THE NOVA SCOTIA MEDICAL BULLETIN

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Medical Services Insurance

A SUMMARY OF THE CANADIAN MEDICAL ASSOCIATION STATEMENT

In June of this year the Canadian Medical Association, at its annual meeting in Halifax, adopted a new statement of policy. The formulation of this statement had been entrusted to its Committee on Medical Economics.

The present policy of the profession is based on previous statements, the last of which was made in 1960, and on changes that have occurred in the intervening years. It reaffirms the belief that medical services insurance should be available and accessible to all Canadians. It states that the relationship between the patient and physician should be kept as private as possible and that information given to insuring agencies should be used for the sole purpose of assessing claims. It also states that health insurance should be of the non cancellable, guaranteed renewable type and that provision be made for continuation of coverage despite unemployment, illness or the death of a wage earner.

The Canadian Medical Association believes that every resident of Canada should have as free a choice as possible among different types of plans and carriers, as well as the free choice of physician. At the same time it believes that every physician should have free choice of patient, except where humane considerations dictate the contrary, and also remain free to participate or not in any plan or with any carrier. There must be no discrimination by any insuring agency against the physician, who, by choice, decides not to participate. Moreover, the subscriber who consults a non participating physician must not be obliged to relinquish any benefits for which he has directly or indirectly paid. It is sincerely believed to be in the public interest to preserve freedom in any system of Canadian Health Insurance.

The Association recognizes that Canada will continue to experience a shortage of physicians and associated health personnel. The provision of medical services insurance will not correct this situation. It will, in fact, place an additional burden on the available personnel and may, if caution is not observed, endanger the quality of medical care. It is in the public interest that quality of care be maintained and enhanced. The best possible conditions of medical practice must be assured and the fullest support must be given to medical and paramedical education and research.

The profession believes that paramedical services and therapeutic agents should be provided under a separate accounting arrangement. It is a fundamental necessity that effective measures be taken to increase the output of health personnel and improve the availability of their services.

The Association also believes that a system of insurance should be developed which is not totally dependent on a single source of funds. It is for this reason that the development of types of plans which include patient participation is encouraged. It is believed to be in the public interest that medical services insurance plans be non political in nature and that the medical profession be adequately represented on governing agencies and be fully consulted during the planning phase. The profession believes the development of medical services insurance is a provincial responsibility and that financial contributions by the federal government should not interfere with this responsibility.

Finally the Association believes that the people of this nation can develop insurance programs which will preserve freedom of individual choice and action, foster personal initiative and responsibility and while so doing make adequate insurance coverage possible for every Canadian.

G. McK. S.

The full text of the Canadian Medical Association Statement of Policy on Medical Services Insurance will be found in the Canadian Medical Association *Journal* of July 3rd 1965. It is recommended reading for all members of the Medical Society.—Editor.

FORTY YEARS AGO

From The Nova Scotia Medical Bulletin
August, 1925

Medical Service is two-fold. The curative form is a blessing to humanity, but the preventive is even greater. The tendency of the age, and of all ages, is to acclaim the comparatively miraculous. Avani and Pharpar are stately and appealing. The Jordan is small and of little fame. The skilful surgeon, the wise physician may cure; but he who prevents disease accomplishes more. What he does may be hidden, and public recognition may be absent; but he who removes the causes of disease is even a greater benefactor than he who cures; for removal saves misery to the masses of men, whilst cure brings blessing to the comparatively few. Preventive service is more and more becoming the inspiration of the medical profession, and though in most instances it may be accomplished by little of the spectacular and less of applause, its contribution to the happiness and well-being of the race is beyond computation.

(From an address to the Newfoundland Medical Association by Dr. Smith Walker of Halifax, 15th July 1925)

The Coronary Muse

By Watson Kirkconnell

4. Drink to Me only with MAALOX!

The cocktail is white and the glass is petite;
I ask for no water, I take the stuff neat,
It kills stomach acid and keeps the thing sweet,
And that is the way that I like it.
No belchings now wrench me, no gripings alarm;
The little white cocktail can act like a charm.
All hail to this draught that preserves me from harm,
For that is the way that I like it.
Feb. 27, 1964.

5. The Electrocardiogram

A sleazy squiggle on my E.K.G.
Can spell out weeks of bitter woe for me;
While stately marching lines in rhythmic grace
Speak glad reprieval to our stricken race.
Mindful of this, and hoping for good marks,
I leave the matter to the X-ray sharks.

THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION
OF
THE CANADIAN MEDICAL ASSOCIATION

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Maritime Medical Care Incorporated

The Annual Meeting of the Board of Directors, Maritime Medical Care Inc., took place on April 14, 1965. Immediately following this the first meeting of the new Board of Directors was held.

Board of Directors M.M.C. Inc., 1965-1966

Director	Branch Medical Society Represented	Appointment Expiring
Dr. H. B. Whitman	Pictou County Medical Society	1967
Dr. B. L. Reid	Halifax Medical Society	1966
Dr. T. B. Murphy	Antigonish-Guysborough Medical Society	1966
Dr. D. F. Macdonald	Western Counties Medical Society	1966
Dr. K. A. Fraser	Cape Breton Medical Society	1966
Dr. F. G. Bell	Lunenburg Queens Medical Society	1966
Dr. P. S. Mathur	Eastern Shore Medical Society	1967
Dr. G. W. Sodero	Cape Breton Medical Society	1967
Dr. P. R. Little	Colchester-East Hants Medical Society	1967
Dr. R. A. Burden	Cumberland Medical Society	1967
Dr. R. L. Aikens	Halifax Medical Society	1967
Dr. A. M. Lawley	Inverness-Victoria Medical Society	1967
Dr. G. W. Turner	Valley Medical Society	1967
Dr. M. T. Cooper	Shelburne Medical Society	1967
Dr. M. F. Fitzgerald	Pictou County Medical Society	1966
Dr. C. H. Young	Past President	1966

Lay Members

Mr. David Zive	—	Halifax	1966
Mr. Eric Miller	—	Halifax	1966
Mr. J. A. Walker, Q.C.	—	Halifax	1967
Mr. J. N. Foster	—	Halifax	1967
Mr. V. N. Thorpe, Q.C.	—	Kentville	1967

The Board of Directors Elected -

Dr. H. B. Whitman—Westville—President
Dr. B. L. Reid—Halifax—Vice-President

The Executive elected are the Officers and -

Dr. F. G. Bell	—	Liverpool
Dr. P. R. Little	—	Truro
Dr. G. W. Sodero	—	Sydney
Dr. G. W. Turner	—	Windsor
Mr. J. N. Foster	—	Halifax
Mr. J. A. Walker, Q.C.	—	Halifax

Annual Report of the President

April 14, 1965

Gentlemen and Guests:

It is my privilege and honour to present the Sixteenth Annual Report of the Corporation for the year ending 31st December 1964. I extend to you a warm welcome to this meeting and sincere appreciation for your continued interest.

It is with deep regret that we meet today without Dr. "Bob" Ross who was taken by death on the 4th January 1965. His contribution as a member of the Board through dedication to the objects of the Corporation, and General Practice in particular, contributed materially to our progress throughout the years.

The demands on your time to attend various meetings during the year reached an all time high and your response under the circumstances was salutory. Dr. P. S. Mathur joined the Board during the year as a representative of the newly formed Eastern Shore Medical Society. Mr. Eric Miller was appointed to fill a vacancy created by resignation of Mr. Frank Rowe on his appointment as Chairman of the Medical Services Insurance Advisory Committee.

Discussions throughout the year failed to produce any new programs for expansion of pre-payment, though certain ideas are presently under advisement. Following a thorough review of experience with the Seniors' Health Plan and the increasing loss position, a decision was made to continue the program. Further enrolment was postponed while awaiting a revision of the benefit range and suitable premium adjustment to provide greater stability in the future. Approval of amendments to the subscriber's contract was made late in the year and a revised premium at $2.75 single and $5.95 family was approved early in 1965. Supplementary Hospital benefits under this plan, were appropriately amended and premiums revised to $1.80 single and $3.75 family, effective at the anniversary date. Other programs continued to be offered unchanged though increasing interest in our E.H.B. and Supplementary Hospital coverage was evident.

Membership Enrolment

As at 31st December 1964, enrolment stood as follows -

	Contracts	(Gain over 1963)	Persons	(Gain over 1963)
(1) Comprehensive	48,375	(3,297)	141,971	(8,779)
(2) Health Security	1,001	(125)	3,278	(495)
(3) Individual	5,250	(598)	17,691	(1,385)
(4) Senior's Health	10,075	(297)	13,637	(402)
	64,701	(4,325)	176,577	(11,061)

An additional 4,664 persons were enrolled in the Supplementary Hospital Plan increasing total enrolment to 8,821 persons. Total enrolment in medical care increased by 11,061 in 1964 compared with an increase of 18,044 in 1963. Some 4,170 persons were enrolled in our Comprehensive Plan.

Financial Results

Details of the Financial Statement have been reviewed by the Auditors but I draw your attention to an increase in subscription income of $369,682 to a total of $4,474,921. Income from investments of $2,161,107 increased by $30,790 to $114,609 reflecting the astute management by your Finance Committee of reserves amounting to $1,287,503 and other monies on deposit awaiting commitment.

Administration costs increased to 11.57% of subscription income from 10.48% in 1963. Details regarding the increased costs of administration are embodied in the report of the General Manager.

Balances appropriated to General Reserve stood at $132,615, some $95,383 less than at 31st December 1963. This reflects diminishing operating income in spite of a reduction in the appropriation for Stabilization of Payment to Physicians from 2% to 1% of the Subscription Income. It is worth noting that this represents the first decrease in operating income since 1960.

General Matters

A closer relationship with Participating Physicians individually and at the Branch Society level was carried out under a program by our Medical Director, Dr. A. W. Titus. Early effect in areas of high utilization is apparent and it is hoped increasingly favourable experience is forthcoming.

Concern with the problem of high utilization continues though corrective measures lagged during the current year. Specific investigations were carried out on two physicians and the offer accepted from The Medical Society of Nova Scotia through their Mediation Committee for aid in dealing with the problems in question. At year's end their recommendations and actions were still awaited though early in 1965 correspondence expressed the recommendations that these and similar instances be dealt with by Maritime Medical Care. Another physician whose Participating Agreement had been cancelled in 1963 was reinstated after agreeing to specific conditions including repayment of monies paid for fees inappropriate to services actually rendered.

A mechanism to more appropriately deal with this phase of our operation is contained in the Terms of Reference of the newly approved Medical Advisory Committee.

Activation of this Committee awaits nominations from our sponsors, who will provide the names of physicians from which the six members will be selected.

