others against fraud. Although it is not part of the ordinary business of a banker to give advice to customers as to investments generally, so that a banker would not be under a duty to advise his customer carefully, there may be occasions when advice may be given by a banker in the course of his business. The nature of the banker's business is in each case a matter of fact and its limits cannot be laid down as a matter of law. But if a banker takes it upon himself to give professional advice, his only obligation is to advise with the care and skill which an ordinary banker in his position might reasonably be expected to possess.

The standard of care and skill required of architects, surveyors or engineers is to use reasonable care and diligence in the exercise of their profession. They must be skilled and must display at least an average ability in their work. If they fail to exercise this degree of skill and competence, they will be liable in damages, and also, they will not be able to recover compensation for their services.

Although the degree of professional standing in some of the aforementioned professions attracted, due to their importance, considerably more attention of the law than that used in the exercise of other professions, there is no doubt that the standard of average skill and competence must be shown in the exercise of any profession. It applies to medical men and lawyers as well as to brokers, auctioneers, surveyors and dispensing chemists. In fact, it applies to all men engaged in the exercise of a profession, trade or calling. The uniformity of approach is remarkable. The law takes the fact in consideration that a beginner will not be able to equal the skill of a man of experience; that professional men practising generally will not attain the degree of skill expected of a practitioner working exclusively within a narrow field of specialization; and also that no practitioner can always give a top performance irrespective of his above average competence. In this way, the doctrine which was first formulated in Roman law was carried in an appropriately developed form into the modern law. True, it has been adopted to suit the new conditions but its function in the legal system is the same today as it was many centuries ago. Being of utmost importance to the proper exercise of professional services in the community, there is no doubt that it will form a permanent part of the law in the years to come.

George E. Glos, J.S.D., of the Faculty of Law, University of Singapore.

INFORMATION ABOUT CANCER

The National Cancer Institute of Canada is currently distributing the American Cancer Society publication "*Ca* - A Cancer Journal for Clinicians", to all Doctors of Medicine in Canada who wish to receive it. This is a well-laid-out, easily-read journal, which contains up-to-date information which doctors might wish to know in respect to their cancer patients. Complimentary subscriptions may be obtained on request to the National Cancer Institute of Canada, 790 Bay Street, Toronto 2, Ont.

A Medical Museum

When the Archives Committee of the Society was constituted in 1963 it was given the suggestion that it should explore the idea of creating a museum relating to the practice of medicine in Nova Scotia.

An initial and very successful attempt had been made in this direction by the late Dr. Kenneth A. MacKenzie. Largely unaided he had assembled a number of instruments, documents and pictures related to medical practice and achievements in this Province since the settlement of Halifax in 1749. Display cases were procured and for several years these items were on display in the Pathological Institute, Halifax. Dr. MacKenzie pursued this field of interest during retirement and up to the end of his life, but in these later years his interest was largely devoted to the geneologies of "medical families" and the educational origins of earlier practitioners. Fortunately a good deal of this work has been preserved in one way or another, and we hope may be available to our present enterprise.

Changes were made in the Pathological Institute involving structural alterations to meet increased demands for teaching space and those consequent upon an expanding public health program. Brick walls cannot be stretched and in the decade from 1935 to 1945 the internal struggles within this building to meet all demands were constant and frustrating. We cannot say when it happened or who was its author, but sometime probably within that period the Museum, cases and all, were removed from the building and vanished. The element of confusion present prevented those persons deeply interested from noting the loss immediately, and when it became evident the "trail was cold". Eventually the display cases, without their contents, were discovered and reclaimed, but the most diligent search failed to locate the contents themselves. Dr. MacKenzie pursued every lead without result. Since your Committee came into being it has repeated the inquiry and is now convinced that further efforts in this direction are useless. The items singly or in toto may turn up in time in some forgotten corner.

So now we have display cases and a good place to put them where it is unlikely that they will be eviscerated again. We are presently in search of available material. We cannot hope at this late date to get many items of medical and surgical equipment though these would be most welcome. What we do hope for is to secure pictures and documents of all sorts bearing upon medical practice in Nova Scotia from the earliest days. There was never a time when this was more important. Changes have taken place so rapidly within living memory that the graduates of today can scarcely grasp the value and richness of their immediate heritage let alone its remoter past. Our ways of living militate against the preservation of material once its usefulness in the immediate locus is at an end. If we are to succeed in our present task it is a matter of NOW or not at all.