The 1963 Schedule of Fees as negotiated between the Corporation and The Medical Society of Nova Scotia was approved and became operative July 1, 1964. The benefits to certain physicians through adoption of this Schedule was lost in the light of controversy arising from modifications necessary to soften our first exposure to a single listed Schedule for surgical procedures.

Re-examination of our position in applying service benefits for subscribers receiving medical care from individual physicians engaged in Group or Clinic practice who pool incomes, and particularly to services rendered within the concept of the Teaching Unit at University Hospitals, was initiated early in the year. Several meetings were held with parties involved including our sponsors and at the present time an arrangement is pending final approval with the first such body known as Physicians Services of Victoria General Hospital. It is intended that experience gained will be closely studied to ensure no wide deviations occur from patterns applicable in the private practice of medicine.

Explicit terms and conditions were approved, pending publication of a Specialist Register, whereby Participating Specialist Agreements might be completed in the absence of certification as a specialist by the Royal College of Physicians of Canada.

Every advantage was utilized through membership in Trans-Canada Medical Plans and the Western Conference of Pre-Paid Plans. Your General Manager attended the Annual Conference of the latter and certain employees benefitted from their organized educational programs. Four Directors attended the Mid-Winter Conference of T.C.M.P. at Montreal. Mr. Brannan and I attended T.C.M.P. meetings as Commissioners and Mr. Brannan served on the Executive of the organization. Dr. Titus attended one meeting of the Medical Directors and participated in their programme by presentation of a paper.

Relationship with our Sponsors

An active program was pursued during 1964 to improve liaison with The Medical Society of Nova Scotia at a tempo previously unattempted. A recall of events leading to this program will refresh your memories and orientate newer members of this Board. Grave concern during 1962 regarding the ability of Maritime Medical Care to fulfill its purposes in the face of increasing interest in Nova Scotia by other carriers with differing philosophies prompted solicitation of strong support and aid of our sponsors. An apparent reluctance to assure this Corporation of unequivocal support prompted a request for an opportunity to appear before the Executive of the Medical Society. Free discussion occurred at this audience on 11th May 1963 and a suggestion that closer liaison between the two bodies could provide better understanding.

At the initiative of our sponsors this Board agreed to the formation of a liaison committee with representatives from both bodies and later to become known as the Joint Study Committee. Terms of Reference were broad and included an opportunity to satisfy aspirations of this Board, whereby basic premises of the profession and knowledge in providing medical care might be examined in the reality of economics by professionals in the mechanics of pre-payment. Thereby through unity professionally sponsored programs could expand in this province.

This Corporation responded to the challenge of some fifteen meetings and other responsibilities with enthusiasm. I challenge you today to examine the experience from the viewpoint of accomplishing a solution to our initial problem. Broad policy expressed by our sponsors failed to be examined in the light of economic application and other issues fell short of practical agreement after examination often devoid of reality. Discussion shortly gravitated to approval of a new Schedule of Fees and later to consideration of dissatisfaction by groups of physicians and individuals in areas entirely of corporate concern. In fact on occasions a question arose whether certain members of the Committee were entirely clear regarding their understanding of the corporate responsibilities of Maritime Medical Care.

In my opinion any gain to the Corporation from this extravagant venture was negligible and could have occurred otherwise. May I suggest for your consideration a thorough examination of

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MARITIME MEDICAL CARE INCORPORATED

Balance Sheet

December 31, 1964
(with comparative figures for 1963)

Assets

	1964	1963
Cash on hand and on deposit	$ 226,379	$ 270,138
Accounts receivable	47,878	61,774
Prepaid insurance	356	307
Accrued interest on investments	32,453	23,356
Investments, at cost - quoted market value December 31, 1964 $2,161,107 December 31, 1963 $1,659,952	2,151,089	1,661,850
Investment of restricted funds	40,411	40,411
Inventory of supplies, at cost	10,230	11,018
Furniture and office equipment, at cost	74,155	66,584
Less accumulated depreciation	32,735	28,379
Net furniture and office equipment	41,420	38,205
	$2,550,216	$2,107,059

Liabilities

	1964	1963
Subscribers' claims payable	$ 682,646	$ 573,104
Unpresented subscribers' claims, estimated	234,630	185,066
Accounts payable	10,855	10,851
Trust funds - Province of Nova Scotia Welfare Plan	48,823	32,890
Payable re railway contract, estimated (note 1)	138,000	73,000
Subscriptions received in advance	107,348	81,059
Total liabilities	1,222,302	955,970
Restricted funds:		
Contingency reserve, re railway contracts	40,411	40,411
Retained by the Corporation:		
For stabilization of payments to physicians	368,812	324,602
Reserve for decline in market value of investments	15,000	5,000
General reserve, per statement attached	903,691	781,076
Total retained	1,287,503	1,110,678
	$2,550,216	$2,107,059

AUDITORS' REPORT

We have examined the balance sheet of Maritime Medical Care Incorporated as of December 31, 1964 and the statement of income and expenditure and general reserve for the year ended on that date and have obtained all the information and explanations we have required. Our examination included a general review of the accounting procedures and such tests of accounting records and other supporting evidence as we considered necessary in the circumstances.

In our opinion, and according to the best of our information and the explanations given to us and as shown by the books of the corporation, the accompanying balance sheet and statement of income and expenditure and general reserve, together with the notes thereto, are properly drawn up so as to exhibit a true and correct view of the state of the affairs of the corporation at December 31, 1964 and the results of its operations for the year ended on that date, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Peat, Marwick, Mitchell & Co.
Chartered Accountants

Halifax, N. S.,
April 14, 1965

MARITIME MEDICAL CARE INCORPORATED

Statement of Income and Expenditure and General Reserve

Year ended December 31, 1964
(with comparative figures for 1963)

	1964	1963
Subscription income	$ 4,474,920	$ 4,105,238
Expenditure:		
Medical care for subscribers		
Current year medical claims paid or provided for	3,845,514	3,418,604
Medical claims of prior years in excess of prior year provision	51,475	(22,329)
	3,896,989	3,396,275
Administration costs, Schedule "1"	517,723	430,579
Total expenditure	4,414,712	3,826,854
Operating income	60,208	278,384
Other income:		
Income from investments	114,609	83,819
Sundry	2,008	753
	116,617	84,572
Net income for the year	176,825	362,956
Deduct:		
Appropriation for stabilization of payments to physicians	44,210	81,772
Appropriation to reserve for decline in market value of investments	10,000	5,000
Transfer to contingency reserve, re railway contract	—	40,411
Adjustment of amount receivable re mutualization of 1961-62 railway contract	—	7,765
Total deductions	54,210	134,948
Balance appropriated to general reserve	122,615	228,008
General Reserve at beginning of year	781,076	553,068
General reserve at end of year	$ 903,691	$ 781,076

Notes to Financial Statement

1. Effective January 1, 1963 the Corporation entered into a two year contract, in conjunction with similar medical service plans in Canada, to provide medical coverage for the employees of Canada's railways. The contract provides that at its termination the experience of the participating plans will be reviewed in order to determine the net gain or loss from the contract. The experience of each plan is then related to the experience of the group as a whole, and then appropriate financial adjustments made among the plans. Based on the 1963-64 exeprience of the Corporation on this contract, it is estimated that at December 31, 1964 a refund by the Corporation to the participating plans of approximately $138,000 will be required.
2. Under the terms of the agreement between the Corporation and the participating physicians, the Corporation may, after the expiration of a twelve month period, cancel any unpaid balance outstanding on approved claims. The Board of Directors has passed the necessary resolution to cancel all such unpaid amounts to December 31, 1963. The unpaid balances of approved claims for 1964, amounting to approximately $629,000, have not been reflected in the financial statements.

future activities of the Joint Study Committee with a view to recommending two meetings yearly.

These might take the form of an all-day meeting in each instance attended by the members of this Board and the Executive of the Nova Scotia Medical Society. Morning sessions would be devoted to reports and new ideas for examination, while the afternoon could be devoted to exploring the practical application of any ideas likely to extend our purpose.

Future Considerations

Awareness of the contribution by this Corporation to enable an increasing number of patients to pay their doctor promptly for personal medical care through voluntary subscription is readily apparent by continuing support at the subscriber level. Despite a socio-economic climate extending to lessening personal responsibility in many areas any demand by subscribers for expansion in benefits has been primarily for services other than personal medical care. I foresee no immediate change in public attitude to our programs though marketing policy demands greater flexibility to meet vigorous competition from other interests in the field.

Benefits to practicing physicians through M.M.C.'s expansion in areas of coverage unpopular with the commercial and other carriers have, at least to certain individuals, created a less durable impression. Any strong persuasion for expansion from our sponsors has been directed to additional benefits primarily at physician level with less pressure for increased enrolment. This persuasion was directed primarily to increased payment for individual services and expansion to payment of certain specialists services heretofore indifferently circumvented. However, relief equally desired by the Plan and our sponsors will only come with a resurgence of support for Maritime Medical Care of a type enjoyed during the last decade when the inadequacies of other modes of coverage was more stinging. A desire for multiple carriers in the field is not untenable but in the interest of promoting the wishes of organized medicine in Nova Scotia as we understand them, the responsibilities of sponsorship must be acknowledged by and communicated to each member of The Nova Scotia Medical Society.

The long range effect of various concepts recently proposed by our sponsors and Patient Participation in particular must be carefully considered in the light of experience by mature family physicians acquainted with practice under programs of varied benefit ranges. Though identification of accounts by the patient at the level of service is highly desirable, it is unlikely that M.M.C. can popularize on a voluntary basis any extensive total enrolment. There is no indication that either the subscriber or the physician cares to depart change from service benefits, except in narrowly selective contracts, and then only to a fraction of from the present arrangements to pay for family physician care.

Current ideas under examination to pre-pay certain specialist services will require an expression of confidence by our sponsors through hearty endorsement and active promotion at the membership level. Though appreciating their tolerance of multiple carriers there could be no question of preference to their own Plan if their intentions and recent requests are indeed sincere. In any case this Corporation must determine at once if they can expect stronger support at the Medical Society level or otherwise consider modifications to programs competitive at the market level.

Consideration should be given by the new Board of Directors to amending the By-Laws to provide additional nominees to the Executive Committee. The present committee of six was established at a time when thirteen members served on the Board and is hardly appropriate for the present membership.

Confidence that continued expansion of physician-sponsored programs through M.M.C. will provide the best assurance of high quality medical care for Nova Scotians in the future reflects, in part, our appreciation and respect for the diligence and abilities of the employees in our service. On your behalf I extend our warmest thanks for their excellent work throughout the year. The Medical Department already reflects the vigor and sincerity of Dr. Titus and you can anticipate his increasing effectiveness in this most important department.