We ask every doctor in Nova Scotia to complete the brief questionnaire contained in this issue of the Bulletin and return it to the Executive Secretary who will put it in our hands. This will give us an idea of what there is, where

it is, and if it can be secured. Do not despise the more recent or the commonplace. How we would like to have the first Insulin containers sent to Halifax from Banting for trial purposes! Junk today is gold tomorrow in our area of interest. Please give us your support so that we can do a worthy job.

THE ARCHIVES COMMITTEE.

1. (a) I have in my possession.....
 - (b) I can secure.....
 - (c) I know of the whereabouts and will endeavour to secure the following which might be of value in assembling a Medical Museum
.....
2. (a) I am willing to **donate** them for the above purpose on the assurance that they will be preserved and protected by all reasonable means.
 - (b) I am willing to **loan** them on these terms.
 - (c) I am willing to surrender all interest in them at my death if I do not reclaim them before that time.

Place:

Date:

.....
Signature

College of General Practice of Canada

GENERAL PRACTICE RESIDENCIES IN CANADA

The College of General Practice of Canada some years ago drew up regulations governing a second year or senior internship designed specifically for doctors planning to enter general practice. These are called General Practice Residencies. The following hospitals have cooperated with the College by establishing these residencies.

The doctor or intern who is interested in registering for one of these courses of training next year should contact the hospital concerned.

British Columbia:

Royal Columbian Hospital, New Westminster — L. F. C. Kirby, F.A.C.H.A.,
Administrator

Royal Jubilee Hospital, Victoria — Dr. J. L. Anderson, Medical Administrator

St. Joseph's Hospital, Victoria — Dr. R. E. Adams, Medical Director

Vancouver General Hospital, Vancouver — Dr. L. E. Ranta, Associate Med.
Director

Alberta:

Royal Alexandra Hospital, Edmonton — Dr. R. C. Nye, Executive Director

Edmonton General Hospital, Edmonton — Dr. R. M. Clare, Medical Director

Misericordia Hospital, Edmonton — Dr. G. R. MacDonald, Medical Director

Calgary General Hospital, Calgary — Dr. J. C. Johnston, Administrator

Holy Cross Hospital, Calgary — Irial Gogan, Medical Director

Saskatchewan:

Regina General Hospital, Regina — Dr. A. C. Pickles, Medical Administrator

Regina Grey Nuns Hospital, Regina — Dr. J. C. Dupont, Medical Director

St. Paul's Hospital, Saskatoon — Sister Y Prevost, Administrator

Manitoba:

St. Boniface Hospital, St. Boniface — Dr. P. L'Heureux, Medical Director

Misericordia General Hospital, Winnipeg — Dr. J. Scatliff

Ontario:

St. Joseph's Hospital, Hamilton, Ont. — Dr. K. J. Williams, Medical Director

St. Joseph's Hospital, London, Ont., Administrator

Victoria Hospital, London, Ont. — Dr. C. J. Kirk

Oshawa General Hospital, Oshawa, Ont., Administrator

Hôpital St. Louis-Marie de Montfort, Ottawa, Ont. — Dr. W. F. Cormier,
Medical Director

(Ontario continued)

Ottawa Civic Hospital, Ottawa, Ont. — Mr. D. R. Peart, Executive Director

Ottawa General Hospital, Bruyère Street, Ottawa, Ont. — Sister Marie-Joseph,
Administrator

(Ontario continued)

The General Hospital of Port Arthur, Port Arthur, Ont. — Dr. Philip Rickard, Administrator

St. Joseph's Hospital, Sarnia, Ont. — Sister M. Pascal, Superintendent

St. Thomas-Elgin General Hospital, St. Thomas, Ont. — Mr. Bertram G. Thacker, Superintendent

New Mount Sinai Hospital, 550 University Avenue, Toronto, Ont. — Mr. Sydney Liswood, Administrator

Northwestern General Hospital, Keele Street, Toronto, Ont. — Mr. F. T. Seymour, Administrator

Queensway General Hospital, Toronto, Ont., Administrator

St. Joseph's Hospital, Toronto, Ont. — Sister Mary Francis, Administrator

Scarborough General Hospital, 3050 Lawrence Ave. E., Scarborough, Ont. — Sister Marie de Liesse, Administrator

Toronto East General & Orthopaedic Hospital, Coxwell at Sammon, Toronto, Ont. — Mr. E. R. Willecocks, Administrator

Toronto General Hospital, Toronto, Ont., Administrator

Hôtel-Dieu of St. Joseph, 1030 Ouellette Ave., Windsor, Ont. — Sister G. Lafond, Administrator

Quebec:

Montreal General Hospital, Montreal, P.Q. — Dr. William Storrar, Medical Director