It is difficult to express the debt of this Board to Mr. S. P. Brannan our General Manager, for his untiring and diligent work. Through your confidence it was my good fortune to work closely with him over the past two years thereby gaining knowledge of his particular attributes only available through this experience. To him I extend personal appreciation for his efforts in easing my task and ask him to extend a comparable gesture to his staff.

My personal thanks is extended to you as members of the Board for your co-operation around this table and at the Branch level. Demands imposed by accepting appointments to the Executive, Finance, Joint Study and Special Committees were indeed heavy and in instances frustrating. It is my hope that retiring Board members will not hesitate to extend the knowledge gained through this association to reorientate their colleagues as well as others in the community to singular advantages in the future through M.M.C.

Respectfully submitted with heartiest good wishes for the future,

Crossman H. Young, M.D., C.M.
President. □

Roadsigns on the Highways of Health Insurance[1]

A. W. Titus, M.D.[2]
Halifax, N. S.

I recently read an article called "Signposts are for Reading", by Dr. C. M. Robertson of British Columbia, in which he compares the practice of medicine to our highways department, the signposts being the changing methods of practice being brought about by the increasing amount of specialization and relating these changes to new highways that pre paid medical plans will have to travel in the future. Each of these roadsigns will have a marked effect on the cost of treatment which is gradually but surely creeping higher and higher. I would like to expand his analogy a bit further to-night.

Our highways department is much like medicine in a sense. Each has its group of workers and a super group of specialists. Our specialties are well known to this audience and the highways department is now using specialists such as planners, traffic controllers, structural engineers, etc. and are constantly building super highways, new roads, repairing and paving some and merely gravelling others. Like medicine, these new highways are costing more and more and are leading us further and further afield. Likewise, the advances in medical and surgical treatment are spiralling the costs of treatment ever upwards. The public must eventually bear these costs as we travel down both old and new highways, whether John Public pays for it individually or protects himself by taking out some form of health insurance coverage for protection against financial catastrophe. Somewhere along the highway a signpost points to an old road but which now looks recently graded and that is the highway of political medicine. Government will soon be paving this highway as it becomes more and more used and more and more of us travel along it. It may not be as scenic as some of the older roads we used to travel and they may have difficulty getting some of us to use it, but by the use of some psychology, they may convince us that it has been paved for our mutual benefit and thereby convince us to use it.

Two of our Canadian Provinces are already on this super highway of government health insurance and both are being claimed as successful. One is voluntary (Alberta) and the other compulsory (Saskatchewan). I will not dwell on the mechanism of each since you are probably all aware of how they work. In Toronto recently we heard some first hand reports of how the plans are working out and both appear to be fairly well accepted now by both profession and public. It has been apparent, however, that in the compulsory one, physicians incomes on their present fee for service schedule and the increased work load imposed have skyrocketed. This is a worry to both profession and government alike. How much further along this highway they will continue to travel is not yet apparent and it appears there will be a speed limit or some other control introduced soon.

My main objective to-night is to point out some of the newer roadsigns that are presently appearing along our highway of medicine. It is these signposts which a pre paid medically sponsored plan such as Maritime Medical Care and in fact, all carriers of health insurance will have to interpret and decide how far to go on this road or that or whether to travel along some at all. Some may only be pathways and others will end in dead ends. What are these highways to be travelled and roadsigns to be interpreted? I would like to-night to discuss briefly the following ones:

The Highway of Multiple Doctor Care
In Here for Annual Physicals and "Check-Ups"
Fragmentation of Services and Fees
This Way to the Teaching Unit
Stop Overservicing and Overutilization
Turn Here and Meet Your Sponsor

Before taking these roadsigns of medicine up individually, I would like to make it clear that any opinions I may express are my own and do not necessarily represent the opinion of the Board of Directors of Maritime Medical Care Incorporated.

The Highway of Multiple Doctor Care for the Patient

The old days of complete care of the patient

1. Address to Cumberland Medical Society's Annual Meeting, 17 February, 1965.
2. Medical Director – Maritime Medical Care Incorporated.

by the 'family doctor' appears to be gone and yet this was primarily the system of practice at the time Maritime Medical Care had its beginning. The evolution of medical practice over the past two decades since the War has changed this from one doctor carrying out the complete care of the patient to multiple doctors on many of our cases, particularly the hospitalized ones. The rise of specialization and group practices has brought this about where at one time general practitioners far out numbered specialists, to-day in Nova Scotia the percentages are now approaching equality. The enrolment of participating physicians at Maritime Medical Care presently is roughly 55% general practitioners to 45% specialists. In 1964 Maritime Medical Care's payment to physicians, amounting to 3¾ millions of dollars, was 53% to general practitioners and 47% to specialists. By way of interest, in 1964 Maritime Medical Care subscribers received 2,440 services every 24 hr or 102 per hour day and night. The increasing number of specialists in many communities, along with aggressive committees on accreditation of hospitals is making it inevitable that a larger percentage of medical problems formerly handled by the attending physician will be directed at some stage to the specialists for attention. This has been particularly true in the field of surgery, and to an increasing extent in medicine. The Halifax, or medical school area, is of course, as expected, still the mecca of specialization in Nova Scotia. The shortage of private bed accommodation also is a factor. It is not unusual any more for us to receive accounts from three or more physicians on a particular case. Indeed, one I processed recently had 12 physicians in attendance, 11 of whom were specialists. Team procedures are getting commonplace, for example, cardiovascular, renal and intensive care units, and as you can appreciate, all these increase the cost of care no matter who is paying for it. This signpost therefore, represents a highway which can be very bumpy for a pre paid plan such as ours, if we are to keep premiums to subscribers at a level competitive with other insurance carriers. They can make up on their costs by selling indemnity types of contracts which eliminate certain high cost items, or by not selling to people who are poor risks, or they may pay a schedule of fees less than your own. To-day, fee schedules contain fees for directional care, concurrent care, continued care, supervisory care and although we would like to cover these items, it will remain for some future work on this highway to smooth out the bumps before it can be ready for paving.

In Here for Annual Physicals and "Check-Ups"

This is as yet a highway still on the planning board. Its route has been altered and examined many times. Most of the pre payment plans have not as yet found any workable way of including this feature as a benefit. Many systems have been thought of but none found practical from a cost angle. You can appreciate the problem when you realize that the average cost for this done by a general practitioner is $10.00 per examination. We have 176,000 subscribers, an increase from 165,000 a year ago. The cost problem becomes immediately obvious. Nevertheless, we, as a profession, have endorsed this as a must for everyone. Every para medical health society I can think of now advertises this advice. We, as a paying agency, agree it is a desirable feature, but as yet have not dared to try this highway for fear it will lead to a canyon into which the company would tumble with a crash. Some have suggested annual physicals should be allowable when a subscriber has not used his policy for illness for a period of two years. The assumption here of course, is that if he has attended a physician for illness, he doesn't need an annual physical examination. This argument is not all that simple and this benefit may have to wait for some form of government sponsorship, for at the moment, I don't think personally it can be financed by the plans and keep the premium within reach of Nova Scotians. This highway is therefore, still one for further planning.

The Road of Fragmentation of Medical Services

We are already on this highway in Nova Scotia. It began with the publication of the 1963 Schedule of Fees. This road must be travelled very cautiously or we may find our maintenance costs very high. It began with fragmenting of services such as the medical consultation and Preamble definitions carried it a bit further. A medical consultation used to cover under one fee, the necessary diagnostic tests such as electrocardiograph, fluoroscopy, etc. Now these are separate items. Surgical procedures are now paid at one-half for any additional one done at the same time as the original surgery planned. Also many of our specialties are now being fragmented into smaller, narrower fields. For example, medicine now includes an internist, neurologist, physiatrist, hemitologist, cardiologist, rheumatologist, endocrinologist and so on. No longer does one get a complete work up from one specialist. This is causing a great rise in medical care cost by the increased use of consultations and is becoming a cause of alarm to pre paid service plans who are trying to keep as comprehensive as possible. By way of interest, our statistics for 1964 shows more consultations were initiated by specialists than by General practitioners. The same fragmentation, if continued in all branches of medicine will cause

us to pause on this roadway and examine where we are heading and can we continue along it at breakneck speed as we are going. Apart from cost considerations, it appears that as doctors, we have ceased to provide what we used to call a doctor's service and we must now adapt our thinking to meet the new doctor image and a new concept of medical practice. I don't deny that this change may have been necessary and good but I do say, how far will it go or should it go. I wonder if we are on the right road in this respect because each time we fragment a service, the cost of medical care is bound to be increased. I can see some bad curves ahead and we should slow down and see where we are heading on this highway of fragmentation of services and fees.

This Way to the Teaching Unit

This is an old pathway that is being widened into a real highway. Patients who were insured and found themselves in the Public Ward, not by choice, have had their accounts paid by the insuring agency for some time now. Recently, however, I'm sure you are all aware that the Nova Scotia Legislature last year made it legal for all Teaching ward patients to be charged, insured or not. It is our understanding that a means test will apply, although we are not aware of its terms. In an area like Halifax, where this situation occurs, you have the added difficulty of the shortage of private or semi-private bed accomodation. Patients who want their own physician are denied this privilege yet now must pay full fees to a stranger for looking after him. Likewise, his attending doctor, unless he is on the staff of the Teaching Unit, has no choice but to turn his patient over to someone else who will now look after him an charge him. The principle involved here does not seem fair to either patient or doctor but there appears there is no solution at present. A large number of new beds for private practitioner use would help, of course. Another principle that bothers a pre payment agency is the request by the Teaching Unit staff to be paid full fees for supervising a resident carrying out a diagnostic or operative procedure, the fee to be based on the qualification of the staff man doing the supervising. What is supervising? Should the staff physician be required to be present at the procedure, or can he remain outside the operating room while his resident does an operation and yet be paid for the surgery? Our present agreements read "only services personally rendered by a physician are to be paid for". This newly erected signpost is one that we will have to study closely before venturing along the route it points to. Many situations arise in public ward care which can be very expensive on a fee for service basis. A medical staff man could be paid daily care for those on his service even though he may only see the patient two or three times per week personally. An anaesthetist could theoretically be paid for two or even three anaesthesias going on at the same time by supervising one or more residents giving anaesthesia in different rooms.

It is cause for alarm by your plan that if too much of our subscribers' premium dollar finds it's way into paying for public ward services in the Halifax area that it will eventually jeopardize our ability to keep the premium low enough that subscribers in the County and smaller town areas can afford to continue coverage with us. We are just starting down this road and it is hoped that both plan and teaching unit staff can travel it together without too many dented fenders. The rules of the road will need revision on this highway until the full impact of utilization is known.