Notre-Dame Hospital, Montreal 24, P.Q. — Dr. J. R. Boutin, Medical Director

Royal Victoria Hospital, Montreal 2, P. Q. — Dr. J. G. Turner, Medical Director

Jeffery Hale's Hospital, 1250 St. Foy Road, Québec, P. Q. — Mr. K. M. Nicholson, Executive Director

L'Hôtel Dieu de Québec, Québec, P. Q. — Dr. F. Roy, Medical President

Sherbrooke Hospital, Sherbrooke, P. Q. — Dr. A. A. Dougan, Medical Director

Hôpital St. Joseph, 779 Ste. Julie, Trois-Rivières, P. Q. — Dr. G. Groulx, Medical Director.

New Brunswick:

Saint John General Hospital, Saint John, N. B. — Dr. E. R. Davis, Administrator

CANADIAN MEDICAL ASSOCIATION

97th Annual Meeting

Vancouver June - 26, 1964

Arrangements have been made with T.C.A. for a "group flight" to leave Halifax, Saturday, June 20, 1964, and to arrive in Vancouver the same evening.

Having accommodated the Nova Scotia representatives to General Council, eleven seats remain available.

A "group flight" means reduced fare. Although it is necessary to fly as a group to Vancouver, each individual may make separate plans for the return flight.

Those interested may contact The Medical Society of Nova Scotia or Trans Canada Airlines.

C.J.W.B.

A Day In Cancer

Nova Scotia Tumour Clinic in association with the
Post Graduate Division, Dalhousie University, and
N.S. Division Canadian Cancer Society,

announce a One Day Refresher Course in Cancer Therapy to be held in Halifax, Saturday, April the 18th. Registration fee — \$10.00. This course is open to all practitioners in the Maritime Provinces and will emphasize recent developments with special attention to Cancer Chemotherapy.

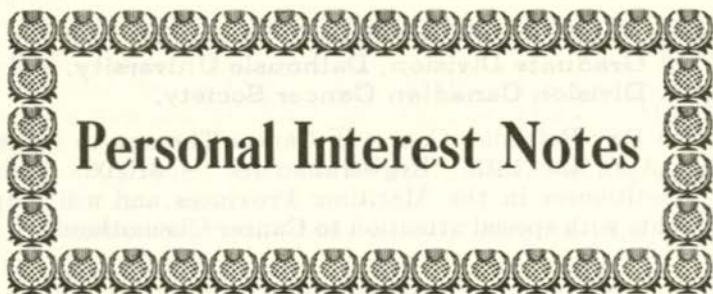
Visiting Teacher: Dr. Robert B. Golbey, M.D.,
Associate, Sloan-Kettering Institute.
(Chemotherapy Group)

PROGRAM

- 8:30 Registration
8:55 Welcome — Dr. C. M. Bethune
9:00 Patterns of Cancer — Dr. Robert B. Golbey, M.D.
10:00 Coffee
10:15 Perfusion in Chemotherapy of Cancer — Dr. J. A. Myrden.
10:55 Radioisotopes in treatment of Cancer — Dr. J. F. Filbee.
11:15 Treatment of Trophoblastic Tumours — Dr. G. H. Flight.
11:40 Management of Carcinomas of the Prostate — Dr. C. L. Gosse.
12:00 Some aspects of Chemotherapy of Lymphomas — Dr. H. C. Read.

Lunch

- 2:00 Experiences of Nova Scotia Program of Cancer Detection —
Dr. S. C. Robinson.
2:15 Problems in Management of Breast Disease — Dr. G. W. Bethune.
(with case presentation)
2:45 The Role of Radical Surgery in Recurrent Carcinoma of Cervix —
Dr. C. Tupper.
3:05 Carcinoma of the Colon — Dr. J. H. Charman.
3:25 Lymphography — Dr. S. Norvell.
3:45 Tea
4:00 The Current Role of Drugs in the Management of Cancer —
Dr. R. B. Golbey.



Personal Interest Notes

CHASED BY A TRAIN, DOCTOR OUTDISTANCES STORK

Dr. Robert Rowter of Bridgewater saw a train approaching him as he was crossing the tracks. Fearing he would not make the crossing, he turned his car onto the tracks and tried to beat the train to the station. The train won, — but the doctor, shaken yet dauntless arrived at the hospital — in time.

FLYING DOCTORS ON VALLEY MISSION

This time Drs. Murray Davis and Harold Baker of Halifax race by helicopter to provide emergency obstetrical aid to a patient in Annapolis Royal Hospital. Both members of the emergency obstetrical team available at any time to doctors throughout Nova Scotia, they landed on the hospital grounds and were able to carry out an operation at once.