The Highway of Overservicing and Overutilization

This is one highway on which Maritime Medical Care knows most of the curves and bumps already. Overservicing appears to be the bigger of these bumps and this is the one of most concern since it is the one which is under the control of the physician. It is he who decides how many calls or services he provides and charges for. Overutilization is a problem too but is nothing of the calibre of the other. At the recent T.C.M.P. Mid-Winter Conference in Toronto, all plans across Canada felt that overservicing by physicians is one of our biggest problems. The Canadian Medical Association is also concerned, as was evidenced in Toronto, when the discussions on policy centered around the introduction of patient participation in our plans, contracts which would include coinsurance and deductible types of coverage as a means of reducing overutilization. The effect of these in controlling overutilization was far from unanimous. There was a good deal of discussion as to whether these methods actually do control it. Evidence from Swift Current, where they were used, seem to prove they do not cut utilization down except for a short time. Certainly these types of contracts are not popular, publicly or politically. The Canadian Health Insurance Association points out that 85% of people in Alberta bought service type contracts with first dollar coverage. Talks were heard from Physicians Services Incorporated and other plans of ways and means of controlling overservicing by physicians and I must say they are following much the same pattern as we are in attempting to control this. Some have more authority in their medical setup for dealing with it, such as Ontario has recently used. Proof of overservicing or fraud is first obtained by various means which include audits, patterns of practice studies, medical advisory committee and finally their College of Physicians

and Surgeons who are capable of disciplinary measures. This is proving to be a very effective way of doctors dealing with doctors so that we do not have to wash dirty linen in the public courts. Maritime Medical Care has examined this system and it is hoped something similar can be worked out here to help our plan in control of such offenders. Thus, it is seen that some red lights and stop-signs are being installed on this road which are for our own safety and to slow down the traffic.

There will, in all probability, still be some traffic violations to be dealt with and it is hoped that the highway Patrol in this case will be made up of physicians themselves.

Turn Here and Meet Your Sponsor

This is a crossroad at which both plan and profession were bound to meet at some point. The formation of the Joint Study Committee has been the result of this meeting Some gravel has been thrown around but there doesn't appear to be any broken windshields yet, although I believe some were cracked. Seriously, though, this Committee has accomplished a great deal and I believe will continue to do so. This was the first time the plan and its sponsor ever sat down together to iron out mutual difficulties. At the onset, it was made clear that the Medical Society wished the plan to deal only with it and not with individual physicians or sections. As our sponsor wished, this is what we have done. All decisions have had the approval of both bodies before being implemented. It was apparent at one stage that some individual physicians and groups did not agree with what we did. Some things do not appear to be very popular even yet but we are at least both travelling the same road in an attempt to work these out. The plan has a responsibility to 176,000 people or roughly 25% of the population of Nova Scotia and thus can't change its mind too often or irresponsibly without affecting the health insurance coverage of a lot of people.

Sponsorship by the medical profession is still necessary and vital for a service type comprehensive plan to work and up until now, this is the only type we have been allowed to sell. Our society has insisted on this although recently there are some second thoughts on this subject if we are to remain competitive with the private insurance industry. Canadian Medical Association policy appears to be evolving this thought as well. Also, the Hall Commission may seriously affect our operation as well, if it is implemented by government. What the future holds, no one knows but I am sure that this is the time we as a profession need to back our plan to the hilt. The road of sponsorship is a responsible one. We must not let outside influences split up the profession when a medicare scheme in Nova Scotia seems to be not too far away. If we are to be strong when it comes time to negotiate, we must be united, not split up with some backing one plan and some another. We must try to remember that we are all working for the good of the profession to provide the best health service for our people. There will be times when our own personal thoughts will have to be suppressed for the good of the whole of medicine. We might not all like Maritime Medical Care 100% but I think we would have all been worse off had it not existed these past 15 years. The older physicians can remember why Maritime Medical Care started. Our younger physicians have known nothing else but practice under such a scheme as well as other forms of insurance. It would do us all good to pull over to the side of this road and reflect for a moment on this subject because sponsorship is still our responsibility. If we as a profession are going to sponsor Maritime Medical Care, let's get behind it again and make it work. □

1000 WORD SERIES (24)

Ankle Injuries

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

Halifax, N. S.

The ankle joint is one of the most frequently injured parts of the body. Because it is also one of the main weight bearing joints of the body, different injuries may cause lasting disability. In any injury the bony damage is usually the least important factor and the prognosis should be based on the surrounding soft tissue damage. Therefore it is very important to assess the degree of the soft tissue injury, especially if the radiographs of the ankle are reported to be negative.

Sprains of the Ankle Joint

The clinical term of "sprain" is used if the radiographs of the ankle do not show a fracture. In the mind of a clinician it usually denotes a relatively mild injury leading to a full recovery no matter what is done. The ligamentous injury varies in extent and should be treated accordingly. From the pathological standpoint there are four degrees of the ligamentous injuries:

1. Strain: It denotes the injury of a ligament without lengthening of its fibers. It is often accompanied by a synovial effusion due to the pinching of the synovial membrane and subsides rapidly with rest without leaving any sequelae.

2. Minor Sprain: Some of the interligamentous fibers are ruptured with little effusion into the tissues and some effusion in the joint space. There is no lengthening of the ligament involved and does not lead to any instability of the joint.

3. Severe Sprain: The interligamentous fibers are ruptured with overall lengthening of the ligament. If not treated properly it leads to some permanent relaxation of the ligament.

4. Very Severe Sprain: Either there is a complete rupture of the fibers of the ligament or a periosteal detachment of the ligament from the bone takes place. If not treated properly it leads to the permanent instability of the joint becoming a lasting source of disability.

The severe and the very severe varieties of the sprains are differentiated from the milder ones by the presence of ecchymosis centered over a ligament with the maximum point tenderness over the same ligament and rather marked degree of the soft tissue swelling. If there is any doubt it is a must that a stress film of the ankle should be taken after the abolition of the pain with a local anesthetic, comparing it with the normal side. The stress film may show a tilt of the talus from 5° to 45° according to the severity of the ligamentous injury.

The treatment of the strain and the minor sprain consist of the elevation of the limb and the application of an elastic bandage. For the first two days a cold application, subsequently the application of local heat helps to relieve the pain. A local anesthetic may also be injected for relief of pain, followed by massage to get rid of the swelling. The active exercises of the toes as well as of the ankle joint are very important to prevent the development of the vaso-motor disturbances. The patient is allowed to be up after three to six days. In severe sprains a walking cast should be applied for five weeks, keeping it six weeks in the more severe varieties. If there is a complete rupture of a collateral ligament allowing 30° to 45° of tilt of the talus the surgical repair of the ligament is strongly recommended. If a patient is seen with a lateral instability of the ankle joint due to an old injury a boot having a steel strip built in is recommended for all strenuous games. For a woman, the heel should be low and wide with a $\frac{3}{16}$" wedge built on the side of the instability. An anklet may also be found to be useful in giving stability. If in spite of these measures the patient continues to complain, reconstruction of the torn ligament is recommended.

The diastasis means the rupture of the ligaments binding the distal end of the fibula to the tibia causing them to separate. The widening of the ankle joint mortise can be seen on the initial films or could be shown to be present by taking a stress film. Sometime a fracture of the upper third of the fibula may accompany it, and should be looked for (Maisonneuve Fracture). Diastasis may accompany the different types of ankle fractures or may be present alone. Whether or not there

is an accompanying fracture, for the future function of the ankle joint, the ankle joint mortise must be restored. This usually can be done by closed reduction, if not, an open reduction fixing the fibula to the tibia with a screw will need to be done. In either case a cast is applied for six to eight weeks according to the degree of the separation. The screw should be removed before the weight bearing is allowed, for normally some motion takes place at the distal tibio-fibular joint.

Fractures and Dislocations

The type of the fractures involving the ankle joint vary according to the direction and the degree of the force causing the injury. To know the direction of the force which caused the fracture is important in carrying out its proper reduction. The majority of the ankle fractures are caused by the external rotation force; according to the degree of the violence there may be only an oblique fracture of the fibula (First Degree), an oblique fracture of the fibula with the fracture of the medial malleolus (Second Degree) or the same including also a posterior marginal fracture of the tibia (Third Degree). The first and the second degree external rotation fractures may or may not show a diastasis, the third degree ones always show a diastasis. The abduction force, according to the degree of the violence causes a transverse fracture of the medial or the lateral malleolus below the tibial plafond (First Degree), transverse fractures of the both malleoli (Second Degree) or the same including also a posterior marginal fracture of the tibia (Third Degree). The first degree abduction fracture does not show a diastasis, the second degree may or may not, the third degree ones always show a diastasis. The adduction force causes a vertical fracture of the medial malleolus or a transverse fracture of the lateral malleolus below the tibial plafond (First Degree), both together (Second Degree) or the same including also a posterior marginal fracture of the tibia (Third Degree). The adduction fractures do not show a diastasis. In general if the both malleoli are fractured it is called a bimalleolar fracture, if also there is a posterior marginal fracture of the tibia it is called trimalleolar fracture. The compression force causes a vertical marginal fracture of the tibia. A fracture of the talus involving the body or the articular surface may be associated with any severe ankle fracture.

First aid in ankle fractures is important as in any other fracture. The limb should be splinted, without any effort to correct the deformity. A pillow tied around the leg and foot is one of the best splints. The limb should be kept elevated to prevent swelling and to relieve pain. Some medication may also be needed to relieve the pain. Compound fractures are true operative emergencies for an early debridement of the wound to prevent infection. A thorough examination is done to assess the degree of the soft tissue injury including nerves and arteries. Along with the general physical examination the knee joint should also be examined carefully, because the forces causing the ankle injury may also cause a meniscus tear or a collateral ligament injury. Adequate multiple view radiographs should be taken including the whole length of the fibula.

The reduction of the fracture should be done under adequate general anesthesia. Occasionally a local hyaluronidase injection may prove to be of value eliminating some of the local swelling. In all fractures requiring reduction the plaster cast should include the thigh. Postoperatively the limb should be kept high. Exercises of the toes as well as muscle setting exercises are very important and should be done every five minutes. The splitting of the cast may be required if it gets too tight. One of the cardinal principles in the treatment of all ankle fractures is the changing of the cast as it gets loose. Weight bearing is not allowed for 6-12 weeks according to the extent of the damage of the articular surfaces.

In the treatment of ankle fractures conservative management is best and the great majority can be treated in this manner. However, occasionally an open reduction may be required. The following are the most frequently encountered indications for an operation:

1. Medial Malleolus. A large percentage of the abduction fractures of the medial malleolus leads to non union because of the interposition of soft tissues. It is extremely rare in fractures caused by the other forces. If the closed reduction proves to be inadequate, an open reduction should be done with a screw fixation.

2. Posterior Marginal Fracture of the Tibia. If it involves the weight bearing portion of the tibial plafond and can not be reduced by closed manipulation, an open reduction is required fixing the fragment with a screw.

3. Diastasis of the Distal Tibio-fibular Joint. If the closed reduction fails an open reduction is done with a screw fixation.

4. Complete rupture of the medial or lateral collateral ligament.

5. Anterior Marginal Fracture of the Tibia. It often requires open reduction.

6. Removal of loose bodies from the joint.

7. All compound fractures.

8. Fracture of the distal end of the fibula, with the proximal fragment locked behind the tibia. □

Reference

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The Lifted Serpent[1]

And as Moses lifted up the serpent in the wilderness, even so must the Son of Man be lifted up;
That whosoever believeth in him should not perish, but have eternal life.
John 3:14-15

First of all, on behalf of the Kirk Session and congregation of St. Matthew's Church, I want to assure the Federation of Medical Women of Canada and the Canadian Medical Association of our very warm welcome to you as you come to worship with us. We welcome you to this province by the sea, to this old seaport city, and to this old church, founded the same year as the city, in 1749. We hope that you will enjoy your stay with us, that your deliberations will be fruitful, and that you will be blessed as you begin your activities here among us in the public worship of Almighty God.

Your officers tell me that it is usual for the sermon on these occasions to have some medical reference; and I have tried to do this. It ought not to be difficult, for the association of Medicine with Theology is a very ancient one.

Down in the basement of this church there is a library which includes many volumes acquired in the middle of the 18th century. I found one book presented to the church about 1755. It is a third edition, printed in 1717, of a volume dated 1715, by one Humphrey Prideaux, Dean of Norwich, and appears to consist of somewhat heavy theology. I thought you might be interested in the preface, which begins as follows: "The calamitous distemper of the stone, and the unfortunate management I fell under after being cut for it, having driven me out of the pulpit, in wholly disabling me for that duty of my profession, that I might not be altogether useless, I undertook this work. . . . . ". It appears that on at least one occasion, medical arts were able to assist in the furtherance of theological study!

By the way, another alliance of the interests of medicine and theology was suggested a century earlier by John Owen, in the following quatrain:

God and the doctor we alike adore,
But only when in danger, not before.
The danger o'er, both are alike requited;
God is forgotten, and the doctor slighted. . .

The Bible has a number of references to medical practices; some of them no more flattering than the Dean of Norwich; and since doubtless you know them well, we shall put them to one side. There are many others, however, which have been inspiring pointers to the link between Christian faith and the healing arts. When Paul lists the gifts of the Holy Spirit in I Corinthians, he does not forget to say "to another the gifts of healing, by the same Spirit"; and when Jesus sends out the Apostles after the Resurrection, he says to them: "and these signs shall follow them that believe; In my name shall they cast out devils; they shall speak with new tongues; They shall take up serpents; and if they drink any deadly thing, it shall not hurt them; they shall lay hands on the sick, and they shall recover".

Indeed, the link is so ancient and so well established that I wonder if in addition to such ancillary medical branches of study as medical jurisprudence, medical economics, medical ethics, etc., there should not be known as medical theology or theological medicine?

Certainly the healing arts occupy a prominent place in the Scriptures; one of the gospel writers was himself a physician, and a beloved one at that; and a large proportion of the work of Jesus has to do with the bodily and mental illness of people, as well as the spiritual.

There is therefore no dearth of Bible material for an occasion like this. I have chosen for subject 'The lifted serpent" with the text from Jesus' words recorded by St. John . . "And as Moses lifted up the serpent in the wilderness, even so must the Son of Man be lifted up, That whosoever believeth in him should not perish, but have eternal life".

The Serpent has a long association with the medical arts. Aesculapius, the Greek God of medicine, described in Homer as a skilful physician, had as his emblem a club-like staff with a serpent coiled around it; and this emblem, of course, survives to our own time, and frequently appears in military and other medical insignia.

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[1]A Sermon to the Canadian Medical Association, St. Matthew's Church, Halifax, N. S., June 13, 1965, by the Rev. C. A. Allan Beveridge.

In ancient legends the healing power of serpents appears quite often. Cadmus and his wife were turned into serpents to cure human ills, and there are antique tales of serpents being tended and fed in sacred places and shrines, supposedly with healing powers.

It is not surprising, therefore, that the same idea appears in those stories from the dim past recorded in the earlier parts of the Old Testament. It occurs first in a curious passage in Numbers 21. It comes from the account of the wanderings of the children of Israel in the wilderness before they came to the promised land.

"And the people spake against God, and against Moses. Wherefore have ye brought us up out of Egypt to die in the wilderness? for there is no bread, neither is there any water; and our soul loatheth this light bread. And the Lord sent fiery serpents among the people and they bit the people; and much people of Israel died.

"Therefore the people came to Moses, and said, We have sinned, for we have spoken agaist the Lord, and against thee; pray unto the Lord, that he take away the serpents from us. And Moses prayed for the people.

"And the Lord said unto Moses, Make thee a fiery serpent, and set it upon a pole; and it shall come to pass, that every one that is bitten, when he looketh upon it, shall live.

"And Moses made a serpent of brass, and put it upon a pole, and it came to pass, that if a serpent had bitten any man, when he beheld the serpent of brass, he lived."

It is curious that here the serpent is both the cause of disease, and the cure. The fiery serpents were presumably venomous ones whose bite caused inflammation. The commentators suggest that the use of a bronze serpent on a stick may have implied some kind of sympathetic magic, or perhaps a naive notion of a counter-irritant. Anyway, whatever primitive ideas the people themselves had at the time, the editor of Numbers, writing long after, is quite sure that whatever healing occurred was the gift of God.

Apparently the bronze serpent caught the fancy of the Israelites, and they seem to have preserved it for a long time. Several centuries later they had become very superstitious about it, and in fact were worshipping it as an idol. When King Hezekiah came along, he started a revival and reformation, and one of the things he did was to smash the brazen serpent, contemptuously referring to it as "Nehushtan" - a bronze thing - a useless piece of brass. "He did that which was right in the sight of the Lord", it says, ". . . . .He removed the high places and brake the images, and cut down the groves (these were the woods where the people carried on degrading rites which I shall not describe even before this audience) and brake in pieces the brazen serpent that Moses had made: for unto those days the children of Israel did burn incense to it; and he called it Nehushtan".

This little sketch brings us to our text, which is a reference Jesus made to the affair, "And as Moses lifted up the serpent in the wilderness, even so must the Son of Man be lifted up, that whosoever believeth in Him should not perish, but have eternal life". He is obviously quoting this curious piece of medical folklore and using it as some kind of parallel to his own person and work. "There is something", he is saying, "There is something in this strange and ancient tradition which, crude though it may seem today, is yet suggestively similar to what I am and what I can do for you".

What was in the mind of Jesus when he uttered these words? Can we peer with a kind of reverent inquisitiveness into His thought?

1. For one thing, I am sure he was thinking about *healing*. The whole incident of Moses and the bronze serpent was associated in the tradition with healing; and Jesus would not have quoted it without that in mind. So our thoughts are driven straight to Jesus as healer - a role in which He appears again and again in the gospel stories. We follow with fascination this gentle compassionate figure as He moves through the pages of the narrative, in which over and over again it is said that "in that same hour he cured many of their infirmities and plagues, and of evil spirits, and unto many that were blind he gave sight". "Go your way", he said one day when they asked for his credentials, "Go your way, and tell John what things ye have seen and heard; how that the blind see, the lame walk, the lepers are cleansed, the deaf hear, the dead are raised: to the poor the gospel is preached".

Modern scholars have studied these narratives with all the resources of recent knowledge; and they have given rational explanations of many of the recorded cures; some, indeed, they would seem to explain away altogether. But when we have listened respectfully, as we ought, to all these clever explanations, we are still left with an unexplained residue; with a figure who, at the very least, impressed his contemporaries with an extraordinary personal power and authority over disordered bodies and minds. We cannot say less than that, and I for one would say a good deal more. It is well known, of course, that an unusually powerful and rich personality in the healer, together with an unreserved trust and confidence on the part of the patient, can be strikingly effective in disorders of the mind. We Christians who are unshakably convinced that God was in Christ, reconciling the world unto Himself, are also sure that in Christ there dwelt the whole power and compassionate love of God in such a unique fashion that even organic disorders of the body yielded in ways that have not yet been scientifically accounted for; if for nothing else than that the conditions are

not present for 20th century laboratory analysis. In the pages of the New Testament we encounter a unique spiritual force which could not be adequately analysed then, and presumably could not be adequately analysed now, and before which we can only say, "This is the Lord's doing, and it is marvellous in our eyes".

We must also notice when we look at Jesus as healer, that again and again he is described as *acting from compassion*. Repeatedly we read that "he was moved with compassion". Indeed, it almost seems that, conscious of extraordinary powers, he would have preferred not to use them lest people should be attracted by mere wonder-working; but when he saw someone in need, the compassion and power overflowed almost in spite of Himself, and "he stretched forth His hand, and healed them". I think I am observing modern medical practice accurately when I say that it strives to unite the utmost scientific knowledge that can be wrested from nature in the laboratory with the utmost compassion of which the human heart is capable. At least I would testify gratefully that this is my own experience; and to that extent modern medicine follows in the tradition of the great Physician.

II. A second factor present to the mind of Christ when he spoke these words was undoubtedly *his coming death*. Certainly we cannot read them in retrospect without turning at once to the Cross. "As Moses lifted up the serpent in the wilderness, even so must the Son of Man be lifted up". And ever since, Christians hearing these words have associated them instantly with Calvary.

No one can understand the Christian faith who does not see what P. T. Forsyth called "the Cruciality of the Cross". . . . .the central place it demands in Christian thought and experience. When in the fulness of time the Lord of the Universe moved among us to identify himself with our human condition, he did not shrink from the final humiliation of death. This is the length to which Love is prepared to go for us. If God and man are ever to be brought together, it will not be by man laboriously climbing to God's level. . . oh no! That can't be done! It must be God coming down to our level, and tasting everything, even death, for every man. This is the grand reconciliation, the ultimate integrating of the human with the divine; that God should be with us, down to the lowest and the dirtiest and the messiest of human experience. So the Son of man must be lifted up. If you cannot see here that compassionate love is at the heart of the universe, you will never see it anywhere else in human experience. If all the complex alienations that bedevil the life of modern man - alienations from himself, from his fellow, from his entire condition - if these alienations do not find their resolution here, I do not think they will find it anywhere.