BABY DEATH OFTEN PREVENTABLE.

It is interesting to read in conjunction with the items above the report of Dr. H. B. Colford, director of the maternal and child health consultation services. He was speaking of the study committee set up in 1958 under the chairmanship of Dr. Donald Smith, by the Medical Society of Nova Scotia to determine the cause of maternal and perinatal mortality — to determine the cause of each death more accurately and to decide whether or not death was preventable. Infant (within the first 28 days of life) and still births are the third largest group of deaths in N.S. Lack of adequate prenatal care was stressed and tribute was paid to the Emergency Obstetrical team". It is felt that this team has saved many lives".

PICS FROM THE PRESS

SHELburnE

Dr. R. W. Campbell has accepted a position with the Can. Pensions Commission, Ottawa as medical adviser. Dr. Campbell after service with the R.A.M.C. in Europe and in North Africa came to Shelburne in 1956 via Newfoundland. For the Shelburne area he has been director of Emergency Medical Services and also has served as coroner and later as medical examiner.

MENTAL HEALTH

SYDNEY

Dr. Clyde Marshall, provincial administrator of mental services recommended an extension of the open ward system at the Cape Breton County

Mental Hospital and use of other newer rehabilitation programmes being tried in Hants Co. and other places in the province.

He spoke of the increasing emphasis on rehabilitation and the returning of patients who have been in municipal hospitals to the community. A "community residence" or boarding home programme in Hants Co. has succeeded in returning to the community a little more than 50% of the patients formerly cared for in municipal hospitals.

REHABILITATION RATE OF ALCOHOLICS IS UP — following the reorganization of the treatment of alcoholics instituted in November 1963. There have been only 3 readmitted out of 51 discharged. Until this time patients with alcoholic problems were admitted through the same channels as the other patients and, during the initial stages of treatment, they occupied the same wards as the less-chronic mental inmates. Now they have their own wing, closed only to those who are denied pass privileges because of their treatment or behavior.

DARTMOUTH BRANCH OF THE CAN. MENTAL HEALTH ASSOCIATION had as guest speaker, Dr. J. Fraser Nicholson, assistant professor of Psychiatry, Dalhousie University.

PROVIDENCE RHODE ISLAND Feb. 25th, Dr. R. O. Jones, head of the Dept. of Psychiatry, Dalhousie, gave an address at Butler Hospital on "Psychiatric Treatment: individual, institutional or governmental". On March 22nd Dr. Jones will address the opening session of the three day conference in Ottawa on the medical aspects of mental health in Canada. After the address he will moderate a panel discussion in which medical, psychiatric and administrative experts from leading centres across Canada will participate.

LEGISLATURE

After a two week cruise on the T.S.S. Olympia to southern waters accompanied by Mrs. MacMillan — and Mr. Charles Goren, the famous bridge master. **Dr. C. L. MacMillan** of Baddeck is very active in seeing that various bills and other matters get proper attention.

Dr. Hector Pothier, 44 years a medical practitioner in Weymouth, is the oldest of the new members in this 48th Nova Scotia legislature. In his maiden speech, which drew the biggest burst of applause of any this session, he pledged that "the French Acadians will keep vigil and endeavour to suppress any extreme views which could lead to racial conflicts and isolationism".

HALIFAX M.D.'S

The role of various doctors in research was noted in the windows which was a feature display of the N.S. Light and Power Co. to make people more aware of the importance of the Canadian Heart Foundation during its drive in the week of Feb. 17-24 last. Dr. W. K. T. Josenhans, Dr. C. M. Harlow and Dr. S. J. Shane are all continuing to carry out the projects already noted in the Bulletin.

Talks on the Health Hazards of Smoking were given to 1450 students at Halifax Municipal High School by members of the Halifax Unit of the Can. Cancer Society, including Dr. John Filbee.

Dr. R. F. Hand is the president for the coming year of the St. George's Society, Halifax.

Dr. W. A. (Bill), Murray is the president of the Halifax Symphony orchestra and readers of the Mail-Star recently had to guess whether that "Know the Face." belonged to him or not.

Dr. Thomas Casey, of whose work in Nigeria the Bulletin has made previous mention, has returned to Halifax and while working as staff member at the Victoria General and Halifax Infirmary and beginning private practice, finds time to share the story of his experiences with various groups.

Dr. H. B. Atlee gave another of his challenging talks on education to the Home and School Association of St. Andrew's on Feb. 14. "What is more important to Halifax in the long run — better education for its youth or a new skyscraper — dominated civic centre?" he asked.