III. Another feature of the Christian faith which comes immediately to my mind as I ponder these words is the *Resurrection* and *Ascension* of Jesus. He was lifted up in the sense that he rose victorious over death. I said that the Cross is central in Christian thought and experience. So is the Resurrection. If you look carefully at the substance of the preaching in the New Testament - Peter, Stephen, Paul and all the rest of them - you will see that the heart of it is Jesus Christ the Son of God, crucified and risen again. Cross and Resurrection - Cross and Resurrection - over and over again this is the message which drew and saved men. There are some in our day who would dilute or reduce these elements - explain them away as not consonant with modern knowledge, forsooth! They would recommend to us some kind of diminished or abridged religion. Well, this is a free country, they say; and people are not forbidden to organize new religions. But let them not be impertinent enough to call this maimed truncated thing Christianity! The only authority we have for the Christian faith is the New Testament, and in that Testament the Resurrection is writ unmistakably large! If you try to take it out, what is left is certainly not the New Testament! *That* book glows with the unshakable assurance that Christ is alive in the power of his Holy Spirit, that the ancient enemy, death, is defeated, and that God's children can share in Christ's risen power! "I, if I be lifted up, will draw all men unto me".

IV. And then, too; when we speak of lifting Christ up, we must speak about *proclaiming* Him. If I hold Him up today, someone may be drawn to Him. When I was a lad, my father lifted Him up; my minister lifted Him up; and I am here today. Here is the responsibility of Christian witness - we not only receive the grace of God, we reflect it and pass it on - we must communicate it to others. I don't know what else will draw all men, if not Christ; do you? Arthur Gossip put the thing in an eloquent passage:

> "Think of that desperate people in the wilderness, dying in multitudes, beset by those loathsome creatures from which there was no escape; and how the word ran through the stricken camp that if only they would keep looking at the brazen serpent lifted up for all to see, that would mean deliverance for such as still survived, and death would be cheated of its victims. So, says, Christ, here is this ailing, sinful, foolish, desperate world that has lost its way, and is living like some primitive, barbaric tribe which imagines that its nasty little customs are the only possible rules of life anywhere and for anyone. And if men see me, and keep looking at me, the heavenly things that are all dark to them will dawn upon them; and the glory of what God really is will come home to them; and the splendor of what a human life can be will storm their hearts, and sicken them of what they are, and bring them to their feet, whole men, ready to live a fuller life than they have ever dreamed is possible".

One other word: and it is about the closing part of the text. Jesus says that the Son of man must be lifted up. . . ."that whosoever believeth in him should not perish, but have eternal life".

My closing word is about "*eternal life*". We usually think of it as life after death only - immortality. But in the New Testament the expression has a richer meaning. It is no mere prolongation of existence, though it includes that; no mere extension of life, but a whole new quality of life, entered upon here and now by faith - so radically new, in fact, that it is often called being born all over again. He who is joined to God through Christ enters on a new wholeness or completeness of life. You know the Saxon identity of the words health and wholeness - it is full life, rich, complete, all that it ought to be. What I'm saying is that whole, healthy, full life is not possible in its completeness without that reconciliation with God which is Christ's gift. Many years ago Professor Jung, who was no Christian apologist, said the following words, which have become famous: "During the past thirty years people from all the civilized countries of the earth have consulted me. . . Among all my patients in the second half of life - that is to say, over thirty-five - there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost that which the living religion of every age have given to their followers, and none of them has been really healed who did not regain his religious outlook".

This wholeness of body, mind and spirit is health. It is eternal life in the richest New Testament sense, and it is the thing which you and I covet passionately for men. In the search for it, you who are in one of the noblest of callings are walking, consciously or otherwise, in the steps of the great archetype healer, who is Christ; and in the 20th century you strive to join the fullest scientific knowledge and skill to the richest Christian compassion. □

Genetics and the Physician

P. L. Delva, M.D.
Antigonish, N. S.

PART I

This series of short articles covers a few of the various interesting facets of modern genetics. In this first article, some basis ideas will be presented concerning the structure of chromosomes and genes, with a few definitions.

Chromosomes

In Sweden during 1956, adopting the squash technique long used by botanists, Tijo and Levan discovered that man had 46 chromosomes, consisting of 22 pairs of autosomes, and one pair of sex chromosomes. Today, chromosomes can readily be examined: at the metaphase stage of mitosis, each chromosome has replicated except at the centromere; at this stage, the chromosome has the appearance of a large X or a large K. Arrest of mitosis at this stage by chemical means easily enables us, with a microscope, to visualise and count the 46 chromosomes, and classify them according to size and shape, as in Fig. 1. Note that chromosomes 13, 14, 15, 21, 22, and the small male sex chromosome have subterminal centromeres; these chromosomes are acrocentric. A woman has two large sex chromosomes, and a man a similar large one, plus a small acrocentric one referred to as the Y chromosome. In humans, the presence of the Y chromosome determines the male sex; an individual without a Y sex chromosome is female, and one with a Y is male. This rule does not apply to all species. In Drosophila Melanogaster for instance, the common fruit fly, it is the proportion of the mass of X sex chromosome material to the total mass of autosome material that determines sex. In humans, the male is the heterogametic sex. In some animals, poultry for instance, the female is the heterogametic sex.

Much work is being done on the structure of chromosomes. Many models have been postulated, none of them proven. Taylor and Freese recently postulated a model consisting of protein and deoxyribonucleic acid, (DNA) as in Fig. 2. With such a model, uncoiling of the DNA strands for replication appears to be a simpler matter than in previous models where the DNA strands were very much longer. A closer look at a DNA strand reveals a coiled structure made of nucleic acids, ribose and phosphate, as suggested by Watson and Crick. The DNA is the genetic material, the protein part of the chromosome being but a supporting backbone. Part of a Watson-Crick helix is shown in Fig. 3. Only four nucleic acids are involved, thymine, cytosine, guanine and adenine. Opposite a purine (adenine or guanine) you invariably find a pyrimidine, this for spatial reasons. The two strands are held together by hydrogen bonds.

Genes

A gene is the length of DNA which controls the production of one particular enzyme, this is a functional definition. A gene thus contains a certain well-defined number, possibly about 400, of nucleotide pairs (Fig. 3), the exact number of nucleotide pairs depending upon the complexity of the enzyme involved. A subsequent article will discuss how a gene controls the manufacture of an enzyme, and will include more details regarding cell function. Each cell thus has many genes (possibly about 100,000) each of a pair of genes occupying an identical position (locus) on each of the pair of chromosomes. Normally, genes at a given locus are identical. Occasionally, one of them may be different and the different gene is known as an allele. An allele is thus a condition of a gene. If the effect of one allele does not express itself unless a pair of identical alleles are present at one locus, the effect is recessive, the gene is recessive. If however the effect of one allele is obvious, the gene is dominant. Sometimes different alleles are present at the same locus, and the effect of each is obvious; these alleles are codominant. A sex-linked gene is one which is situated on a large sex chromosome, the Y chromosome being for practical purposes genetically inert. Thus, the effect of one recessive gene on a sex chromosome, such as the gene for hemophilia, will be obvious in the male and hidden in the female.

Penetrance and Expressivity

The effect of the presence of an identical pair of recessive alleles, or of a dominant allele, is not necessarily obvious in all persons; this is known as penetrance. For instance, the gene for retinoblastoma, a dominant inherited malignancy affecting the retina, will in 20% of cases, remain inactive, although capable of transmitting the disease.

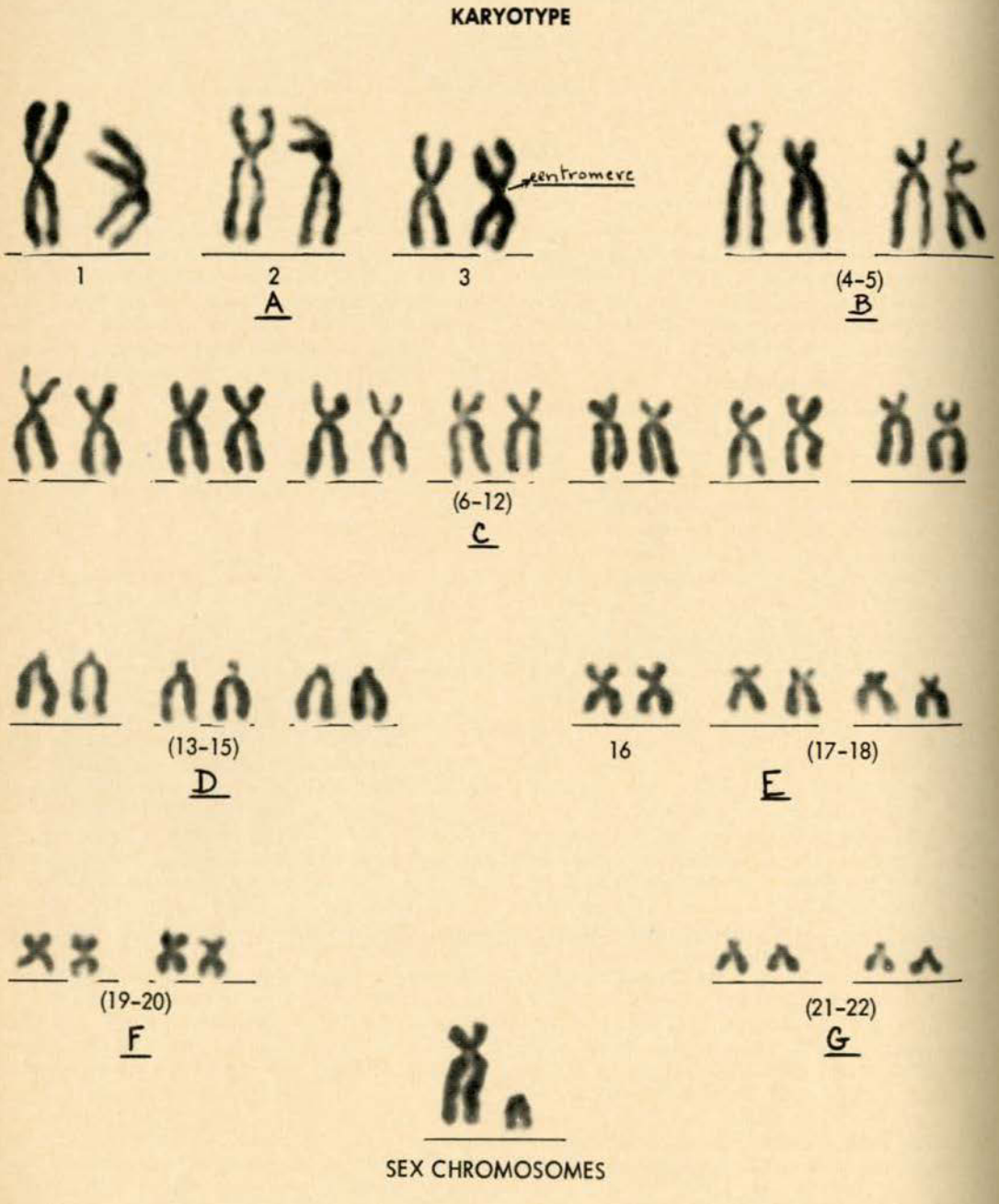

Fig. 1 Male Human Chromosomes. Note the six groups, A–G. The X chromosome belongs to Group C, and the Y to Group G.

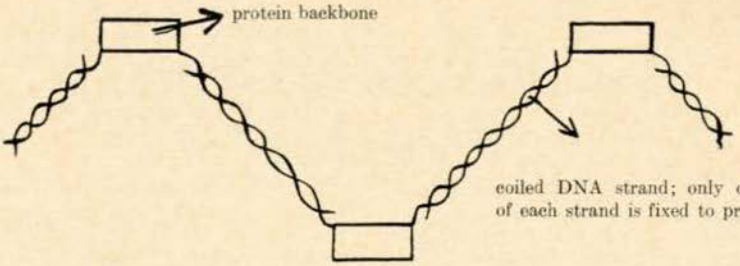

Fig. 2. Taylor and Freese's model of a chromosome.

The penetrance of retinoblastoma is then 80%. On the other hand, the clinical severity of a disease is the genetic expressivity of the condition. When we say a disease has an expressivity of 100%, we mean that all affected patients show all the features of the disease. If 20% of patients are fully affected, the remaining 80% showing just some of the different manifestations of the disease, the expressivity is then 20%. The incidence and severity of diabetes mellitus for instance is compatible with the theory that the disease is due to a pair of recessive genes occurring with a frequency of 5%, a penetrance of 20%, and an expressivity of 20%. The concept of expressivity is of fundamental importance; the expressivity of bad genes can be altered by changing the environment, as in diabetes, phenylketonuria, galactosemia, cystic fibrosis; it is partly dependent upon the environment. □

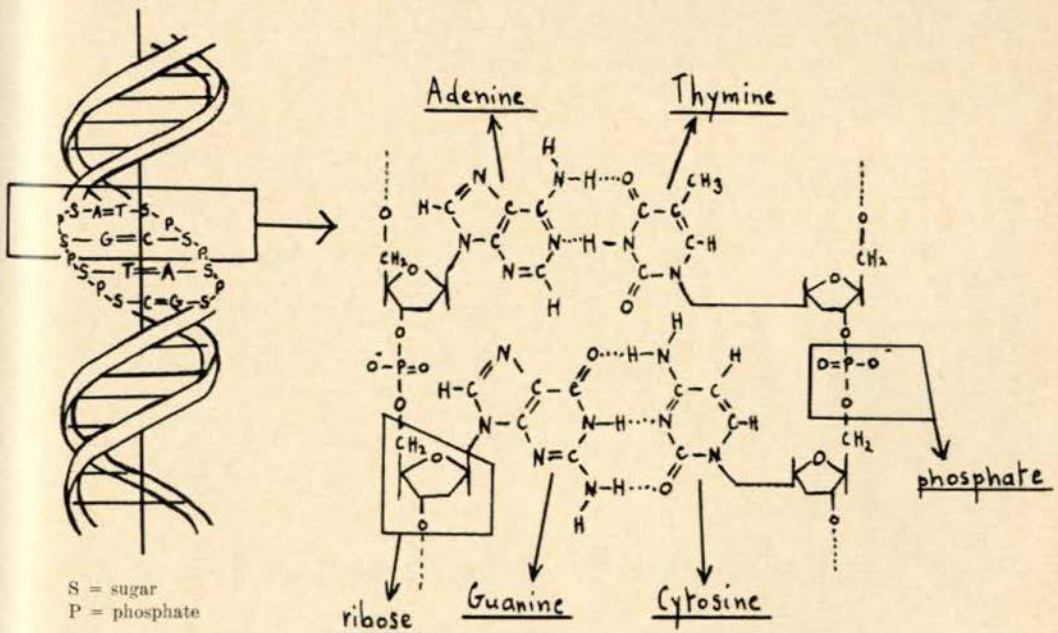

Fig. 3. Watson-Criek Helix. Normal Base Pairing: a nucleotide = nucleic acid, plus ribose sugar, plus phosphate.

Reactivation of Inactive Pulmonary Tuberculosis[1]

In a study conducted among former tuberculosis patients whose names were on the registry of a local health department, 8 per cent were found to have reactivated. Long-term medical supervision of inactive cases, with bacteriologic studies, is recommended.

The reactivation of apparently inactive pulmonary tuberculosis has drawn increasing attention from both clinicians and those in public health.

Most studies of reactivated disease have been among Veterans Administration hospital patients or patients discharged from sanatoriums. The present study was conducted among patients whose names were on the tuberculosis registry of a local health department.

The study had several objectives. They were (a) to determine the number of reactivated cases among persons with apparently inactive pulmonary tuberculosis; (b) to obtain data, for both the reactivated and inactive groups, on sex, age, extent of disease, and type and duration of treatment; (c) to compare the extent of disease in the reactivated group with diagnosis at the time of reactivation; (d) to establish and maintain a register of inactive cases of pulmonary tuberculosis; and (3) to determine an effective method of following inactive cases to prevent reactivation.

Records were reviewed of persons with a diagnosis of active pulmonary tuberculosis known to the Long Beach Health Department from 1935 to 1960. Of these, 2,536 were selected because the disease had become inactive, and 1,508 were invited to participate in the study because of availability of addresses.

Former patients living in the Long Beach metropolitan area were asked to visit the health department for a chest X-ray and bacteriologic studies. If they preferred, they could request these examinations of their private physicians.

Procedure Followed

Those residing outside the Long Beach area were asked to visit their physician or local health department. Results were to be forwarded to the Long Beach Health Department. The health department of jurisdiction and hospitals and other health agencies were informed of the project.

Of the 399 responses, 343 persons visited the Long Beach Health Department, and 28 others, under the care of a private physician, gave the health department permission to obtain the desired information from the physician. Information concerning another 28 was received from such sources as hospitals and health departments. Only 16 refused to participate in the study.

History was obtained for each person who visited the health department for the interval between prior treatment and the beginning of the study. In addition, a 14- x 17-inch chest X-ray film was taken and a specimen for bacteriologic study was requested.

Bacteriologic studies were extended over a two-month period to allow time for adequate cultures. All studies included a niacin test to exclude unclassified mycobacteria. A health department physician reviewed the test results and completed the study history form. The latest chest X-ray was compared with earlier films available in the patient's records.

A summary of findings was sent to the patient's private physician, and the patient was notified by mail of the test results. Persons with positive chest X-rays or bacteriologic findings indicating active disease were urged to obtain medical care.

Reactivated Disease

Evaluations were completed on 383 persons, or 15 per cent of the 2,536 selected for the study. Thirty-one persons, or 8.09 per cent, were found to have reactivated disease. The status of 352 persons remained inactive.

I. D. Litwack, M.D., and John Gardner, M.D. *Public Health Reports*, September, 1964.

[1]Reprinted from the Abstracts of the National Tuberculosis Association, January, 1965.

Printed through cooperation Nova Scotia Tuberculosis Association.

Moderately advanced tuberculosis had been the most frequent diagnosis in both the inactive and reactivated groups: 58 per cent of those with reactivated disease and 42 per cent of the inactive group. In the reactivated group about 23 per cent had minimal disease, and 19 per cent, far advanced; among those with inactive disease, 41 per cent had a diagnosis of minimal disease, and 16 per cent, far advanced.

Men outnumbered women in both groups, comprising 55 per cent of the reactivated group and 60 per cent of those with inactive tuberculosis. Most of the 383 persons in the study were in the 35 to 64-age category, forming 71 per cent of the reactivated group and 74 per cent of the inactive group. In the reactivated group, only 2 were under 35 and 7 were 65 or older. In the inactive group, 8 per cent were under 35 and 18 per cent were 65 or older.

A smaller percentage of the persons with reactivated disease had received drug treatment (35.5 per cent) and had undergone one or more surgical operation (22.6 per cent) than those in the inactive group, of whom 42.6 per cent had taken drugs and 29.5 per cent had been treated surgically.

Of those with reactivated disease, 6 had had tuberculosis drugs for two years or more, 5 for less than two years, and 20 had received no drugs. In the larger inactive group, 58 had received chemotherapy for more than two years, 92 for less than two years, and 202 had had none.

When previous X-ray films of the 31 patients with reactivated disease were compared with those taken during the study, 22, or 71 per cent, showed no evidence of change; 9 revealed a new infiltrate. Chest X-rays of those in the inactive group showed no change in disease status.

Diagnosis of 10 patients with reactivated tuberculosis changed from that recorded at the time of inactivation. Improvement in the disease status was noted in 5.

Cases of reactivated pulmonary tuberculosis undoubtedly exist among those who did not respond to letters inviting participation in the study and among those for whom no current address could be obtained. The records of 635 deceased persons will be followed to determine if active pulmonary tuberculosis was a cause of death.

Based on results of the study, the following recommendations are made concerning cases of inactive pulmonary tuberculosis:

1. Annual medical supervision is needed for years, possibly for life.

2. Bacteriologic studies should be included, as well as comparison of chest X-ray films with earlier films.

3. All patients who have not received adequate chemotherapy should be on a prophylactic medical regimen for two years.

4. An orientation program for both physician and patient should be undertaken. □

Personal Interest Notes

"This Year - think - don't sink. Be water wise". This is one of the slogans for Water Safety Week sponsored by the Canadian Red Cross Society. No daily paper in the province is without a record of some drowning fatality. Over 25% of the drownings are associated with boating mishaps. (A doctor's son in Shelburne was fortunate early this season when he was rescued from a sailboat). The grim statistics are a warning but to Nova Scotians the call of the sea is irresistable. Congratulations to Dr. Gordon Bethune whose "Encounter" won the DeWolfe Memorial Trophy, to Dr. John Filbee, whose "Chanteh" won the Macintosh cup, winning all three races for the trophy, and to Dr. Brownie Trask whose "Sakoose" won the Hensley Bell cup, on July 3.

HOSPITALS:

The corner-stone for the new 200 bed, $3,000,000 **Colchester Hospital,** Truro was laid on June 23 by Lieutenant Governor H. P. MacKeen, at impressive ceremonies presided over by Mayor Hector Hill, chairman of the building committee. It is expected to be officially opened in late summer or early fall.