CONGRATULATIONS

It is quite apparent that doctors still retain the warmth and respect of their patients. Dr. John McCleave of Digby was recently a patient in the Victoria General Hospital. During that time he received from Digby County no less than 376 "Get Well" cards.

Written on one of them was the following: "Married November 29th and want to get pregnant when you get home to look after me, so hope you get home soon so B..... and I can get started".

BIRTHS

To Dr. and Mrs. Kenneth Gladwin (née Beverley McKinley, R.N.) a daughter, at the Halifax Infirmary on Feb. 26, 1964.

To Dr. and Mrs. Randolph Tsang (née Judith Banks) a son, Mark Robertson, at Hong Kong on Feb. 25, 1964.

OBITUARIES

Perry S. Cochrane, prominent Wolfville Surgeon and chief of staff of Eastern Kings' Memorial Hospital died there on Feb. 28 after several weeks illness. He graduated from Dalhousie in 1923 and practised in Inverness for two years before moving to Wolfville where he has practised since except for postgraduate study in England. He contributed greatly to the life of the community and church and was an outstanding Mason. Dalhousians of pre-first-war vintage will remember him and his brother Dara. He was a past president of the Valley and of the Nova Scotia Medical Societies. To his family we extend our sympathy.

DOCTORS & LAWYERS IN CAHOOTS

..... not against but for their clients and patients' interests. See the following report of the symposium held Saturday, February 22, in which both professions took part.

MEDICAL - LEGAL PANEL

On Saturday, February 22, Drs. C. L. Gosse; C. J. W. Beckwith, and A. J.M. Griffiths represented The Medical Society of Nova Scotia on a panel discussion at the Eleventh Annual Refresher Course of the Nova Scotia Barristers Society. The subject was "Preparation of a Case for Trial and Relationship Between the Doctor and Lawyer in General". The proceedings were reported at some length in the Halifax press. Discussion was frank and good-humoured and the large attendance was regarded as a great compliment by the Medical members at least.

The obvious steps which might be taken to improve liaison between the barrister and the Medical witness were aired, and some misunderstandings between the professions were discussed. In addition to all this, one or two matters came up which might prove of great interest if given further study. For instance, what to do about publishing Medical evidence in Press reports of legal proceedings. Some of the evidence may be embarrassing for the patient and it is not inconceivable that a very bad prognosis might be better withheld from the patient altogether, even though such information should be before a Court if an equitable judgement is to be reached. (No criticism was raised about the way in which the press has reported cases in the past).

The ethical position of the Medical witness was considered (the C.M.A. recommends that he should endeavour to assist the court in reaching an equitable decision and not act as advocate for one or the other party to the case). It is not always easy to reconcile this lofty position with the adversary concept of litigation which is held by members of the barristers. One of the Medical members of the Panel made a plea for trying to persuade plaintiff and defendant to agree on medical evidence concerning the nature and extent of injuries and disabilities and for settling the questions of liability and the amount of damages by argument before the Court. This was not too well received by the Barristers who seemed to think that cases could be made or broken by skillful questioning of medical witnesses. However, a few of the audience indicated interest in the idea and it may merit further study.

Speaking of the adversary system brought a loaded question from the medical men — Where does the lawyer's duty to his client end and his duty as an officer of the Court begin, especially with respect to possible suppression of the truth or suggestion of falsehood by the selection or suppression of evidence to bring before the Court. This is not a matter of which the medical profession can properly comment, although we did ask for guidance on what

to do if a medical witness felt that "the whole truth" of what he wished to say to the court had not been elicited either by examination or cross-examination. After various suggestions were made it seemed that we were dealing with a very hypothetical case as it was unlikely that a doctor would be called unless the evidence as a whole was likely to support the case of the side for which he was asked to appear.

The afternoon was an enjoyable occasion and it is to be hoped that in due course a similar panel can be arranged at a Medical Educational meeting. It was a happy thought for His Honor the Lieutenant Governor and Mrs. MacKeen to include the panel members and their wives in their invitation list to a reception at Government House in the evening.

UNEXCELLED OPPORTUNITY

For two young married General Practitioners with a long established Group Practice in Dartmouth, Nova Scotia, comprising G.P.'s and specialists. Initial salary \$9,000.00 per annum with increases on a percentage basis, leading to Partnership. First class housing provided by Group at moderate rental.

If seriously interested, please apply to

R. D. THOMSON, Esq.,
Administrator,
180 Portland Street,
Dartmouth, Nova Scotia.

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