Th- Cape Breton Post for May 14 had an account and picture of the **Inverness County Memorial Hospital** at Inverness. This hospital was incorporated in 1922, suffered total destruction of the 1930-31 building, but was rebuilt in 1939 with a nurses' Residence, added in 1941. The chief surgeon at the present time is Dr. A. MacD. Lawley. The present Medical Staff also includes Dr. N. J. MacLean, Dr. C. B. MacLean and Dr. B. W. D. Balley with Dr. W. MacIsaac as associate member.

St. Elizabeth Hospital, North Sydney during the last year, received full accreditation from the Canadian Council of Hospital Accreditation. Improved pathological service was provided when Dr. Hilda Tremblett, Pathologist, joined the staff in July 1964.

Early this spring **Yarmouth Regional Hospital** received full approval of its Laboratory facilities from the Canadian Medical Association. This approval means that this hospital can participate in the training programme for Laboratory Technicians conducted by the Nova Scotia Institute of Technology. The Yarmouth Regional Hospital Laboratory Department is directed by Dr. M. J. Cassels. Later in the spring the X-ray department, which is directed by Dr. F. S. Ozvegy, installed a Dual Cone Image Intensifier. The only other such instrument has recently been installed in the Victoria General Hospital in Halifax. This addition to the already modern equipment in the department makes X-ray facilities available to the people in this area among the most up-to-date on the continent. In June the first sod was turned for the combined Nurses' Residence and Training School which will cost nearly a million dollars by the time it is fully equipped.

During the spring, the **New Waterford Consolidated Hospital** in co-operation with Civil Defence successfully exercised their "Hospital Disaster plan".

A mock disaster at Mt. Carmel School sent 40 casualties to their hospital for immediate treatment. Within 45 minutes all casualties were efficiently taken care of. The exercise was under the general direction of Dr. Kryzek, head of emergency medical service for the province, who professed himself well satisfied.

Dr. J. A. Roach of the hospital staff, was special speaker on June 27 for the second annual graduation of the **New Waterford Consolidated Hospital School for Nursing Assistants. This** school is the only one in Cape Breton conducting the one year course leading to certification as "Certified Nursing Assistant".

Mayor Russell Urquhart of Sydney looks forward to the day when Sydney has a 300 bed hospital with all the services and facilities available at the V.G. in Halifax. Studies have already been initiated by the Nova Scotia Hospital Commission, Halifax of hospital needs in the Sydney area.

Dr. Kryzek (see above) has become a **Serving Brother** in the Most Venerable Order of the Hospital of St. John of Jerusalem (St. John Ambulance). The 1965 HONORS LIST of the Order, whose Commissioner in Nova Scotia is Dr. C. B. Weld, recently retired Head of the Department of Physiology at Dalhousie, includes the names of **Col J. E. H. Miller,** provincial vice president of St. John Council and divisional surgeon, as being appointed a Serving Brother, and **Dr. Arthur Hines, Dr. Charles Henry Hines,** Cheverie, **Dr. John Burris Reid,** Truro and **Dr. Donald Stirling Robb,** Sydney as having received Priory Votes of Thanks.

Dr. Charles Leon Gass, of Tatamagouche was the only Nova Scotian to receive an Honorary LLD at the special Convocation of Dalhousie, held during the recent

CMA Convention in Halifax. He was also the special speaker and stressed the "doctor-patient relationship" which, he said was the "heart of the medical profession". "Ethos and science of medicine are not mutually exclusive". We must not lose the traditional spirit of our profession expressed in integrity and devotion to the patient as an individual" . . ."There is a growing tendency for the doctor to work within a purely materialistic and mechanistic situation, in which the doctor is merely a technician operating with the aid of modern scientific discoveries." Dr. Gass who served overseas with the RCAMC and practised for over 30 years in Sackville, N. B., graduated from Dalhousie in 1913.

Dr. **David Sherman,** a native of Sydney, Director of Research of the Rehabilitation Institute of Montreal and Specialist in Internal Medicine and Geriatrics was the recipient of the Malford W. Thewlis Award presented at the annual dinner of the American Geriatrics Society held recently in New York City. The award is given to the member who has made outstanding contributions to the Society and its objectives in the field of Gerontology. Dr. Sherman, in 1963, was the first Canadian to be elected president of the 10,000-member society and during the past year served as Chairman of the Board of Directors. Dr. Sherman is chairman of various Canadian associations which deal with the problem of the Aged and has appeared before Parliament to present their case on various occasions.

Dr. **W. D. Stevenson,** Head of the Department of Neurosurgery at the Victoria General Hospital, Halifax, and Associate Professor of Surgery (Neurosurgery) at Dalhousie, was elected head of the Canadian Neurosurgical Society for 1965-66 at the annual meeting of the Society held recently in Halifax.

The Annual Meeting of the Nova Scotia Tuberculosis Association was held in Halifax on May 8. **Dr. J. E. Hiltz.** administrator of tuberculosis control services announced that significantly less new active cases of tuberculosis were reported and also a further decline in reactivated cases. The Christmas Seal campaign totalled $97,336, a record gain.

A research grant of $5,200 was presented to **Dr. Leon Cudkowicz** for the fifth consecutive year; while **Dr. Paul Landrigan,** for the second year received a fellowship grant of $7,000. Both doctors are on the staff of Dalhousie. **Dr. J. J. Stanton** was the guest speaker. Dr. Stanton is provincial administrator of health services. He deprecated the public apathy which makes complete co-operation in tuberculosis testing difficult.

In Toronto, at the annual meeting of the National Tuberculosis Association, **Drs. Hiltz, Helen Holden,** and **J. J. Quinlan** of the Nova Scotia Sanatorium at Kentville advised that lung cancer should also be suspected in every TB patient over 50.

Reports of Meetings:

Canadian Orthopaedic Association

The 21 annual meeting of the **Canadian Orthopaedic Association** was held this year in Halifax.

The president this year was Dr. G. F. Pennal of Toronto and the guest speaker was Mr. H. Osmond-Clarke, president of the British Orthopaedic Association and orthopaedic surgeon to the Queen.

A total of one hundred and twenty-seven orthopaedic surgeons were in attendance. This included several orthopaedic surgeons from the United States.

Prior to the main scientific session, the clinical session was presented at the Victoria General Hospital Nurses' Residence Auditorium. This was in the form of a panel discussion on degenerative hip-joint disease and several clinical presentations. This part of the programme was presented by the Atlantic Provinces Orthopaedic Society.

Among the papers presented at the scientific sessions held at the Lord Nelson Hotel were those dealing with degenerative arthritic conditions in the knee and modern trends in Arthroplastic procedures for these. Dr. D. R. MacIntosh, a former Nova Scotian, now on the staff of the Toronto General Hospital presented a series of excellent results of arthroplasty of the knee in rheumatoid arthritis.

Mr. H. Osmond-Clarke discussed the problem of recurrent dislocation of the shoulder and showed an excellent film and technique of the Putti-Platt repair for this lesion.

Dr. Paul Harrington of Houston, Texas, the orginator of the Harrington method of correction of the spine for scoliosis, also presented an excellent paper showing the results of the use of his method. It was emphasized by several speakers that the problem of scoliosis is probably better managed by an assessment and treatment of the condition in special Scoliosis Clinics.

Other papers presented were those dealing with the subject of spinal fusion for degenerative disk disease and spondylolisthesis, the management of certain foot problems in children particularly the congenital club foot.

An audio visual programme was also presented as part of the meeting.

In his presidential address, Dr. Pennal emphasized the necessity of the Canadian Orthopaedic Association working in close co-operation with other under graduate and post graduate institutions to increase the number of orthopaedic surgeons in the country. This would require utilization of all possible training centers and he emphasized the determination of the CAA to work with the

medical schools and establish training centers for the training of an increasing number of orthopaedic surgeons.

The delegates to the convention were welcomed by Mayor Vaughan and Premier R. L. Stanfield. The guest speaker for the Presidential dinner ws Mr. Hugh MacLennan, well known Nova Scotian born author, and the final day saw the Minister of Health, Mr. Donahoe present the "Order of the Good Time" to Mr. Osmond-Clarke.

Section of Salaried Physicians

The report in the Press notwithstanding, the general meeting of the section held in the Fundy Room of the Nova Scotian Hotel on June 15th did **not** have as its principal topic a push for pay increases. The main field of interest was the feeling that the interests of salaried physicians deserved more attention both by CMA and The Medical Society than they have in the past, and a request was made to the Executive that this be brought up at CMA general Council. Other matters discussed included postgraduate education for the group, and the professional and economic standing of salaried physicians both within and without the profession.

COMING MEETINGS:

WORLD CONGRESS ON DIABETES IN THE TROPICS BOMBAY JANUARY 20-22 1966.

For further information write Organising Secretary, Dr. N. G. Talwalkar, Maneckji Wadia Bldg. Mahatma Ghandi Rd., Bombay, 1.

TENTH CONGRESS OF THE PAN-PACIFIC SURGICAL ASSOCIATION

Part 1 - September 20-28, 1966 in Honolulu, Hawaii.

SECOND MOBILE EDUCATIONAL SEMINAR:

Part II - September 28 - October 10, 1966 in Japan and Hong Kong.

Part III - September 28 - November 1 1966 in Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia and New Zealand.

For further information write: Pan-Pacific Surgical Association, Room 236, Alexander Young Bldg., Honolulu, Hawaii 96813.

COLLEGE OF GENERAL PRACTICE OF CANADA:

Provincial Chapters of Nova Scotia, New Brunswick and Prince Edward Island.

October 11 and 12, 1965 - Charlottetown, P.E.I.

Fuller details in September Bulletin.

BIRTHS

To Dr. and Mrs. N. H. Andrews (née Evelyn Hartling), on June 20, 1965 at the Winnipeg General Hospital, a daughter, Cynthia Lindsay.

To **Dr. and Mrs. C. Bernard MacLean** (Jean Weiburn), at St. Rita's Hospital, Sydney, a daughter, Heather Joan. (Halifax paper, July 5, 1965)

OBITUARIES

Funeral services were held recently in Philadelphia, for **Dr. Norman M. MacNeil,** a native of Grand Narrows, Cape Breton. Dr. Macneil, brother of Dr. Malcolm F. MacNeil, Massachusetts industrialist, was a graduate of St. Francis Xavier University, and entered Jefferson Medical College in 1912. He served as Captain with the Canadian Army Medical Corps in World War 1 and from 1920 until his retirement four years ago, was on the staff of Jefferson, and at the time of his death was honourary clinical professor of Paediatrics at Jefferson Medical College Hospital, and retired chief of Paediatrics at Nazareth Hospital. In 1961, he was named Doctor of the Year by the Federation of Catholic Physicians Guild of the United States.

ADVERTISER'S INDEX